First-tier Tribunal Care Standards

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

[2022] 4785.EA
Neutral Citation Number: [2023] UKFTT 1066 (HESC)

Hearing at Royal Court of Justice at the Strand
Heard on 25 –28 July 2023 and 20-23 November 2023, and 24 November 2023 deliberation in the absence of the parties

BEFORE
Tribunal Judge Daley
Specialist Member Mr. M Cann
Specialist Member Mrs. D Forshaw

BETWEEN:

UK International Nursing Agency Limited

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Application

1. This is an application brought by the Appellant UK International Nursing Agency Limited ("The Provider") to appeal against the decision of the Care Quality Commission ("the Commission") dated 9 November 2022.

2. The application is dated 7 December 2022 and is brought on behalf of the agency by their solicitors Stephenson Solicitors LLP, against the Commission's decision to cancel the registration of The Provider to carry out the regulated activities of providing accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury.

3. The reasons for the decision for the refusal were set out in the NOD which are that -:

- The organisation had not demonstrated that relevant training with regard to safeguarding was kept up to date. The agency failed to investigate or report an

incident whereby a service user suffered a serious injury, Regulation 13 (Safeguarding) of the Health and Social Care Act 2008.te The CQC report raised concerns about your food preparation and storage areas. It was highlighted that The Agency failed to ensure that staff had undertaken appropriate training in food hygiene.

- Concerns were raised regarding lack of appropriate risk assessments and the failure to consistently carry out assessments under the Mental Capacity Act (MCA) 2005. A service user B was noted to be in an environment where hazards were evident. There was no evidence that a risk assessment had been carried out to understand whether Service User B had capacity to consent to living in a hazardous environment.
- The provider failed to ensure universal masking was observed.
- There was a failure to ensure that deep cleaning was taking place and the CQC observed areas that were in an unsanitary state. Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008.
- The provider failed to ensure that adequate pre-assessments were carried out, in that information was taken from the discharge team rather than a holistic assessment involving service user and their families.
- The provider failed to follow a prescribed rehabilitation plan for a service user who had suffered a stroke. Further there was a failure to provide appropriate equipment to enable the service user to make use of their showering and bathing facilities.
- Staff of the provider were heard to speak to service users in harsh tones, there was a failure to ensure appropriate advocacy for service users who required such support.
- Personal care was not always provided in line with the preference of service users and was not always given by considering the gender preference of the service users.
- There was a failure to assess the risk of social isolation for service users who were cared for in bed Regulation 9 (Person -centered care) of the Health and Social Care Act 2008.
- There was a failure to obtain appropriate consent or consult service users regarding CCTV, or to carry out Mental Capacity Assessments(“MCA”) or best interest assessments.
- MCAs and best interest assessments were not recorded as decision specific Regulation 11(Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
- There was a failure to learn from incidents and accidents at your service such as when a service user sustained a deep muscle injury. The relevant funding authorities were not informed about serious concerns raised by CQC following the inspection. Regulation 20 (Duty of Candour) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
- The CQC considered that the service operated a closed culture due to lack of effective training of staff and abusive behaviour towards service users. The use of labelling language and no partnerships with appropriate health organisations, lack of understanding of MCA principles which led to denying service users access to property and threats to destroy property. Regulation 17 (Good governance) of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

The Parties

4. The Appellant is a company registered with the Respondent as the registered provider to provide regulated activities of accommodation for persons who require nursing or personal care: personal care and treatment of disease, disorder or injury.

5. The Respondent is the CQC, the independent regulator of all health and social care services in England. Under section 3 of the Health and Social Care Act 2008 (HSCA 2008) the Respondent's objectives are to protect and promote the health, safety and welfare of people who use health and social care services. Under Regulation 8 of the Health and Social Care Act 2018 (Regulated Activities) Regulation, the respondent is under a statutory duty to ensure that the provider complies with the fundamental standards of care (The Standards). The CQC is also tasked with protecting the interests of vulnerable people including those whose rights are restricted under the Mental Health Act.

Attendance

6. In attendance on behalf of the Appellant was Ms. Collette Renton - Counsel, and on behalf of the respondent, Mr. Oliver Connor- Counsel. Also in attendance was Ms. Winifred Mbieli- Solicitor for the Respondent.

7. As witnesses on behalf of the Appellant were Dhanwati Ramdarass Registered Provider, Lalita Pradhan Clinical Nurse Manager, Mary Chege Health Care Assistant, Vasantkumar Patel, Deputy Manager. In attendance on behalf of the Respondent were Catherine Perrins CQC Inspection Manager, Noemi -Eszter Traian CQC Inspector, and Gareth Page CQC Inspector.

Preliminary Issues

8. While reading the bundle two members of the Tribunal had become aware that both Ms. Ramdarass and Mr. Benson Idun were registered nurses and that the CQC had made a referral to the NMC. Both Judge Daley and Mr. Cann declared an interest in that they both performed roles for the Nursing and Midwifery Council. However, neither had knowledge of either registrants' referral. As such if the matter came before them in their roles in the NMC they would recuse themselves.

9. Neither Mr. Connor nor Ms. Renton made any objection to the case being heard by the Tribunal as constituted.

Reporting Restrictions

10. The Tribunal decided to make an order that there shall be a Restricted Reporting Order under Rule 14(1) (b) of the a. Tribunal Procedure Rules (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 ('the 2008 Rules')

prohibiting the publication (including by electronic means) in a written publication available to the public, or the inclusion in a relevant programme for reception in England and Wales, of any matter likely to lead members of the public to identify any service user or their family member mentioned in the appeal.

Late Evidence

11. At the start of the hearing the Tribunal heard an application under rule 5(3) of the Tribunal Procedure rules to permit the appellant to introduce further evidence, in the form of a witness statement of Mr. Marc Amron, who had been recruited as the new manager of the service, commencing on 3 July 2023. The Tribunal heard from Ms. Collette Renton on behalf of the Provider, she referred us to the Application notice to admit the evidence of Mr. Marc Amron, the proposed registered manager.

12. We were informed that the reason for the late application was that there had been a change of representation for the Appellant. Ms. Renton stated that Mr. Amron was an integral part of the business. He was able to present a forward-facing view of the business. The Appellant was intending to call him to give evidence. The Respondent did not object as it considered his evidence to be relevant.

13. We decided to admit the statement of Mr. Amron.

14. In relation to all of 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, on the grounds that the late evidence provided up-to-date information concerning the provider and it was in the interests of justice that the Tribunal was able to consider all of the relevant information before making our decision.

15. Ms. Renton also made an application for a reference from Ms. Beard to be admitted. She told the Tribunal that the reference of Ms. Beard had been sent to the Tribunal and the respondents. She told us that the reference relates to service user B, who was related to Ms. Beard. She had visited with patient B during the time B was cared for. Ms. Renton told the Tribunal that it was a reference and as such was not signed with a statement of truth.

16. She submitted that it was relevant, however, Ms. Beard could not attend to give live evidence and as such the evidence would be untested. She also stated that she did not know why the reference was so late, she believed that Ms. Beard offered to give this reference late in the day.

17. She told the Tribunal that Mr. Connor had been sent a copy as soon as it had been available.

18. Mr. Connor objected to the reference which he stated was an unsigned witness statement. He said that Ms. Renton had made sensible concessions. He submitted that the reference lacked provenance. There was opinion evidence and

questions of whether she was qualified to speak on the matters that she referred to which involved questions of whether regulations had been breached. There was no information about how often she visited Service User B or how long she stayed. Further she was not available to give evidence by cross examination. He submitted that although the Tribunal would be able to place the appropriate weight to the statement, he considered that the Tribunal ought not to give the reference any weight.

19. The Tribunal decided that it would not decide this matter, at this stage, but would hear evidence from other witnesses and then decide on whether the reference was relevant, and whether it ought to be admitted, once the relevance of the statement became clearer.

20. On the resumed hearing on 20 November 2023, following evidence from the Appellant's witnesses, the Tribunal decided on 21 November 2023 to admit the reference which was signed but undated into evidence. The Tribunal also decided that it was appropriate to admit into evidence the following documents-:
    a. Personal Reference – Marc Amron TLC Care from Paavan Popat dated 17.11.2023
    b. Reference from prospective occupant "Relative A dated 17.11.2023 headed "To whom it may concern".
    c. NVQ certificate

Background

21. The Appellant is a limited company, UK International Nursing Agency ("the Provider") was registered by the CQC as a provider in respect of regulated activity accommodation for persons who require nursing or personal care, and prior to that on 25 January 2011 for regulated activities for Personal Care and Treatment of disease, disorder or injury at UK International Nursing Agency Limited Mayapur House 2A Station Road Radlett Hertfordshire ("the service/home").

22. UK International Nursing Agency Limited Dom Care is registered to provide accommodation for up to seven people who may require nursing and/ or personal care. It is also registered to provide personal care to people living in their own home, although at the time of inspection no one was in receipt of personal care in the community.

23. Mayapur House ("The Home") offers accommodation on two floors. The home had dining and communal living space for people to spend time together. Some bedrooms had en-suite facilities with shared bathroom and toilets available.

24. On 18 May 2022 Noemi Traian inspector from the CQC carried out an inspection at UK International Nursing Agency. On 20 June 2022, Ms. Traian and Mr. Gareth Page returned to the service for a second day of the inspection. During the inspection serious breaches of the regulation were found.

25. A Notice of Decision ("NOD") was issued on 9 November 2022 which, required the written consent of the CQC for the Provider to admit any new service users.

26. On 16 August 2022 the CQC issued a Notice of Proposal to cancel the Providers registration.

27. The Provider lodged written representation against the Notice of Proposal on 15th September 2022 along with 49 appendices which set out the Provider's response. On 9 November 2022, a Notice of Decision (NOD) was issued, which rejected the Provider's representations of 15.09.23 on the basis that the provider had not demonstrated that the CQC's concerns had been adequately addressed. The CQC decision was that the provider was carrying out a regulated activity in a manner which was not in accordance with the relevant requirements.

28. The notice set out that the CQC proposals identified the following breaches which demonstrated that the provider was not meeting the following Regulations-:
    a. Regulation 9 (Person-centered care) H & SCA 2008 and Regulated Activities("RA") Regulations 2014
    b. Regulation 11 (Need for consent)
    c. Regulation 12(Safe Care and Treatment)
    d. Regulation 13 (Safeguarding) of service users
    e. Regulation 17 (Good Governance)
    f. Regulation 18 (Staffing)
    g. Regulation 20 (Duty of Candour)

29. An appeal was lodged by the Provider on 2 December 2022 and a further inspection by the CQC took place on 4 January 2023, the CQC. A telephone case management hearing was held on 25 January 2023. Directions were given and a further CMC was listed for 25 May 2023. On 9 March 2023 the matter was listed for a hybrid hearing for 4 days commencing on 24 July 2023.

Legal Framework

30. The Health and Social Care Act 2008 ("the Act") and the Health and Social Care Act (Regulated Activities) Regulations 2014 ("the Regulations").

    Section 26 of the Health and Social Care Act 2008 sets out that except where it makes an application under section 30 or gives notice under section 31, the Commission must give any person registered as a service provider or manager in respect of a regulated activity notice in writing of a proposal—

    (a)to cancel the registration (otherwise than by virtue of section 17(2) or in accordance with an application under section 19(1)(b)),

    (b)to suspend the registration or extend a period of suspension,

    (c)to vary or remove (otherwise than in accordance with an application under section 19(1)(a)) any condition for the time being in force in relation to the registration, or

    (d)to impose in relation to the registration any additional condition.

31. The Commission may at any time cancel the registration of a person ("R") under

this Chapter as a service provider or manager in respect of a regulated activity— (i) on the ground that R has been convicted of, or admitted, a relevant offence; (ii) on the ground that any other person has been convicted of any relevant offence in relation to the regulated activity (iii) on the ground that the regulated activity is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements; (iv) on the ground that R has failed to comply with a requirement imposed by or under Chapter 6 v. on any ground specified by regulations.

32. Section 32 provides for Appeals to the Tribunal: An appeal against- any decision of the Commission under this Chapter, other than a decision to give a warning notice under section 29 or 29A, or an order made by a justice of the peace under section 30, lies to the First-tier tribunal No appeal against a decision or order may be brought by a person more than 28 days after service on the person of notice of the decision or order. On an appeal against a decision of the Commission, other than a decision to which a notice under section 31 relates, the First-tier Tribunal may confirm the decision or direct that it is not to have effect. on an appeal … the First-tier Tribunal may confirm the order or direct that it is to cease to have effect. On an appeal against a decision to which a notice under section 31 relates, the First tier Tribunal may confirm the decision or direct that it is to cease to have effect.

33. On an appeal against a decision or order, the First-tier 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, to direct that any such discretionary condition is to cease to have effect, to direct that any such discretionary condition as the First-tier Tribunal thinks fit shall have effect in respect of the regulated activity, or to vary the period of any suspension.

34. The Tribunal was provided with a Scott Schedule which set out the parties' responses on each of the alleged breaches of the care standards

The Issues

35. We identified the following issues-:
    a. Whether there were breaches of the domains as set out in the NOD
    b. Whether the CQC had acted proportionately in serving the NOD
    c. Whether the circumstances at the date of the hearing had changed so that the decision reached to serve the NOD was no longer proportionate and the appeal ought to be allowed.

The Hearing

36. We considered all the evidence that was presented in the hearing bundles which comprised 3938 pages, and the oral evidence and additional documents

including written submissions at the hearing. We have summarized the evidence insofar as it relates to the relevant issues before the Tribunal. We have not set out to repeat the evidence verbatim.

37. The hearing was conducted over 8 days with a day in chambers for deliberation. As this was an appeal of the Notice of Decision dated 9 November 2022, we heard this matter afresh. We were reminded that the burden of proof was with the Appellant the Provider. However, the CQC took the Tribunal through the decision, through the findings set out in the inspection by the CQC inspectors and the decision-making process used by the CQC decision makers, in reaching its decision to issue the Notice of Decision.

38. We also heard about the process which was followed to issue the NOD, and the information that the inspectors obtained either by way of the inspection on 3 January 2023, or because of any information obtained after the inspection or because of information obtained from the appellant the Provider. We heard from the following witnesses on behalf of the CQC Ms. Perrin, Ms. Traian and Mr. Page.

Ms. Perrin CQC Operations Manager

39. The Tribunal heard from Ms. Perrins by video link, her statement consisted of 10 pages and was dated 10 March 2022, she had signed and read the statement and she confirmed that the statement was accurate and true. She told us of the circumstances which led to the NOD being served.

40. Ms. Perrins set out that her role at CQC was Operations Manager. She had held this position since the beginning of April 2022. Prior to that she was an inspection manager and had been one for 9 years. She was first involved with the service provider, when she started in her role.

41. In her statement she set out that she was employed as an inspection manager with CQC. “A post I have held for 9 years. I work predominately in the Hertfordshire area regulating adult social care services. My main responsibilities are:

- Maintaining oversight of the risks and issues and managing the inspection programme within my area.
- Having oversight of civil and criminal enforcement action. Contributing to decision making in relation to enforcement and other regulatory action following the appropriate decision making and methodology.
- Ensuring decisions are subject to the appropriate level of authorisation within CQC in line with policy and the scheme of delegation.
- Managing a team of inspectors.
- Working with internal and external partners to maintain a system view of the risks and issues and to inform quality improvement priorities.

41. We were told that a virtual assessment had been undertaken which flagged up concerns, that the CQC needed to do an inspection and site visit.

42. A site visit took place on 18 May 2022. Following the inspection on that date, the inspector Ms. Traian was unable to conclude the inspection as there was some information outstanding from the provider, concerning fire safety and further action that the manager needed to take in relation to food hygiene. There was also a proposal that an inspection from an Environmental Health Officer needed to take place.

43. Ms. Perrins told us it was usual to conclude a site visit in one day. Given the size of the provision the CQC considered that it was proportionate to allow the registered manager to carry out certain action and to provide the information requested prior to the second visit which was organised for June. Following the second day of inspection, it became apparent that some of the things the Registered Manager said he would do in May 2022 had not been carried out. In addition, there were further concerns which came to light during the inspection. Ms. Perrins stated that the concern was significant enough that the threshold might have been met for a management review to be carried out with a plan of action.

44. A decision was made to serve a letter of intent to inform the provider that the CQC were thinking of taking enforcement actions.

45. Ms. Perrins told us that the CQC wanted to avoid Section 31 (of HSC Act 2008) enforcement action. However, the Appellant was unable to provide sufficient reassurance, so given this, the decision was made to restrict the admission of further residents to the provision. One of the conditions was to submit information to the CQC, however the Appellant did not comply with that condition. She told us that this was really concerning as the conditions at the premises, in relation to fire hazards posed significant risk to people's safety.

46. Ms. Perrins stated that the provider did not appear to understand the severity of the risk, or how they could take action to ameliorate that risk. She was also of the view that they also did not understand the regulations, enforcement action or their role as registered person to comply with their registration. Accordingly, the decision was taken to serve the NOP to cancel the registration.

47. The provider made representations against the notice and set out that improvements had been made. Following consideration of the representations, the decision was confirmed. The provider appealed to the Tribunal against the service of the notice. Following this the premises were re-inspected in January 2023.

48. At the time of the inspection the LA was in the process of finding alternative accommodation for the residents. Ms Perrins told us that the CQC would not want to cancel a registration unless it was the right and proportionate thing to do. However, despite the gaps between the inspections there were still significant concerns even though there was only one resident. The concerns centered around mental capacity, safeguarding and personal individualized care. There were insufficient plans in place to continue to make improvements.

49. In answer to questions from Ms. Renton, Ms. Perrins explained the scheme of delegation within the CQC. In line with the scheme of delegation, enforcement

notices were signed off by her line manager. The two inspectors fed their findings back to her, and it was her decision as to whether to call a meeting or refer the matter to her manager. She made this decision by applying the CQC enforcement policy.

50. Ms. Perrins was asked about the further concerns that she stated had been identified at the inspection in June. She told us that some of these were a continuation of concerns which had been raised at previous inspections however the concerns were now more widespread.

51. In paragraph 58 of her witness statement Ms. Perrins stated as follows-: "On 29 June 2022 18:22 I received an email from Noemi Traian after she had reviewed information sent to her by the registered manager along with information seen on the inspection visits." Noemi Traian stated that she was particularly concerned about the punitive approach to care and infringements of people's human rights.

52. She explained that she considered that the seriousness of the failings in addition to the concerns raised by information sent by the Registered Manager on 29 June 2022 met the threshold for the CQC to consider urgent enforcement action to keep service users safe from harm. She said agreed [with Ms. Traian] that they needed a management review meeting to review the inspection findings and the level of risk. This was to determine what action was needed by CQC as she felt that the information they had and the lack of any robust response from the registered manager to show an understanding of the actions needed to be taken had increased the level of risk to people using the service."

53. Ms. Perrins was asked whether concerns were identified during the inspection on 28 June 2022 which had not been raised at the early May visit. She was asked by Counsel whether these were new concerns or concerns which had not been picked up at the earlier inspection because the focus of the inspection had changed on the second visit. Ms. Perrins stated that she could not say whether those things happened between May and June, or whether they existed at the time of the May inspection and had not been picked up.

54. She stated that she considered that some of the matters were not new and were a lack of response to risk identified. However, some of the matters were new risks identified.

55. Ms. Perrins stated that these would have included "broken promises" and further issues in leadership and governance of the provider.

56. Mrs. Perrins was asked about the role of the manager Mr. Alex Banson- Idun and whether the CQC had been communicating with the nominated individual, Mrs. Ramdarass. She explained that there had been an opportunity for the nominated individual to be present during the inspections.

57. In her witness statement at paragraph 21 she set out that-: "Noemi Traian and Gareth Page explained their concerns that Service User B's mobile phone and tablet were being taken away from them by the Registered Manager and they

were denied access to use them. Noemi Traian and Gareth Page explained that recordings they had seen in daily notes, which evidenced that Service User B was not being given these items back when she is asking for them and was being refused support to go out. This concerned me as it demonstrated a poor understanding and approach from the leadership of the service." As a result, a letter of intent was sent to the service provider on 30 June 2022.

58. There was a further management review meeting held by CQC on 1 July 2022 to review the service providers response. Ms. Perrins was asked about the Action Plan which had been produced by the provider and whether this had given the CQC the assurances that they needed. Ms. Perrins stated that the Action Plan had been a start, however part of the plan was vague, which meant that for example where the Action Plan referred to care plans, the Action Plan simply stated that 'care plans were in place'. Ms. Perrins considered that it was not enough simply to say plans in place. She did not accept that the Action Plan was robust.

59. In her statement Ms. Perrins set out that -: "…Due to widespread nature of the concerns, the significant concerns about the management and leadership of the service and the lack of robustness in the response to our urgent enforcement action we concluded that a Notice of Proposal to cancel the provider's registration was the proportionate and appropriate course of action. We did not consider that there were any other conditions that we could impose on the provider's registration or warning notices or any other regulatory response that was appropriate to the level of risk or that would lead to sufficient improvement. In addition, we agreed that a referral to the Nursing and Midwifery Council (NMC) for provider and Registered Manager in relation to their failings to adhere to the professional standards of safe nursing practice evidenced by the restrictive and punitive approach to caring for people and a referral to HMRC for potential financial irregularities should also be made. The decisions of the Management Review Meeting were approved by Louise Broddle as Head of Inspection in line with CQC's Scheme of Delegation. Following the Management Review Meeting Noemi Traian commenced work on drafting the Notice of Proposal to cancel the providers registration…"

60. Ms. Perrins was asked about the representations which were sent following the NOP. She stated that representations are considered by a different team. She told us that the NOP did not become a notice of decision until after 28 days. This gave the provider the opportunity to put in their representations and another opportunity to tell us what they have done and provide evidence of improvements. If it had been deemed that sufficient improvements had been made representations might be upheld.

61. Ms. Perrins was asked about the systems which had been put in place, and whether the provider could demonstrate that appropriate systems were in place when there was only one resident. She did not accept that there was a practical difficulty in demonstrating the effectiveness of the systems with only one resident.

62. Ms. Perrins was of the view that the service of the notice was an appropriate

and proportionate response.

Ms. Noemi Traian - former CQC Inspector

63. Ms. Traian had provided two witness statements. She informed us that she wished to update the statements as she was no longer employed by the CQC although she worked on their bank as an inspector. She set out details of her background and qualification

The inspection history of the service

64. In her statement she set out the inspection history of the home which provided information that on 22 and 30 January 2015, an inspection was carried out and breaches of regulations 9,10, 11,13,15, 18, 20 21, 22 and 23 of the H & SC Act 2008 and Regulated Activities Regulations 2010 were found. The overall rating of the home was that it was inadequate.

65. A follow up inspection was carried out on 16 July 2015 to check what improvements had been made. The inspection noted breaches of regulations 17 and 18 and the home was rated as requiring improvement but was identified as inadequate in respect of being well-led. A focused inspection was carried out on 3 February 2016 where the home was found to require improvement overall but was rated good in being safe and responsive and requiring improvement in being effective and well led. No breaches of the regulations were identified.

66. A comprehensive inspection was carried out on 2 October 2017, the service was rated good overall, but requiring improvement in response to people not always being supported to lead an active and fulfilled life.

The May 2022 Inspection

67. Ms. Traian explained that she conducted the inspection of Mayapur House on 18 May 2022. She told us that when she visited, the registered manager had been working within the numbers of staff, he had been administering medication. On arrival she had noted three people chatting inside the home without wearing masks. (This was a requirement at that time due to the Coronavirus Pandemic). In paragraph 25 of her witness statement, she set out that “Very early in the inspection I identified several concerns, these were in relation to cleanliness of the kitchen, fire risk, environmental health and safety risks, lack of personalized care and infection control risks.

68. She stated that the registered manager told her that the kitchen and food preparation area had not been inspected by Environmental Health since the service registered in 2010. She was also concerned that Mr Banson-Idun (the registered manager) and Mrs Dhanwati Ramdarass, (registered provider) had failed to act in response to an independent fire risk assessment carried out in 2019.

69. As a result of the inspection and her concerns, she decided that she should clarify these concerns with other regulators; such as the Fire Safety Authority and Environmental Health. She also decided to ask Mr Page to accompany her

on the second visit, as she had identified that some residents had mental health needs. This was Mr Pages area of expertise, he also had previous experiences with the service.

70. Ms. Traian contacted the registered manager on 19 May 2022 and organised verbal feedback. The manager, Mr Banson-Idun, informed her that they had a visit from Environmental Health and had arranged for an external fire risk assessment on 10 June 2022. As a result of the reassurance that she had received she decided to carry out the further inspection after the fire risk assessment.

71. As a result of this second visit on 28 June 2022 she had further concerns around the areas of safeguarding, staffing and managing risk. Ms. Traian also had concerns around personal care, however she told us that "to be proportionate I could not look at all the areas of personal care as I wanted to finish the inspection".

72. Ms. Traian then analyzed evidence on 29 June 2022 and as a result it became clear to her that there were major failings. The procedure that she followed was that she then requested a meeting with her manager Ms. Perrins to discuss the matter further. It was her opinion that the urgent action threshold had been reached. She stated that she measured the level of risk, to establish if the risk was high or very high by completing a decision-making tree. If the risk was high or very high, the decision-making tree set out what to do next. In this case it was to arrange a management meeting to present evidence to the panel.

73. Her evidence centered on potential breaches of the Regulations, in relation to 12 (Safe Care and Treatment), 13 (Safeguarding), and 17 (Governance).
She told us that on 30 June, due to the major breaches which had been found, a decision was made to initiate a section 31 procedure.

74. In her statement she set out that on 1 July 2022 a response was received to the Section 31 letter from the registered manager, and that she organised a management review meeting with Inspector Gareth Page, Inspection Manager Catherine Perrins and Lynda Higgins, Head of Inspection Louise Broddle and legal colleagues from the CQC.

75. Following this meeting a Notice of Decision was sent on 1 July 2022 together with written feedback about the inspection. One of the conditions imposed was for the provider to give a written weekly update to CQC on the first Monday of each week commencing on Monday 4 July detailing actions taken in relation to the conditions that were imposed.

76. The conditions were that "...1.The registered provider must not admit any service users to Nursing Agency Limited Dom Care without the prior written agreement of the Care Quality Commission. This includes service users requiring respite, short-term or emergency admissions and any re-admissions from hospitals or treatment centres of service users who have previously resided at Nursing Agency Limited Dom Care. 2. The registered provider must review 11 July 2022 all restrictions in place for every service user to ensure

these are the least restrictive option. This review to be done in line with the Mental Capacity Act 2005 principles and Deprivation of liberty safeguards requirements. This must include people who are being supported in bed. 3. The registered provider must develop a plan for each service user with restrictions applied to their liberty to evidence how to staff and the management in the service is actively working to safety minimize the impact of these restrictions on people. These plans to be in place by 11 July 2022. 4. The registered manager must ensure multidisciplinary teams' referrals are considered and made as necessary, include all relevant health professionals needed…5. The registered provider must increase staffing numbers to ensure sufficient staffing levels day and night for a safe and timely evacuation in case of a fire until such time as the fire doors have been replaced. In addition, the registered provider must assess the risks and take any other action to mitigate the risks of fire. 6. The registered provider must provide a written weekly update to CQC on the first Monday of each week commencing on Monday 4 July detailing actions taken in relation to Condition 2,3,4 and 5…"

77. Ms. Traian stated that she was not reassured by the response to the Section 31 letter, the provider should have been complying with the letter on the same day. On 3 July 2022, on Sunday Ms. Ramdarass, asked for an extension to comply as she was due to commence jury duty.

78. Ms. Traian said that she opened the email on Monday, she contacted the registered manager. She spoke with the registered manager, Mr Alex Banson Idun and told him that he had to comply by Friday. Alex said he had complied and that he was expecting to increase the staffing as necessary due to the identified fire risk.

79. Ms. Traian stated that: "On 5 July 2022, my manager Katherine Perrins sent an email asking for urgent assurance that the provider had been complied.
On 6 July the provider sent us confirmation of agency bookings so we could see staffing numbers had increased.
Increase of staffing meant they could safely evacuate the building in case of a fire, risk mitigated from extreme to high."

80. In paragraph 46 of Ms. Trian's witness statement she stated-: "…The registered manager sent an updated action plan to me and Gareth Page via e-mail on 11 July 2022. The action plan was of poor quality, lacked detail and had no reference about how the provider was planning to oversee the improvements. For example, the action plan detailed that the registered manager obtained a dependency tool to calculate staffing and they were planning to complete this to ensure their staffing was based on service users' needs. When Gareth Page asked for this to be sent to us, the registered manager responded that they did not have the dependency tool but were trying to get one. They also detailed in the action plan that they discontinued the Care Programme Approach for Service user B because of the restrictions applied, however they have not detailed what approach they were adopting and how they were positively managing support for service user B. All the improvement actions had been attributed to the registered manager except for one action involving the arrangements for fire doors to be replaced which was attributed to the provider. I felt that given the

concerns identified Mrs. Ramdarass should have been more involved to ensure the improvements were made and sustained."

81. In her evidence, Ms. Traian referred to the action plan which was produced following the inspection on 28 July 2022, which the registered manager had completed. She stated that this showed that he did not understand what the CQC wanted him to do. For example, Ms. Traian stated that the action she would have expected was that he should have reviewed all the mental health capacity assessments to see if they were the least restrictive, which were proportionate. She stated that at the inspection it was noted that service users were not going out, some were in bed socially isolated. The mental capacity assessments which had been carried out were not in line with the Mental Capacity Act. The assessments did not record the questions asked, were general, and every service user had the same restrictions in place with no variations. Ms. Traian stated that she had expected him to "tell us that he had plans for these reviews to take place and provide information on where support was needed from external professionals." Rather than to merely state that he had completed all the assessments.

82. The CQC was not asking them to develop personalized plans but if there was a concern of someone lacking capacity, for example where a service user was distressed at personal care, there should have been a plan "to minimize anxiety, understanding their distress". For example, if they identified one staff member was better at meeting needs of a particular service user, where possible there should have been a plan to have that member of staff meet those needs. Ms. Traian stated that she did not believe it was realistic to change all the plans within 7 days. She stated that it was "Just not possible to have done it within that time frame".

83. In cross examination, Ms. Traian was asked about the improvements which had been made by the provider, Ms. Renton referred her to the fact that there were matters which had been identified in the June inspection and not in the May report. She asked Ms. Traian whether it was realistic for the appellant to have made improvements in the time scale.

84. Ms. Traian stated that she would have expected am immediate response to the Notice to Improve. Given that a date for the action plan was the 11 July 2022, the CQC would have expected the plan to detail compliance. The immediate action required was restricting admissions and increase staffing. She noted that Ms. Ramdarass asked for an extension to complete this action.

85. She told us that "…On the Monday when we spoke with the registered manager, he had not increased staffing. Service users were at risk in the event of a fire. He stated he had tried to book agency staff and was unsuccessful, on 4 July 2022. No confirmation of staffing increase was received until the 6 July 2022".

86. In answer to questions from Ms. Renton she agreed that the Appellant had provided updates which complied with the Mental Capacity Act on 7 December 2022. She also agreed that the care plan produced for Service User A, had

been completed however she did not agree that it had been updated appropriately by listing all the actions she would have expected.

87. She accepted that training had been undertaken however she questioned the amount of training which had taken place, in such a short space of time.

88. Ms. Renton went through each of the regulations and the actions that had subsequently been taken by the Appellant for example the kitchen improvements, and the kitchen hygiene measures and the action on the fire inspection. She referred to the fact that the provider had accessed external support, she referred to the referral made to Elizabeth Griffiths community advocate, on 10 November 2022.

89. Ms. Renton also referred to the fact that the overall governance and leadership had improved. Ms. Traian agreed that whilst there had been changes, the CQC was not just concerned with the registered manager Mr Banson- Idun who left the service by November 2022, but the concerns about leadership which went further than the registered manager. She stated of Mr Patel that the registered manager should have a clinical background, or if not, there should have been a clinical practitioner. Ms. Traian stated that the Nominated Individual may have a clinical contractor who provided this role. There had been a lot he was planning to do, but Mr Patel needed to be tested as to whether he was suitable for the position of registered manager.

Gareth Page CQC Inspector

90. He informed us that he was an inspector of The Care Quality Commission ('the CQC'), He confirmed that his two witness statements were true.
He told us that "Prior to working at the CQC, he had worked as a support worker, deputy manager then manager and area manager in health and social care settings since 2002. In his statement he set out that-: "My roles have included managing residential substance misuse services, working with a broad range of service users including mental health."

91. He confirmed that the reason for his being asked to accompany Ms. Traian was his previous experience with the provider and the details of the regulatory inspection of the provider.

Inspection on 28 June 2022

92. In paragraph 33 of his first witness statement, he set out as follows-: "33. During our visit on 28 June 2022, I reviewed overall governance and managerial oversight with Alex Banson-Idun. I ask for a copy of the overall service improvement plan. This is a document which encompasses all the actions arising from internal audits, reviews, assessments, feedback etc. It is used as a tool to identify improvements and monitor developments in a timely way. Alex Banson-Idun in response says, "Enlighten me, what do you mean." I explain once more, and he then provides me with a copy of "The Blue Cross Mark of Excellence – Quality Management System - Royal Nursing Home Association." I note this was last completed in March 2022 and due again in March 2023. This audit tool was

a self-assessment completed by Alex Banson-Idun. I noted across every domain, he had assessed the quality of care as 100%. This indicated that Alex Banson-Idun had assessed the quality and safety of their service at that time as compliant. This audit tool had not been updated following concerns raised from the first inspection regarding for example fire safety or food safety."

93. Mr Page looked at the fire safety compliance, and although he was satisfied work had been undertaken, he was concerned that staff had not undertaken Fire Marshall training. He spoke to the manager who informed him that the provider was awaiting training from Hertfordshire Care Providers Association ("HCPA") to contact them. However, on Mr Page contacting HCPA on 28 June 2022, on the following day,29 June 2022, HCPA responded to state there had been no engagement for training.

94. In his witness statement he confirmed that one other observation was that in respect of the training records, he noted that where staff had undertaken training a number of units of training occurred on one day. In one instance, a member of staff on 4 December 2020 had completed; practical basic life support, moving and handling, IPC, fire safety, safeguarding, mental capacity and deprivation of liberty safeguards, equality and diversity, complaints management, information governance, lone working and health and safety.

95. Mr Page stated that on his visit, he reviewed mental capacity of service users. At that stage there were five service users. He stated that two were cared for in bed but had capacity, two had deprivation of liberty orders and one who had capacity was not allowed out in the community on her own. The inspectors were concerned that all the service users were treated the same, and that one service user had had her phone and tablet taken from her although she had capacity.

Allegations of Closed Culture and Service Users A & B

96. In paragraph 28 of his witness statement Mr Page stated "The registered manager told us that this person was able to leave the service only when they have positive observed behaviours. We saw an example where the registered manager cancelled a birthday celebration because this person did not act in a manner the registered manager considered appropriate. We asked the registered manager what they understood by closed culture. They were not able to demonstrate to us a sufficient awareness of closed cultures." On cross examination Ms. Renton referred to photographs of the party she stated that it was the provider's case that the party had not been cancelled.

97. Mr Page was asked about what he meant by closed culture. He explained that this was a service in which there is no external scrutiny which could allow abuse to occur.

98. He set out that the causes were, a lack of leadership, effective oversight governance, training of staff, care plans reflecting the needs of the users.

99. Mr Page stated that for service user A he would expect to see a referral to a

positive behaviour support team which was part of the wider mental health services. He said this was evidence of a closed culture, in that Service user A had not been referred for behaviour support, so that the Provider could manage the behaviour of the service user with supporting strategies. Service User B disengaged with the psychiatrist. However, no additional support had been sought. With Service user B there was use of punitive strategies to control behaviour. A planned birthday party was cancelled due to behaviours that she displayed. The registered provider believed she had capacity. Removal of her mobile phone was done because she made frequent calls to emergency service. Steps should be put in place to limit the amount of call outs.

100. He accepted that the emergency service would be overwhelmed with calls, but this was Service User B's choice. He stated that no risk assessment had been made of the impact of removing the phone.

101. Mr Page informed us that punitive strategies were being used. Service User B was asked to sign a behaviour contract and if she did not sign it then she would not be allowed to leave the premises. This was a punitive measure. To manage the behaviour, good quality risk assessment should have been used with care planning. Other Health Care professionals should have been consulted which may have included Pharmacological options.

102. He also reviewed the records and was concerned that an appropriate safeguarding referral had not been made in respect of one of the service users.

103. Mr Page was referred to a Quality of Management document dated October 2022, He was asked about the practical impact of this document. In particular, he was referred to the column *Assessing and Monitoring the quality-of-service provision.* He stated that although this document was a start, to be more effective, it had to be more detailed to capture the finer points around the service and there should be analysis of trends and patterns. He told us that you would want to consider trends so if there was a rise in chest infections, you should ask what has caused this?

January 2023 Inspection

104. Mr Page was asked about the January 2023 inspection. He informed us that this was unannounced. At that time there was only one service user, he asked Mrs. Ramdarass for documentation around the service. Mrs. Ramdarass told him that Vasant Patel was developing a new framework on the computer, and these were emailed to him. He explained that they needed to see the audit tools. However, he was told that the provider was in the process of developing the tools. He stated that he could see the direction that Mr Patel was taking. However, in his view although the Provider was beginning to understand the requirements of the CQC they had not met the standard at the time.

105. He was asked about Mr Marc Amron's witness statement. He stated that Mr Amron's witness statement provided exhibits of the QCS platform, however this was basically a library of policies and procedures for risk management and care planning. PCS had also been suggested which were policies brought off the

shelf. However, there was a need of the provider to adapt the template. He conceded that this was an effective governance system however it needed to be adapted and used by the provider.

106. He was asked about service user B and the fact that she had signed a behaviour agreement which had been agreed with her GP concerning the use of her phone and laptop which enabled the provider to take it away. He stated that he had had a detailed conversation with Servicer User B, and she had told him that she had only signed the document because she would not be allowed to leave the building unless she signed, however she had been upset about this. He did not agree that she had consented, and although the agreement had been evidenced, he preferred Service User B's account.

107. Ms. Renton asked him about Service User A who had said that "she wanted to go home." Ms. Pradhan said the sister of Service User A said it was not her own home, she was a council tenant. Her children were residing there. The social worker dealing with her case had said her home was assessed as not suitable for her occupation. Minutes could be obtained to be sent to all parties. She also asked him about whether he acknowledged that The Application for the DOLS (Deprivation of Liberty) was made before the CQC inspection. Mr Page noted that regardless of the DOLS which were in place, all the service users appeared to be under the same level of restriction.

108. Ms. Renton asked about Mr Page's conversations with staff on 4 January 2023. He stated that he spoke to Ms. Pradhan, Ms. Ramdarass, and Mr Patel. He was asked did you ask what would happen to the building or whether he had a conversation about what Ms. Pradhan would do if things did not work out.

109. He stated that he did not remember if he asked what would happen to the building. He stated that in hindsight "if I asked what would happen to the building I accept that it may have been seen as a forgone conclusion, however we had reached no conclusions." He stated that he did not have long conversations with Lalita Pradhan or Vasant Patel, it could have been up to an hour in total. There were formal interviews, but the conversation with the managers and providers was more fluid. He accepted that this might not have been recorded on the tablet.

110. He was asked about Mr Patel and whether he showed promise, as a manager and whether, given Mr Banson- Idun's departure, the CQC acknowledged the urgency of putting a manager in place. He told us that Mr Patel had applied to be the registered manager and a separate department of the CQC refused his application.

111. Ms. Renton put it to him that the CQC had been heavy handed, and that the NOP was a disproportionate response. Mr Page did not agree.

112. He was asked in re-examination whether conversations with managers and providers post event were recorded on the tablet. He stated that he would not expect a conversation with Lalita Pradhan about her plans to be recorded.

113. We heard from Mr Connor on behalf of the CQC that this was the Respondent's case.

The Appellant's case

Mrs. Lalita Pradhan- clinical lead

Experience and role and involvement in the service

114. We heard from Mrs. Lalita Pradhan who was a registered nurse and who had the role of Clinical Nurse Manager. Mrs. Pradhan had provided a witness statement which was dated 23 March 2023. She told us that she had 24 years of experience of nursing in the UK. She was an acting band 7 within a cardiac care unit and had been a band 6 nurse for a long time. She had undertaken Mentorship and Preceptorship. She had carried out national audits for the Trust she was employed by and taken part in her Trust benchmarking exercise.

115. She told us about how her involvement with the home had come about. She knew the Provider as an agency nurse, since 2013, when she did some shifts for them and she was asked to oversee the nursing side of the service when Ms. Ramdarass was suspended by the NMC.

116. She told us that when she started, she investigated the documentation, she looked at and implemented changes to improve hand over and documentation overall.

117. Mrs. Pradhan was involved in Care Planning and Care Plans. She told us that these were reviewed weekly, and changed monthly, if for example the Waterlow score changed or nutritional plan had been updated. She told us that she inherited the care plans and that they had been reviewed by the CHIT team and they were happy with the care plans.

118. The Care Home Improvement Team ("CHIT") team was already on site, when she commenced at the home. They had done multiple training with staff. The role of the CHIT Nurses was to support the improvement of the care setting. She explained that if for example; "we have a resident with challenging behaviour, they can train our team, and can change our care plans. They act as a fresh pair of eyes with the improvement that needed to be made."

119. The CHIT team had been coming on a weekly basis, going through all the care plans. She told us that although they made a few recommendations, overall, they were happy with the care plans. She told us that they had numerous meetings looking into new care plans and she understood that they needed to be more evidence based and more recent.

120. Mrs. Pradhan told us that the new manager Mr Amron had plans to put the care plans online. This meant that it would leave a footprint if someone edited it. If changes made this would be recorded. We were referred to a care plan at D985

of the bundle. She told us that this is what care plans looked like in 2022. They had an index. This one was for Skin care. The tick boxes were digitally completed. The Table entries were completed over time, they were typed and inputted on computer. Every time there is an update, will be printed and filed with the hard copy.

121. Mrs. Pradhan told us that whilst she had worked with the provider, they had 5 registered nurses up until August 2022 when Service User B left. She had introduced a safety huddle, (which was inspired by her time working as an NHS nurse) and a WhatsApp group. She would look at diary activities for the day and consider how we could help every resident to be looked after safely. The 'Huddle' would be on every shift and would last for 5 minutes. When she started in August 2022, there were two health care assistant and one Registered General Nurse ("RGN") for the Night shift. 1 RGN and 4 health care assistants for the day. This was reduced to 1 RGN and 1 HCA, at night and one RGN and 3 HCA during the day when the home went down to one resident. However, there was always at least two members of staff to one resident with one member of staff being an RGN.

Culture of the Home

122. She was asked about the type of culture that was within the home.

123. She explained that she found the culture to be very open and transparent. She had personally not witnessed staff speaking to service users inappropriately. She found the home to be very accommodating to friends and families. There was good teamwork, staff were ready to learn and accepted changes.

124. She explained that between Vansant starting and her undertaking her role a lot of changes had been made. She stated that "My experience not a closed culture all opened to friends and family no set visiting time, chiropodist, dentist GP CHIT Nurses. OT, Physiotherapist. Dietician builders and plumbers, Fire inspectors had all visited the home. There were also visits from a Church group." One resident requested a church group to see her, and they came in to see her, this was Service User B.

Service User A and issues raised in the CQC Reports

125. She was asked about the issues that the CQC had noted concerning the care of patient A.

126. She told us that Service user A had mental capacity, and that at the time she was in the home prior to transfer she was waiting for the local mental health team to assess her. They came and confirmed that she had capacity, and no DOLS was needed.

127. Mrs. Pradhan told us that Service User A had stated that she wanted to go home. A SIP meeting was held in October 2023, as in accordance with the LA policy Service User A needed to be transferred from the home.

128. She told us that Ms. Julie Mbdike who was the Lead Practitioner at the London Borough of Barnet, recommended to the group that a revisit of care homes previously visited should take place to find a home which could support her.

129. Mrs. Pradhan had attended the meeting and told us that the meeting was informed that Service User A's next of kin's position was that she could not go home. Mrs. Pradhan was aware that Service User A, had a flat, although she did not know if it was a local authority, rented or privately owned. However, Service User A had young adult family members, living at the flat who could not cope with her and were frightened of her behaviour. Further the Occupational Therapist had said that her home environment was not suitable for Service User A. It was agreed that although she had capacity Julie Mbdike should be present when another home came to assess her.

130. Mrs. Pradhan was asked about the report of the CQC in which it had been noted that Service User A had capacity and her wish to go home had been ignored. Mrs. Pradhan explained that Service User A would make conflicting statements concerning her desires within minutes. She sometime said "... I love this place I don't want to go". However, if she was being hoisted out of bed to sit on a chair she would say "I want to go home." Several homes had come to assess Service User A and there had been discussions with her sister well before, when service user A was the only one left (as Service User B, following a hospital visit, was moved to a Premier Inn). She told us that in the end Service User A, was discharged to her home, against the wishes of her adult children.

131. Mrs. Pradhan was asked about the Bed rails risk assessment for the safety of Service User A which had taken place. Mrs. Pradhan agreed that Service User A was able to roll over, however she could also roll out of bed. She stated that although she agreed that the bumper is used to protect the individual from potential damage caused by the bed rails, Service User A had her bedrails up but was not making use of her bumpers. This was because she objected to the use of her bumpers as they obstructed her vision of the television. She liked lying flat in her bed and could not then see the TV and would ask for the bumpers to be removed, in the daytime.

132. She explained that as Service User A had capacity the choice as to whether to use the bumper was Service User A's. There had been a discussion with Service User A, about the risk of not having the bumpers. Mrs. Pradhan had told her "… you are putting your hand through you will get hurt, she said I don't do that…"

133. Mrs. Pradhan explained that Service User A had not wanted to leave the home and was crying, shouting and screaming not wanting to go. Service User A's family contact me on a regular basis, they would like her to return to the home. She stated that they told her she is not doing well, that she smells, her hair is greasy, and she is in a bad state. Her Foot drop has also got worse. She told us that the family of Service user A, is liaising with the social worker and that they want to know the results of the Tribunal hearing as they would like Service User A to return to the home, as although she had capacity, she had complex

care needs.

Service User B

134. Mrs. Pradhan was asked about Service User B being prevented from using her electronic devices. She told us that at the time she joined the home, Service User B, always had her devices with her, however she was not good at charging her device, she would regularly misplace her device and charger. She told us that on one occasion, her phone was missing and had to be replaced by the mobile phone provider.

135. However, if Service User B did not have her phone, she still had access to a Landline, as there were phones within the dining room, clinical room and lounge. Also, upstairs.

136. These phones were open to residents' use. Only three had capacity, one was blind and so she needed assistance to use the phone. Service User B was upstairs. She was asked by Ms. Renton about Service User B's birthday party; she stated that in her presence no birthday took place. Not aware of family member having a birthday.

137. Regarding Service User B's discharge from the service; Mrs. Pradhan told us that Service User B was privately funded and that Barnet Social Services were involved in her move she was transferred to a Premier Inn. Service User B made her own arrangements with social workers actively involved. Service User B was given notice to leave but could not find a suitable place, tried her best. Barnet decided that they could not find a suitable residence although she had a flat, so she moved to a Premier Inn. The Service were not involved in the decision. Although they helped facilitate the discharge, Service User B was able to self-medicate, and the decision was made by Barnet Council that this would be suitable for Service User B.

138. She understood from the family of Service User B that things had not gone well and that she was in hospital on hunger strike declining her medications.

The Inspection on 4 January 2023

139. Mrs. Pradhan told us that she had not been present when the inspectors arrived at the service. However, she had come into the service as she lived about half an hour away. She spoke with both Mr Page and Ms. Traian. She told us that they asked her about staff morale, and she agreed that it was low. She stated that new procedures and policies were being introduced and staff were being asked to read and implement these, they were aware that the service was under threat of closure despite their best efforts. At paragraph 88 of her witness statement, she set out that she did not accept that she had told the CQC inspector that she did not want to introduce a new form for staff to record when they were doing exercises because staff morale was low. She stated that this had arisen

in the context of staff supervision.

140. Mrs. Pradhan stated that she was aware that at least part of her conversation was being recorded. However, she was asked about what would happen to the building, and what she would do. She stated that Mr Page also mentioned that the home could always re-register. She was surprised by this.

141. She told us that she showed them the training that had taken place and how she used a training matrix like one used by Watford General Hospital so that she could be aware of when training needed to be updated.

142. In her witness statement she set out that in relation to the Waterlow score this covered several areas. In relation to Service User A she stated that her score was high because she had suffered a stroke. However, she remained free from pressure sores, she stated that she had an electric operated air mattress which helped with skin integrity.

143. Mrs. Pradhan, in her statement, concluded by stating that the home (at the time the statement was made) was fully compliant, and that the new team, which included Vasant Patel was implementing changes which had moved the service in the right direction.

144. Mrs. Pradhan was asked in cross examination about the hours that she worked. Mrs. Pradhan stated that she arrived in August 2022, but by January there was only one service user left. When she first took up post working part-time, she worked2 days, and had worked 4 to 5 days. She was working 4-5 days in August around her full-time role. She also worked at Guys and St Thomas as an ITU nurse and worked at the home whilst on annual leave. She had leave November time and was working 2-3 days. When she worked at the service it was part-time 2 days, 12-hour shifts, on nights. She currently had no set hours but was called for meetings on a “needs basis”.

145. There was a discussion around her role in care planning and in cross examination, Mrs. Pradhan confirmed that the CHIT Nurses were happy with the care plan documentation. She was shown a photograph copy of a Care plan, at D986 of the bundle.

146. At page D988, a comparison with the Waterlow noted that the service user was at risk of bed sores (this was at page C348 of the bundle) This was a photograph taken by the CQC at the time of the inspection and showed an entry made on 16 March 2022. However, in the documentation provided by the Service in section D of the bundle, a copy of that same document had an entry for 16 March 2022, which was different from the photograph of the same document made by the CQC. One noted “skin integrity” and the other said “risk of pressure sores”. Ms. Pradhan accepted that the entries were different and that although they purported to be made on the same day by the same nurse, one contradicted the other. Mrs. Pradhan was not able to explain why this may have

come about as the entry had been made by Ms. Adam's who was the other nurse who worked within the service.

147. The hearing adjourned on 29 July 2023, and resumed on 20 November 2023. Directions and the date for the resumed hearing were given.

Mrs. Dhanwati Ramdarass- Nominated Individual

Mrs. Ramdarass role and the opening of the Mayapur House

148. At the resumed hearing we heard from Mrs. Ramdarass, who was the registered provider and director of the Service. She was also the sole proprietor and the nominated individual.

149. Mrs. Ramdarass had prepared a witness statement consisting of 84 paragraphs which was signed on 24 March 2023.

150. In her witness statement Mrs. Ramdarass, set out her professional background and how she had set up her own business as a domiciliary service in 2011.

151. She set out how she had decided to set up accommodation to provide care in the community and had added Mayapur House to her existing registration in 2013, with the home opening in 2014, to provide accommodation and nursing care for up to seven people who had mental health needs.

152. Mrs. Ramdarass set out the registration history of the Service which included the home being rated inadequate in January 2015, and requiring improvement in July 2015, however she stated that it made improvements and by March 2016, had achieved Good in the safe, caring, and responsive domains and in October 2017 the service was rated as Good in four of the five domains.

153. Mrs. Ramdarass set out how the home had previously been managed by Mr Alex Banson- Idun. She told us that she had a good overview of the home as she had attended the service daily and oversaw the running of the home.

154. She set out details of the inspections which had led to the NOD, and how Mr Banson-Idun had left the service in November 2022. At the time of her statement, her focus was on Mr Vasant Patel as a manager, however in her oral evidence she dealt with her decision to employ Mr Marc Amron and her plans for him to become the registered manager. She also dealt with the plans for the service going forward if the appeal was upheld.

The May 2022 Inspection and the response of Mr Banson-Idun

155. She told us that at the time of the May 2022 inspection, the Manager had been Alex Banson-Idun. She stated he had been an experienced manager, had taken a home from poor to good and she had known him as he had worked for the

agency before joining the home as the registered manager. However on reflection during the time he worked at the care home, she now realized that he had been very laid back. and slow to deal with things. This was reflective of his personality, she noted that nothing seemed very urgent, this was reflective of his approach to putting policies and procedures in.

156. Mrs. Ramdarass told us that he always presented as being “not willing to be led by others, and he did not always take things on board.” He was somewhat set in his ways and slow to respond to new ideas.

157. She told us that prior to Mr Banson-Idun leaving she was dealing with issues relating to her sister who was very ill and receiving end of life care. As her sister was in the USA, this had involved traveling between Florida and the UK. As such she had been very dependent on Mr Banson -Idun. However, in response to the challenges raised by the inspections although he was there, he was slow to take the business forward.

The Regulations found to have been breached and how concerns were addressed

158. In her statement she acknowledged that concerns had been raised amongst other issues, about Safeguarding Training (Regulation 17). She set out that as a result they had arranged for all staff to undertake a refresher course, on safeguarding. Within the bundle copies of the training certificates were provided.

159. At the hearing she told us about her understanding of the criteria for a Safeguarding referral. She told us that, it was necessary - if any harm or possible harm is likely to come to a service user, then it must be reported to the safeguarding authority. Mrs. Ramdarass, stated that the role of the service was to comfort them and make sure that the resident felt safe. That if there were close relative they should be informed and involved in any incident. In addition, the funding authority, and social services and possibly the police, were the relevant agencies who should be notified.

160. She told us that CQC could report a safeguarding concern and that the CQC made a safeguarding referral post the January 2023 Inspection. They reported a possible choking incident involving the one resident who was remaining. Mrs. Ramdarass stated that sometime after she had eaten, the service user had a choking/ coughing fit this was dealt with by staff. There was no adverse outcome to the resident, and although it was reported no steps were deemed necessary by LA Safeguarding.

161. In respect of safe care and treatment – Food Safety and Hygiene, in her statement she pointed out that food was not stored directly on the floor, as alleged by the CQC, as it was in sealed containers in crates. However, this had been addressed by the installation of additional cupboards, for food storage, and work surfaces for food preparation. Regarding food temperatures, food and meat temperatures were being checked daily at the time of her statement.

162. Mrs. Ramdarass set out in her statement that the kitchen was cleaned daily and deep cleaned weekly. In September 2022, the home was re- inspected by a Health and Safety Environmental Health officer, who rated the home as five stars in food hygiene. She acknowledged the concerns raised around the cleaning of the home and the home being cluttered. She stated that more storage was installed. She stated that deep cleaning of the carpets had been undertaken because of issues concerning staining of the carpets.

163. Mrs. Ramdarass accepted that at the time of the inspection which was during Covid19 Restrictions, there were incidents where staff had pulled their masks down. She stated that there were contractors who were carrying out work, who had advised them that they were medically exempt and as they were accessing the kitchen through the laundry area, they had not been pressed to provide evidence because the risks had appeared low.

164. Her statement also dealt with concerns over staffing (Regulation 18) and how the home had implemented a dependency tool to assess the numbers of staff needed.

165. In respect of Regulation 9, Person centered care. Mrs. Ramdarass did not accept that there was a lack of documentation prior to service users entering the home in the form of pre-assessments or that the information provided was contradictory. She stated that the service user had been assessed by either the manager or the deputy, there were issues that often the information provided on file appeared sparse, however this was when the information was provided by a discharge team.

166. She set out that although improvements had been made, it was difficult to demonstrate this because of the restriction placed on the home in admitting new service users.

167. In respect of regulation 11, she set out that she accepted that consent had not been gained for the use of CCTV when it was first installed, however at the time of her statement this issue had been addressed.

168. In her oral evidence she addressed concerns about service users A & B. and provided information on what had happened at the January 2023, inspection and subsequently.

Inspection on 4 January 2023

169. She stated that on 4 January 2023, Gareth Page and Neomi Traian had carried out the inspection and she had had very little communication with the inspectors on the day.

170. She stated that Vasant Patel was the acting manager. He had joined in November 2022, and had become acting manager from the end of December 2022.

She stated that the inspectors' communication had been with Vasant.

171. She had been asked to provide documentation and although she knew it was there, as Vasant had more familiarity with where it was stored, Vasant had joined the inspectors. Mrs. Ramdarass stated that as they generally go through files it was not her practice to stay with them whilst they are there saying "if they want files, they generally ask". She told us that she was only with them for about 5 minutes at the end of the visit. She was asked what will you do with the business? I said Vasant and Lelita would carry on the business. She stated that a comment was made about re-applying for registration using the same company name.

172. Mrs. Ramdarass told us that she "… was totally confused about what that meant. If we were not good at that current time, why would CQC re-register us. Why close us down to re-apply?" She stated that she found this totally confusing.

The Role of Mr Vasant Patel

173. She was asked by Ms. Renton about how Vasant Patel had come to be employed. We were told that Lelita Pradhan knew his wife. Mr Vasant Patel had worked in a hospital setting on the switch board and in the laboratory. He had experience of working in the hospital and was working with the Integrated Care Board (ICB) which allocate money across the health care services.

174. Because Vasant Patel had some experience within health care management, Mrs. Ramdarass had interviewed him and he was happy to take on the role. She told us that in the SIF meeting Alex Banson- Idun was said to be incompetent, therefore he was of limited assistance in helping Mr Patel take on his role. Mrs. Ramdarass told us that it had been necessary to hire someone quickly to implement changes in the light of the CQC reports and given Mr Banson- Idun's departure. Vasant was interested in recruitment and keen to work in a care home. He had two BSCs, basic care qualifications but needed more experience.

175. She told us that he had done NVQ level 5 Chartered Institute of Management. He had worked with HCPA to gain a qualification as a safeguarding champion, but he had been ill so had not formally completed his training. Mrs. Ramdarass explained that Vasant Patel worked full-time in his employment by ICB. He had therefore worked at the service only during weekends and evenings.

176. Mrs. Ramdarass stated that it was very difficult to recruit registered managers. The service provision was a small 7 bed-home, so in terms of employment they were competing with larger homes with 20 to up to 100 beds. Also, it was not easy to find people with experience of complex needs.

Service User A and B

177. Mrs. Ramdarass was asked to comment on Service User A and B and the observations of the CQC. She told us Service User B's relative, had power of

attorney for Service User B's finance. She said that Service User B's relative also kept in touch. The service user had a sick daughter, who was not involved with her during Covid. So although B's relative was more distant she had power of attorney.

178. She told us that Service User B had been in 7 homes in a 12-month period. She has a Stoma. Apart from her physical needs she had negative behaviour. She was able to move about briskly. However sometimes Service User B would lie on her bed and act as if her limbs were floppy. She would refuse food and drink and then act perfectly normal. Service User B would make derogatory remarks about the staff and the service. However, she stated that despite this "We always acted positively towards her and supported her during shopping". She would say things such as "It's my money I can do what I want with it". She would offer to give service users, things, then accuse other service users or staff of taking her things. Mrs. Ramdarass stated that although the CQC felt practices used on Service user B were restrictive, they had been fully discussed with Service User B, and her family. She stated that Service User B had money and could have lived outside. She was financially able, and there were plans to support her living independently as her behaviour meant that she was not suitable for living in a home.

179. Mrs. Ramdarass stated that service user B's relative was still in contact with her, Service User B's relative would say "Service User B has destroyed your business". She told us that on reflection they should not have taken Service User B as a resident.

180. She stated that Service user B had moved to a Premier Inn and was moved from there because of her behaviour. She had been banned nationwide from Premier Inns. She was at Barnet General Hospital in the Psychiatric care department.

181. She stated that Service User A, had spoken to us about returning. Her sister was concerned about her current care and stated that she smelt, and was unkempt, her skin was unwashed, and she was not wearing a splint. Her sister has been in contact, said that they raised safeguarding concerns about her care.

Level of the on-going need for the service

182. She was asked by Ms. Renton about the level of need for the service.

183. She explained that the Independent Commissioning Board (ICB), kept in touch with her as they were always looking for placements. She stated that there had been interest in placements at the home. Service user C's, partner and ICB had contacted her asking whether Service User C could return. She had to explain to them that the business was dormant, and she could not admit anyone.

184. The Service User's partner wanted her to be placed. Another brokerage was looking to place service users and she had explained the situation. Mrs. Ramdarass had been told by the brokerage that they could find service users

who would take all the beds immediately.

185. Also there had been three private enquiries through Mr Amron. She stated that they had always been transparent, open and welcoming to all our residents and their family

186. Mrs. Ramdarass explained how she had become aware of Mr Marc Amron as a potential registered manager for the service. She also told us of her plans to continue to operate for service users who had complex needs due to her experience and Mr Amron's. She accepted that until her NMC case was resolved she could not provide nursing care. She was confident of the systems that had been put in place or were proposed to be put in place at the home.

Cross-examination

187. She was asked by Mr Connor about her role as nominated individual and what she had done in response to concerns raised by the CQC. She did not accept that she had not been proactive.

188. She also did not accept that she had failed to supervise Mr Banson-Idun or that he was now being made a scapegoat for the failings of the home. Mrs. Ramdarass denied that her decision to engage Mr Vasant Patel, had not been a considered one given his lack of experience. She referred to the experience he had working for the NHS and his qualifications, she believed that he was a suitable candidate.

189. She also did not accept that she had just signed off policies he had put in place without detailed consideration. She agreed that she had not been able to access the policies when the CQC came on 4 January 2023, however he had shown her how to access the policies, but it had been easier to get him to do so as he could be there in half an hour. She was asked why did she not step into the role of manager? She explained that she did not want to do this. Mrs. Ramdarass stated that this was "a position I chose not to work with." On being asked why, she explained that she did not have the patience to work in this role, on further questioning she set out that she did not have patience for the licensing side of things such as working with the CQC. On questioning she stated that although she had accepted the concerns raised by the CQC, this was on advice from Mr Banson-Idun, and she did not believe all the findings were justified.

190. She was asked about what enquiries she had made concerning the changes to the care plan document which appeared to have been doctored, which had been discussed with Mrs. Pradhan at the last hearing. She stated that she had not been able to confirm what had happened.

191. She was of the view that the service would be able to operate effectively with Marc Amron as registered manager and with the new systems in place. She explained that he was at the home daily, that he worked well with Vasant Patel,

and that if the appeal was upheld, they had staff who could be in place, within 3-4 weeks and the home could attract service users.

Mary Chege Health Care Assistant

192. Ms. Chege had been a health care assistant at the service. She had provided a statement signed 24 March 2023.

193. In her statement Ms. Chege set out her work history and the health care qualifications that she gained in the UK and how she came to be employed by the service. In November 2020 she was interviewed by Mr Banson-Idun and accepted the position as a health care worker. She told us that her experience of working at the home was good and that the culture of the home was positive.

194. She stated that it was a small home and that as staff members, it was viewed as a family home. Communication was very easy, and they worked as a team, on the task and took turns in ensuring the routine worked smoothly. There was a lot of understanding about the service users which made it easier to communicate. Members of staff, management and residents all knew each other. She stated that "There never came a time when I heard a member of staff speaking in a manner which would cause offence to members of staff or residents."

195. She described the routines of the home and accepted that staff were busy however she denied that there was ever a time when the staff were too busy to care for the needs of the service users. In her statement she set out that she worked two twelve-hour shifts from 7.00am until 7.00pm. Her main role had been to provide personal care to the service users such as assisting with feeding bathing and observing their well-being. However, she stated that due to the size of the home it was expected that the HCA would also undertake domestic chores which needed to be carried out.

196. She stated that typically the HCA would undertake personal care for each service user who needed support, give them breakfast and make sure that they were ready for the day. They would look at the diary to see whether a service user had appointments. If anything was needed, they would work out a plan to tackle it. More long term, Service users who had capacity would let us know what they would like for their birthday, who they wanted to attend would be part and parcel of the plan.

197. She was asked about what she understood from the term Closed culture, Ms. Chege stated that this meant that they did not engage with other services. She stated that there was "no closed culture to her knowledge." Service Users' family members, the GP, and CHIT Nurses all attended and were welcomed at the home. There were no issues that we could not discuss with management.

Care plans

198. Regarding care plans she stated that there had been a handover, at the end of the shift, or quick meeting if necessary. This allowed staff time to read care plans and review them.

199. She was asked about the January 2023 inspection.

200. She told us that when staff heard the news of the decision taken by the CQC it was very hard for everyone. She told us that dedicated staff who did everything they could were disappointed. However, they agreed to give, management and members of staff support. Morale went down. Ms. Chege stated; "But we did not take our eyes off the ball," and "continued doing the right thing". She told us that Training was always advocated however now it was emphasized. She did the mandatory training and any other which came with it. Did on-line training, face to face, the CHIT nurse also came in. The staff were aware that there were hard times ahead but were ready for it.

201. She was asked whether there was more supervision after the CQC Inspections? Ms. Chege stated that it had always been there but due to enhancing the training things had to change a bit. So the HCAs were "not supervised every minute, but had to know who's doing what at the end of the shift had to sit down and look at what was being achieved". She denied that supervision caused the staff to be demoralised.

202. She told us that on 12 May 2023, when the doors closed. She had nowhere to go although there was some work preparing for the appeal. She told us that on 1 September 2023 she started working 3 days elsewhere, (providing personal care, for 82-year-old). However, if the appeal were allowed, she would go back to doing 2 days a week at Mayapur House. Other staff would be willing to go back to Mayapur House.

Safeguarding within the home

203. She agreed that when Safeguarding was reviewed that she had signed a form saying she had read and understood the policy. She told us that during the supervision time she would go through this and other policies, within a supervision session. She was asked how her knowledge of the safeguarding was assessed. She told us that she would go through the policy and any reviews. She would be asked if she understood the policy. She told us that "I would be asked if there was anything I did not understand and wanted to go through". Sessions would take an hour or two hours.

204. She would ask how she would deal with an incident; she told us she would speak to the service user if they were aware, she would then report to the nurse on duty, and would tell them what she had noticed. The nurse would then decide whether to go with me to the service user or then handle it. If Nurse investigated, they would guide the whole team as to what to do going forward.

205. She was asked if she had undergone any further training since May 2022, she

told us that she had taken Hertfordshire Council first aid Mandatory training on-line.

Mr Vasantkumar Patel

His qualifications and experience

206. We heard from Mr Vasantkumar Patel (known as Vasant) and were provided with his witness statement, which was signed by him on 23 March 2023, comprising 121 paragraphs. There was a material change in his position, in that when the statement had been prepared, he was being put forward as the potential registered manager for the home, however this position was now potentially to be filled by Mr Marc Amron who had been recruited by the service to fill that role. In his evidence Mr Patel dealt with events which had occurred between November 2022 and January 2023 when he had been brought in as acting manager, and the position which now existed and how he planned to support the service as deputy manager.

207. In paragraph 4 of his witness statement, he set out as follows-: "I have completed a Master of Science in Health Informatics. My previous roles have included a hospital porter, working on the switchboard, a medical lab assistant, and a dietician assistant. My clinical experience has accumulated within hospital settings."

208. In paragraph 11, he acknowledged that "Whilst I have no experience of working at or managing at a care home prior to joining the Home, I am confident I have the experience and ability to carry out the necessary managerial tasks and administration. For example, Lalita is responsible for monitoring the day-to-day care staff provided to service users at the Home, I am more so responsible for conducting staff meetings, ensuring safeguarding reports are dealt with correctly, and conducting audits. "

209. He told us that when he joined the home he was working part-time during the evenings and weekends. He told us that although Mr Banson Idun had been at the home there had not been much of a hand over or an opportunity to shadow him as he had been leaving the service due to the unsatisfactory inspection and issues surrounding it.

210. Mr Patel told us that his role had been to deal with the issues which were outstanding from the CQC Inspection and to update and implement new systems.

211. He explained that he had attended the home on 4 January 2023 when the January inspection was carried out. He told us that he arrived in the afternoon at 5pm and met two inspectors who were present at the home. He spoke with them for roughly 15 minutes. He did not see them recording or writing down anything. They could not find the December audits.

212. He was asked by Ms. Renton to explain how the computer system worked.

January 2023 inspection and IT within the Home

213. He told us that there were three lap-tops with files in his laptop (audit files) where there were audits on the new system. There were also some old and some new records. Microsoft forms were new, those not yet implemented used the old form, three lap tops use Microsoft. However, there was an issue in that the laptop might not synchronize, so a document on the lap-top might not be in the same format of that put in the cloud.

214. He told us that this might result in two different versions of the same document.

Application for Registered Manager of the Service

215. He told us about his application for registered manager and how the interview process had lasted over 4 hours. He was of the view that his application had been unsuccessful as he had lacked relevant qualifications. He had since undertaken a Level 5 Diploma in management and leadership, the SBL, chartered management institution, this was a generic management course for healthcare for NHS management. He had undertaken a Quality Improvement Practitioners course, which is due to be completed in March/April 2024.

216. He told us that at the CQC interview for the registered manager role they wanted evidence of his experience. He decided to gain additional qualifications in response. He undertook the courses due to feedback from the CQC, and for his own career development.

217. He told us that he felt the home was well led, he referred to the fact that he felt as if he could discuss changes with Ms. Ramdarass, and that he could call both her and Lalita Pradhan at any time. He was very confident working with Mr Amron, whom he assessed as being very capable and knowledgeable and saw him as a mentor, someone who was “easy to approach.” His plan was to work full-time as a deputy within the home. Mr Patel spoke of there being some uncertainty around his current role. However, he stated that he would continue to work part-time for the first 6 months.

218. In cross examination he explained that he had taken the role of acting manager to assist Mrs. Ramdarass as he considered that he could support the service by implementing system changes. He had worked to improve the audit process.

219. In answer to questions from Mr Connor he explained that in January during the inspection Ms. Ramdarass could not access the policies. This was because he had sent them embedded in an email. But she could not remember where to locate them. This was not because the policies could not be accessed.

220. He was asked about the creation of the policies. He explained that Mrs. Ramdarass was impressed with the policies. He showed her all 21 policies and in January 2023 he created an additional 20 policies. He stated that Mrs.

Ramdarass encouraged him to improve the care home. She provided resources, engaged with the CHIT Nurses and external sources. Mr Patel also sought some mentoring from another care home. He also had a friend working in a care home who supported him if any issues arose and if he was unsure, he would ask him questions for example on safeguarding. His friend provided guidance over the phone; He was asked whether his friend observed him face to face. He stated that he had not observed him or shadowed him.

221. He told us he had a session with a consultant on a Sunday. They had gone through the care plans together. The consultant helped the home to see what the CQC was looking for and the factors to be considered in the audit tools. He had also helped him with the CQC registered manager questions.

222. Mr Patel told us that "My friend advised me that supervisors should be external to the organisation, he stated that Mrs. Ramdarass was going to hire the ex-inspector but decided not to, because of the NOP". He was asked about his supervision by Ms. Ramdarass. He told us he had one supervision between December 2022 and May 2023 when the service became dormant.

Marc Amron Prospective Registered Manager

Knowledge of the Home and his qualifications and experience

223. We heard from Mr Marc Amron, his statement was provided within the supplemental bundle, signed and dated 19 July 2023. He told us that the statement was true to the best of his knowledge and belief. In his statement he set out his qualifications, and previous experience. He had an NVQ in Health and Social Care levels 2-5. He set out that his first role within a care setting had been at Sunridge Court a 44- bed residential care home where he held the role of senior carer. In 2019 he was promoted to deputy manager. In 2022 he left Sunridge Court and was employed as deputy manager for Windsor Care Centre.

224. In paragraph 14 of his witness statement, he stated that "...I was made aware of an advert by U.K International Nursing Agency Ltd for the position of a manager. The current position of the Home and their proceedings with the CQC was made very clear and I was excited by the home's plans for the future..." In his statement he set out that the home's plans were to offer post-operative care.

225. However, since his statement had been made, we were informed by Mrs. Ramdarass that this position had changed, and the home was now expecting to care for service users with complex behaviour.

226. At paragraph 19 of his witness statement, he stated that from his discussions with Ms. Ramdarass and personal review of the Home, their policies and documentation, I believe I have insight into where the Home's previous downfalls stemmed from. In summary the downfalls originated from poor leadership of the previous managers, which was then reflected downwards into the Home's atmosphere, practices and documentation. I am personally of the impression that

the previous registered manager. Alexander Banson-Idun may not have had a sufficient understanding of CQC's regulations, and the standards expected, especially in terms of managerial oversight. I believe audit was seen to be a tick box exercise which is something that I will not tolerate."

227. He told us of his previous experiences, and why he left his roles, he also provided us with references.

228. He told us that since the statement had been made, he had obtained a freelance consultancy role, with a compliance experts' international company. This involved advising hospitals and care homes on all aspects of social care.

229. He stated that he had been asked to take on this consultancy role by the CEO whom he had met when he was working at Windsor Care, as the CEO had valued his input. He was a Safeguarding Champion HCPA (Hertfordshire Care Providers Association) August 2023. He told us about courses he had undertaken. He had a diploma in Psychology and Psychiatry, a 280 hours' level 3 course. He had undertaken a fire safety day, earlier this month and a course by Hertfordshire County Council for managers of care homes, concerning the dementia environment and dementia awareness. A two day first-line care managers course, LGBTQ awareness Hertfordshire training course. Conflict resolution, anatomy, dealing with racism, medication online course, nursing diploma food safety level 3 food safety and Venipuncture.

230. He was also a district councillor, however he stated that "Council work came third, after his commitment to his family and then his work, he did not think that it would interfere with his role as registered manager.

His day-to-day activities within the home

231. Mr Amron was asked about his current activities within the home.

232. He told us that he was at the home from Monday to Friday, he kept in touch with Vasant Patel, Lelita Pradhan had also attended for meetings. He had spent his time going through systems and looking through documents for this case, which included the systems created by Alex Banson-Idun. He also carefully considered the CQC reports and investigated marketing for Mayapur House.

233. Mr Amron set out his previous roles, and why he had resigned from his last appointment.

234. He told us that although I have not been a registered manager before, he took on a lot of the role at Jewish Care. He was asked about his employment with Windsor Care and that about a week after he accepted the appointment, Windsor Care contacted him and told him that their service had received a poor inspection outcome. They had asked him whether he was still willing to come and

work for them. Mr Amron explained that he agreed. He stated that when he joined the organisation it had a “really bad culture” and he had done the best he could to change that culture and make improvements.

235. However, the reason that he had decided to leave was not due to the culture. He stated that when he first started working there it had taken half an hour to get in to work, however this had crept up to an hour to get there and 2 hours to get back home. This was unsustainable and did not provide Mr Amron with the work life balance that he wanted.

236. He stated that he had then become Care Manager of Blue Bird Care in East Hertfordshire, which is a domiciliary care provider, however this was only for a period of about 6 weeks, when Mr Amron made the decision to leave. He told us that he was not enjoying being in that environment.

237. In his evidence he stated that there had also been issues at work which he had wanted to address, whilst he had made suggestions to improve the culture, his line manager who was the Registered Manager would not sign off on improvements and changes that were needed. He stated that by March or April 2022, he thought that “enough was enough.” There was no real support to improve things. Given this he had decided to leave the organisation and when the opportunity came to apply for the role at the home he decided to apply.

238. He told us that during his time at Sunridge Court, he had to “practically do the job of a registered manager”. As this Registered Manager was less hands on and as a result, he had gained experience of the roles that needed to be undertaken as the registered manager.

239. Mr Amron stated that Mayapur House was a smaller home, a 7-bed home. This was a good size home and he loved being hands on. He enjoyed meeting families and working with staff. He wanted to be with residents every day and staff and “use our knowledge and empathy”. He told us that he loved being with staff.

240. In his witness statement he went through each of the domains that the care home was found to be in breach of and how these would be addressed by him.

241. Mr Amron told us that he was in the process of overhauling the home. He informed us that he had reviewed the documentation and had come to the view that it was not of the quality and standard expected. He informed us that he planned to use Quality Compliance Systems (QCS). The system was not in use because there were no residents and due to uncertainty surrounding the Tribunal decision on the appeal. However, it was his plan to customise the system for the use of the home. He told us he would not be using the forty or so policy documents that Mr Patel had prepared.

242. He told us that he planned to hire a professional cook or two part time cooks

and there would also be dedicated cleaners. These roles would be part-time however this would free up the health care assistants to focus on the role of caring.

243. As Registered Manager he would be responsible for recruitment and for carrying out the checks, however he expected that as the nominated individual, Mrs. Ramdarass would oversee recruitment. He told us that there were at least three staff who he had worked with previously, who had indicated a willingness to work with him in the future. He was also aware of previous staff of the home such as Mary Chege had also indicated that should the home re-open, they would be willing to resume employment.

244. He told us that he was aware of people from his role of deputy manager who would be interested in working with him again. He was also aware of previous staff of the home who would also be willing to resume working for the home. In answer to a question from Mr Connor he denied that this would create a closed culture. He told us that all these individuals would be interviewed and only appointed if they were deemed suitable.

245. Mr Amron indicated that he had skills for care, which could provide support to staff to ensure that the home was person centered. He also referred to the digital care package QCS which would enhance record keeping and would ensure compliance with the CQC domains. This would be an important safeguard and alert for a manager, care staff would input data using a handheld device or laptop. He stated that it was possible to have all the assessments on the QCS system, which is helpful as there are prompts on the system. He told us that the system was also very usable but in addition the company would do a full induction for staff.

246. He was asked by Mr Connor about the existing policies. He referred to two policies, food hygiene, and safeguarding. He was asked about the plans to use these policies going forward. Mr Amron stated that they could use the safeguarding policy, but he was not planning to use the food hygiene policies. He stated that the Safeguarding Vulnerable Adults, date September 2022, this was like the QCS Safeguarding policy. He stated that this was the basic, minimum required, needs some work.

247. In answer to Mr Connor's questions Mr Amron denied that there was nothing in existence in terms of policies at the home. He stated that if the service "wins this appeal, the service won't start until everything is in place." He stated that an ex CQC inspector was happy to come in to spend a day or two with the service and go through all the systems and make sure that they were compliant.

Waterlow Assessment and Pressure Documentation

248. He was asked about the possibly doctored document, he stated that he was

aware of it and that Mrs. Ramdarass had spoken to Ms. Ward and Ms. Pradhan who were the two nurses. However, when he joined there were no staff. He stated that his approach was that he could tolerate mistakes but would not tolerate dishonesty. He asked what steps he had taken hearing to investigate this matter when it had first been raised at the hearing. He stated that although he was aware of the issue that had been raised at the hearing, he did not ask questions, as he was not involved in original conversations and was not the manager when the incident occurred. However, he would audit the records and make sure that if a document was doctored, he would suspend the person as he would not tolerate dishonesty.

249. He was asked about whether his method of recruiting staff from friends from other services that he had worked for, and previous members of staff would result in a closed culture. He stated that they were not personal relationships, they were professional relationships, as such there were people he had worked with, and everyone would go through a proper recruitment process. He denied that the approach adopted would lead to a closed culture.

250. He was asked why he had not yet applied to be registered manager and whether there were plans for him to be nominated individual. He stated that this had been discussed. Mr Connor pointed out that the written evidence on this point was different from the oral evidence of Mrs. Ramdarass. In respect of Mrs. Ramdarass he stated that “Mary was the nicest person he had worked with, every day she was passionate about what she wanted. He was asked about the financial viability of the business and told us that he had satisfied himself that the business was viable.

Application for Registered Manager

251. He was asked why he had not yet applied for the position of registered manager.

252. He stated that his perception was that this would have had a negative impact on him given that there were on-going proceedings. He stated that he had written to Mr Page and asked for his advice, but did not speak to anyone else in CQC. He accepted that Mr Page was not able to give him advice. He stated that he had drafted an application for registered manager, and it was “all filled in should I apply but felt that I should not apply until the outcome was known.”

253. He told us that he had spoken with Gareth Page who had phoned him, on mobile, number came up had a 25-minute conversation, gave me information about his own background in the care home.

254. He stated that Mr Page told him that If the appeal did not go in the service’s favour, the service could apply for re-registration.

255. In answer to our questions, he accepted that it had come as a surprise to him

that even if the appeal was successful the stay on accepting service users only if approved by the CQC would remain until such time as the condition was varied.

Closing Submissions

Mr Connor on behalf of the CQC

256. Mr Connor in his closing submissions set out the powers open to the Tribunal He stated that we could grant the appeal, dismiss the appeal or grant the appeal with conditions. In his closing submissions he stated that -: The matter for the Tribunal to determine is whether, pursuant to section 17(1)(c) of the 2008 Act, the relevant regulations have been complied and will continue to be complied with, as of the date of the hearing.

257. "The Tribunal must determine the matter anew making a fresh determination on the evidence which has been presented by the parties.

    Having heard the evidence in the case, the Respondent contends that the burden of proof has been adequately discharged and has demonstrated that the Appellant is not complying with (or will comply with) the regulations and invites the Tribunal to dismiss the appeal.

258. He further submitted that-: "Due to the Service having been dormant since May 2022 the focus has moved from strict analysis of the decision to cancel the Appellant's registration on the basis of the conditions which presented at the Service in January, to a wider consideration of whether the decision to cancel remains reasonable and proportionate in light of the present circumstances. Whilst the previous history of the Service will undoubtedly assist the Tribunal in determining the facts at present, the Respondent submits that the issues in this case can now be summarised as follows:

    a. Continued lack of effective leadership;
    b. Continued lack of effective policies and procedures;
    c. A closed culture; and
    d. Lack of clarity on the requirements/timescales in re-opening the Service.

259. He then set out the evidence which he submitted supported the CQC, in its submission that the decision remained reasonable and proportionate. Although we have not fully set out the submissions in this decision, they were fully considered by us.

260. In response it was confirmed to Ms. Renton that although the CQC bore the burden of proof in respect of the decision to serve the NOP and that the decision remained proportionate, there was a persuasive burden to be discharged by the Appellant.

Response of Ms. Renton on behalf of the Appellant

261. Ms. Renton also set out how the Appellant had satisfied each of the standards, or proposed to meet the standards if the appeal was allowed. In her written submission, she stated in paragraph 3;" In outline it is the Appellant's case that A. Significant staffing changes have been made effectively overhauling the management structure at Mayapur House. B. There has been substantial procedural change and evidence of procedural and regulatory compliance e.g. in relation to environmental health issues, training, cleaning person centered care. C. Care planning documentation and procedure has been reviewed and altered changing the manner in which care is delivered and giving greater accountability of the Home's documentation. D. The home is currently vacant of service users, however, should the appeal be allowed they intend to alter the type of service user...E. Unfortunately, the Appellant has not be able to evidence the substantial change in governance and practice due to the disproportionate and unjustified decision of the CQC in adopting the notice of proposal."

262. Ms. Renton in her oral closing submissions also went through each of the domains that the appellant was alleged to have breached and how they had evidenced that they would now be able to comply with the standards. We have considered these submissions in our conclusion below

The Tribunal's conclusions with reasons

263. **I**n reaching our decision, we considered the submissions of the parties, and reminded ourselves of the issues that we had determined as relevant in this case. We were also assisted by the Scott Schedule which had been prepared by the parties setting out each of the domains and the case of the parties on each of the regulations.

264. We reminded ourselves that the issues we had to determine were-:
    a. Whether there were breaches of the domains as set out in the NOD
    b. Whether the CQC had acted proportionately in serving the NOD
    c. Whether the circumstances at the date of the hearing had changed so that the decision reached to serve the NOD was no longer proportionate and the appeal ought to be allowed.

Whether there were breaches of the domains as set out in the NOD

Regulation 9 (Person-centered care)

265. The CQC alleged that people's needs were not met at the service. The registered manager and staff were unable to demonstrate knowledge and understanding of current guidance and recommended best practice when supporting people with mental health conditions.

266. The Appellant accepted that the standard was not met in part, they denied that health professionals were not involved in people's care, and that referrals not

made were appropriate. However, it accepted that although staff were kind and compassionate, sometimes the language used was not appropriate.

267. In the CQC report it was stated that the registered manager admitted people with physical disabilities, sensory impairment, living with dementia, mental health needs without clear plans on how to meet people's needs. For example, a person had been in rehabilitation following a stroke. They were discharged to their own home but after a few weeks moved to the service. The registered manager failed to implement the rehabilitation plan recommended by health professionals, this put the service user at risk of harm. We heard from both the witnesses from the CQC and Mrs. Ramdarass, and Mrs. Pradhan. We heard about service users at the home in particular service user A & B. We accept that they and other service users had complex needs. However in choosing to accommodate the service users who were admitted to the home, (given the variety of the service users' needs) the home had to be prepared to offer a bespoke service which was capable of accommodating the variety of needs. We find that their different needs were not always met. We find a failure to follow the rehabilitation plan and a failure to carry out appropriate pre-admission, meant that this put service users at risk of harm.

We also find that there was evidence that a service user who had been within the home did not have access to a bath or showers and as a result was provided with only bed baths. We find that although there is some evidence that staff were caring the care given was generic and as such it failed to meet the requirements of the regulation to meet person centered care.

Regulation 11 Need for consent

268. We heard that the issue concerning the need for consent, was about the installation of CCTV and the lack of seeking consent from the residents concerning this. The Appellant accepted that this standard had been unintentionally breached and that there was an intention going forward to obtain consent of any future service users. We accept that the Appellant was in breach of the standard at the time the Notice of decision was served.

Regulation 12 (Safe Care and Treatment)

269. The CQC in the Scott Schedule refer to service user's being exposed to risks in case of fires. They also cite the following breaches of the regulations: service users were not safe from the risk of food-borne illnesses; and there was insufficient guidance given to staff concerning how to lower risks. Bed rails were used inconsistently, and risk assessments had not been carried out concerning their use, that service users were placed at risk of infection, and that although there were cleaning schedules during the time of the inspection no cleaning practices were observed.

270. We accept that at the time of the May/ June inspection, and the final visit on 28 June 2022, that the Appellant was in breach of regulation 12. We heard from

Mrs. Ramdarass, that on 5 July 2019, an external assessor identified fire safety work which needed to be carried out and that this was not actioned by the time of the inspection. We also heard that no additional work had been undertaken in the kitchen after the initial registration and that there was an issue with storage. We heard that by the time of the January 2023 inspection that both the work in relation to the fire safety and the kitchen had been completed and that the fire safety work had been signed off, and an EHO inspection gave the kitchen a 5-star rating.

271. We heard that there were concerns regarding one service user who had capacity, concerning her cluttered environment. The registered manager at the time did not accept this breached the standard, citing that this was the person's choice. We also heard from Mrs. Pradhan and Mrs. Ramdarass, that one of the service users had bed rails but refused to use the guards for the rails during the day. We accept that the service at that time was of the view that an informed choice had been made, however we accept the CQC, report in which it was noted that "... they failed to assess the risk to the person and others living in the home and show how they had discussed this with the person and supported their understanding of living in a safe environment…" There was a lack of documentation to show that such discussions had taken place.

272. We noted that although there was an assessment by the CQC that service users were at risk of infection, we heard no evidence that any of the service users acquired any infections.

273. We accept that changes were made to the physical environment so that the premises were safe. However, we were concerned that at the time when the issue of the service user and the environment within their room was being discussed the manager displayed an underlying attitude towards safe care and treatment which amounted to a casual disregard. We find that at the time the Notice of Decision was served at paragraph 5 of the decision the CQC stated as follows-: CQC drew attention to a lack of appropriate risk assessments and highlighted your failure to consistently carry out assessments under the Mental Capacity Act (MCA) 2005. It was noted that Service User B lived in an environment where hazards were evident: you had not carried out a risk assessment or an MCA assessment to understand whether Service User B had capacity to consent to living in a hazardous environment.

274. "6. Your representations state that you have addressed the hazards, and you present photographs of what you claim are wires that have been tidied. The photographs presented clearly show wires still trailing across the floor. You have not presented a copy of an appropriate risk assessment or an MCA assessment, as described in the Notice of proposal." We find that there was a lack of documentation, to support the care of the service user at the time that the NOD was served and that in the absence of informed choices having been made the Appellant was in breach of Regulation 12.

Regulation 13 Safeguarding

275. We heard evidence concerning the standard of care. While there is no suggestion that the service users were subjected to abuse, the standard in respect of safeguarding is to safeguard people who use services from suffering any form of abuse or improper treatment whilst receiving care. At the time of the May/June inspections there was a lack of evidence concerning up to date training on safeguarding. There was also a service user who had sustained an injury to their arm and neck and that a relative had raised a concern. There was an absence of any robust complaints or reporting of this concern to the appropriate authorities. We noted that the CQC raised concerns about staffs' understanding of safeguarding. We heard that the completion of training was evidenced by a tick sheet in which all the staff were asked to complete training and then tested on their knowledge of it. Ms. Chege informed us that supervision could take up to two hours. We were concerned that although the monitoring forms demonstrated detailed areas of safeguarding there was no information about how staff knowledge was tested, or of any areas which needed review Given this we could not be satisfied that this was anything more than a tick box exercise.

276. We noted Mr Page's written evidence concerning a lack of curiosity or appropriate procedures for dealing with the bruising, which was witnessed on the service user. There was no investigation, no incident report, no body map or review of the risk of injury. We accept that once this incident was reported the LA were satisfied that no further action was required however we find that at the time the Notice of Decision was served the Appellate was in breach of the standard of care.

Regulation 17 Good Governance

277. Regulation 17 is to ensure that providers have management systems policies and procedures to help them achieve other fundamental standard such as person centered, safe, effective and compassionate care. We heard that one of the concerns of the CQC was not only the lack of effective policies and procedures, but also that they observed at the time of the May/June inspection a closed culture which meant that the service had a lack of outside independent professional scrutiny.

278. For the purpose of our decision, we have accepted the following definition of closed culture. The CQC guidance entitled, "Identifying and responding to closed cultures" identifies an inherent risk factor of weak leadership and management when "workforce comprises many members of staff who are either related or friends, causing 'cliques' to form"

279. The Appellant accepted the criticisms regarding good governance, following the 2022 inspections, accordingly we find that at the time the notice was served there was a breach of this standard.

Regulation 18 (Staffing)

280. Regulation 18 provides that employers shall deploy sufficient and suitably qualified staff; staff should receive the support training and professional development and supervisions and appraisals to enable them to carry out their role and responsibilities.

281. In the Scott Schedule provided that staff were not trained and lacked skills and knowledge to meet people's needs effectively. The training staff received were "…basic all in one sessions…".

282. In respect of the numbers of staff we heard that the service had started to use a dependency tool to assess the number of staff who were needed for the Rota. Ms. Traian accepted that this was an appropriate way of dealing with the staffing level. We accept that this was an appropriate tool to use.

283. However, we found that the training was too basic for the needs of the service users and that the training that had been undertaken was undertaken on one day. We noted that 13 areas of training had been undertaken in one day. There was no information about how the staffs' understanding of the training had been assessed. This gave the impression that training was considered a tick box exercise. We find that although the number of staff had been addressed the service had not adequately addressed the training needs of the staff. We find that the Appellant had breached the standard in respect of regulation 18.

Regulation 20 (Duty of Candour)

284. In the Scott Schedule the CQC alleged that the service provider failed to inform relatives and staff concerning the action the CQC were taking following inspections. This breach was accepted by the service provider. We find that this breach occurred.

Whether the CQC had acted proportionately in serving the NOD?

285. We heard evidence of Mrs. Catherine Perrins. She set out that the CQC followed the decision-making tree in reaching its decision to issue the NOD, after considering the representations made. In her witness statement Ms. Perrins stated as follows-: ".... I believe that the decision to cancel the Appellant's registration as a provider remains proportionate and the appropriate response to the continued failings and lack of improvement of the provider and the risks that this presents to people using their service. Significant risks were identified at the inspection 18 May and 28 June 2022 and the more recent inspection 4 January 2023 found continued risks to people's safety and well-being and a lack of understanding by the provider of their responsibilities as a registered person and a lack of systems and governance arrangements to ensure people using the service were safe and received care that met their needs and respected their rights. The provider repeatedly demonstrated that they were not aware of what constituted good, safe care. The provider throughout the process following the inspection in May 2022 to the present day has failed to understand

and acknowledge the level of risks to people living at UK International Nursing Agency Limited Dom Care and has not taken the necessary actions to make sufficient improvement to the service."

286. We accept that at the time the Notice of Decision had been made, the Service had a history of inadequate inspections, and that as stated by both Ms. Traian and Mr Page the response to serious concerns demonstrated a lack of understanding of the potential risk of harm to service users. There was a lack of urgency by the management of the home which included both Mr Alex Banson-Idun and Mrs. Ramdarass in their response to the concerns, as a result of the wide-ranging concerns addressed in the inspection reports the CQC decided to serve the Notice of Proposal.

287. In the witness statement of Catherine Perrins, she provided information about the service of the Notice of Proposal she stated that-:

288. The Notice of Proposal to cancel the provider's registration was served on 16 August 2022 and representations received from the provider on 15 September 2022. The Representations were considered by a team within CQC who are independent of the inspection team. The decision not to uphold the provider's representations was authorised by a head of inspection in line with CQC's scheme of delegation. The details of the reasons for not upholding the representations are outlined in the letter to the provider dated 9 November 2022. The Notice of Decision to cancel the provider's registration was served on 9 November 2022."

289. We heard that Mr Alex- Banson-Idun was laid back and slow to initiate change, we also find that there was a reluctance on Mrs. Ramdarass' part to address the changes that were needed and to place herself in the "hot seat" of responsibility. She made the decision to appoint Mr Vasant Patel even when she was aware that he had no day-to-day experience of managing (or even working in any other capacity in) a care home, let alone one which was subject to a Notice of Decision.

290. Another example of this is when urgent compliance action was needed and the service requested more time as Mrs. Ramdarass was due to undertake Jury Service. This demonstrated that the service showed no sense of urgency in initiating the required changes and was unlikely to fully implement the necessary actions for compliance

291. We find that at the time the decision was made the Respondent acted proportionately in serving the Notice of Decision.

Whether the circumstances at the date of the hearing had changed so that the decision reached to serve the NOD was no longer proportionate and the appeal ought to be allowed.

292. In their closing submissions the CQC focused on four areas: lack of effective leadership, Continued lack of policies and effective procedures, a closed culture and lack of clarity on the requirements and timescales in re-opening the service. The Appellant took us through each of the domains that were alleged to have been breached. We decided to consider the issues in their totality.

293. Ms. Renton in her submissions considered regulation 9, she stated that in her statement, Miss Ramdarass explains at para 48" ...a rehabilitation plan was added to the care plan of service user A, but she was reluctant to engage and make use of the aids provided.

294. However, we noted that there was no evidence that the service asked for support in dealing with these issues and there was a lack of recording of attempts to get the service user to engage with the plan. We also considered that there was evidence of a closed culture in that the service did not seek support from external agencies in order to manage the service users' behaviour. We have heard evidence from Mr Amron about changes that he will put in place in order to deal with care planning, however we find that although care planning was an issue there was a lack of external scrutiny. Further there was an attitude that the service could justify its decisions without subjecting them to external scrutiny. We note that Mrs. Ramdarass is still the nominated individual and we heard little about how she had strengthened her understanding of this role.

295. We heard and accepted the submissions from Ms. Renton that the carers did attempt to meet the needs of Service user A, and that the staff considered the home staff and residents to be like family. We heard that Service user A, was upset at leaving the service. We accept that staff were in the main caring and that they had good relationships with service users. However we consider that a failure to appropriately support a service user in changing their behaviour, may put them at risk of harm, notwithstanding that they may be happy within the home. Further there is a lack of documentary evidence to show that the service user was appropriately challenged.

296. We accept that there is an intention to improve care planning by using QCS care systems, however we have born in mind that these systems are not yet in place. For this reason, we have not been able to assess the service as having the systems in place to provide person centered care.

297. In respect of regulation 11, we accept that the service will be able to meet the standard, accordingly we have not considered this standard further. We also accept that there is some evidence before us of steps taken by the service to address safe and effective care in that the fire report had been actioned and improvements made to the kitchen.

298. We also noted that Mr Amron told us about plans to hire a cook and cleaners, however we found that there was a lack of clarity around these plans as they

did not appear to be included within Mrs. Ramdarass' written or oral evidence to us. Given this, we were unable to be reassured that these plans would resolve the issue of HCAs having sufficient time to provide care to the service users.

299. It was also clear to us that the plans appeared to have been predicated on the basis that the service would be able to reopen following the appeal with service users in place. However, we find that without detailed plans concerning this, these plans may be little more than a wish to do things differently. Accordingly, we are not satisfied that the service would provide safe and effective care.

300. With regard to safeguarding, we noted that the same concern arises concerning the lack of systems. We note that this is dependent on the QCS system, we have noted that this is not yet in place. Accordingly, we have been unable to satisfy ourselves that if the appeal was allowed, without more, the Appellant would be able to meet the standard concerning safeguarding.

301. We have considered good governance. We heard from Mrs. Ramdarass. We noted that she did not seek to place all of the blame on Mr Banson-Idun. She told us that he was slow to accept change and it was to her credit that she acknowledged that he had been a good manager, albeit he had not responded quickly or effectively to what was required following the May/June inspections.

302. We noted that during the time of the May/June inspections, as the nominated individual there were also requirements on Mrs. Ramdarass to put together an action plan and see to its implementation. We heard that during this period Mrs. Ramdarass had a sister who was seriously ill and that this had an understandable impact on her. However, we were concerned that Mrs. Ramdarass did not take responsibility and show leadership concerning issues that had arisen during the wider period of her management. We were made aware of the issue concerning the discrepancy concerning the Waterlow documents and the care documents of a service user which appeared to have been altered in some way, without the alteration being acknowledged on the face of the document.

303. Mrs. Ramdarass did not appear to have placed sufficient importance on this and taken steps to satisfy herself as to what had occurred and document her enquiries. We found that Mrs. Ramdarass was well liked by her staff which was displayed by the way in which they spoke of her, it would appear that she was also hands on in providing care. However we noted that her approach to employing staff, did display a lack of understanding concerning closed cultures. We further found that there was a weakness in her decision making in that although she thought Mr Patel displayed potential, he was inexperienced and untested as a manager and had never worked in a care home. It should have been apparent to Mrs. Ramdarass that this was not a role which could be undertaken on a part-time basis. Nevertheless, she was prepared to put him forward as registered manager.

304. We noted that she was equivocal about her role going forward in the service. We also noted that she told us that she lacked the patience to deal with the CQC. We found that although this was an open and honest admission it was somewhat telling, in respect of her role as nominated individual. We heard that she was very hands on with her care. However, she was insufficiently professionally curious about the supervision and auditing that had taken place and accepted that everything had been signed off without interrogating the documentation and the staff within the home. For all these reasons we consider that the issues concerning good governance have not been fully addressed. We are not satisfied that Mrs. Ramdarass is capable of adequately undertaking the role of Nominated Individual.

305. In his closing submissions Mr Connor set out (paragraphs 86-89) the Respondent's position that "The Respondent has not inspected the Service since January 2023. Between the last inspection and July 2023 when this matter came to tribunal for the first time, the Appellant had become dormant, Mr Patel and Ms. Pradhan stopped working at the Service in May 2023, and Mr Amron did not begin until July 2023. As such, very little had improved by the time of the first part of this hearing. Following an unexpected adjournment, the Appellant was given an opportunity to use the time to begin to affect real change and improvement under the direction of Mr Amron in order to seek to persuade the Tribunal that they were in a position to re-open the Service in a compliant manner. However, despite such an opportunity, the Appellant has merely sat on its hands.

306. No new polices, procedure, audits or risk assessments have been carried out. The Appellant has confirmed that these will all be completed with the assistance of QCS and PCCS if the appeal is allowed. Mr Amron has not applied for registered manager."

307. We found that in their appeal the Appellant placed considerable weight on Mr Amron becoming registered manager however Mr Amron is not at this time the registered manager. We had to consider this, and also ask ourselves whether the service's ability to implement what was required was wholly dependent on Mr Amron? We did not answer this but it is a concern going forward.

308. The Appellant has failed satisfy us that the decision to serve the NOD was disproportionate.

309. We are not satisfied that the circumstances at the date of the hearing have changed so that we can be satisfied that the decision reached to serve the NOD was no longer proportionate and the appeal ought to be allowed

Decision:

I. The appeal against the Notice of Decision dated 7. 12. 2022 is dismissed.
II. The decision of the CQC set out in the Notice of Decision 7 November 2022 is upheld.

Judge Daley
Mr M Cann- Specialist Member
Mrs Forshaw- Specialist Member

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

Date Issued: 21 December 2023