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Case No: AC-2024-LON-000069

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27 August 2024

Before :

HHJ KAREN WALDEN-SMITH
sitting as a Judge of the High Court

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Between :

THE KING (ON THE APPLICATION OF SEABROOKE MANOR LIMITED)	**Claimant**
- and –	
THE CARE QUALITY COMMISSION	**Defendant**

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- -

VIKRAM SACHDEVA KC (instructed by **HCR Legal LLP**) for **SEABROOKE MANOR LIMITED**
VICTORIA BUTLER COLE KC and ARIANNA KELLY (instructed by The **Care Quality Commission, Legal Services**) for **The Care Quality Commission**

Hearing dates: 25 June 2024 and 27 June 2024

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Approved Judgment

This judgment was handed down remotely at 10.30 am on 27 August 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Judgment Approved by the court for handing down.

HHJ WALDEN-SMITH:

Introduction

1. The Claimant, Seabrooke Manor Limited, run a care home known as Seabrooke Manor which is located at Lavender Place, Ilford, Essex IG1 2BJ ("Seabrooke Manor").

2. The Claimant is permitted to provide services for a maximum of 120 people at the care home who must be over 18 years old and in need of personal or nursing care, including people diagnosed with dementia. Many of the residents lack the capacity to make decisions with respect to their care, or the conduct of their daily lives, and are accommodated pursuant to an authorisation by the relevant local authority issued pursuant to the Mental Capacity Act 2005 ("the MCA 2005")

3. The Claimant took over the running of Seabrooke Manor on 9 August 2022 and registered with the Defendant, the Care Quality Commission ("the CQC") on 10 August 2022. The Claimant registered as a service provider in respect of the regulated activities of "accommodation for persons who require nursing or personal care" and for "treatment of disease, disorder or injury" at Seabrooke Manor.

4. The CQC is the independent regulator of health and social care services in England and its statutory objective pursuant to section 3 of the Health and Social Care Act 2008 ("the 2008 Act") is to protect and promote the health, safety and welfare of people who use health and social care services. The five "Key Questions" answered in a CQC inspection report equate to the key responsibilities of the CQC to ensure that health and social care services are providing people with safe, effective, compassionate, responsive and well-led care. The CQC provides a rating of Outstanding, Good, Requires Improvement or Inadequate for each of the Key Questions and also provides an overall rating for the service.

5. Seabrooke Manor had previously been assessed by the CQC as "Good" in all areas (safe, effective, caring, responsive, and well-led) after an inspection on 16 and 26 April 2018. The CQC undertook an unannounced inspection on 13 to 14 June 2023, which resulted in a draft report dated 2 August 2023 and then a Factual Accuracy Check, where the Claimant's challenges to the draft report were responded to on 6 October 2023 before the publication of the Report on 10 October 2023. That Report dated 10 October 2023 erroneously referred to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations") which was corrected for the final Inspection Report dated 30 November 2023 which provided that the overall rating for the service at Seabrooke Manor was "Requires Improvement" and that Seabrook Manor was found to fall within the "Requires Improvement" category in relation to the questions of whether the service was safe and well-led. The questions: Is the service effective? Is the service caring? Is the service responsive? were all answered "Good". The consequence of the two questions: Is the service safe? Is the service well-led? being determined to be "Requires improvement" resulted in the overall rating being "Requires improvement". Karthika Sivananthan, a Director of Seabrooke Manor said in her statement dated 6 February 2024 that by 2 February 2024 the occupancy had dropped to 108 residents. The effect of the "Requires Improvement" rating has, it is said by Ms Sivananthan, made lenders show unease, that staff morale is lower, and that insurance is likely to be considerably higher.

6. The Claimant disagrees with the ratings in the individual areas and the overall rating. The Claimant contends that the ratings are unlawful and should be quashed. The Claimant further contends that the CQC ratings for both the individual and overall ratings ought to be "Good" in each and that the court should make its own decision with respect to those ratings and replace those of the CQC so that the overall rating is also "Good".

7. The contention of the Claimant is that the decisions of the CQC are based on substantial and demonstrable errors of fact and the differences between the views of the CQC and the Claimant's arrangements of the management of medication "cannot rationally or reasonably amount to an allegation of lack of safety" and that it was wrong for the CQC to carry across allegations of errors in the safe key question to the well-led key question without an objective and critical assessment of the well-led question.

8. The judicial review challenge to the determination of the CQC's is brought under four grounds:

   (i) That the CQC's policy recommends that an individual's medicine care plan should include how medicines should be administered covertly and that the CQC guidance goes beyond NICE (National Institute for Health and Care Excellence) guidance and is irrational and/or lacking cogent evidential underpinning;

   (ii) That the CQC's finding that Seabrooke Manor "Requires Improvement" in the safe key question is not rational or lawful;

   (iii) That the CQC's finding that Seabrooke Manor "Requires Improvement" in the well-led key question is not rational nor lawful;

   (iv) That the CQC's finding that the overall rating "Requires Improvement" cannot be supported if any of the Grounds 1-3 succeed as the overall rating is dependent upon the individual findings.

9. Permission to bring these judicial review proceedings was granted by Sweeting J by an order made on 20 February 2024 with a 1 day time estimate. There were no reasons given for permission being granted. The hearing in fact took a day and a half's court time as a consequence of the detailed oral submissions on 25 and 27 June 2024.

10. The Claimant accepts that in bringing this challenge, the court will always be cautious in overturning the good faith factual assessment and evaluative conclusions of an expert regulator. That is particularly the case where, as here, the regulator is operating in an area where public safety is of primary concern.

The Inspection and Report

11. The unannounced first inspection of Seabrooke Manor under the ownership of the Claimant ("the Inspection") was undertaken by the CQC on 13 and 14 June 2023. The inspection team comprised three inspectors, a medicines inspector - Joanne Charlesworth, a nurse specialist advisor and two experts. In her role as the medicines inspector, Joanne Charlesworth (as set out in her witness statement dated 26 March 2024) supports and works with inspectors to gather and assess evidence in relation to medicines. During the Inspection the CQC inspectors spoke with staff, residents and family members and also undertook an inspection of the records, policies and procedures. Joanne Charlesworth said that if any issues with medicines are identified on the day of the inspection then she would discuss those with staff so they could be addressed promptly. Contemporaneous notes were taken of what was seen by the CQC inspectors but no photographs or photocopies of what was seen by the inspection team were taken. It is not usual for photographs or photocopies of every care record they have viewed to be taken by the CQC inspectors carrying out the site visit, as that is not the practice of the CQC. The site visit notes included reference to a number of medication errors and noted that there were 4 individuals in one of the houses who were on "covert meds" namely MY, GC, VF, MA (initials used for confidentiality).

12. Joanne Charlesworth, as the medicines inspector, drafted a report specifically on the medicines inspection on 13 June 2023. She said she found the ratings on safe and well-led to be borderline and she said that she considered carefully the possibilities of recommending rating the service as "Good" with recommendations for improvement or rating it as "Requires Improvement." This was a borderline matter. After her careful consideration she recommended the rating as "Good" with recommendations for improvement as there were strengths as well as issues in the service. Charlene Perryman, the lead inspector, was responsible for the drafting of the report dated 18 July 2023 which took into account Ms Charlesworth's findings and the medicines report as well as the findings of the whole inspection team. Ms Perryman rated all key questions as good and sent the report for peer reviewing. Mohammed Miah reviewed the report and agreed with the rating but suggested that the issues with the medicines in the safe key question could be a breach of regulation 12 of the 2014 Regulations and in the well-led key question there could be a breach of regulation 17 of the 2014 Regulations. After feedback from Mr Miah, Ms Perryman made changes and sent it to Ram Sooriah for review.

13. The report was reviewed by Mr Sooriah on 21 July 2023 who concluded that the main issue with respect to the safe key question was the management of medicines and that the appropriate rating was "Requires Improvement". He also queried what the well-led domain should be and whether there was a breach of the 2014 Regulations.

14. Charlene Perryman amended the report and sent it back to Mr Sooriah who reviewed the report for a second time on 1 August 2023 and Mr Sooriah said that the report was now much clearer. He said that in his professional view, and having reviewed hundreds of reports, a rating of "Requires improvement" on the safe key question was the correct rating. Mr Sooriah was concerned about the negative information contained in the safe key question, in particular the paragraphs dealing with covert medicines, time sensitive medicines and medicines to be given when required (PRN - pro re nata). His concerns were that the systems were not sufficiently robust for patients to receive their medicines safely. He said that he had no doubt that the service should be rated as "Requires

Improvement" in the safe key question and his only concern was that there had been an additional breach of a regulatory requirement. Mr Sooriah's statement of 28 March 2024 sets out in detail the process he undertook in reaching his conclusion. He set out that he would expect care records to be clear how to give a service user their medicines covertly, where this has been assessed as in their best interests, and that he would want a plan with clear information either in the care plan, or a specific form on how to administer covert medicines and, if not in the care plan, he would expect clear signposting as to where detailed information on the covert administration of medicines could be found. The Claimant contends that Mr Sooriah introduced a more stringent test based upon his own interpretation or understanding and that the Claimant was being marked down for failing to do something which had not been specified as needing to be done.

15. Further, Mr Sooriah found that the well-led question should also be "Requires Improvement" as there was an issue with the Claimant's medicine audits failing to identified the shortfall around the management of covert medicines, PRN – when required – protocols, and time-sensitive medicines and the Claimant's own quality assurance systems had not been effective and had not identified the concerns found at the inspection, including those around medicine management and care-plans. At that time he found a breach of Regulation 17 of the 2014 Regulations.

16. There was comment made on behalf of the Claimant in the course of the hearing about the length and nature of the experience of Ram Sooriah, who reviewed the report of Charlene Perryman. Mr Sooriah's witness statement is clear with respect to his length and depth of experience. The challenge to his experience appeared to be withdrawn in the course of oral submissions but if lack of experience or understanding is still relied upon by the Claimant, I do not find any merit in that contention.

17. The draft of the report was sent to the Claimant on 2 August 2023 with both ratings safe and well led key questions "Requiring Improvement", but with the overall rating still said to be "Good". The Claimant was invited to respond with respect to the factual accuracy of the report. The inclusion of "Good" for the overall rating was an error and corrected before the report dated 6 October 2023. Mr Sooriah says in his witness statement that he had made the professional judgment that the overall rating for the service should be "Requires Improvement" as per his comment on the Quality Assurance Tool which determination was in accordance with the CQC's ratings aggregation principles, in that the overall rating of a service cannot be better than requires improvement if there is a breach of regulations. If two or more of the key questions are rated as requires improvement, then the overall rating will normally be "Requires Improvement", although this is not mandatory. The inclusion of "Good" was an administrative error on CQC's part.

18. The Claimant engaged in the CQC's Factual Accuracy Check (FAC) and provided a 35-page Factual Accuracy submission on the draft report on 22 August 2023, which it submitted to the CQC together with 44 documents. These documents included patient information leaflets for various medications; prescriptions, audit documentation, a table on information available on covert medication for residents; PRN protocols; covert medication forms; care plan for patient DS; Medication Administration Records (MAR); feedback from Charlene Perryman and Provider Information Return Request; Training records and the Seabrooke Manor newsletter for May 2023.

19. Responses were provided by the CQC to the Claimant on 6 October 2023 and changes were made to the draft report, including the removal of the conclusion that there had been a breach of regulation 17 of the 2014 Regulations. The CQC did not alter its conclusions that the safe or well-led key questions both "Required Improvement." On 10 October 2023 the final report was published.

20. Further documents were provided by the Claimant after the publication of the final report. The documents that the CQC relied upon in reaching their conclusions were those that were available at the time of the inspection, including those available during the inspection and produced during the report writing process, including the Factual Accuracy Check. The Claimant cannot rely upon any documentation not available to the CQC at the time of the inspection. Any produced afterwards were not relied upon. If there was a factual error on the part of the CQC in the initial report or any lack of documentation, then that would have been documentation the CQC would expect to see during the Factual Accuracy Check (and the Claimant did submit 44 documents during the Factual Accuracy Check).

21. The Claimant sent a letter before claim on 26 October 2023 and on 9 November 2023 the CQC wrote to the Claimant acknowledging that the finding that there had been a breach of Regulation 17 of the 2014 Regulations was an administrative error. That correction, by the removal of reference to a breach of Regulation 17, was made for the publication of the final report on 30 November 2023. The letter before action also noted that there had been a downgrade from "Good" to "Requires Improvement" in the final report, but that had been as a consequence of the initial error not to amend the final rating to reflect the other ratings.

22. As a consequence of the contents of the letter before action, the CQC decided to request another adult social care specialist to review the inspection report in order that they could give their opinion on the rating of the key questions and of the service overall. That specialist, Teresa Anderson, undertook a paper-based review on 15 November 2023 and supported the decision that the appropriate determination for both safe and well-led questions, and overall, was "Requires Improvement".

23. The final date of the Report is 30 November 2023. The Report provides that the safe and well-led questions are "Requires Improvement" and that the overall rating for the service is "Requires Improvement."

24. On 27 December 2023, another Senior Specialist, Julia Spencer-Ellis, was asked to undertake a further paper-based review by the CQC in light of a further pre-action protocol letter. She also concluded that the evidence gathered from the inspection in both safe and well-led key questions had the characteristics of "Requires Improvement" rather than "Good".

25. The Claimant received feedback from Ms Charlesworth that she noted that in certain documents the Claimant had amended care plans to take into account the mistakes highlighted by the inspection team to the Claimant at the time of the inspection. There is no criticism made of the Claimant with respect to the making alterations in response to the CQC's criticisms as it shows that the Claimant was responsive to the concerns raised at the inspection. However, the CQC make the point that the amended documentation was not the documentation as it was seen by the inspection team on 13 and 14 June 2023. The CQC is entitled to judge the Claimant on the basis of what

was seen in place as at the date of the inspection. (*R (Hexpress Healthcare Limited) v CQC*[2023] EWCA Civ 238*).*

26. Insofar as there is a dispute between what the CQC are saying they were shown at the time of the inspection, and what the Claimant says was available at the time, then the CQC rely on the fact that there was the opportunity for the Claimant to produce that evidence at the time of the Factual Accuracy Check. The Claimant did make use of that facility by submitting 44 documents at the time of the Factual Accuracy Check and the CQC asks why, if the documentation was available, the Claimant did not produce any other documentation it relies upon.

27. The following corrections were made by the Claimant in response to the CQC's inspection feedback:

    (i) Resident CB's PRN protocol was amended as the PRN protocol first seen by the inspection team did not contain the correct information. This was altered on 13 June 2023 and submitted by the Claimant as part of the Factual Accuracy Check submissions in August 2023.

    (ii) Resident HN's PRN protocol was also amended on 13 June 2023 as it was noted by Ms Charlesworth to be nearly identical to CB's PRN protocol. This amended protocol was submitted with the Factual Accuracy Check submissions in August 2023.

    (iii) Resident GC's covert medication plan suggested that the medication could be mixed with tea, which was not in fact a suitable course to take as the tea could denature the medication. Tea was crossed through and porridge used in its stead. While a document dated 17 May 2023 was submitted with the Factual Accuracy Check submissions, the CQC do not accept that was the document provided in the course of the Inspection.

Legal Framework

28. The CQC is a body corporate under section 1 of the 2008 Act and, as is referred to above, the main objective in the performance of its functions is "to protect and promote the health, safety and welfare of people who use health and social care services" (section 3(1) of the 2008 Act); and to perform its functions for the general purpose of encouraging – "(a) the improvement of health and social care services, (b) the provision of health and social care services in a way that focuses on the needs and experiences of people who use those services, and (c) the efficient and effective use of resources in the provision of health and social care services." (section 3(2) of the 2008 Act).

29. Section 4(1) of the 2008 Act sets out the matters to which the CQC must have regard in the performance of its functions. This includes (e) "the need to ensure that action by

the Commission in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed,"; and (g) "best practice among persons performing functions comparable to those of the Commission (including the principles under which regulatory action should be transparent, accountable and consistent)." Section 4(2) of the 2008 Act provides that in performing its functions the Commission must also have regard to such aspects of government policy as the Secretary of State may direct.

30. Section 20(1) of the 2008 Act provides that the Secretary of State must "by regulations impose requirements that the Secretary of State considers necessary to secure that services provided in the carrying on of regulated activities cause no avoidable harm to the persons for whom the services are provided". Those are the 2014 Regulations.

31. Section 46(1) of the 2008 Act provides that the CQC must conduct reviews of the carrying on of the regulated activities by the service providers, assess the performance of the services providers following each such review, and publish a report of its assessment. Section 60 of the 2008 provides the power to carry out inspections; section 61(2) provides that where an inspection is carried out then a report must be prepared and a copy of the report must be sent to the person or manager who carries out the regulated activity.

32. Regulation 12(1) of the 2014 Regulations provides that care and treatment must be provided in a safe way for service users which includes, without limitation, (2)(a) assessing the risks to the health and safety of service users of receiving the care or treatment; and (2)(b) doing all that is reasonably practicable to mitigate any such risks. With respect to good governance, regulation 17 of the 2014 Regulations provides that (1) systems or processes must be established and operated effectively to ensure compliance with the requirements of regulation 17 and, again without limitation, such systems or processes must enable the registered person to (2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity; (2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (2)(d) maintain securely such other records as are necessary to be kept in relation to (i) persons employed in the carrying on of the regulated activity and (ii) the management of the regulated activity.

33. The process for compiling an inspection report is set out in the CQC guidance "How we monitor, inspect and regulate adult social care services" ("the CQC Guidance"). The CQC Guidance provides definitions of different ratings for each key question, and defines the Key Lines of Enquiry, are set out in the Adult Social Care framework.

34. With respect to the Key Question of safe the CQC considers the use and administration of medications as set out in S4. The Key Question of whether the Service is well-led is in W2. The issue considered is: "Does the governance framework ensure that responsibilities are clear and that quality performance, risks and regulatory requirements are understood and managed?" The Adult Social Care framework also provides a description of services which fall within the categories of Outstanding, Good, Requires Improvement, or Inadequate

35. The guidance for the provision of medication is set out in NICE guidelines for the "Managing of medicines in care homes", which is dated 14 March 2014, and the CQC's guidance on the "Covert administration of medicines".

36. The Claimant acknowledges that as the CQC is a specialist regulator, concerned with upholding standards and protecting members of the public, the court should properly accord deference to its decisions. A decision will be irrational and unlawful if a material finding is made where there is no evidence to support that finding.

37. In *R (Hexpress Healthcare Limited) v The Care Quality Commission* [2023] EWCA Civ 238, the Court of Appeal held that the process of the CQC of sending the draft report to the organisation allowing comment through the Factual Accuracy Comment process, considering those comments and making modifications in light of those comments before producing the final report, was a procedurally fair process. Dingemans LJ, giving the judgment of the court, referred to the determination of Andrews J (as she then was) in *R (SSP Healthcare Limited) v CQC* [2016] EWHC (Admin) 2086, pointing out that the judgment was not a statute and that the requirements of procedural fairness are to achieve fairness. In *Hexpress*, the Court of Appeal were satisfied that the procedures that had been adopted in that case gave both fair notice of the proposed findings and a fair opportunity to answer them.

38. In *SSP Healthcare*, Andrews J criticised the CQC for reaching findings on the basis that systems did not exist purely on the basis that the inspectors had not seen evidence of the system and further criticised the CQC for not amending the report after SSP Healthcare responded in the FAC process that there had been such systems in place. Andrews J found that the CQC could either accept the word of the inspected body and make appropriate adjustments or ask to see evidence (which might involve a return to the practice) or that it had found no evidence of the matter at the time of its inspection but that it had been informed subsequently that such evidence existed:

> "What it [the CQC] cannot do is make adverse findings that something does not exist if the regulated body tells it that it does, and it does nothing to test that assertion. That would be tantamount to finding that the complainant is lying without taking any steps, let alone reasonable steps, to ascertain whether what it has said is true."

39. It is apparent that in *SSP Healthcare* there were factual issues which should have been resolved in favour of the service provider, but which had not been and it was in this context that it was found that procedural fairness required the CQC to undertake a review of its response to the proposed factual corrections to the draft report. The court is looking at what fairness requires in any particular case.

The Challenge

40. Overall the Claimant challenges the decision of the CQC to find that both key questions safe and well-led were "Requires Improvement", leading to an overall finding that the overall rating is of one "Requires Improvement". The Claimant submits that the rating should be "Good" on both categories and that the overall rating be "Good".

41. An underlying criticism made by the Claimant is that during the Internal Quality Assurance process, the determination of the inspectors, including the lead inspector Ms Perryman, and the medicine inspector, Ms Charlesworth, was overridden by another, Mr Sooriah, who, it was incorrectly alleged "had only been there for a few months" and who it was alleged had acted irrationally in applying a more stringent policy. The position of the CQC is that the writing of the final published report goes through a process of checking and assessment in order to ensure accuracy and, insofar as it is alleged that the care plans available at the time of the inspection, the CQC submit that if the Claimant considered that there had been a failure to refer to any existing care plans within the initial report then that could be dealt with during the process of the Factual Accuracy Check,

42. The Claimant further raised in the course of oral submissions and within the skeleton argument a challenge to the decision on the basis that it failed to provide adequate reasons and that the CQC was relying upon ex post facto reasons for its decision making.

43. A challenge based upon the CQC not providing adequate reasons or relying on ex post facto justification did not form part of the application for judicial review. There is not any proper challenge on this basis in any event. Reasons must be intelligible and adequate and reasons must enable the reader to understand why particular decisions are made and what conclusions are reached on the principal important controversial issues:

> "The reasons for a decision must be intelligible and they must be adequate. They must enable the reader to understand why the matter was decided as it was and what conclusions were reached on the "principal important controversial issues", disclosing how any issue of law or fact was resolved. Reasons can be briefly stated, the degree of particularity required depending entirely on the nature of the issues falling for decision. The reasoning must not give rise to a substantial doubt as to whether the decision-maker erred in law, for example by misunderstanding some relevant policy or some other important matter or by failing to reach a rational decision on relevant grounds. But such adverse inference will not readily be drawn. The reasons need refer only to the main issues in the dispute, not to every material consideration. They should enable disappointed developers to assess their prospects of obtaining some alternative development permission, or, as the case may be, their unsuccessful opponents to understand how the policy or approach underlying the grant of permission may impact upon future such applications. Decision letters must be read in a straightforward manner, recognising that they are addressed to parties well aware of the issues involved and the arguments advanced. A reasons challenge will only succeed if the party aggrieved can satisfy the court that he has genuinely been substantially prejudiced by the failure to provide an adequately reasoned decision." (per Lord Brown in *South Bucks DC v Porter (No 2)* [2004] UKHL 33

44. In *R v City of Westminster ex p Ermakov* (1995) 28 HLR, the Court of Appeal made clear that the purpose of the requirement to give reasons in a public law decision is to

enable the applicant to assess whether there is a ground for challenging an adverse decision and that the wholesale amendment or reversal of the stated reasons would be inimical to that purpose and might lead to practical difficulties if it were to be suggested that the alleged true reasons were in fact second thoughts designed to remedy an otherwise fatal error.

45. As set out above, none of the four grounds upon which permission to judicially review the CQC determinations was granted because of lack of reasons or reliance upon wholly new reasons. In any event, the reasons given by the CQC for their various findings were both intelligible and accurate and allowed the care home management team to understand the reasons for why the findings were made. Further, I do not accept that the CQC was altering its position or amending reasons in order to make ex post facto corrections to remedy a fatal error. The system of inspection, internal quality control and the process of the Factual Accuracy Check result in a complex system of checks which inevitably mean that the original draft of any report will be considered with care and may well be amended prior to final publication. In this matter, while there were some errors in the drafts of the report which have been amended, these have been acknowledged by the CQC and do not amount to second thoughts or remedying an otherwise fatal error and the witness statement of Mr Sooriah dated 26 March 2024 does not fall foul of the *"Ermakov* principles" as applied in *R (Wallpott) v WHSSC* [2021] EWHC 3291. While there can of course be a natural tendency to seek to defend and bolster a decision being challenged, in this matter Mr Sooriah is doing no more than providing further clarification. In his second statement he sets out that he would expect care records to be clear in setting out how to give "a service user their medicines covertly where this has been assessed as in their best interests, as well as containing evidence of the involvement of healthcare professionals such as the pharmacist and the GP." He sets out that he would want a plan with clear information in a care plan or a specific form to address how to administer covert medicines. That is not an "after the event" justification but elucidation of what had already been set out by the CQC.

Ground One

46. The first ground of challenge, developed in detail in oral submissions, is with respect to the CQC's policy with respect to the "covert administration of medicines". The Claimant's case is that the CQC's policy recommends that the medicine care plan of an individual should include how the medicines are to be administered covertly and it submitted, on behalf of the Claimant, that the guidance goes beyond the guidance provided by NICE and is irrational and/or lacks cogent evidential underpinning.

47. The Claimant's challenge under ground one is based upon the contention that the CQC considered the Claimant's lack of compliance as a reason for finding that Seabrooke Manor "Required Improvement" for the safe key question.

48. The covert medicines policy of the CQC provides as follows:

> "**Policy**
>
> The medicine policy should include a clear explanation of your covert medicines process. The policy should be specific and up to date. Your staff must read, understand and follow the policy"

The CQC contends that the policy is logical and sensible, but the Claimant avers that the CQC has a far stricter policy when it comes to records, requiring that all relevant information be contained in the care plan:

> "**Records**
>
> Include in a medicine care plan
>
> …
>
> - How medicines will be administered covertly."

It is the Claimant's contention that this is a change from the general requirements in the policy and goes beyond the NICE guidelines. The Claimant contends that the CQC is acting irrationally to impose the requirement as effectively a mandatory requirement so that an absence of compliance is considered as threatening the safety of the patient. The Claimant contends that there is no rational or sufficient reason advanced for such a restrictive policy which it says goes beyond the NICE guidance without identifying any inconsistency.

49. The CQC say that this is non-statutory, best practice guidance which is entitled the Covert Administration of Medicines Guidance ("the CAM Guidance"). Its purpose is to provide basic advice to care providers about the administration of covert medication. The CAM Guidance is provided by the CQC as best practice guidance and not setting mandatory requirements. It is clearly said to be a Best Practice Guidance on the CQC's website which makes it clear it is not statutory guidance.

50. Covert administration of medicines is when medicines are administered in a disguised format, such as when they are hidden in food and drink without the knowledge or consent of the person who is receiving them. The NICE Guidance, "Managing medicines in care homes" (NICE Guideline SC1) provides that Care Home providers have a care home medicines policy which should include written processes for care home staff giving medicines to residents without their knowledge (paragraph1.1.2). Section 1.15 deals specifically with care home staff administering covert medicines, which includes requirements that the process complies with the Mental Capacity Act 2005. The NICE Guidance does not include specific requirements for the recording of the administration of the covert medicines and does not require that the recording be within one document.

51. The CAM Guidance sets out that when a person has mental capacity to make the decision about whether to take a medicine they have a right to refuse that medicine even if the decision to refuse appears ill-judged to staff or family members and so:

> " Covert administration is only likely to be necessary or appropriate where:
>
> - A person actively refuses their medicine and
>
> - That person is assessed not to have the capacity to understand the consequences of the refusal. Such capacity is determined by the Mental Capacity Act 2005 and

- The medicine is deemed essential to the person's health and well-being"

52. The CAM Guidance goes on to set out that covert administration must be the least restrictive option after trying all other options; that a functional assessment should be carried out to try to understand why the person is refusing to take their medicines; and alternative methods of administration should be considered. This is a sensible, logical and rational piece of advice pointing out the potential dangers of giving medicines covertly.

53. The CAM Guidance also recommends that the way in which medicines are to be administered covertly should be included in a medicines care plan, which is a sensible and rational piece of advice to prevent errors in the covert administration of medication by ensuring that care homes maintain proper detailed recording of the provision of covert medicines for any particular patient. It is not necessary for that information about the administration of medicines covertly to be within one document, and the care plan may refer to other documentation containing information about the resident's covert medication.

54. I do not find that there is anything within the CAM Guidance issued by the CQC which runs counter to the NICE guidance.

55. The NICE guidance: Managing Medicines in Care Homes (NICE Guideline SC1) sets out that care home providers should have a care home medicines policy which should include written processes for care home staff giving medicines to residents in a care home. Paragraph 1.14.6 provides that care home staff must have the training and skills to use systems adopted in the care home for administering medicines in accordance with the regulations for both adult and children's care homes and that paper based or electronic medicines administration records should be legible, signed by the care home staff, be clear and accurate, be factual, had the correct date and time, be completed as soon as possible after administration, avoid jargon and abbreviations, be easily understood by the resident, their family member or carer (see paragraph 1.14.7).

56. Paragraph 1.14.8 of the guidance provides that:

"Care home providers should ensure that medicine administration records (paper-based or electronic) include

- The full name, the date of birth and weight (if under 16 years or where appropriate, for example, frail older residents) of the resident

- Details of any medicines the resident is taking, including the name of the medicine and its strength, form, does, how often it is given and where it is given (route of administration)

- Known allergies and reactions to medicines or their ingredients, and the type of reaction experienced

- When the medicine should be reviewed or monitored (as appropriate)

- Any support the resident may need to carry on taking the medicine (adherence support)

- Any special instructions about how the medicine should be (such as before, after or with food).

57. Paragraph 1.14.9 sets out that care home providers should ensure that a new, hand-written medicines administrations record is only produced in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.

58. Paragraph 1.14.10 provides that care home providers should ensure that all information included on the medicines administration record is up to date and accurate. They may need support from the health professional prescribing the medicines and the supply pharmacy to do this.

59. In paragraph 1.1.1 of the NICE guidance provides that commissioners and providers (organisations that directly provide health or social care services) should review their policies, processes and local governance arrangements, making sure that it is clear who is accountable and responsible for using medicines safely and effectively in care homes. In paragraph 1.1.2 it is set out that care home providers should have a care home medicines policy that is reviewed to make sure it is up to date, based on current legislation and the best available evidence. The policy should include written processes for, amongst other things, ensuring that records are accurate and up to date; care home staff administering medicines to residents, including staff training and competence requirements; care home staff giving medicines to residents without their knowledge (covert administration). Paragraph 1.15 of the NICE guidance deals with care home staff giving medicines to residents without their knowledge (covert administration). It provides that medicines should not be administered covertly if the resident has the capacity to make his/her own decisions about care and treatment; covert administration should only take place in the context of existing legal and good practice frameworks to protect both the resident and the care home staff and that the process for the covert administration of medicines to adults in care homes includes assessing mental capacity, holding a best interests meeting, recording the reasons for presuming mental incapacity, planning how the medicines will be administered covertly and regularly reviewing whether covert administration is still needed

60. I accept the evidence provided by Ms Charlesworth, that the CQC guidance is based upon the NICE Guidance. The Claimant is incorrect when submitting that the CAM Guidance contains a mandatory requirement for all information pertaining to covert administration of medication to be in one document. That is clear from the fact that in the course of the inspection of Seabrooke Manor, the CQC considered the various documents and care plans that were provided by the Claimant. While the Claimant contends that the CQC has gone further than the NICE Guidance requires, it is clear that the concern of the CQC which led to the "Requires Improvement" rating was not the location of the information with respect to the administration of covert medicines (was it in one or more document) but the lack of that information across the documentation provided by the Claimant.

61. I have considered both the NICE documentation the CQC documentation. The CQC has provided a "best practice" document. It is plainly not statutory guidance and the CQC do not seek to present it as such. It makes recommendations which are to assist in the avoidance of errors and it is appropriate for the CQC to undertake the provision of such best practice guidance in fulfilling its own function. The NICE Guidelines provides under "covert administration" that covert administration only takes place in accordance with the Mental Capacity Act 2005 and that the care home ensures that the process for covert administration clearly defines who should be involved in, and responsible for, decision making, including providing authorisation and clear instructions for care workers in the provider's care plan. There is nothing in the CQC best practice which contradicts what is set out in the NICE Guidelines. During the CQC inspection of Seabrooke Manor, the inspection team reviewed that which is in the care plan and in any further documentation containing direction for the administration of covert medication for those residents who require the administration of covet medication.

62. The Claimant does not establish that the CQC CAM Guidance is inconsistent with the NICE Guidance or that it goes beyond the NICE Guidance. The CQC were properly setting out advice about the administration of covert medication for care providers such as the Claimant. In the circumstances, Ground One of the challenge cannot succeed and I do not need to consider section 31 of the Senior Courts Act 1981.

Ground Two

63. The Claimant contends that the CQC has found that the appropriate rating for the key question safe was "Requires Improvement" rather than "Good" on an irrational basis. As the Claimant makes clear in the statement of Kathika Sivanathan, the finding of "Requires Improvement" is a significant finding for the Claimant. In addition to it being a criticism of the running of Seabrooke Manor in that it indicates that, rather than protecting the residents from avoidable harm, there is a potential risk as it has the commercial impact of discouraging new admissions, and undermines morale. The Claimant does not seek to undermine the CQC's need to protect public safety but it avers that in this instance the CQC has failed to apply its own policy correctly and has reached factual findings which are not justified by the evidence.

64. The Claimant contends that the CQC erred with respect to the administration of covert medicines in three material respects: it is averred that the CQC attached weight to the fact that the information relating to the administration of covert medicines was not all within the medicines care plan, and in doing so misconstrued its own policy; the standard on review was more demanding, which cannot be reasonably inferred from the published policy; there were material errors of fact with respect to four patients.

65. The CQC's response is that while the Claimant has focussed upon the administration of covert medication as being determinative of the finding that the running of Seabrooke Manor "Requires Improvement", that was not in fact the case and the rating was based upon the cumulative findings.

66. In the response to the Factual Accuracy Comments the CQC did not set out that there was a failure to contain all information with respect to the administration of covert medicines within a single medicines care plan. For example, it is said that *"Medicine administration records* (plural) *should clearly record which medicines you administer*

covertly and when." While there is reference to instructions regarding how to give medicines *"must be recorded on the MAR chart for all staff to follow [including agency staff]";* the CQC were inspecting *"all relevant records relating to covert medicines … This included the medicines record [MAR chart], mental capacity assessments, best interest decision, care plans and covert medication form."* Consequently, all of the documents dealing with the covert administration of medication were reviewed. In the final report, the CQC set out that the *"Covert medicines records did not always have enough information about how staff should give the Medicine or if there had been any advice sought from a pharmacy professional. There was therefore a risk that people might not receive covert medicines in a consistent way".* I do not read this as setting out that there is some mandatory minimum standard for a care home to meet before it can properly be judged to be "Good". The CQC, through the on-site inspection and the following internal quality assurance and Factual Accuracy Check, is evaluating the evidence about Claimant's practices on covert medicines. It was found on the inspection that some of the necessary information was found recorded in the residents' records, but not all of the necessary information was so recorded. For example, the front sheets of the MAR stated if the resident was on covert medicines *"however there were not detailed instructions on how this should be done. For example, some front sheets stated "give in porridge or tea". This does not support staff to know what they should be doing with the medicines and care plans did not contain detailed information about crushing etc."* It was also recorded with respect to one resident that they *"did not have information about who had been included in the decision or consent. There was also no evidence of pharmacy input or review."* Further, covert medicines had not been included in the DoLS (deprivation of liberty) applications. This was all evidence that the CQC properly took into account in its assessment of the safe key question.

67. Given the findings by the CQC that some of the necessary information was included in the paperwork and some was not, there was a concern that the system for the administration of covert medicines was not sufficiently robust. The determination that the Claimant "Requires Improvement" on the safe key question was an entirely rational determination to reach in the circumstances and, although the CQC readily accepts that it is a borderline matter it was not irrational not to find the safe key question as "Good". The CQC did not find that the Claimant "Requires Improvement" in the safe key question because of a lack of all the information being within one document.

68. The Claimant's second complaint is that the CQC do not specify precisely what information is required in documenting how covert medication is to be given as a minimum so as to ensure a finding of "Good". The criticism of the operations manager, Mr Sooriah, is that he specified a number of additional matters that needed to be recorded in the covert medicines administration records, including: the quantity of food and drink that should be used to allow for the covert medications to be administered; whether priority should be given for medicines where there is more than one administered covertly; whether multiple medicines should be concealed in the same cup of liquid.

69. It appears that the Claimant does not accept that a covert medication plan should include the amount of food or drink to be used, the priority in which medicines should be given, nor whether multiple medications can be covertly given in the same food or liquid. In my judgment, there is nothing irrational or unreasonable about the CQC expecting the

covert administration of medicines to deal with these specifics. It is an obvious concern that if a resident is being given covert medicines and starts to refuse to take food or liquid that it is known how much of the covert medicine has been consumed. It is also an obvious concern that if some medicines are more essential to administer that they should be ranked higher than other medicines, should a resident start refusing to take food or liquid and for the care home employees who administer covert medicines to know if they can be concealed in the same cup of liquid or plate of food.

70. It is a matter for the CQC to determine whether a covert medication plan, contained within one or more documents, fulfils the requirement to provide sufficient information. The administration of covert medications is very important to control. The provider, such as the Claimant, will have an understanding of the administration of covert medication for the purpose of ensuring the safety of residents and the inspection team is entitled to exercise its own expertise in determining whether the Claimant's covert medication plan provides adequate information for the purpose of the covert administration of medication. In my judgment, the CQC was entitled to reach an evaluative judgment as to whether the safe key question was to be answered as "Good" or "Required Improvement". The CQC, through the inspections teams and through its operations manager, Mr Sooriah, is entitled to determine whether the administration of the medication was safe. The role of the CQC is not simply to compare the records of the provider against NICE guidelines or the statutory guidance. If that were the function of the CQC then it would not require an expert body to be making these decisions. The inspection and reporting process is multi-layered, and the CQC provides an evaluative judgment making use of the professional experience of the inspection team and the operations manager. The determination of the CQC is not an irrational one.

71. The final basis upon which the Claimant alleges that the determination that the safe key question "Requires Improvement" is that there were material errors of fact on the part of the CQC. The Claimant further alleges that the CQC is relying upon late reasons.

72. The first point made in response to this criticism is that the Claimant cannot rely upon documentation that was not available at the time of the inspection or during the Factual Accuracy Check, which were available at the inspection. Developments or improvements which occurred after the inspection are not relevant for the purpose of making the rating determination.

73. The response to the Factual Accuracy Check contained confirmation that the CQC reached a finding, on the basis of all the submitted records, that there was insufficient detail on how to administer medication:

> "In line with the guidance above, information was missing for GC, MA, MY and VF regarding how each individual medicine should be given. For example, crushed, dissolved in water, what to mix a liquid with. All medicines should be reviewed by a pharmacist and written information must be provided as to how each medicine should be given e.g. crushed and given in a spoonful of yoghurt. Any medicines not given as per the manufacturers licence are being given off licence so the patient information leaflet would not apply. Please see additional professional advance here."

74. The CQC also found that there were some wrong instructions which could result in medication being natured and therefore ineffective. For example:

> "On the paperwork reviewed for GC it stated risperidone (liquid) should be given with tea or juice. Risperidone must not be given in tea as it denatures the active ingredient. This was discussed with the clinical lead. On the records provided as part of this FAC submission this entry has been overwritten with the word porridge."

75. Where the CQC found that a pharmacist's signature was not on a resident's notes as it should have been, the Claimant contends that there is an explanation for that apparent failure. That explanation, however, is included in a witness statement not signed until 28 May 2024 and therefore long after the inspection process.

76. The CQC do not suggest that the Claimant did not act appropriately in making an immediate remedy to the instructions. However, the CQC says that the original error cannot simply be ignored.

77. The CQC recorded further concerns about the lack of review dates on any of the paperwork provided by the Claimant; that there was a lack of adequate signposting and detail within the main care plans; that there was a lack of instruction on the MAR charts and that, by reference to the NICE Guidance "Managing medicines in care homes", certain information should be included in the paper or electronic medicines administration records.

78. The Claimant contends that the lack of reference to review dates in the future does not mean that there would not be future reviews, as there was evidence of reviews in the past and that there was procedural unfairness by not accepting the Claimant's submissions on this matter. The CQC was legitimately entitled to find that the failure to record review dates going forwards meant that there was no evidence to support that there was a regular review of the administration of covert medicines going forwards.

79. The CQC gave a detailed response to the Claimant's submission on the use of the MAR charts by referring to the NICE guidance on "Managing medicines in care homes" which states at point 1.14.8

> "Care home providers should ensure that medicines administration records (paper-based or electronic) include:
>
> - the full name, date of birth and weight (if under 16 years of where appropriate, for example, frail older residents) of the resident
>
> - details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration)"

and then said "this to us seems to demonstrate that MARS should be clear about how to administer a medicine". The CQC cannot be legitimately criticised for this determination.

80. The various factual findings reached by the CQC gave the CQC the basis for finding that the safe key question properly "Required Improvement". There was no procedural unfairness in the process undertaken by the CQC and there are, in my judgment, no material errors of fact.

81. The Claimant further alleges that the CQC was relying upon "late reasons". It is set out in *Hexpress Healthcare Limited* that it is for the CQC to determine whether the date of the inspection was the correct date for the making of the ratings, or whether it should adopt a later date for the making of its ratings. The CQC determined that the date of inspection in this matter was the correct date for the making of the ratings and later developments or improvements are not relevant for the ratings decision.

82. With respect to specific users:

    (1) the CQC had not been provided with the November 2021 care plan for GC until the second pre-action protocol letter and therefore it is not an error for the CQC to not have taken that care plan into account; the Claimant further contends that the CQC was wrong to criticise the Claimant for a breach of NICE Guideline 1.2.5, the error was only with respect to the particular point (it should have been 1.5.2) not the substance;

    (2) the Claimant criticises the CQC for failing to note that MY was no longer on regular covert medication by 13 June 2023, however the notes record that the staff at the care home notified the inspection team that MY was on covert medication and the CQC was entitled to rely upon that information.

83. In order for a factual mistake to give rise to unfairness, the decision must be based upon a mistake upon an established fact which was uncontentious and objectively verifiable, that the party alleging such a mistake was not responsible for that mistake, and the mistake played a material part in the reasoning (see *E v Secretary of State for the Home Department* [2004] EWCA Civ 49). In this matter there is no mistake on the part of the CQC which could fulfil the criteria of *E v SSHD* such that there is unlawfulness based upon errors of fact.

84. The Claimant further complains that the CQC have provided late reasons in the second statement of Mr Sooriah by providing specifics of the information which it is said was missing from the covert medication care planning documents. The second statement of Mr Sooriah undoubtedly provides greater details about what the CQC says was the information missing from the covert medication care plan documentation. The Claimant contends that it is the provision of late reasons and therefore not admissible. I do not read it as such. It does not put forward new reasons but gives further detail for the reasons already provided in the decision made. The CQC are not endeavouring to justify a decision after the event, they are properly seeking to elucidate their decision yet further.

85. Even if the statement of Mr Sooriah is not taken into account (and in my judgment there is no reason as to why it cannot be relied upon) both the Inspection Report and the response to the FAC provide sufficient reasons for the particular audience to understand the basis upon which the determination was made. Both set out that the opinion of the CQC is that the covert medication plans lack sufficient detail: in the Inspection Report the CQC set out that the covert plans lack sufficient detail which is enough detail to

allow a potential service user to understand the basis upon which the CQC reached its conclusion and the response to the FAC sets out examples of where the CQC considered there was a lack of sufficient detail for the benefit of the care home operator (the Claimant) with an understanding of the business and of good practice.

86. The CQC further concluded that *"… there was not a robust system in place to ensure people receiving time sensitive medicines had them at the time they were prescribed."* The reason that the CQC came to that conclusion was because, while there was a system in place at the site inspection it became apparent that staff were not using the system and/or were unaware of the system. In Ms Charlesworth's statement dated 26 March 2024 she set out that one of the unit managers had been unaware of the system and the staff she spoke to did not know about the system of setting alarms on the phones in order to alert them to when medicines are due. The Claimant cannot properly challenge the conclusion that the administering of time-sensitive medication was less than robust, as it was not a system that always worked.

87. With respect to the PRN protocols, the site inspection revealed that with respect to 2 PRN protocols for lorazepam there was not appropriate individualisation: *"CB and HN are 2 different people and therefore their PRN protocols must reflect their individual needs. As the protocols were both written in the same way and both referred to "her" when one was a male suggests that they were not accurately written and in addition the circumstances which caused them anxieties were written as the same when in practice the circumstances were different. Staff during the inspection confirmed the information in the protocols did not provide the correct information… For HN and CB, the PRN protocols dated 16/1/23 and 27/1/2[3?] respectively say to give a variable dose of ½ to 1 tablet when required, but the PRN protocol does not make clear when ½ tablet should be given or 1 tablet so that the medicine was constantly administered …"* . With respect to the PRN protocol for CB did not match the information in the care plan which stated that they may become anxious when their movements were restricted or their room cleaned, rather than when she is constipated or having personal care. The Claimant contends that the issues are dealt with in the PRN protocols dated 13 June 2023, but it is clear from Ms Charlesworth's notes that she was presented with the earlier PRN protocol of January 2023. The Claimant prepared a new PRN protocol for both CB and HN on 13 June 2023 which were submitted to the CQC with the FAC submissions in August 2023. Again, the Claimant is correct to take remedial action to amend the difficulties highlighted by the CQC but it does not mean that Ms Charlesworth was in error in what she recorded.

88. The CQC was also concerned that the Claimant was using template forms without making sure the individual PRN needs of a service user were recorded accurately, thereby leading to the PRN protocols being written very similarly which could lead to the incorrect administering of sedative medication.

89. In all the circumstances therefore, while the issue of whether the key question safe was "Good" or "Requires improvement" was a question of judgment, the determination of the CQC that it fell within the "Requires improvement" side of the line was supported by the evidence and not an irrational conclusion.

90. Ms Charlesworth had originally come to the conclusion that the safe key-question was Good on the same evidence but that does not make the final conclusion as "Requires Improvement" irrational, given the matters set out above. The CQC were justified in

reaching the conclusion, after careful consideration of all the information gathered, that there was not always enough information provided on how and when the covert medication might be taken.

91. The CQC did not reach a conclusion that was either irrational or perverse and ground two of the judicial review must therefore fail.

Ground Three

92. The Claimant contends that the determination by the CQC to find that the well-led key question "Requires Improvement" was because of the finding that the safe domain "Requires Improvement."

93. Mr Sooriah explains in his second witness statement that the decision made with respect to each key-question is determined individually but the information gathered with respect to any key-question may be of relevance to another key-question. With respect to the well-led key question, consideration is given to information systems, clinical governance and quality assurance and how future performance is managed. If there are risks in these areas which have not been known to management then this is relevant to whether the home is well led and Mr Sooriah's evidence is that the "ASC inspection guidance: Judgments and Ratings" sets out that inspectors *"have to consider management and leadership failures and the effectiveness and robustness of their governance systems where there are shortfalls in the Safe, Caring, Effective and Responsive Key Questions".*

94. The CQC set out in the Report why the well-led key question "Required Improvement": first that the medicines audits were not always effective as they had not identified the shortfalls found by the CQC with respect to the management of covert medicines, PRN protocols and time sensitive medicines; secondly, the audits of care records were lacking as they had not identified that not all care plans were detailed enough to comprehensively address people's needs and preferences so that they could make the necessary improvements. In response to the Factual Accuracy Check, these were said not to be one-off issues and repeated audits had not found the issues identified around medications.

95. The issue was also raised with respect to lack of communication with relatives of those in the home. Mr Sooriah noted that during the inspection *"13 out of 14 relatives we spoke with told us there was a lack of communication with them, in that they did not feel always involved in their family members care and they were not always kept informed about them. People's relatives had told us there were not feedback forms or relatives meetings"* although it was acknowledged that the Claimant did work closely with people using the service *"to understand their views and how they wanted to be cared for"* but *"feedback from relatives suggested that they were not always engaged and kept informed about their family members and what was happening within the service"*. This failure to engage fully with relatives would not be a reason for finding that the well-led key question "Required Improvement" on its own but it was a further factor that the CQC could properly and rationally rely upon in its overall assessment.

96. The CQC's determination of "Requires Improvement" for the well-led key question was based upon the way in which the Claimant was running the care home and the inspection team discovering discrepancies between the Claimant's processes and

policies and what was in fact being carried out. The description given by a number of staff with respect to how the home operated was at odds with the policies that the Claimant had devised, the lack of a robust system for the administration of covert medications, the lack of understanding or knowledge of the discrepancies and the quality assurance processes not being consistently applied gave rise to the finding that the well-led key question "Requires Improvement." This was a rational, evidence-based determination and was not, as the Claimant contends, an automatic finding of "Requires Improvement" because of the finding that the safe key-question "Requires Improvement." In the circumstances, the challenge brought as ground three cannot succeed.

Ground Four

97. The Claimant seeks a finding that overall rating of "Requires Improvement" be quashed and replaced with a "Good" rating. This ground is parasitic on the other grounds, as is acknowledged by the Claimant, and with two "Requires Improvement" ratings upheld for both the safe and well-led key questions, the overall rating is normally the same. There are no exceptional reasons to depart from that finding and the overall rating remains as "Requires Improvement".

98. Even if I had come to the conclusion that the ratings of "Requires Improvement" ought not to stand on the basis of this public law challenge, it would not have been appropriate for this court to replace the findings of the CQC with its own determinations that the safe and well-led key questions be rated as "Good". The only appropriate remedy would have been for the determinations to be quashed, the report to have been removed from the CQC's website and a further inspection and report process to be undertaken on Seabrooke Manor by the expert body who has responsibility for judging the various key questions.

Conclusion

99. The Claimant seeks to establish in these judicial review proceedings that the CQC acted irrationally both with respect to the policy for the covert administration of medicines and its determinations. The Claimant contends that, on the basis of what was before the CQC inspection team, and after the internal quality assurance and factual accuracy process, the CQC could not rationally determine that the safe and well-led key questions should be ranked "Requires Improvement" and that they could only rationally be determined to be "Good."

100. The whole inspection process undertaken by the CQC is plainly a complex one and in this particular with the inspection followed by internal reviewing for accuracy and consistency and a Factual Accuracy Check. In addition to the normal process undertaken by the CQC, in this matter the CQC responded to the two pre-action letters sent by the Claimant by arranging for further desk-based reviews. Those reviews resulted in findings that the "Requires Improvement" ratings were correct.

101. I have found that the challenge contained in ground 1 cannot stand. The CQC issued a sensible piece of guidance and advice in the Covert Administration of Medicines (CAM) guidance. The CQC are not relying on a hidden policy that everything must be within one document, the care plan. The CQC have merely issued guidance to assist care homes with best practice.

102. With respect to grounds 2 and 3, and the parasitic ground 4, he CQC have accepted that the initial findings were borderline between "Good" and "Requires Improvement" and has accepted errors in the reporting, such as giving an overall rating of "Good" when that was not possible due to the findings of "Requires Improvement" in two areas. The issue for the court is whether the determinations of the CQC were such that they could not rationally find them to have been made out. For the reasons given in detail, I do not find the determinations on the safe and well-led key questions to be irrational and, consequently, while the overall rating did not necessarily have to be "Requires Improvement" with two findings of "Requires Improvement", it is more likely that the overall rating would be "Requires Improvement". The CQC were entitled to reach the findings that it did, acting on the basis of the information obtained from the inspection and through the complex internal quality assurance and accuracy process that was undertaken.

103. I cannot find that the CQC failed to act rationally and grounds 1, 2, 3 and 4 in this claim for judicial review must therefore fail.

104. I am grateful to Counsel for both the Claimant and for the Defendant for their oral and written submissions. This judgment will be formally handed down remotely on 27 August 2024.