Neutral Citation Number: [2025] EWHC 1 (Admin)

Case No: AC-2023-LON-002648

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21st January 2025

Before :

Richard Kimblin KC sitting as a Deputy Judge of the High Court

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Between :

The King on the application of Cygnet Health Care Limited	**Claimant**
- and -	
Care Quality Commission	**Defendant**

- -
- -

Patrick Green KC and Jack Castle (instructed by **Mills & Reeve LLP**) for the **Claimant**
Simon Myerson KC (instructed by **Care Quality Commission Legal Services**) for the **Defendant**

Hearing dates: 4th and 5th December 2025

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APPROVED JUDGMENT

Richard Kimblin KC sitting as a Deputy Judge of the High Court:

Introduction

1. The Claimant ('Cygnet') is a healthcare provider. The Defendant, Care Quality Commission ('CQC'), was established by the Health and Social Care Act 2008 to regulate NHS services, private healthcare providers and social care services for adults in England.

2. In other proceedings, Cygnet pleaded guilty to matters which arose from the investigation of the death of a patient in its care. There were serious and admitted failings at other sites. But CQC had appointed an Inspector whose declared conflicts of interest were not sufficiently considered when giving him the task of leading inspections of Cygnet's hospitals. CQC's failure to apply its policy on such conflicts went wider than this case. This case is about CQC's decisions not to withdraw inspection reports and enforcement decisions by reason of apparent bias.

3. The narrative and evidence in this case extends from 2012 to November 2024, all of which ultimately concern a CQC Inspector, 'AA'. After leaving NHS employment as a mental health nurse, AA was an inpatient at Cygnet's Blackheath Hospital and Cygnet's Stevenage Hospital in 2012/13, where he was detained under the Mental Health Act 1983. He recovered from his ill-health and later joined the CQC as an Inspector. The statements of case and evidence in this case are subject to the Court's order dated 14th January 2024 which maintains the anonymity of the CQC Inspector who is to be referred to only as 'AA'. That remains the position pursuant to the final order in this case. The effect of those orders is to prevent disclosure of AA's identity or the obtaining of the statements of case or documents produced in evidence. The reasons for this order are to protect AA's privacy, particularly as to his medical records.

4. The CQC's policy is that an Inspector will not take part in the inspection of a care provider if there has been a relevant connection with that care provider during the past five years. In 2019, AA was appointed as the 'relationship owner' for Cygnet's London Hospitals. Shortly thereafter, there was a fatality by suicide at Cygnet's Ealing premises. The investigation by CQC of that event included AA as an Inspector.

5. After the fatality at Cygnet's Ealing premises, a series of proceedings commenced, of which this judicial review is a part. There are four sets of proceedings and a further claim which was intimated but not commenced, namely:
    a. The prosecution of Cygnet by CQC, arising from the fatality at the Ealing hospital;
    b. Judicial review of the decision of DJ(M) Pilling to refuse to stay the prosecution as an abuse of process;
    c. Intimation of a judicial review of CQC's conflicts policy;
    d. Judicial review of CQC's decisions to refuse to review inspection reports which involved AA as an Inspector (these proceedings);
    e. A claim for damages arising from misconduct in public office, issued on 2nd March 2023 and presently stayed.

6. The consistent theme of the arguments in these cases has been the role of AA and the impact of the fact of him having been an inpatient of Cygnet in 2012/13. That theme has developed by reference to alleged actual bias, apparent bias, complaint by AA about his care while an inpatient of Cygnet, and the terms and application of CQC's conflict policy.

7. On 8th June 2023 CQC wrote to Cygnet. That letter contains two decisions which are now challenged, namely:

a. That none of the Inspection Reports or enforcement decisions in which AA was involved (there are seven such reports between 13th November 2019 and 18th August 2021 and four enforcement decisions between 11th March and 16th May 2021) are tainted by apparent bias. The parties referred to these as the 'Impugned Decisions';
b. That the CQC would not *"revisit or review or withdraw"* any of those Inspection Reports or enforcement decisions.

8. The Impugned Decisions are seven reports in respect of five different Cygnet sites along with the enforcement action taken in respect of one of those sites, at Beckton. They are:

Reports
i. Acer Clinic Chesterfield, published 13 November 2019;

ii. Bostall House, published 4 March 2020;

iii. Blackheath, published 16 July 2020;

iv. Harrow, published 11 September 2020;

v. Harrow, published 14 December 2020;

vi. Beckton, published 28 May 2021;

vii. Beckton, published 18 August 2021, and;

Enforcement
The decision to take enforcement action against the Beckton site under the Health and Social Care Act 2008 following the inspections on 1, 3 and 8 March 2021 in which AA was involved, being:

i. The 'Urgent notice of decision to impose conditions on your registration as a service provider in respect of regulated activities', dated 11 March 2021, and consequential decisions varying said conditions as follows:

ii. 'Notice of Proposal to vary a condition on your registration for the regulated activities', dated 12 April 2021;

iii. 'Review of urgent conditions', dated 7 March 2022 (after the date on which AA left CQC);

iv. 'Review of urgent conditions', dated 16 May 2022 (after the date on which AA left CQC).

9. On 24th April 2024, on renewed application for permission to apply for judicial review, Mould J granted permission.

10. Counsel and solicitors have prepared and presented this case to a notably high standard. That has assisted the court considerably in the analysis of these complex and unusual circumstances, and in the preparation of this judgment. I am grateful for each of their contributions.

The Grounds of Review

11. The Statement of Facts and Grounds is now a lengthy document. It was amended further to the Order of Lang J dated 23rd November 2023 which had the effect of incorporating the materials from the judicial review of DJ(M) Pilling's refusal to stay the CQC's prosecution. It was re-

amended on 11th October 2024, after the grant of permission and after the filing of four witness statements by CQC.

12. The CQC's witness evidence prompted re-listing of the substantive hearing as a case management hearing, as ordered by Sir Peter Lane, sitting as Judge of the High Court. At the hearing on 8th October 2024, Clare Padley, sitting as a Deputy Judge of the High Court, heard argument on Cygnet's application to cross-examine Ms Edwards and Ms Ray, who had made witness statements which the CQC relied upon, and on applications to amend. She gave detailed reasons: [2024] EWHC 2893 (Admin). The court gave permission for specified amendments to the Statement of Facts and Grounds. The court refused applications to include new claims which were directed to the CQC review of the application of its conflicts policy. This was on the agreed basis that the review did not amount to a defence of the claim of apparent bias and is not a fresh decision. The court ordered Ms Edwards and Ms Ray to file further witness statements in lieu of cross-examination.

13. The result is that the Impugned Decisions are challenged on the single ground that they were in fact tainted by apparent bias and that the CQC erred in its letter of 8th June 2023 in concluding otherwise. It supports this ground with five reasons for which the headline summaries are:
    i. Erroneous reliance on the judgment of DJ(M) Pilling as deciding that the Impugned Decisions were not tainted by apparent bias, whereas she decided not to stay the proceedings, applying a different test of whether it was fair to try the defendant;
    ii. Further to DJ(M) Pilling's ruling, her analysis was without knowledge of AA's complaint while an inpatient, that he was a Lead Inspector and that there had been a failure to follow the whole of the CQC's conflict policy;
    iii. Erroneously considering that a decision which involves more than one person is not tainted by the apparent bias of one person;
    iv. Misdirection in failing to revisit or review the underlying facts;
    v. Failure to assess the extent of AA's role in the Impugned Decisions.

14. The decision not to *"revisit or review or withdraw*" any of those Inspection Reports or enforcement decisions is challenged by reference to five alleged errors of law: (1) irrationality; (2) failure to have regard to relevant considerations; (3) misdirection as to the test for apparent bias; (4) taking irrelevant matters into consideration; (5) failure to give adequate reasons. These grounds are acknowledged by Cygnet to be different ways of putting its core case that it is unlawful for a public authority to refuse to consider, review or withdraw decisions tainted by apparent bias or to apply the wrong approach in law in deciding not to do so.

15. The Claim Form states that the remedies sought are quashing of the two decisions and a declaration that the Impugned Decisions were tainted by apparent bias.

16. It is plain that the analysis of each of Cygnet's grounds will be informed by an over-arching conclusion as to whether or not the Impugned Decisions are tainted by apparent bias, or not. The most efficient course is to address that question first.

Law

17. The legal test for apparent bias is whether a fair-minded and informed observer, having considered all the relevant facts, would conclude that there existed a real possibility of bias: *Porter v Magill* [2002] 2 AC 357.

18. It is the fair-minded and informed observer who is the fictional person who is called upon to decide whether there has been apparent bias. That observer has attributes which many of us might struggle to attain, as Lord Hope of Craighead explained in *Helow v Home Secretary* (HL) [2008] 1 WLR 2416 at [1] to [3]. He or she always reserves judgment on every point until both

sides of the argument are fully understood and is not unduly sensitive or suspicious. The fair-minded observer does not adopt the complainant's assumptions unless they are objectively justified, but is not complacent either and so will not shrink from a conclusion that things said and done may make it difficult for a person to judge things impartially. In reaching a conclusion either way, the informed observer will take the trouble to read the totality of the material, in its overall context, which will be an important part of that material.

19. Factors which may or may not give rise to a real possibility of bias depend on the nature of the issue to be decided: *Locabail (UK) v Bayfield Properties Ltd* [2000] QB 451 per Lord Bingham CJ, Lord Woolf MR and Sir Richard Scott V-C at [25]. There may be a real possibility of bias if there were a personal friendship or animosity between the judge or decision-maker and a person involved in the case, or if there were real grounds for doubting the ability of the decision-maker to ignore extraneous considerations, prejudices and predilections and bring objective judgment to bear. In most cases, the answer, one way or the other, will be obvious. But the greater the passage of time between the event relied upon in objection, the weaker the objection will be.

20. The first step is to ascertain all of the circumstances which will have a bearing on the suggestion of bias. Having considered all the relevant facts, the second step to ask whether a fair-minded and informed observer would conclude that there existed a real possibility of bias: *Re Medicaments and Related Classes of Goods (No 2)* [2001] 1 WLR 700 per Lord Phillips of Worth Matravers MR at [85].

The Relevant Circumstances

Ealing Fatality and AA's Medical Records

21. It is convenient to start with the first set of proceedings because it is from the time of that prosecution that the evidence starts to emerge and be collated. Cygnet was prosecuted by the CQC for offences which related to the death on 22nd July 2019 of a young female patient of Cygnet Hospital Ealing. There was a preliminary inspection and an investigation by the CQC, led by AA.

22. Mr Young's evidence is that around this time the Chief Operating Officer of Cygnet knew that AA had been an inpatient of Cygnet but was not aware of any complaints by AA during his treatment by Cygnet.

23. On 30th September 2021, the CQC decided to prosecute Cygnet for offences which were disclosed by the suicide at the Ealing hospital. In December 2021, AA was dismissed from the CQC for reasons unrelated to any inspection or investigation of Cygnet. AA's medical records were requested by the Chief Executive Officer of Cygnet on 19th January 2022 but were not read by him nor any other Cygnet employee. They were passed to Cygnet's then solicitors on 2nd October 2022. Those solicitors reviewed the medical records and shared the review with counsel instructed in the criminal proceedings. These facts founded an application to stay the prosecution as an abuse of process, which is explained by the District Judge in her judgment dated 25th January 2023:

"[2] This prosecution is brought by the Care Quality Commission and arises out of the tragic death of a young woman on 22 July 2019 whilst receiving treatment at Cygnet Hospital Ealing. Cygnet Healthcare Limited was the service provider and has been charged with failing to provide care and treatment in a safe way resulting in her being exposed to a significant risk of avoidable harm occurring.

[3] The applications relate to the involvement of AA who had initial responsibility for the investigation carried out by CQC. In January 2022, after the summons commencing these

proceedings had been issued, it was discovered that AA had been detained at different Cygnet Hospitals in 2012 and 2013 pursuant to section 2 of the Mental Health Act 1983. During his detention AA made serious complaints about the care and treatment he received at both hospitals.

[4] Essentially the submissions centre on the fact that a person who had received care from the defendant and criticised the defendant was permitted to conduct a criminal investigation into the quality of care provided by the defendant which subsequently resulted in a decision to prosecute the defendant.
…

[9] I was invited by Mr Greaney KC [leading counsel instructed in the criminal proceedings] to closely analyse the factual background, which he split into four distinct areas: (i) the period before AA was detained; (ii) the period of AA's detention; (iii) AA's recruitment to the CQC; and (iv) the subsequent events. I was taken through various CQC policy documents, records relating to AA's employment, including disciplinary matters, as well as extracts from AA's medical records. I have analysed all the material before me but do not repeat it here.

…..

[16] This case involves the death of a young woman who had been placed in the care of the defendant and who was able to take her own life. The prosecution brought by the CQC alleges a number of specific failures in providing safe care and treatment including that the young woman had previously attempted to take her own life in the same way whilst at Cygnet Hospital Ealing; that the internal alarm system did not operate; that no one was on duty to let the ambulance in; and that available staff did not know how to perform CPR.

[17] There is no dispute that AA was an inpatient in 2012 and 2013, and that he raised significant complaints about his treatment at that time. However, this cannot, without more, amount to evidence of bias towards the defendant company some 9 years later. AA had been an inpatient but had been discharged and no longer needed to be detained.

….

[21] In my assessment the basis of the application by the defendant amounts more to a criticism of the internal processes at the CQC which resulted in AA, who was (i) an unsuitable appointment from the outset due to complaints about his behaviour, (ii) who had been a previous inpatient at Cygnet hospitals; (iii) who had made serious complaints about the care he received whilst there, all of which the CQC should have been but were not aware. Whilst this might be true, this does not automatically mean that the Defendant cannot have a fair trial, or that it would be unfair for the Defendant to be tried.

Section 78 PACE 1984

…

[26] While there may be a concern of an appearance of bias from AA based on his history with Cygnet Hospitals, this is a case in which most of the evidence is produced by those with a duty to accurately record the matters stated therein, whether historic documents from the CQC, the process relating to the admission of the young woman of documents provided by the defendant. Any concerns which remain about the involvement of AA could be rectified by an appropriate warning or considering what weight to ascribe to a particular piece of evidence."

24. Cygnet had AA's medical records. It did not ask AA for his consent to use them, which was evidently the correct course having regard to the risks of causing distress or harm to AA. Cygnet did ask the CQC for disclosure of AA's medical records but did not apply to the Magistrate's Court to use the records. Those proceedings, like these proceedings, were subject to an order to prohibit the reporting of the name of AA or of any matter which would tend to do so.

25. On 7th September 2022, Cygnet sent a pre-action protocol letter to the CQC, challenging the lawfulness of CQC's ongoing decision to rely on the Declaration of Interest and Resolution of Conflicts Policy. The remedy sought was review of the policy and review and quashing of the decision to prosecute. No claim form was issued.

26. At some point between August and November 2022, Cygnet and its then solicitors reviewed AA's medical records and then made the application to the Magistrates' Court to stay the proceedings as an abuse of process.

27. The fact that AA made a complaint while he was an inpatient at Cygnet's hospitals is now a matter of public record by reason of the District Judge's judgment. Beyond that fact, the detail and the content of those records are not public and there is an order in place in these proceedings which prevents public access to the statements of case and evidence. No application was made by any party or non-party for the hearing of this judicial review to be heard in private, nor for any particular issue or evidence to be heard in private.

28. Taking all of these circumstances into account, my judgment is that the balance of interests is properly served by maintaining the anonymity order, limiting references in this judgment to the fact of complaint by AA about his treatment, and not further describing or rehearsing either the medical history nor the submissions made directly about that medical history. My reasons for coming to this conclusion start with a real concern as to the potential impact on AA and his rights to privacy of going beyond that which is already within the public record. The witness statements in this case and the disclosure submissions in the criminal case each raise significant concerns as to potential harm in this regard. I do not consider it to be necessary within the meaning section 35 (1) of the Data Protection Act 2018 to go any further. It is clear to me that it is the fact of AA's complaint which is key to Cygnet's case. The parties know what material I have been shown and it is neither necessary nor proportionate to the adverse risks to AA to set it out or summarise it in this judgment.

29. In the criminal proceedings, Ms Judith Edwards, a CQC Inspection Manager and AA's line Manager, explained in her witness statement that she met AA on his first day of employment with the CQQ, on 10th November 2014. He was assigned to the London Mental Health Team. He told Ms Edwards about the circumstances of his dismissal from his previous job with a London mental health trust and that he had then been detained in Cygnet hospitals in London under the Mental Health Act 1983 for a period of about five months during 2012/13. They discussed AA's ongoing treatment.

30. Ms Edwards told AA that "*in line with CQC policy"* he would not be involved in inspections of Cygnet hospitals for a period of five years, a point which I return to below when looking at the final evidential position on the application of that policy.

31. Ms Edwards' evidence is that at no point did AA express any negative opinions of Cygnet as a result of his care. On the other hand, AA asked not to be involved in the inspection of the NHS trust at which he had previously been employed because he could not be sure that he would remain objective, given his experiences as an employee.

32. In these proceedings, Ms Edwards has made two witness statements, in July 2024 and in October 2024, following an application to cross examine. Those witness statements are very much more detailed than the witness statement in the criminal proceedings. In respect of

recruitment and induction of AA, she explains that she was aware that he was on medication and with the Community Mental Health team when he joined CQC, until he was discharged to his GP. She understood that AA had made disclosure of his mental health during recruitment.

33. During his employment, AA provided training sessions for managers in CQC on the importance of supporting staff with mental health issues and wrote about his own experience in a piece called '*this is me'* in which he explained his personal experiences including his detention. He explained to Ms Edwards that he had little memory of his period of detention.

34. Her evidence is that AA was a good inspector. He was detailed, thorough and would ensure that his findings were backed by evidence. He was frank and open to the point of being abrupt but was equally open with positive feedback. He made progress as an inspector and by 2019 his reports provided the right level of detail without making them overly long with unnecessary detail. Ms Edwards did not have any sense that he had preconceived ideas about any of his inspections. Even on focussed inspections when the CQC was looking for particular information, he was very fair and would investigate thoroughly, but was happy to find nothing. His work felt fair and objective and he was always positive about finding good services being provided. Ms Edwards never felt that AA showed any bias. Indeed, his lived experience was an asset because AA was very attuned to using services and sensitive to patients' experience. Ms Edwards is clear that AA had no animus against Cygnet. She cites the example of his role in the Cygnet Hospital Beckton inspection in March 2021. I turn to this in detail below, but the short point is that he argued to keep the service open and that it could be turned around, whereas others sought its closure.

35. In June 2019, AA took eight Cygnet locations into his allocated list of hospitals. He said that he was happy with the changes and did not feel that his judgement and impartiality was affected by reason of his previous admission at two of those hospitals.

36. Shortly thereafter, in August 2019, AA was asked to assist with an inspection of a Cygnet hospital outside of London, called Acer, in Chesterfield. I will return to that inspection, below. Within London, AA undertook six inspections at six Cygnet locations between January 2020 and June 2021. Two of these were comprehensive inspections, and the remaining four were focussed inspections, looking at only particular issues or parts of a setting.

37. The CQC has given extensive disclosure of its records from these inspections. In order to do so, it has contacted individual members of the inspection teams who remain employed by CQC, including those who are absent from work, for example on maternity leave. Paper-record archives have been reviewed by the Head of Legal at CQC. A CQC National Investigator has searched electronic records.

38. No complaints were raised about AA save in respect of the Chesterfield inspection, after which Cygnet alleged that AA was biased. In its letter of complaint, solicitors then acting for Cygnet said that staff found the lead inspector (AA) was selective in his approach and asked leading questions. It was said that he appeared to have a pre-judged opinion. The complaint was investigated but not upheld.

<u>Some aspects of CQC regulation</u>

39. The CQC has statutory duties to inspect care establishments. It undertakes periodic inspections but will also undertake focussed inspections if an event or information suggests that is necessary or desirable. The inspections focus on five questions: Is the location or service: (1) safe; (2) effective; (3) caring; (4) responsive; (5) well-led?

40. The available outcomes of the inspection, called ratings, are: Outstanding; Good; Requires Improvement, and; Inadequate. Normally, there would only be a rating for a full (or

comprehensive) inspection. There may, unusually, be a rating for a focussed inspection, depending on the sufficiency of information.

41. The inspections are undertaken by teams of inspectors, the number of whom depends on the nature and size of the setting which is to be inspected. The data provided by the hospital and the information collected during the inspection is reviewed according to procedures and criteria which changed during the time of the Impugned Decisions. The general pattern and function remained the same. An inspection would result in a draft report from the lead inspector. An inspection manager would assess the evidence in support of the judgments and proposed ratings in accordance with CQC's assessment framework.

42. For independent health services such as Cygnet's, the report would then go through a further level of quality assurance. A meeting is convened by a Head of Inspection which would determine the final ratings. In addition to the Head of Inspection, an Inspection Manager and Inspector who were independent of the inspection would make up the quality assurance group. They were further accompanied by other inspectors and a record keeper who are described as 'non-quorate attendees'.

43. In addition to quality assurance, some reports required approval from the Ratings Agreement Meeting (RAM) which would be chaired by a head of inspection or a deputy chief inspector. Such meetings would be called if the overall rating was 'Outstanding' or 'Inadequate' or if a head of inspection recommended a RAM meeting.

44. So far as the provider is concerned, there is an opportunity to comment on factual accuracy of a draft report. There is a pro-forma for that purpose which records the points taken and the action taken by CQC, with reasons. The opportunity was taken up by Cygnet. I have reviewed the nature of the factual challenges. The points taken are fully and carefully responded to. Errors are acknowledged, e.g. extensive changes to the Bostall Report in respect of prescriptions.

45. There is a right of appeal to the First-tier Tribunal (Health, Education and Social Care Chamber) pursuant to section 32(1) of the Health and Social Care Act 2008 against a decision of the CQC. Such a decision would include the conditions imposed on 11th March 2021 in respect of the Beckton site. However, an inspection report does not comprise a decision of the CQC. There is no right of appeal against the outcomes of an inspection.

The Review

46. In her *Independent Internal Review*, Odette Coveney (Deputy Director, Integrated Care Assessment), dated 6th August 2024 ('the Review'), records her findings after an extensive review of the inspection records and reports for each of the Impugned Decisions. The essence of the Review is twofold: (1) review of the evidence and justification of the impugned reports and decisions; (2) the application of the Conflicts Policy.

47. She concluded that the ratings and any enforcement action taken were consistent with the findings and the inspection report, following CQC's enforcement process and accompanying guidance. She found the reports and ratings to be based on evidence, to be proportionate and fair in accordance with the identified risks of harm. From the records which she reviewed, there was evidence that inspection activity had driven improvements and addressed poor and unsafe practices. She gave detailed reasons for her conclusion that the CQC's findings and enforcement action were justified.

48. She noted that decisions were not made by any one individual in any circumstance and that the scheme of delegation had been used up to the level of Chief Inspector, where required.

49. As I have recorded at paragraph 12, the review is not relied upon by the CQC as a defence nor as a fresh decision. Nevertheless, it is evidence before me and I have taken account of it. The

report has been signed. It is not annexed to a witness statement nor is there a statement of truth. I gave Ms Coveney permission to prepare a witness statement to exhibit the Review.

50. The Review is criticised by Cygnet via a long letter dated 12th September. It is a tendentious letter, best exemplified by the choice of the phrase '*Due to the particularly dogged Nelsonian blindness..'* in suggesting that the Reviewer should have been provided with details of the nature of the bias, how it arose and the fact of AA's complaints. The main points taken are that the witness statements should have been provided to show how the conflicts were considered at the material time. The reviewer therefore did not have all the relevant circumstances available to her. It was wrong to take account of the role of others in the inspection and reporting process. In any event, it is not necessary to prove that apparent bias had an operative effect: *R (Al-Hasan) v SSHD* at [42]-[44]; a decision of the House of Lords in which relief was granted and findings of guilt quashed in circumstances where the order which was breached was perfectly lawful.

51. Moreover, identified errors in the inspection documents undermine the finding that the decisions were not affected bias or apparent bias. In overview, the main complaints are directed to the finding that the impugned reports and decisions were not affected by apparent bias.

52. I now turn to the five Cygnet sites and six reports.

[1] Cygnet Acer, Chesterfield Inspection (13th November 2019)

53. By a report dated 13th November 2019, the CQC placed the Cygnet Acer, Chesterfield, service into special measures due to its failure to actively minimise risks to patients, a failure to ensure there were sufficient qualified nursing staff and due to the failure to effectively identify and learn from incidents, including serious incidents. The inspection, on 19th, 20th and 28th August 2019, followed a serious incident and other information which the CQC had received. That meant that there had been a patient death, in addition to which there were two other serious incidents, one of which resulted in a brain injury. There had been three staff whistleblowers.

54. The report records: "*On at least four occasions during the inspection patients congregated on the ward, in front of the reception area, banging on windows to attract the attention of staff who were not on the ward. Staff were not available to support patients when they needed them".* This observation goes alongside the finding that 75% of the nursing staff were unqualified and that on 60% of shifts there was only one registered nurse on each ward which was not recognised by those staff as insufficient to support the complex needs of patients. Those staff were working 12 or more hours per day or night, up to seven days without a day off.

55. The report presents precise data on the number of incidents and how these changed in recent months. For example, in Upper House there were 156 incidents in May; 63 of which involved a ligature. In June there were 335 incidents; 130 of which involved a ligature. By July, there were 577 incidents; 340 of which involved a ligature.

56. Following a patient death, the June 2019 ligature risk assessment did not identify or assess other ligature risks, save for one. Important areas for learning were missed. The inspection found a number of ligature anchor points on both wards which were not included in ligature risk assessments. These included anchor points which patients had previously used to attach a ligature. During the inspection, the ligature assessments were repeated and improved to the extent that they were structured, detailed and comprehensive. However, work remained to be done in actually removing the ligature risks rather than relying on staff being present to mitigate the risks.

57. The report also made favourable findings. Staff spoke favourably about leaders, were proud of the work which they did and felt able to raise concerns without fear of retribution. There were

clear processes for dealing with complaints and dealing with referrals to CQC. There was a good response to the findings of the inspection.

58. After taking legal advice on whether it was appropriate to give a rating after a focussed inspection, the setting was found to be inadequate overall, and by reference to whether or not the services were safe and well-led.

59. There was criticism of Ms Edwards' witness statement in the criminal proceedings to the extent that she said that she asked AA whether he would like to help with the Inspection. In fact the email exchanges show that the Inspector with responsibility for the Acer facility made a broad request for assistance from a number of Inspectors and AA offered dates on which he could assist. Ms Edwards approved that involvement.

60. In my judgment, nothing turns on this. Ms Edwards' explanation of events is a perfectly reasonable summary. The fact that AA offered dates does not reveal anything about his attitude towards Cygnet.

61. The Review looked at 556 pages of inspection notes for the Acer Hospital along with management review records. Ms Coveney reviewed the factual accuracy check which she found to be clear and professionally responded to, with clear rationale and information as to the evidence and decision-making process.

62. The inspector feedback at the end of the inspection was that the inspection report would not lead to a rating, i.e. there would be no overall conclusion as to whether the service was good, inadequate etc in terms of safety and leadership. In fact, the inspection was rated. Legal advice was sought as to whether a focussed inspection could lead to a rating. The advice was that there was a discretion to do so. The recommendation of the Management Review Meeting was to rate these questions. The review states *"At the Ratings Approval Meeting, this decision would ultimately be decided by the Deputy Chief Inspector. The call note records what the likely rating would be. The Registered Manager (RM) was informed that due to the concerns found it was likely to be the lowest rating, and that due to the enforcement action taken, the rating may be limited to Inadequate because of this. From the note I can see that the Inspector apologised to the RM for the feedback following the inspection that CQC would not rate the inspection and was asked that she extend this apology to the rest of her team. The note records the inspector told the RM there was no intention to mislead the management team at the inspection regarding whether it would be rated.*

63. As I have indicated, a complaint followed, alleging bias by AA.

[2] Cygnet Bostall House (published 4th March 2020)

64. On 13th January 2020 there was an inspection of Bostall House, Abbey Wood, London by a CQC Inspector (AA), an Assistant Inspector and a learning disabilities nurse. By a report dated 4th March 2020, the service was given an overall rating of 'Good', and was 'Good' in all respects save for care in which it was 'outstanding'.

65. Staff collaborated well with patients and involved them in decisions, seeking their views on a wide range of topics. There was a strong focus on relationships with patients and meeting their social and emotional needs. Families were invited to understand the setting before admission and the feedback from families was consistently positive. Staff were nice and patients felt respected. Care followed best practice. Staff turnover and sickness was low.

66. Governance was well developed and the leadership was knowledgeable and experienced. Risks were identified on the basis of appropriate information and action was then taken to minimise risks.

67. The Review contains a factual summary of the inspection and comments on record keeping by way of audit. It says nothing about AA's role.

[3] Cygnet Hospital Blackheath (June 2020)

68. On 2nd and 4th June 2020 there was an inspection of Cygnet Hospital, Blackheath. The Hospital provides psychiatric intensive care and low secure care to men over the age of 18. It was an unannounced focused inspection, prompted by three incidents in which staff were alleged to have assaulted patients and other staff allegedly failed to report those incidents.

69. By a report dated 16th July 2020, it was found that the allegations were responded to promptly by managers of the service. Staff were suspended by Cygnet and reports were made to the local safeguarding team, the police and CQC. There were some referrals by Cygnet to the Nursing and Midwifery Council. The need for a wide-ranging investigation was recognised by the management team and action was taken accordingly.

70. There was a high level of confidence shown by the nursing team in its ward manager. Staff were reported by patients to be kind and '*very, very nice people'* though there were also some mixed responses. Patients reported that when staff restrained patients this was done in a professional manner. Patients knew how to raise issues and if they did, they were listened to and supported.

71. There were some concerns amongst staff as to the provision and use of personal protective equipment at the start of the Covid-19 outbreak.

72. When AA had finished the inspection he emailed two of Cygnet's leadership team to explain that "*Once I've digested all of the evidence I'll be able to give you some headline feedback – if there were major concerns, I would have already informed you. …. Thank you all once again for being so accommodating, and please thank the staff. They have been very open in the interviews and some are clearly destined to move much further in their careers."*

73. The Ward Manager emailed AA to say *"Thank you so much for your patience at my computer skills today; the staff and service users all reported how nice it was to speak to you and how you put them at ease."*

[4] Cygnet Hospital Harrow (August 2020)

74. On 2nd August 2020 there was an unannounced, focussed inspection of Byron Ward of Cygnet Hospital Harrow. The inspection, comprising three inspectors, focussed on patient observation levels, physical restraint and how nursing staff cared for patients. The inspection was prompted by information received about Byron Ward which described frequent physical restraint of patients other than in accordance with best practice.

75. The inspection found training deficiencies. However, it was found that restraint was used as a last resort after verbal de-escalation. Staffing levels were appropriate and risk management was also appropriate. Staff treated patients with compassion and kindness: "*magnificent, fantastic, very gentle and really good"*.

76. Ms Edwards was one of the Inspectors. She explains that staff were not wearing face masks as was then required by the provider's policy. AA wrote up the report but did not identify a breach on this basis, whereas Ms Edwards argued that it was a breach.

[5] Cygnet Hospital Beckton (published 28 May 2021)

77. On 1st, 3rd and 8th March 2021 there was a focussed inspection of the psychiatric intensive care unit and the ward for patients with learning disabilities following four incidents of alleged abuse of patients by staff, which were reported by Cygnet to the CQC. The hospital was placed into

special measures via a letter from the Chief Inspector of Hospitals and a report dated 28th May 2021.

78. There had been four serious incidents between December 2020 and February 2021 which had raised concerns about the potential abuse and poor care of patients. CCTV showed unjustified restraint, using unauthorised techniques, seclusion without safeguards and the apparent physical abuse of a patient by staff. These incidents were not being reported by staff in accordance with Cygnet's policies. There were instances of shifts being understaffed. Recruitment and retention was not being addressed by senior leaders. Ward managers were not provided with appropriate leadership training despite the concern having been raised by the hospital manager since 2019.

79. Feedback from patients and relatives was mixed. However, the management team had actively raised these issues with the CQC and the least restrictive practices programme was relaunched to address the serious issues in that regard.

80. Ms Edwards explains that this was AA's first inspection of the Beckton site. She recalls that AA looked at CCTV of very poor care and inappropriate restraint of patients which was reminiscent of the Winterbourne View scandal. She explains that the reaction of senior CQC managers following the inspection was that they were looking to close the service. However, AA argued that the management team could turn the situation around. He identified the root cause as the high vacancy rate, high use of agency staff and the absence on site of a capable manager during the pandemic. He had faith in the manager. Consistent with his general approach, AA wanted to see improvement, to make things better.

81. There was a Review of Assessment Meeting (set out on a RAM record). The attendees were AA, a lawyer, an observer, a recorder and Jane Ray, the Head of Inspection. On the topic of 'care', the initial rating was 'Requires Improvement'. This was on the basis of the high level indicators of patients being abused, that patients felt neglected and ignored by staff and that there were complaints from relatives who were not always getting accurate information. This initial rating was changed to 'Inadequate', i.e. a more severe rating than 'Requires Improvement'.

82. The inspection was followed by letter dated 11th March 2021 which gave urgent notice of a decision to impose conditions on the provider's regulated activities pursuant to section 31 Health and Social Care Act 2008. There were ten conditions for which reasons were given which were a summary of the main issues in the May Report. The conditions included a requirement not to admit further patients and measures to correct the identified failings in methods of restraint, their observation and associated reporting and also sought to tackle the poor staff resources. The conditions were reviewed and amended on several occasions. By May 2022 the number of patients to be admitted to particular wards had been increased gradually. The primary concern in this regard was staffing levels.

83. Ms Ray explains that a number of meetings took place between CQC and Cygnet to monitor progress at the hospital and to keep conditions under review. They allowed for close monitoring or staffing and other data such as incidents and other feedback to decide if requests for admissions would be safe.

84. AA was dismissed (for reasons unrelated to any Cygnet inspections) at the end of December 2021. Another inspector took over and reviewed staffing at the hospital in order to review the conditions in 2022. Ms Ray states that the 2022 meetings were part of CQC's usual processes and regulatory action and shows that the findings from the inspection of the Beckton site in March 2021 were made on the basis of evidence of how the service was operating at that time. The Beckton site required a significant period of time to improve and thus enable the restrictions to be lifted. I have seen no evidence to contradict this view and I accept it.

[6] Cygnet Hospital Beckton (published 18 August 2021)

85. There was an unannounced comprehensive inspection which the report records as being on 13th May and 10th and 11th June 2021. Meeting notes suggest that the inspection extended to 15th, 16th and 17th June. At this inspection, the rating improved to "Requires Improvement', i.e. was no longer 'Inadequate', but the service remained in special measures. The inspection team comprised a head of inspection (AA), an inspection manager, three inspectors, an enforcement inspector, two specialist advisors who were senior nurses and two experts by experience. Experts by experience are people who have used, or have a relative who has used, similar services. There were, therefore, ten specialists from CQC on the inspection team. The report was published on 18th August 2021 and extends to 43 pages of detailed reporting and analysis.

86. The overall rating of 'Requires Improvement' is not helpful in understanding the outcome of the inspection which rated the setting as 'Good' for each of 'effective', 'caring' and 'well-led'. It was in respect of 'safe' and 'are services responsive to people's needs' that the rating was 'Requires Improvement'. Moreover, the overall rating obscures the lengthy narrative findings of positive features of the setting. This showed a high degree of focus on patient physical health and care delivered in a compassionate and respectful manner. Systems and training were praised. The governance systems and local leadership were strong and appropriate.

87. Improvement was required in respect of patient safety and responding to their needs. Staff were observing patients at exactly the same intervals which presents the risk that a patient will plan risky behaviour between these times. There was an instance of records of observations showing intermittent observation when in fact it was regular and predictable.

88. Despite a strong recruitment drive, there were significant vacancies for support workers and in one ward only half of the required number of registered nurses were in post.

Enforcement Decisions

89. Ms Ray was involved in the decision to issue an urgent Notice of Decision to impose conditions on 11th March 2021. She approved it along with Mr Cleary, Deputy Chief Inspector Mental Health and Community Services. The reasons given are reflective of the matters set out in the reports, much of which is based on uncontested facts. There is a particularly troubling description of the treatment of a patients. Staff members forcibly swiped away a patient's arm. Highly intimidating facial expressions and body language were observed. A patient's arm was forcibly pushed, causing her to move. The following day, the patient was found to have a fracture in their arm, the cause of which was investigated but not reported by the date of the imposition of the conditions.

The Declaration of Interests and Resolution of Conflicts Policy

90. Mr Assall is the Network Director for London and East operations at CQC. He is familiar with the organisation, having previously held the posts of Head of Inspection for the Central Region and a senior post for adult social care in the South Region. He also has experience in other inspection regimes, having been seconded to OFSTED during 2020/21. He is responsible for making decisions on behalf of the CQC in these proceedings.

91. He reviewed the operation of the CQC's Conflicts Policy. He found that at the relevant time the policy was not followed in this case and in other cases. He considers that it is essential to recognise and disclose any activities which might give rise to conflicts or any potential conflicts in order to ensure that CQC's regulatory activity is impartial and objective.

92. In this case, the policy specified that the decision to allocate Cygnet's inspection to AA should have been escalated to the Deputy Chief Inspector or Chief Inspector, but this was not done, as is confirmed by Ms Edwards. It was not the custom and practice at the time to escalate these decisions to a Deputy Chief Inspector. The way that conflicts are considered before each

inspection did not accord with the policy. As a result of Mr Assall's findings, he asked for an internal review by a Deputy Director.

93. In her October 2024 witness statement, Ms Edwards provided further detail of her discussions of AA's history with Cygnet and the application of the policy. She explains that her witness statement in the criminal proceedings, from May 2022, was a correct account of how she had understood the policy to operate, namely to prevent AA inspecting Cygnet for a period of five years. She had not appreciated at that time that the policy required such a decision to be made by Deputy or Chief Inspector.

94. In my judgment, this explanation is consistent with Ms Edwards' evidence elsewhere in her three witness statements and with the general practice in CQC. I find that her May 2022 evidence was honestly given, but like others at CQC was based on an erroneous understanding of who, under the policy, should make the decision in circumstances such as those which related to AA. She, like others, genuinely thought that she was following the policy correctly.

Discussion

95. The court was not taken to any decided case in which a regulator was said to be biased. Rather, the decided cases are in respect of litigation in criminal and civil proceedings and of administrative decisions such as the grant or refusal of planning permission. Such cases tend to have common characteristics which have informed the way in which the law has developed. For both criminal and civil proceedings, there is a single case to resolve a particular dispute or set of issues. The parties prepare their cases in accordance with procedural rules and with court directions. They present and test them via an adversarial process. Once the judgment or order has been given, that is the end of the interactions between the parties and the tribunal, though there may be an appeal. It would be rare for there to be a series of cases involving the same parties.

96. Save for the court's judgment, there is unlikely to be very much information to shed light on the approach which the court or tribunal took in making its decision. There will be no disclosure of the thinking, discussion, options considered nor any earlier drafts of a judgment.

97. Administrative decisions to determine an applicant's right or permission to undertake a regulated activity tend to be specific to the application. The applicant seeks a firearms licence, to sell alcohol, to obtain a visa or discharge pollutants into the air. The applicant presents the evidence and justification for what is sought, others may comment, there may be discussion and then a decision, probably with reasons. Such cases may provide more insight into the circumstances of the decision because the interactions between the applicant and the decision maker are direct and likely to be available to be scrutinised. For example, there may be informal email traffic or notes of meetings between the applicant and the decision maker, whereas such material would not exist in respect of litigation.

98. In this case, a regulator, the CQC, is auditing and enforcing statutory requirements and policy-based standards which give effect to the statutory scheme of supervision. It is a type of regulation which is a continuing relationship. In contrast, some similar forms of regulation are much less focussed on particular businesses. For example, every employer operates under the scheme of the health and safety legislation and the Health and Safety Executive may have reason to inspect or enforce in every workplace. The result is that, save for workplaces with very particular risks, it is unlikely that there would be a series of interactions between one operator and the Executive. The nature and number of interactions between the CQC and Cygnet is very different to the typical interactions between a business and the Executive.

99. Mr Assall spent some time on secondment to OFSTED. Some parallels can be seen between the work of CQC and OFSTED, each of which is concerned with a specific sector. Each of them undertakes comprehensive inspections from time to time of each school, hospital etc. But in the case of Cygnet, there are numerous sites even within one geographical area, which here is the southeast of England. The result is that CQC appointed an Inspector to manage that relationship over that region and he did so over a period of years.

100. Correctly, neither party submitted that there was a different legal test or any additional principle to apply to an issue of bias or apparent bias in the context of regulation. Rather, the court in a case such as this has a range of circumstances to consider which is more extensive than in other types of case. Similarly, the information which informs the fair-minded observer is a matrix of sources and may be detailed and comprehensive. Regardless of the level of the detail and whether the totality of the material is comprehensive or not, it is the court's task to consider it all. The informed observer will take the trouble to read the totality of the material: *Helow*.

101. Understandably and helpfully, the parties emphasised particular and quite different features of the material. This provided a vivid illustration of the feature of apparent bias which is that the picture is quite different if you look at only parts of it, whereas the court must look at the whole, i.e. the totality of the circumstances. For Cygnet, Mr Green, King's Counsel, drew attention to AA's treatment, detention and serious complaints about the adequacy of Cygnet's care and treatment. This was accompanied by AA's apparent failures to disclose these complaints which was required by CQC's policy repeatedly during his employment, and was not disclosed even when Cygnet made an express written complaint of bias in respect of the Acer site. CQC's own policy, which was not correctly applied, shows that a conflict of interest existed throughout, as acknowledged by CQC's Reviewer in the Review. Indeed, before the failures to follow the policy had been identified, CQC had relied on the policy as a complete answer to the allegation of apparent bias. Consistent with this, those working with and supervising AA, particularly Ms Edwards and Ms Ray, had trivialised those conflicts.

102. For the CQC, Mr Myerson, King's Counsel, fairly acknowledged the impact of the CQC's Conflicts Policy and the admitted failures to apply it. He did not accept that AA either recalled his complaints about Cygnet or that his complaints were his concluded view of his treatment. The extracts from the medical notes were only that, whereas the extent of that material was substantial. In any event, it was neither appropriate nor necessary to read and consider that material. It was not correct to rely uncritically on a complaint which was made by somebody who was, at the time, so very unwell. Moreover, there was no evidence of bias. CQC had disclosed all of the documents which underly the impugned reports, which are not normally seen by the service provider. They show a balanced and fair approach by AA even to the extent that he sometimes took a softer position on rating Cygnet than his superiors actually adopted. When all of the circumstances are considered, they show that there was no bias.

103. Mr Green also drew attention to the fact of AA's dismissal by CQC. I give little weight to that fact because the basis of the dismissal was both unrelated to Cygnet and was not based on his competence or fairness in producing assessments and inspection reports.

104. Mr Green did not accept that the documents which underly the Impugned Decisions showed that there was in fact an unbiased and untainted process which was not influenced by AA. He drew attention to features of those documents which he submitted were supportive of the opposite conclusion. He submitted that there was no evidence to support Mr Myerson's assertion that AA was grateful for his care, and indeed I was shown none.

105. If the circumstances which were known to the court were limited to those on which Cygnet primarily relies, a finding of apparent bias would follow. The matters which are summarised at paragraph 101 above give rise to a conflict of interest for AA in his work inspecting Cygnet, in

which his role was significant, not minor. Like many conflicts of interest, it was capable of being properly managed by full disclosure which would necessarily include disclosure to the party which may be affected: Cygnet. This conclusion would be reached without reference to either the fact of complaint or the detail and substance of it. The fact of complaint is highly material and its disclosure was important.

106. The CQC set out how it would ensure that its work would be undertaken with independence of mind and without influence from extraneous factors. The CQC did that via its Conflicts Policy and it is reasonable to take that as the appropriate and justified standard against which to work.

107. The Conflicts Policy was not followed in full. The potential for conflict arising from the use of a service by an inspector was one which CQC identified and thought about. It was of such obvious relevance that the decision to allow inspection by a former service-user was to be taken at a senior level, but it was not. It is the role of those in senior leadership to deploy long experience, overview and insight which might not be evident to those who do not have that level of responsibility. For those who should have referred the matter to senior leadership to have failed to do so is indicative of the Conflicts Policy not being taken as seriously as it should have been. Equally, the failure of senior leaders to ask and check whether the correct decision-making process was being implemented also indicates that senior leadership was not taking sufficient interest in potential conflicts. For an organisation which is entirely focussed on assessing compliance with methods, procedures and policies, these are striking features of the case.

108. The tenor of Cygnet's case is that AA had an animus against Cygnet. In my judgment, that analysis is too restricted and pays insufficient regard to the nuanced nature of biases, and indeed, the facts. Bias may be positive or negative in the sense that a biased person may consciously or unconsciously favour or take against the subject of their decision. But that bias, either way, may be in respect of only a limited set of issues, or one issue. In this case, there was insufficient, and insufficiently structured, enquiry into AA's recollections of his experiences and his concluded views to be able to understand the potential for unduly favourable or adverse approaches to the inspection work which he was to undertake. In the absence of that understanding, there was no proper opportunity to deal with the result and mitigate appropriately. I have taken into account the evidence of AA's openness about his past, such as sharing his experiences with colleagues in a '*this is me'* piece. But that is not a substitute for complete application of the Conflicts Policy.

109. Again, if only this part of the circumstances were considered, as emphasised by the Cygnet, and if the available evidence was limited to these matters, then the conclusion would be arrived at relatively easily: the fair-minded observer would find there to be apparent bias. But the available evidence is not so limited. The court must consider the totality of the circumstances.

110. As I have observed, the contemporary records of the care that was taken in rating the services and deciding to take enforcement action offer a valuable insight to the Impugned Decisions. Moreover, the Impugned Decisions span the period between November 2019 and August 2021 and include 6 sites. In this case, there is therefore the opportunity for the court to see the deliberations which preceded the impugned result and to consider decisions made on quite different facts at each site. This is a different exercise to the collated cases in *Locabail* which are single-event pieces of litigation.

111. Taking the impugned reports and enforcement decisions alone, I find that the issues which had to be assessed and reported upon covered a notably wide spectrum. That spectrum included restraint practices (Beckton) which were seriously irregular and admitted to be so, along with hazards which presented real risks that a patient would be able to take their own life (Acer). In contrast, there were sites at which the outcome was positive and Cygnet could be rightly proud

of the feedback received (Bostall). Even when inspection took place after receipt of complaint, the overall tone of a report could be positive (Harrow). Ms Edwards' evidence is that she never had any complaints from other inspectors to the effect that he was biased or asked leading questions, nor did she have any such concerns. On a review of all of the detailed evidence which has been disclosed I find no plausible evidence of such bias having an effect on a report or a decision, save for the Acer complaint.

112. The situation at Beckton was evidently serious. Two features of the impugned reports and enforcement decisions show those decisions to be robust and, within their own four corners, show considered and fair assessment. First, there is the fact of the quality assurance meetings which took place along with the role which AA had. He was the one contending for 'Requires Improvement', rather than 'Inadequate'. He was more positive about Cygnet than other and more senior inspectors. He was overruled. Second, there was a RAM meeting which is a further level of scrutiny of the decision by fresh and experienced eyes.

113. Individually, and viewed in the round, the Impugned Decisions are cogent, balanced bodies of evidence and assessment. On their own, without consideration of other features of this case, applying the law at paragraphs 17 to 20 above, it would not be fair to find them tainted in any way.

114. Therefore, the outcome is that the circumstances which are now known in respect of AA point towards a finding of apparent bias whereas the circumstances which relate to the Impugned Decisions point towards a substantial body of carefully prepared, checked and balanced regulation. The remaining task is to consider the totality of the material, as a whole. Giving equal weight to AA's history and to my findings as to the cogency of the reports and decisions, that is sufficient to demonstrate a real possibility of bias, but even if I gave less weight to AA's history I would still conclude that there was apparent bias. That is because the relevant threshold is 'real possibility' and in my judgment the cogency of the reports and decisions does not overcome the findings at paragraph 105 above. That real possibility remains when proper account is taken of my findings as summarised at paragraph 111 above. In my judgment, the totality of the circumstances which relate to AA, the care taken in producing cogent inspection reports and the failure to comply with the Conflicts Policy give rise, in my judgment, to a real possibility of bias.

115. Having found apparent bias by AA, I turn to the two decisions which are challenged.

116. The first decision is challenged on the single ground that the CQC erred in concluding that the Impugned Decisions were not tainted by apparent bias. This ground succeeds because I have found that AA was apparently biased. It is therefore not necessary for my decision to work though the five specific reasons advanced by Cygnet to show why the first decision was flawed. I shall however give brief reasons for my conclusions on the relevance of DJ (M) Pilling's ruling.

117. The ruling on the application to stay the criminal proceedings as an abuse of process was relevant to the question in these proceedings. The District Judge had to reach a view on the source of the alleged bias, including as to the serious complaint made by AA against Cygnet. She gave her reasons in that regard and they were relevant because she held that *"…AA was an inpatient in 2012 and 2013, and [that] he raised significant complaints about his treatment at that time. However, this cannot, without more, amount to evidence of bias towards the defendant company some 9 years later."* However, the ultimate question for the Magistrates' Court was whether the defendant could have a fair trial, or whether it would be unfair to try the defendant. They were different matters to the issues in this judicial review, involving additional considerations, as the District Judge explained. The District Judge noted the gap in time between AA's treatment by Cygnet and the investigation in Ealing, i.e. 9 years, but she did not have the range of materials and submissions in this case. The District Judge reached her

conclusion with the knowledge of AA's complaint. I do not accept Cygnet's criticisms of the first decision so far as there was reliance on the District Judge's ruling.

118. The second decision is the decision not to *"revisit or review or withdraw"* any of those Inspection Reports or enforcement decisions. The principle of review has been conceded to the extent that the Review was undertaken and the grounds are overtaken accordingly. In those circumstances and having found apparent bias, it is convenient to consider the grounds and relief together for the second decision.

Relief

119. The Claim Form states that the remedies sought are quashing of the two decisions and a declaration that the Impugned Decisions were tainted by apparent bias. Given the finding that there was apparent bias, the court will grant a declaration in appropriate terms. Such a declaration, along with the findings in this judgment, are the appropriate and clear remedy. To quash parts of the letter dated 8th June 2023 would be cumbersome and would put the parties in no different position.

120. It follows that those elements of the Review which address apparent bias are to be read in the context of this judgment and the declaration. However, the Review is not a decision or document in respect of which relief is sought in these proceedings. Indeed, it amounts to a concession that a review was needed, and to that extent the claim succeeds in respect of the second decision.

121. However, the Review reaches conclusions on the appropriateness of the impugned reports and the enforcement decisions and whether or not they should be withdrawn. In effect, the Review maintains CQC's position that it will not withdraw the impugned reports and decisions.

122. By s31(2A) of the Senior Courts Act 1981, the High Court must refuse to grant relief on an application for judicial review if it appears to the court to be highly likely that the outcome for the applicant would not have been substantially different if the conduct complained of had not occurred. The principles to apply to an assessment of the s.31 test were summarised by Kate Grange KC (sitting as a Deputy Judge of the High Court) in *R (Cava Bien Ltd) v Milton Keynes Council* [2021] EWHC 3003 (Admin) at paragraph 52. I have revisited those principles. A witness statement could be very important: *R (Harvey) v Mendip District Council* [2017] EWCA Civ 1784 at [47] , per Sales LJ, although the court should approach with a degree of scepticism self-interested speculations by an official of the public authority which is found to have acted unlawfully about how things might have worked out if no unlawfulness had occurred: *R (Public and Commercial Services Union) v Minister for the Cabinet Office* [2018] ICR 269 at [91]. I also bear very much in mind that it is not necessary for a claimant to establish that apparent bias had an effect on a decision: *Al-Hasan, supra*.

123. Firstly, the key facts and circumstances underlying the findings and assessments in this case will always remain as the key facts and circumstances, regardless of AA's role. Much of the key evidence originates from Cygnet and its employees. For example, it counted 577 incidents in one month at Acer; 340 of which involved a ligature; the CCTV at Beckton showed inappropriate restraint, the appropriateness of which will not change; gaps in staffing are matters of record, as are gaps in training. In my judgment, this is a feature of the case to which Cygnet has paid insufficient regard.

124. Secondly, the unusual number of decisions and their time-depth provides the court with a more detailed picture of the operation of the CQC in respect of Cygnet than is typical in an apparent bias case. As I have explained earlier in this judgment, I find that the reporting has been responsive to the seriousness of the circumstances encountered, including as to giving

positive feedback where it is due. I bear in mind, with due scepticism, the findings of the Review, so far as relevant, which I find supportive of this view.

125. Thirdly, while one biased person plainly can influence others who are involved in decision making, it is nevertheless relevant that inspections are undertaken by multi-disciplinary teams. It is also relevant that there is a quality control process(es) as I have described from which the court has been able to see important features of the decision making which give confidence in its robustness. I do not accept that, in the particular circumstances of this case, a finding of apparent bias automatically compels withdrawal of the decisions. The assessment under s31(2A) of the 1981 Act requires consideration to be given to whether the outcome would be substantially different, measured against the high bar of whether that is highly likely. I have considered each of the Cygnet sites separately and given anxious consideration to the material available as to whether it is highly likely that the outcome would, or would not, be substantially different. My conclusions are as follows:

> **[1] Acer** – This is a serious case involving real risks of fatality. It was a focussed inspection which unusually gave rise to a rating. It is therefore an unusual mix of procedures. For that reason I am unable to conclude to the necessary high standard that the same rating decision would be highly likely and will direct reconsideration of that report and its rating in the light of this judgment;
>
> **[2] Bostall** – for the reasons given above (paragraphs 47, 64-67, 110-113), I find that the same or substantially the same decision would be highly likely and decline any further relief in this regard;
>
> **[3] Blackheath** – for the reasons given above (paragraphs 47, 68-73, 110-113), I find that the same or substantially the same decision would be highly likely and decline any further relief in this regard;
>
> **[4] Harrow** - for the reasons given above (paragraphs 47, 74-76, 110-113), I find that the same or substantially the same decision would be highly likely and decline any further relief in this regard;
>
> **[5]/[6] and the Enforcement Decisions for Beckton** – this is a serious case in which the staffing numbers speak for themselves, the restraint issues were conceded and serious, the quality control measures are particularly robust, AA was arguing in Cygnet's favour, the assessment has been on-going, the decision making has been at the highest level and the identified issues have continued beyond the date (December 2021) on which AA left the employment of the CQC. I will limit the declaration to those enforcement decisions made when AA was in CQC's employment. For these reasons and the reasons given above, I decline any further relief in this regard.

126. Mr Myerson submitted that Cygnet had delayed its application for judicial review. There is force in this submission having regard to the date on which the Chief Operating Officer knew that AA had been an inpatient, i.e. in July 2021. The medical records were with Cygnet's solicitors in October 2022. However, the challenge is not, in form, to the lawfulness of the impugned reports and decisions in themselves. The challenge is to the two decisions of 8th June 2023. The Claim Form was issued on 8th September 2023, three months later. Given the nature and extent of the relief sought and obtained in this case, such delay as there is does not give rise to any significant detriment to good administration. I therefore do not refuse relief on this basis.

Conclusion

127. The claim succeeds in respect of the CQC's first decision, namely the CQC's position that the Impugned Decisions were not affected by apparent bias. There will be a declaration accordingly.

128. The claim succeeds in respect of the CQC's second decision to the extent that the Review was undertaken and that the decision not to withdraw the Acer decision shall be quashed and CQC will be directed to reconsider that decision.

Costs

129. Cygnet seeks an order for its costs to 28th October 2024 on the indemnity basis and thereafter on the standard basis. The significance of 28th October 2024 is that until this time the evidence in Ms Ray's and Ms Edwards' second witness statements had not been made known in the way then set out. Cygnet seeks a payment on account of 50% of its costs. Its submissions in support include a prolonged and significant lack of candour and lack of compliance with the judicial review protocol and a refusal to mediate. The CQCs' defence on the apparent bias issue was unrealistic. Wider conduct was unreasonable, such as refusing to agree the adjournment of the first hearing. All of these matters increased costs.

130. CQC submits that there is nothing in this case which takes it outside of the norm. The court found that CQC's witnesses gave honest evidence. It is accepted that an order on the standard basis should be made in Cygnet's favour, but for 50% of its costs because Cygnet failed on 5 or the 6 decisions, there was no breach of duty of candour, the pleaded case went further than permitted by the court. Moreover, CQC succeeded on much of its S31(2A) Senior Courts 1981 defence.

131. Cygnet succeeded on the over-arching question of apparent bias and costs should follow that event. It obtained relief which was pleaded, namely a declaration. It also prompted the CQC to undertake a review and obtained an order to reconsider the decision not to withdraw the Acer report. However, the remainder of the Impugned Decisions remained undisturbed. In my judgment any issues-based reduction in costs can only be small, which reduction I put at 10%, i.e. Cygnet shall recover 90% of its reasonable costs. That is to be on the standard basis. It is unfortunate that mediation was declined by CQC and that important features of the case emerged late in the day. However, I have found that CQC made substantial attempts to provide full disclosure and I do not find its conduct of the litigation to be unreasonable. The costs schedule exceeds £550,000. Given the magnitude of the costs sought for a two-day judicial review and its previous hearings, I shall take a cautious approach to the sum to be paid on account. I shall order payment of £125,000 on account which is approximately 25% of the costs schedule after deduction of the adjustment which I have made on an issues-basis.