Care Standards

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

[2017] 2977.EA-MoU

Heard at the Employment Tribunal, Manchester on
1 & 2 August 2017
11 & 12 October 2017
24 November 2017

BEFORE
Mr H Khan (Tribunal Judge)
Ms S Last (Specialist Member)
Mr J Hutchinson (Specialist Member)

BETWEEN

Button Space Limited

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. Button Space Limited ("the Appellant") appeals to the Tribunal against an order dated 8 March 2017, made by District Judge Goozee at Manchester Magistrates Court.

2. The order was made pursuant to Section 30 of the Health and Social Care Act 2008 to urgently cancel the registration of the Appellant in respect of the provision and delivery of a regulated activity, namely, accommodation for persons requiring nursing or personal care.

Restricted reporting order

3. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of

any documents or matter likely to lead members of the public to identify the service users so as to protect their private lives.

Attendance

4. The Appellants were represented by Mr Andrew Drummond, Company Secretary. Mr Christopher McKenzie, (Director of Button Space Limited), Ms Lianne Webb, (Former Manager, Grimsargh Care Home) and Mr John Love, (Handyman) gave evidence on behalf of the Appellant.

5. The Respondent was represented by Mr David Pojour (Counsel). Ms Alison Martin (Head of Inspection) and Mr Gary Walker (Specialist Adviser to the Care Quality Commission on Electrical Installations) attended and gave evidence on behalf of the Respondent.

6. It was agreed between the parties that the statements of Mr David Coop, Mr Darren Jones and Ms Samantha Anyon would be read.

Late Evidence

7. The Tribunal was asked to admit additional evidence by the Appellant on the first day of the hearing (1 August 2017). This included witness statement of Mr Darren Jones (dated 16 November 2016) and the witness statement of Ms Vivienne Morris (dated 18 November 2016). The statements were made in the course of previous proceedings. Mr Drummond made it clear that he would only be referring to a small number of paragraphs in each statement. The Respondent did not object to the admission of this evidence.

8. We admitted the late evidence as its admission was agreed between the parties and it was relevant to the issues in dispute.

9. At the hearing on the 11 October 2017 (day 3), the Appellant asked to admit some further late evidence in the form of photographs of Grimsargh Care Home. The Respondent objected to such evidence on the grounds that it was not supported by a witness statement and it did not set out when the photographs were taken.

10. We refused the application to admit this as late evidence as the photographs were not supported by any witness statement indicating who took the photographs and when they were taken. It was also not made clear as to why such evidence was not produced earlier.

11. In considering any late evidence, the Tribunal applied rule 15 and took into account the overriding objective as set out in rule 2 of the Tribunal Procedure (First Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008.

Events leading up to the issue of the Notice

12. Button Space Limited has been a registered Social Care Provider since 19 March 2014. It was registered under the provisions of the Health and Social Care Act 2008 to provide the regulated activity of accommodation for persons who require nursing or personal care.

13. There is one registered location for Button Space Ltd which is, Grimsargh House, Preston Road, Grimsargh, Preston, Lancashire PR2 5JE ("the Home"). The Home is registered to provide accommodation for up to 28 people.

14. The Home is currently rated as inadequate and has been in special measures since May 2016. There have been a number of inspections at the Home. These took place on the 21, 22 and 23 March and 11 April 2016 when it was alleged that 11 breaches of the regulations were identified. A Notice of Decision was served to cancel both the providers and managers registration. The Registered Managers registration was cancelled in July 2016. The Home was inspected on 10, 11 and 12 October 2016 and it is alleged that eight breaches of the regulations were identified.

15. There Appellant has submitted two appeals in relation to decisions taken by the Respondent. It had lodged an appeal to the Tribunal against the condition as set out in the Notice of Decision dated 14th April 2016;

    "The Registered Provider must not admit any service users to Grimsargh House until compliant with the Health and Social Care Act (Regulated Activities) Regulations 2014".

16. The Appellant also appealed the Notice of Decision dated 6 October 2016 to cancel the registration of the Service Provider. It was agreed by the parties that the appeals would be consolidated and heard together. Those appeals are part heard and subject to separate proceedings, which have, by agreement between the parties, been stayed pending the determination of these proceedings.

17. Over the weekend of the 4-5 March 2017, there was an emergency evacuation of the home, as it was alleged by the Respondent that a water pump for the home was overwhelmed and flooded, compromising the electrics and safety of the building.

18. On Saturday, 4 March 2017, the Respondent's Inspector, Ms Martin received an email (at 13:29) from the Appellant's Deputy Manager, Michael Yates informing them the Appellant was in the process of evacuating service users from the Home. The email states that:

    "Due to recent issue with flooding on the car park outside the home, the issue has gotten into our electrical system and we feel now the home is not safe

until the issue is fixed. We are taking the residents to a nearby hotel named the Tickled Trout in Preston"…

19. The Respondent contacted the weekend Emergency Duty Team (EDT) at Lancashire County Council to ascertain the action taken. The EDT visited the home on 5 March 2017 and identified a number of concerns.

20. The application for urgent cancellation was made under section 30 of the Health and Social Care Act 2008 on 7 March 2017. On 8 March 2017, an order was granted and the registration certificate of Button Space Limited was cancelled with immediate effect. This is an appeal against that order.

21. The Respondent submits that the decision made on 8 March 2016 was right in the circumstances and that there remains a serious risk to a person's life, health or well-being should the order cease to have effect.

22. This appeal was received by the Tribunal on 5 April 2016. Directions were given for the filing and serving of the evidence. The matter was heard on 1 & 2 August 2017 but due to insufficient time, the matter was then relisted for 11 & 12 October 2017. Ms Webb did not attend the hearing on 12 October 2017 due to work commitments and the matter was listed on 24 November 2017 to hear from Ms Webb. We should add for the sake of completeness that it would not have been possible to hear all of Ms Webb's evidence had she attended on 12 October 2017 as planned.

23. Following the hearing on 24 November 2017, it was agreed that the parties would file and serve written closing submissions and the Tribunal received the Respondents closing submissions on 1 December 2017 as directed.

24. The Appellant, for some unexplained reason, attached the original appeal documentation to the email enclosing its closing submissions. The Appellant's closing submissions were, therefore, received by the Tribunal on 4 December 2017. Whilst it was not helpful that we received the Appellant's closing submissions after the date directed, nevertheless, we have taken them into account in reaching our decision.

25. The Tribunal reconvened again and deliberated on 11 December 2017.

Legal framework

26. The statutory framework for the registration of providers of regulated services is set out in the Health and Social Care Act 2008 ("2008 Act"). Section 32 provides a right of appeal to the Tribunal against any decision made pursuant to Chapter 2 of the Act or an order made by a

Justice of the Peace under section 30 and specifically provides as follows:

"(4) On an appeal against an order made by a justice of the peace the Tribunal may confirm the order or direct that it is to cease to have effect."

27. When deciding whether to order urgent cancellation of registration, the test is set out in section 30 as follows:

"1 If (a) the Commission applies to a justice of the peace for an order cancelling the registration of a person as a service provider or manager in respect of a regulated activity and

(b) it appears to the justice that unless the order is made, there will be a serious risk to a person's life health or well-being,

the justice may make the order and the cancellation has effect from the time when the order is made."

28. The powers of the Tribunal are set out in section 32 of the 2008 Act and it stands in the shoes of the decision maker so that the question for the Tribunal is whether at the date of its decision, it reasonably believes that unless the order is made, the continued provision of the regulated activity by the registered provider will present a serious risk to a person's life, health or well-being.

29. The burden of proof is on the Respondent and the standard of proof is the balance of probabilities.

Evidence

30. We took into account all the evidence that was presented in the bundle and at the hearing. We have summarised the evidence insofar as it relates to the relevant issues before the Tribunal. We wish to make it clear that what is set out below is not a reflection of everything that was said or presented at the hearing.

31. Ms Alison Martin, explained that on the weekend 4/5 March 2017, there was an emergency evacuation of the home because the water pump for the Home was overwhelmed and this flooded the carpark compromising the electrics and safety of the building. She explained that the Deputy Manager of the Home, Mr Michael Yates, emailed her on 4 March 2017 at 13:29 to say that they were in the process of evacuating the Home. This was due to recent issues with flooding in the car park outside the home. His email stated that;

> "the issue has gotten into our electrical system and we feel now the home is not safe until the issue is fixed. We are taking the residents to a nearby hotel named the tickled trout in Preston".

32. On 5 March 2017, Ms Martin read the email and contacted her manager and agreed the move was potentially unsafe. She contacted the weekend Emergency Duty Team (EDT) to ascertain the action taken.

33. The EDT visited the hotel and found a number of concerns. These included a lack of support under the deprivation of Liberty safeguards, lack of support for people at risk of falls and lack of knowledge of those who required support in this area.

34. Ms Martin explained that the issue in relation to the adequacy of the water pump was well known prior to the emergency incident and was not managed properly by the Home. In her view, the incident which occurred on 4 March 2017 was a consequence of the Home's pump station no longer pumping the water away.

35. Ms Martin acknowledged that United Utilities had stated that a cattle trough had been running in a nearby field, which has caused additional water to run onto the property, however, in her view, the problem was exacerbated by the fact that the pump was not working.

36. Ms Martin set out that Appellant had been warned previously about the water pump. She referred to the engineer's site report from G &G pump services dated 3 February 2014 which stated that "*corroded pipework is now leaking badly and pump station will fail in the near future if repairs are not made".* G & G then attended on 19 August 2015 where they warned that "*as previously reported, pump station pipework leaking very badly. Repairs need to be made urgently a failure of the station is to be avoide*d". In her view, it was clear that the Appellant was made aware that this was a problem.

37. Ms Martin was aware that Mr McKenzie was stating that the circumstances of the flood or the evacuation of the building had nothing to do with the pump.

38. Ms Martin also provided detailed testimony of what occurred over the weekend of the 4/5 March 2017. The Respondent's position was that the Appellant failed to recognise that moving residents created a risk of harm, specifically, where residents lacked mental capacity and were subject to deprivation of liberty safeguard. The move was conducted haphazardly without a proper consideration of the responsibilities and duties the Appellant owed its residents.

39. Ms Martin explained that the residents were moved to the Tickled Trout Hotel but it was not a care environment. Ms Martin had contacted a number of care homes in a 20 mile radius of the home. They confirmed that they received no contact by anybody on behalf of the Appellant seeking any space to take residents, yet some of them had rooms to offer. The Appellant had provided no documentary evidence to the Respondent to confirm who it had contacted and when.

40. Ms Martin set out that its inspections which took place over the weekend showed residents were not supplied with adequate equipment to meet their needs and staff were unable to adequately

meet the resident's needs at the hotel. The risk assessments were inadequate and medication was provided late. Furthermore, the contingency plan was inadequate and lacked appropriate safeguarding details. It had not been approved by the Respondent.

41. Mr Walker set out that he attended the Home on 8 March 2017 to carry out an electrical inspection. His findings included that the two main sump pumps, which removed excess water, were located below a manhole cover in the gardens and were switched off. The electrical condition report for the electrical installation at the Home was found to be out of date. The last inspection was 23 July 2010, with a report recommendation for retesting installation after three years (due 22 July 2013). He concluded that this could "lead to a potential risk of electrical shock". He had made a series of recommendations which were set out in his statement including that a full electrical installation condition report is carried out as soon as possible.

42. Mr McKenzie believed that the Respondent's inspector, Ms Alison Martin was "vindictive". He denied that the water pump for the septic tank was at any time overwhelmed and claimed that the fact that it had burnt out played no role and had no impact on the flooding. Mr McKenzie denied that the electrics were compromised but accepted that a small section of the Home's electrics were impacted by the flooding. He managed the situation regarding the pump properly by having the septic tank regularly emptied by a contractor.

43. Mr McKenzie denied that any service users at the home were subject to a DoLS order at the time of the evacuation. He considered that there were appropriate and proper risk assessments carried out by the Home's manager, Ms Webb prior to moving any of the service users from the home. He accepted that the evacuation was a new experience for the Appellant but denied that it was in any way haphazard and considered that the Appellant had fully and properly considered its duties and responsibilities prior to and during the evacuation of the home.

44. Mr McKenzie confirmed that Ms Webb had contacted the surrounding care homes to enquire if they could accommodate any of the service users on a temporary basis and was advised by Ms Webb that all of the homes she had contacted were full and could not assist. Ms Webb would be able to confirm what care homes were contacted and when.

45. Ms McKenzie confirmed that the Appellant's staff had contacted the LA before the evacuation in March but the LA's EDT team had not come back to them in a timely manner. It had taken six hours before the EDT contacted the Appellant.

46. Mr McKenzie set out that the Appellant had a contingency plan and this had been approved by the Respondent. The residents had been moved into the Tickle Trout Hotel as there was no alternative care

accommodation available. The booking at the Tickle Trout Hotel involved a rolling contract which was to continue after the initial 72 hour stay. Some service users had agreed to share rooms and all the rooms were fitted out for a disabled person. Mr McKenzie considered the evacuation was properly planned and organised. Furthermore, all the necessary equipment was taken from the home to the hotel including a hoist, wheelchairs and cushions. All medication was provided on time and all the required risk assessment's had been undertaken.

47. Mr McKenzie confirmed that no work had been carried out at the Home since it was closed. He was waiting for his insurance claim to be processed. He confirmed that the Home could not open tomorrow. There were no service users in the home nor were there any staff. There was an existing restriction in place imposed by the Respondent which meant that he could not take in any new service users.

48. Mr McKenzie confirmed that substantial works were needed before the home could open and these included that an electrical condition report was required, fire doors needed to be replaced because they were warped, a new contract was required for the lift maintenance, replacement flooring in rooms 10, 11 and 12 was required and replacement of the conservatory roof was needed.

49. Furthermore, carpets were required for the hallway, dining room and rooms 10, 11 and 12, decorating was required throughout the premises, new curtains were required and the pumps had also not yet been fixed but would need to be fixed. The Appellant would also have to employ staff, ensure that the call bells were working and he would also have to ensure that the Fire Authority were happy with the fire arrangements in the Home.

50. However, despite all the outstanding work identified, he did not consider there was a serious risk to a person's life, health or well-being. This included service users.

51. Mr John Love confirmed that there was a minor flooding November 2016. One of the two pumps was still working in March 2017. He did not think the tank overflowed or became full. It was being emptied every few weeks.

52. Ms Webb acknowledged that her witness statement contained significant errors. Ms Webb made it clear that she did not make the calls to the other care homes. These were made by her deputy, Mr Michael Yates. However, there were no written records that this had been done. Ms Webb was not sure why her written statement made reference to her making those calls. Her written statement had been prepared by Mr Drummond and she confirmed that she had read the statements had made corrections and returned the amended statement with the corrections. However, no one had pressurised her as to what to say.

53. Ms Webb confirmed that the Home had a contingency plan. This was seen and approved by the Respondent. However, she could not say if this was Ms Martin. She was not sure why her written statement named Ms Martin.

54. Ms Webb accepted that they should have chased the EDT for a response. Ms Webb could not produce written documentation of the risk assessments covering the hotel (such as size of beds, toilets, risks in the environment, for example, stairs etc.), consents and details of communication with family members. She accepted that there were some issues with the service users at the hotel including one of the vulnerable service users being left in a room with a kettle. This should not have happened as the service user had not used a kettle for several years.

55. However, due to the urgent nature of the evacuation, Ms Webb explained that they did the best they could. She could not produce any other risk assessments other than the general risk assessments that had been provided in the evidence bundle.

56. Ms Webb was not at court on 8 March 2017. She therefore could not know what was said. She did not know why this was referred to in her written witness statement. The evidence relating to what the Respondent's electrician, Mr Walker, did at the home was not her direct evidence. It was what her father, Mr John Love had told. She acknowledged that the written statement did not make this clear.

57. Ms Webb considered that, although the decision was made to vacate the home in March, looking back, she would not have made the same decision. She had not dealt with any evacuations before and believes, on reflection, there was not a serious risk to anyone. She considered that she could have moved some service users to other rooms rather than evacuate the Home.

58. Ms Webb confirmed that there was no prepared schedule for checks and policies to be updated, such as the electrical condition and lighting report and other checks which were outstanding. Ms Webb confirmed that no schedule for maintenance had been prepared since the closure of the Home in line with the Respondents electrician's findings.

59. Ms Webb did not think the home could open tomorrow. She would not be a part of any reopening unless the work was carried out. In her view, around £50,000 worth of work was needed to be done before the Home was capable of taking in any service users.

60. Ms Webb identified a significant amount of work that that needed to be undertaken before any reopening. This included "*risk assessments, risks for toilets and other things being at risk need to be undertaken in the future*". In her view, the contingency plan needed to be updated to

make reference to all eventualities and "*everything needed to be made safe*". This included the electrics, the gas certifications, call bells, two new bathrooms and attention to the fire doors. Furthermore, there would need to be staff recruitment and training. Decorating and carpet needed to be put in place and there would need to be repairs to the conservatory roof, office windows and general maintenance. She could not confirm if the pumps had been fixed. Ms Webb confirmed that she would not be willing to return unless all these works were undertaken first.

61. Ms Webb confirmed that service users could not be accommodated as "*there were no carpets, doors were not fitting and it needs sorting out*". Furthermore, she identified the risks as "*risk of trips, falls, fire risks with the doors and there was no staff present – so risks existed*".

The Tribunal's Conclusions with Reasons

62. We took into account all the evidence that was included in the hearing bundle, presented at the hearing and took into account the written closing submissions.

63. We concluded that we preferred the evidence of the Respondent, whose evidence we found to be clear and consistent. It was clear from the way in which the evidence was presented that the relationship between the parties was strained. However, in our view, the Respondent's witnesses including Ms Martin provided a credible and consistent account of what occurred.

64. We did not find the Appellant's evidence to be credible. The evidence of the Appellant's witnesses, Mr McKenzie and Ms Webb, contradicted each other. For example, Mr McKenzie in his oral evidence stated that it was Ms Webb who had made calls to the other care homes in order to try and ascertain whether or not any beds were available. We noted that this assertion was also referred to in the order of District Judge Goozee dated 8 March 2017. This assertion was repeatedly made throughout Mr McKenzie's oral evidence and Mr McKenzie submitted that Ms Webb would provide further details as part of her oral evidence. However, Ms Webb in her oral evidence denied that it was her who had made those calls. We were concerned that the Appellant was still not clear of who had made the calls to the other care homes despite there being an extensive passage of time since the order was made.

65. We also found that Mr McKenzie was evasive and inconsistent in his evidence. We had to repeatedly remind Mr McKenzie of the need to answer the question that was asked. For example, a large part of Mr McKenzie's evidence focused on blaming the Respondent's Inspector, Ms Martin for the situation that the Appellant found itself in. Mr McKenzie was also at one point during the hearing asked to refrain

from shouting out a reply to a question that Ms Webb was asked whilst she was giving evidence.

66. We were concerned about the evidence of Ms Webb. We found her oral evidence to be inconsistent with her written evidence. Ms Webb accepted that her written witness statement, dated 10 May 2017, did not accurately reflect the events as they occurred. For example, her written statement states;

> …" I felt that as the home was likely to be evacuated for 72 hours that the village hall was not suitable for this, so I contacted local care homes that day to ask if they could accommodate any of our service users. All of the Homes I called said they were full and could not assist"

67. However, in her oral evidence to the Tribunal, she confirmed that this was simply untrue. It was Mr Michael Yates who had made the calls to the care homes. She was unable to say which care homes he had called and there was no written documentation to support this. There were also other discrepancies such as Ms Webb referring in her written statement to the contingency plan being seen and approved by Ms Alison Martin. In her oral evidence to the Tribunal, she confirmed that she did not identify Ms Martin as being the individual who had approved it and could not explain the reference to Ms Martin.

68. We were also concerned that Ms Webb's written statement was misleading in places. For example, the written statement described the Respondent's electrician as looking at the different fuse boxes in the Home which had trip switches. Her written statement criticised this approach to say that Mr Walker did not test them or take any readings from them or apparatus in the fuse boxes and cupboards. However, Ms Webb accepted in her oral evidence that this was not her evidence and but reflected what her father, Mr John Love, had told her. We were troubled that the written statement, as it was submitted, suggested that she had first-hand experience and knowledge of events when it was clear that this was not the case.

69. Although Ms Webb stated that she had made amendments to the original draft of her written statement, she confirmed that those amendments had not found their way into her final statement but could not explain why.

70. We concluded that there was a serious risk to a person's life, health or well-being if the order made on 8 March 2017 ceases to have effect. Our reasons for doing so are set out below.

71. We heard significant evidence around the circumstances which led to the making of the order in the Magistrate's Court. We reminded ourselves that the question for the Tribunal is whether at the date of its decision it reasonably believes that unless the order is made, the

continued provision of the regulated activity by the registered provider will present a serious risk to a person's life, health or well-being.

72. We considered the risks as they were presented at the date of our decision. Mr McKenzie confirmed that he had done nothing to address the risks because he was waiting for the insurance situation to resolve itself. There was agreement between Mr McKenzie and Ms Webb that the Home was not ready to open and would not be for some time. Mr McKenzie and Ms Webb confirmed that various works needed to be done before the Home could reopen including;

- An Electrical Condition Report was required.
- Replacement of the warped fire doors.
- Replacement of flooring in rooms 10, 11 and 12.
- Replacement of the conservatory roof.
- New carpets for the hallway, dining room and rooms 10, 11 and 12.
- The property needed to be redecorated and new curtains were required.
- The pumps needed to be fixed
- A new contract was needed for the maintenance of the lift.
- A new contract needed to be arranged to empty the tank.
- New staff needed to be employed including a Registered Manager.
- Approval was required from the Fire Authority to ensure that it was content with the arrangements.
- Testing to ensure that the call bells were working.

73. We were surprised that Mr McKenzie maintained his position that he did not consider there to be a serious risk to a person's life, health or well-being despite setting out the extensive list of matters that required attention before the Home could even consider reopening. In our view, this was consistent with the lack of insight that Mr McKenzie demonstrated throughout these proceedings.

74. On any reading, it is clear that, for example, not having a valid electrical report, having warped fire doors, pumps which do not work and call bells which do not work would pose a serious risk to a person's life, health or well-being.

75. For example, the electrical condition report for the electrical installation of the Home is out of date. It was last inspected on 23 July 2010 and should, according to the Respondent, have been tested every three years. Mr Walker, Specialist adviser to the Respondent and whose specialism is electrical installations, made it clear as to the action that needed to be taken by the Appellant. This includes ensuring that a full

electrical installation condition report is carried out as soon as possible to render the service satisfactory.

76. However, despite the Appellant being aware of this since 10 May 2017 (date of Mr Walker's statement), this work has not been undertaken. Therefore, all of the risks and failures which were present at 8 March 2017 are still present. Whilst the Appellant referred to the evidence of the invoice from the Able Group, dated 7 March 2017, as evidence of it being safe, Mr McKenzie accepted that an electrical condition report would still be required before the Home could open. We were, therefore, not satisfied that the buildings electrics were safe

77. We should add that we preferred the evidence of Mr Walker who had carried out a detailed inspection rather than the evidence of the Appellant, which consisted of an invoice, provided following a short cursory inspection which lasted half an hour. Mr Walker clearly set out the risks. This includes the possibility of electrical shock. In our view this is a serious risk. We noted that despite this risk being raised with the Appellant, no work had been undertaken. Therefore, that risk remains.

78. Ms Webb, very fairly, accepted she would not admit service users at this time. She accepted that "*risk assessments"* would need to be undertaken. She acknowledged that the contingency plan would need to be revised and she had to be satisfied that the Home was safe including the electrics and gas. Furthermore, Ms Webb accepted that there was a *"risk of trips, falls, fire risks with the doors and there were no staff present, so risks existed".*

79. We rejected the Appellant's contention that the effect of such order being made by this Tribunal cannot and will not result in a serious risk to a person's life, health or well-being due to the restriction imposed on 15 April 2016 being in force preventing the Appellant from admitting new service users to the home.

80. We rejected it on the basis that whilst we acknowledge that there are restrictions in place, we reminded ourselves that concluded that question for the Tribunal is whether at the date of its decision it reasonably believes that unless the order is made, the continued provision of the regulated activity by the registered provider will present a serious risk to a person's life, health or well-being. We concluded there was a serious risk based on the list of outstanding work provided by the Appellant's own witnesses.

81. The Home is arguably worse now than it was when it was closed in March 2017. In addition to there being no electrical condition report, or a contract for repairs to the pumps, the Home has been empty for nine months. During that time, the Appellant accepts that it has fallen into further disrepair (for example, the conservatory roof is now damaged).

The list provided by both Mr McKenzie and Ms Webb of work that needed to be done before the Home could reopen is a lengthy one. The Appellant accepts that improvement works will need to be taken to the Home before it can reopen. It accepts that this will not be an overnight process and the steps will take a number of months.

82. It is also accepted by the Appellant since the Home closed in March 2017, no works have been undertaken to the Home to either improve it or to rectify any damage at the Home. This is an important consideration and demonstrated to us that the Appellant has simply failed to understand what it is required to do. For example, whilst we took into account that the Appellant was waiting for its insurance claim to be processed, in our view, it was not clear, why, for example, the contingency plan had not been updated to ensure it was more comprehensive and covered all eventualities. In short, no work has been undertaken since the order was made on 8 March 2017.

83. In addition, there was no action plan presented as to what would be done and by when. There was no schedule of policies which were to be updated. The contingency plan which was wholly inadequate for a professional care providing environment had not been updated despite Ms Webb accepting it needed updating.

84. We, therefore, having considered all the circumstances, concluded that there remained a serious risk to a person's life, health or well-being if the order ceased to have effect.

85. As we have made findings in relation to the serious risk to a person's life, health or well-being as at the date of our decision, we do not need to make further detailed findings around the events as at 8 March 2017.

86. However, if we had gone on to consider the circumstances as at the date of the order, we would have agreed with the observations of District Judge Goozee as set out in his order dated 8 March 2017. We agreed that there were inadequate measures taken to address the risks in managing the evacuation, there was a lack of effort to find alternative appropriate care accommodation or liaise with the Local Authority and there were inadequate care facilities at the hotel as well as poor contingency planning.

87. We also noted that from the Appellant's own evidence, it accepted that it would have done things differently. For example, Ms Webb, whilst recognising that it was an urgent situation, accepted that the contingency plan should have been more detailed and should have been a fully comprehensive set of documents covering almost every eventuality that could lead to a change in circumstances at the home. Furthermore, there should have been individual risk assessments

which would have also avoided situations whereby vulnerable service users were placed in accommodation which was clearly inappropriate.

88. We also carefully considered and rejected the other grounds put forward on behalf of the Appellant, including, for the reasons as set out above.

89. We, therefore, concluded that there remained a serious risk to a person's life, health or well-being if the order ceased to have effect.

Decision

The appeal is, therefore, dismissed.

The order made on 8 March 2017, at Manchester Magistrates' Court, against the Appellant, is confirmed.

Judge H Khan
Ms S Last
Mr J Hutchinson

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

Date Issued: 4 January 2018