NCN: [2021] UKFTT 245 (HESC)

Care Standards

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

[2020] 4159.EA VKinly

Hearing held by video link
on 8, 9, 10 and 11 June 2021
Deliberation on 15 June 2021

Before

Ms S Brownlee (Tribunal Judge)
Ms Jane Everitt (Specialist Member)
Mr John Hutchinson (Specialist Member)

Nightingale House

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. Mr Abiodun ('Abi') Oduyelu, the nominated individual and proprietor of Nightingale House, ('the Appellant'), appeals pursuant to section 32 of the Health and Social Care Act 2008 ('the Act'), to the Tribunal. The appeal relates to a decision of the Care Quality Commission ('the Respondent') dated 29 October 2020 to cancel the registration of the Appellant in respect of the regulated activity 'accommodation for persons who require nursing or personal care' at Nightingale House, 69-71 Crowstone Road, Westcliff-on-Sea, Essex SS0 8BG.

The Hearing

2. The hearing took place on 8, 9, 10 and 11 June 2021. This was a remote hearing which was not objected to by the parties. The form of remote hearing was by Kinly CVP video. A face to face hearing was not held because it was not practicable and no-one requested the same. We considered that the issues in this appeal could be determined in a remote hearing. The documents that

we were referred to are in the electronic hearing bundle provided in advance of the hearing. Page references follow the pagination on the original bundle for ease of reference, as some participants were working from a hard copy bundle and some from a digital bundle. We also worked from two supplementary hearing bundles. One was a bundle consisting of late evidence (updated Scott schedule, second witness statement from Ms Jo Govett and exhibits, witness statement from Ms Gaynor Chamberlain and exhibits, second witness statement from Mr Oduyelu, witness statements from Mr Olu Martins and Ms Jodie Campbell), agreed by the parties and ordered by Judge Khan, following a telephone case management hearing on 27 May 2021. The second bundle consisted of a third witness statement from Mr Oduyelu and exhibits. During the hearing, we received the Respondent's enforcement policy and decision making tree, an independent fire risk assessment dated 17 October 2019 and an environment improvement plan prepared by Ms Campbell/Mr Oduyelu.

3. There were no significant connectivity issues during the hearing. All participants were able to connect their video and audio for most of the hearing. Mr Hutchinson, specialist member, had some connectivity issues for a short period on day three of the hearing, but he was able to connect using a telephone for that time. Overall, no participants experience significant connectivity issues – to such an extent that their engagement with the hearing was impacted. At the conclusion of the hearing, both parties confirmed that they considered they had been able to engage with the appeal hearing effectively.

Attendance

4. Mr Oduyelu, the Appellant, was represented by Mr Mark Harries QC of counsel, instructed by Mr Bradley Wood of Giles Wilson LLP. Mr Oduyelu called one witness: Ms Jodie Campbell, who is currently engaged as a consultant (in the capacity of clinical and governance lead), assisting Mr Oduyelu with making improvements to Nightingale House. Mr Martins, the planned registered manager for Nightingale House, was due to attend the appeal hearing to provide oral evidence. He did not attend and despite being warned, indicated to Mr Oduyelu's solicitor that Mr Martins was unable to attend when the point came to provide oral evidence. The CQC, the Respondent, was represented by Ms Georgia Luscombe of counsel, instructed by Ms Sarah Potter, solicitor, in Legal Services at the CQC. The Respondent called five witnesses: Ms Zoe Cattermole, Ms Stacey Jones and Ms Gaynor Chamberlain, inspectors at the CQC, Ms Jo Govett, inspection manager at the CQC and Mr Benedict Leigh, Director of commissioning at Southend Borough Council.

5. There were observers at various points over the course of the public hearing and attendees from the legal teams of both parties, taking notes of the proceedings.

Background

6. Nightingale House has been registered with the CQC since 1 October 2010 and was registered with its predecessor since 2002. It has been registered since 2010 to carry out the regulated activity of accommodation for persons who

require nursing or personal care at the one site. By way of recent regulatory history, Nightingale House was inspected in February and November 2016, with overall rating of 'requires improvement'. In March 2018, it received an overall rating of 'good', with all five key questions rated as 'good'.

7. Nightingale House was next inspected on 4 and 5 March 2020, following safeguarding and regulatory concerns being shared between the CQC and Southend Borough Council in the early part of 2020. Breaches of Regulations 10,11, 12, 14, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the 2014 Regulations') were recorded and the report produced as a result of the inspection rated Nightingale House as inadequate across the five key questions. On 6 March 2020, the Respondent issued an urgent Notice of Decision under section 31 of the Health and Social Care Act 2008 ('the 2008 Act') to impose a condition on the Appellant's registration – restricting admissions to Nightingale House. On 17 March 2020, a focused inspection was carried out and continuing breaches of Regulations 12 and 17 of the 2014 Regulations were identified. Nightingale House was rated as inadequate on the two key questions of safe and well-led service. After both March inspections, the inspectors raised safeguarding referrals to Southend Borough Council and a medication audit was conducted on 7 March 2020. As a result of the second inspection of 17 March 2020, on 19 March 2020, the Respondent issued an urgent Notice of Decision to impose additional conditions on the Appellant's registration and Southend Borough Council took a decision to rehome the service users. On 19 July 2020, the Respondent issued a Notice of Proposal to cancel the Appellant's registration. Mr Oduyelu submitted written representations to the Respondent, dated 11 August and 9 October 2020 (which were not before the Tribunal). On 29 October 2020, the Respondent issued its Notice of Decision, confirming the proposal to cancel the Appellant's registration.

8. On 11 November 2020, the Appellant lodged an appeal to the First-tier Tribunal against the decision to cancel the registration of Nightingale House. On 18 January 2021, the Respondent contacted the Appellant to arrange a follow up inspection in preparation for the appeal hearing and to consider if appropriate improvements had been made/were planned to provide sufficient reassurance for the purposes of the inspection rating. Mr Oduyelu and his legal representative sent questions to Ms Govett, the inspection manager. She responded to them and did not receive any further contact. On 23 April 2021, she requested further details from the Appellant with a view to arranging an inspection. On 3 May 2021, the Appellant responded and 6 May 2021 was agreed as the date for the inspection. Ms Govett and Ms Chamberlain attended on that day and conducted a focused inspection – focused on two key questions – well-led and safe service. The inspection resulted in continued breaches of Regulations 12 and 17 of the 2014 Regulations, individual ratings of inadequate and an overall rating of inadequate.

Legal Framework

9. Section 3 of the 2008 Act invests in the Respondent registration functions under Chapter 2.

10. By virtue of section 3(1) of the 2008 Act, the Respondent's main objective is to protect and promote the health, safety and welfare of the people who use the health and social care services.

11. Section 4 of the 2008 Act sets out the matters to which the Respondent must have regard, including the views expressed by or on behalf of the members of the public about health and social care services, experiences of people who use the health and social care services and their families and friends and the need to protect and promote the rights of people who use health and social care services. Any action taken by the Respondent is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed.

12. Section 17 of the 2008 Act gives the CQC the power to cancel the registration of a service provider of a regulated activity on the grounds that the regulated activity is being or has at any time been carried on otherwise than in accordance with the relevant requirements. Relevant requirements include any conditions imposed by or under Chapter 2 and the requirements of any other enactments which appear to be relevant to the Respondent – i.e. the 2008 Regulations.

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

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

15. Section 32 of the Act provides for a right of appeal to this Tribunal against a decision to cancel the registration of a service providing a regulated activity. The Tribunal may confirm the decision or direct that it is not to have effect, or it can vary, cancel or impose any conditions on the registration that it sees fit.

16. The Respondent bears the burden of persuading the Tribunal that cancellation of the service is a proportionate decision as at the time of the appeal hearing. The Respondent must establish the facts upon which it relies to support satisfaction of the proportionality of the decision on the balance of probabilities.

17. The Tribunal is required to determine the matter afresh and make its own decision on the merits and evidence as of the date of hearing and should take into account evidence which post-dates the notice of decision (subject to fair notice).

Issues

18. The key question for the Tribunal is whether the Respondent is able to demonstrate, on the balance of probabilities, that the decision to cancel the registration of the Appellant remains a proportionate and reasonable one, when considered alongside the requirements in sections 3, 4 and 17 of the 2008 Act.

19. We had helpful skeleton arguments from both parties, which we considered in advance of the hearing and as part of our deliberation.

The Appellant's position

20. The Appellant has accepted many of the breaches found during the two inspections of March 2020 and the inspection of May 2021. The Appellant contends that he has worked responsively to address the failures and has managed to put in place considerable improvements to such an extent that he is no longer in substantial breach of Regulations 12 and 17. Ultimately, the Appellant does not accept that the service remains in substantial breach of Regulations 12 and 17, considers that the Respondent has failed to give any or sufficient weight to the improvements made to the service and has failed to acknowledge the improvements so as to alter the overall rating to the service. The Appellant is also confident that with more time, the service will be able to achieve a better rating, with the improvements planned under the guidance from Ms Campbell and in conjunction with Mr Martins.

21. The Appellant requests that the Tribunal should direct that the decision to cancel should cease to have effect and the Tribunal should give consideration, in the alternative and as a proportionate response, to whatever conditions it considers necessary to meet any ongoing risk.

The Respondent's position

22. The Respondent submits that the decision to cancel the Appellant's registration should be confirmed, as a decision that remains justified, reasonable and proportionate given the Appellant's poor history of compliance with the requirements of the 2008 Act and the 2014 Regulations, particularly since March 2020. The Respondent further submits that the evidence presented of the improvements made since the closure of Nightingale House is not substantial enough to engender confidence in the Appellant to be able to provide safe and effective care in a well-led and governed service in the future.

Evidence

23. We considered all the evidence that was presented in the hearing bundle, the two supplementary bundles and during the hearing. We have summarised the evidence insofar as it relates to the relevant issues for the Tribunal. What is set out below is not a reflection of everything that was said or presented at the hearing or in the hearing bundles.

24. We heard oral evidence from Ms Cattermole, Ms Jones, Ms Chamberlain, Mr Leigh, Ms Govett, Mr Oduyelu and Ms Campbell. We also carefully considered the witness statements of Mr Martins and Ms Anita Martin (previously the registered manager at Nightingale House from 2003 to 2019 and for a temporary period from late 2019 to March 2020).

25. Ms Cattermole attended the second inspection on 17 March 2020 with the lead

inspector, Mr Kieran Atreed-James, who had not provided a witness statement or attended the hearing on behalf of the Respondent. Ms Cattermole explained that information was lacking on the fire evacuation policy and the equipment needs for that. She noted that evacuation mats were not being used and appeared to still be in their packaging. She was told that staff had not received training in the equipment. She observed a water leak in bedroom 17 and confirmed that the description in her statement was correct – the leak caused the floor to be properly wet, which could have led to damage to the ceiling below. Ms Martin made her aware of the choking risk posed by a service user (when eating). She had to intervene to point out to a member of staff that a service user had stood up and was trying to walk with a L shaped table in front of them. She could not find and was not given an explanation as to why two service users had L shaped tables pushed right up in front of their chairs. From Ms Cattermole's perspective, such a technique posed the risk of falls for the service users and she was not provided with a reasonable explanation as to the arrangements. In the absence of a reasonable explanation, she concluded that the tables were being used to restrain the service users to ensure they did not move. She explained that she made a note of all direct quotations during conversations with staff. On 17 March 2020, there was no effective plan in place for improvement and on speaking with the deputy and registered manager, Ms Cattermole observed that they were confused by what action plan they were working towards and were not aware of which tasks had been delegated to them. In short, they did not know what they were supposed to be focusing on. She explained how, by that point, after the inspection of 4/5 March 2020, she would have expected the leadership team to have a thorough understanding and clear direction from the provider so that everyone could work together to ensure improvements to the service. She observed that Ms Martin knew there were failings which needed to be addressed.

26. Ms Cattermole observed the fire doors, many of which were held open with wedges. She explained that fire doors ought to be fitted with magnets to hold them open, magnets which are connected to the alarm system to ensure that if the alarm sounds, the doors will be closed by the alarm system. She explained that she had been made aware of the issues from the first inspection in March 2020 and two weeks later, she would have expected to see significant progress towards the immediate concerns being rectified.

27. Ms Jones attended the first inspection with Mr Atreed-James on 4/5 March 2020. She observed a service user who was distressed and fixed on wanting to wash their hands. There was a sink in their room but they said they were told they weren't allowed to get up and use the sink and there was no bowl as an alternative for hand washing. The service user said to Ms Jones that sometimes they dipped their hands in a jug of drinking water to clean them. She explained how you can get a feeling for how people are cared for from the type of interactions between service users and staff. She observed staff only speaking the service users to help them with something – she did not observe any general conversations. A relative stated that the home was different when Ms Martin was not there. Ms Jones explained that one service user needed inhalers to help alleviate COPD and was visibly distressed about the lack of them. Two were prescribed on the MAR chart, but one appeared to be crossed

out. The code 'F' was used in recording administration of the inhaler, which was not explained any further on the record. A staff member explained that the inhaler had been stopped by a GP, but it was not clear from the chart.

28. Another service user had 48-hour care plan in place following admission to Nightingale House. There was no information in the care plan to support the service user, who had necrotic heel injuries and a grade 2 pressure sore on their sacrum. There was no information in the care plan as to the steps to be taken to meet the needs of the service user. She explained that there was a record of accidents and injuries but no analysis as to the root causes.

29. In cross examination, Ms Jones accepted that a number of the deficiencies noted – from the mould spores in the drinking jug to the broken lights, odour and unclean areas were capable of rectification. The impression she got was that staff were not happy.

30. Mr Leigh explained that the issue with Nightingale House was that contract officers would observe the physical condition of the home, the care records and care being delivered in the home and the pattern, over time, was that immediate fixes would be made, when brought to the attention of the home, but Mr Oduyelu did not have a consistent approach to maintaining the issues. The quality of the physical environment was a significant concern to Southend Borough Council and indicative of this was the number of visits carried out on behalf of Southend Borough Council in 2019 and 2020 – this was unusual and demonstrated the amount of support being given to the home. There was a need to ensure, through follow up visits, that the actions which had been agreed, had been carried out and there was a pattern of the provider failing to follow through on the agreed actions. Southend Borough Council arranged a meeting with Mr Oduyelu on 31 January 2020, but he did not attend.

31. Given the level and severity of the concerns, Mr Leigh would have expected the majority of the physical improvements to have been done immediately and a detailed plan for longer term improvements, with a training plan for staff and engagement with the offered external support, given that there were significant concerns with the culture at the home. By the time of March 2020, Southend Borough Council was deeply unhappy with the quality of care but the pressure for urgent action did not come from the Council as it wanted the service users to have a decent quality of life. As such, the Council asked the CQC not to pursue urgent cancellation of the home, as a result of the inspections in March, in order to give the Council time to work with the service users and their families to ensure effective moves to other services.

32. Mr Leigh explained that the frequency of the visits was to keep the pressure on the service and to provide assurance that agreed actions had taken place. That assurance was not in place by January 2020 and that was why the meeting was arranged with Mr Oduyelu – his improvement plan was not sufficient to alleviate the safeguarding concerns from the Council.

33. Ms Chamberlain attended the inspection of 6 May 2021 as support for Ms Jo Govett. Mr Martins was present as the new proposed manager and Ms

Campbell was introduced as a consultant. She had been engaged a couple of days before 6 May. Due to the state of the environment, Ms Chamberlain considered that Mr Oduyelu would not be ready to admit new service users by July or August time, as projected in the improvement plan (which was submitted on the morning of 6 May 2021) provided to Ms Chamberlain and Ms Govett on the day of the inspection. There was no preparation of thought about the type of service he was going to deliver, and the policies and procedures required for the service. Ms Chamberlain stated that they were looking for how the service was going to improve and evidence that lessons had been learnt. The inspection focused on governance and the state of the environment and Ms Chamberlain was hoping there would be something to tell her how Mr Oduyelu was going to address things and to show the improvement from 2020. She considered that a number of the issues were easily rectified, but they had been outstanding for quite some time and she could not understand why they were still outstanding. From her perspective, the production of the new policies and procedures, which Mr Oduyelu organised after the 6 May inspection, were not enough – there was no understanding of the 'how' – to explain how the changes would be made.

34. As the environment stood, it was shabby and appeared unloved and uncared for – it did not demonstrate dignity and respect due to the state of the décor and the quality of the repair/remedial works which had been undertaken. Nightingale House was empty at the time of the inspection and not operating. Ms Chamberlain observed the work which had been undertaken in each of the bedrooms and in the communal areas. She noted an offensive smell in two bedrooms, coming from the toilets, crudely plastered areas and crudely altered gaps in the radiators covers which she did not deem to be safe, even with the remedial work, as service users would still be able to place their hands on the radiators. Wardrobes had been secured to the walls, but not effectively. The fire doors had not been remedied to the standards required, even though work had been done on them – by installing new doors. They were not fitted with the automatic device used to close the doors when linked to the alarm system. When asked about it, it appeared that it had not even been considered – Mr Oduyelu said that wedges would still be used to keep doors opened and the devices could be fitted to individual doors. The kitchen area and in fact the entire home, as Ms Chamberlain observed, had been left untouched since people had moved out of it just over one year ago, to the extent that there were still bottles of soap in rooms and incontinence pads. Nothing had been moved out the home to demonstrate that it had been cleaned. There were dead flies on the windowsills and the kitchen fridges had food debris and mould in them.

35. The door had been upgraded and had locks which could be turned on the inside of them. This surprised Ms Chamberlain as the service users would have varying degrees of dementia and it would be a clear risk that service users could lock themselves in bedrooms and bathrooms. When this was pointed out to Mr Oduyelu, he explained that if someone did not have capacity, the locks would be removed.

36. She considered that there was a heavy reliance being placed on the proposed manager and the consultant. When issues were pointed out to Mr Oduyelu, he

would say 'oh yes, we will do something about that'. It appeared as if he was seeing the issues for the first time. On the day, he felt that he had made all of the necessary refurbishment, which was required, but he had not looked at everything. She saw Mr Oduyelu as reactive rather than proactive, citing the example of the various policies and procedures which were organised after the inspection of 6 May. Ms Chamberlain had concerns about the policies and procedures, which she viewed as generic and not service specific. Mr Oduyelu felt that he had put things right and did not appreciate that the steps undertaken were not sufficient to reassure the CQC. Ms Chamberlain accepted that with time and conditions, improvements could be made.

37. Ms Govett explained that Mr Atreed-James was asked to provide a witness statement but as he had left employment with the CQC and he could not be compelled by the Respondent, it was not pursued. She stated that information sharing between the CQC and local authorities is ongoing as the local authorities have a duty of care to all service users in their area and where there are safeguarding concerns the local authorities will take the lead on that. The CQC will monitor any actions taken by the service in response to the safeguarding concerns and with the aim to protect service users. The threshold for carrying out inspections is base don risk. Ms Govett was asked to allocate inspectors as the information shared by Southend Borough Council was that there was a lack of engagement from the provider about providing up to date information, particularly in relation to the fire risk assessment. There was also the added risk caused by the loss of a long-standing manager – Ms Martin, in 2019.

38. In response to a letter of intent, sent in March 2020, Mr Oduyelu sent a risk assessment on 8 March 2020, which was dated October 2019. This was an example Ms Govett gave of Mr Oduyelu not appreciating that he was being given an opportunity to respond and explain what he was going to do to meet the concerns of the CQC. By the time of the action plan being submitted on 6 May 2021, it still contained outstanding information regarding the fire risk assessment. The action plan indicated that the service would get quotes for it and send them to the CQC by 21 May 2021. By the time of Ms Govett giving her evidence, on day 2 of the hearing, the CQC had still not received the information. Ms Govett had no assurance that Mr Oduyelu would take on board what was being said and implement it as previous advice had not been taken. She gave the examples of the previous advice from the CQC, from Southend Borough Council and from the managerial oversight team which went in to help in March 2020.

39. When Ms Govett attended to inspect on 6 May 2021, it was quite disorganised and did not look like a service that people could move into relatively easily. There were pictures of previous residents on the wall and although Mr Oduyelu said that lots of work had happened, but apart from the carpets and the fire doors being upgraded, Ms Govett did not consider that the service was a welcoming environment. Ms Govett remained of the view that conditions would not satisfy her as she did not see any overall improvement plan and there were no indicators as to how things could be done to improve the service. She was expecting a plan which covered this, but there was no assurance provided from

the plan Mr Oduyelu submitted on 6 May or in the updated one which followed on 11 May 2021.

40. Ms Govett had had a chance to review the late evidence submitted by Mr Oduyelu, regarding procedures, policies and job descriptions. She explained that the documentation is very basic and does not link to anything about the service, its vision, strategy, values and behaviours from staff. She explained that Mr Martins had been registered with the CQC in the past and while she had not seen a copy of his CV, she stated that for any manager coming to service like Nightingale House, their history and ability to demonstrate that they had improved services coming out of crisis would prove essential. From what she knew of Mr Martins' history, she did not consider him to have that history and experience. She explained that the CQC is still waiting on an independent fire risk assessment and a legionella assessment, as well as a gas certificate for the building.

41. From Ms Govett's perspective, she could not think of what conditions could be put in place as she explained that the conditions would need to be compliance with the current Regulations as the service remains out of compliance and due to the amount which remains outstanding, she did not consider conditions to be easily to formulate to meet the risk. Ms Govett observed that the difficulty is at what point do you stop directing someone – the CQC is no there to manage a service on behalf of a provider. Throughout the recent inspections and the history with Southend Borough Council, there has been a lot of signposting and pushing the service to best practice. It's about where that stops and where is that threshold.

42. Mr Oduyelu explained that Ms Martin had worked for him for 17 years and she was a kind, caring and compassionate individual who shared the same values as him. It meant they were able to work very well together for years. The agreed approach between Ms Martin and Mr Oduyelu was that he was responsible for the management of the care of elderly service users and he for dealing with the building maintenance and facilities of the home. They held twice weekly meetings to discuss issues with an ongoing and open dialogue to ensure aims were achieved. It was his practice to attend the home about four times per week, to speak with service users and meet with families and next of kin. Some meetings would feature the deputy manager and the chef and any work which was not up to date was personally pursued by Mr Oduyelu. Problems started for Nightingale House when Ms Martin retired from post in around May 2019 and a different manager took over an interim basis. Mr Oduyelu noticed that things were being run different and he was concerned with the financial arrangements. The relationship between Mr Oduyelu and the interim manager worsened and she walked out of her post in September 2019. The staff were shocked and when she left, Mr Oduyelu believed that she sabotaged some operations at the home, telling some of the staff that she was going to teach him a lesson and that she was going to get the home closed down by speaking with friends at the CQC. Mr Oduyelu believed that she tampered with the fire alarm and disconnected the CCTV.

43. Ms Martin agreed to return to her old post in October 2019 and stayed in post

until the last service users had been moved in April 2020. Mr Oduyelu described the period of later 2019 and into 2020, leading up to the first CQC inspection of 4/5 March 2020 as traumatic as there were visits from social workers and inspectors on what felt like virtually every day. He felt that the people were coming to manufacture and create stories in order to ensure that the home was closed. Initially, he was shocked by the outcomes of the two inspections and wanted time to reflect and consider his position. After a few months, he came to the decision to drive improvements to put the issues right, with the encouragement of his legal team. He described the period of March 2020 to May 2021 as a 'work in progress' and he explained as much to Ms Govett when she was in touch about attending for an inspection. He explained that the major, vital issues such as the carpets and the floor levelling had been completed, but the pipes needed to be boxed in (as per concerns raised by Ms Chamberlain). He was affected by the standstill to building work caused by the pandemic and dedicated time, even over the Christmas holiday period, to attending the home to check on progress to the works. Since the outcome of the inspection in May 2021, he explained that he has people working on the premises to attend to the issues and each room will be assessed to check for the call bell, rail guard, wall light, sink, painting and decorating. The work will also focus on the further improvements needed to the fire doors, which he explained were deemed to be compliant in 2018 and for some reason, are no longer compliant. From Mr Oduyelu's perspective, all of the issues identified from the May 2021 inspection are easily remedied.

44. Mr Oduyelu stated that Mr Martins is the proposed new manager for the home, having worked previously as a registered manager for at least 10/12 years, including at an inadequate home which he helped move to 'requires improvement'. Mr Martins was suggested to Mr Oduyelu through his social circle to take over from Ms Martin, with support from Mr Oduyelu – along the same role division as was in place with Ms Martin. In the same social circle, Mr Oduyelu received a recommendation for Ms Campbell, who visited the home in January 2021. The plan is for the two prospective staff to jointly manage the home. Ms Campbell directed Mr Oduyelu to companies which could put together a suite of policies and procedures and recommended the implementation of a care management system, which allows Mr Oduyelu to have enhanced oversight, from a remote setting. He can log on to his computer at home or smartphone and see what is going on.

45. Mr Oduyelu has set aside between £70,000 and £100,000 to complete further improvements to the home, on which he has a relatively small mortgage. Mr Oduyelu is still convinced that the interventions of Southend Borough Council and of the CQC were caused by the malicious actions of one disgruntled ex-employee – the interim manager from 2019. He stated that Ms Govett would mention Regulations to him and as soon as he made improvements, the 'goalposts move'. He described it as on ongoing state of manufacturing grounds to achieve their goal and asked what has he done. He cited, as an example, that in the past the CQC had said that carpets were homely and now it says that linoleum is best.

46. In cross examination, Mr Oduyelu explained that he accepted that he has

breached the Regulations – some of which he takes very seriously and some he doesn't accept. For example, he could see now, during the hearing, that the fire doors should link to the fire alarm system, especially if some service users wished to have their doors open. He accepted that a fire risk assessment was last completed in October 2019 and he could not say if the work would be compliant.

47. Mr Oduyelu accepted a number of the breaches set out in the Scott schedule during the course of his oral evidence. He broadly accepted that issues with staffing, poor supervision of staff and the poor culture, at the time of March 2020 were his fault, but that the home has endured a period of crisis when the interim manager had been in post and after she left.

48. He made it clear that he now has a team in place and he was working on an environmental plan with his team of Ms Campbell and Mr Martins. The environmental plan was still being worked on during the hearing and was ready to be submitted as Mr Oduyelu was giving evidence on the last morning of the hearing. Mr Oduyelu had been working on the document until 2 or 3 in the morning of Friday. He explained that he saw his role as managing the managers, supervising the supervisors and taking control for the actions of the supervisors. That was how he defined overriding governance and management issues. He explained that he will ensure that the home manager will work well with him to make sure that the 'fluke' occurrence of the manager walking out does not happen again. This will be made easier by the new care management system, which Mr Oduyelu can access remotely at any time. He explained that he plans to visit the home up to six days per week with the enhancement of the new care management system and his new team, which he will oversee. Each of the team will have job descriptions, supervision and monitoring of their performance against expected goals and appraisals – all worked on and conducted by Mr Oduyelu. He explained that he will base the goals on the values and requirements of the home and manage by consensus. Mr Oduyelu articulated his vision for the home, acknowledging that there have been setbacks, mistakes and accepting that things would have to be much better. The vision, which he confirmed he had shared with Mr Martins and Ms Campbell: we need to ensure that we provide safe, comfortable, secure, happy, pleasant environment for the residents and staff and in so doing, we need to work as a team to ensure that the goals of providing that are achieved.

49. He confirmed that he had arranged the legionella risk assessment to be undertaken and he was waiting on a date. The same with the fire risk assessment. The gas safety check had now been booked for 16 June 2021. He confirmed that he did not raise a referral with the manager's regulatory body, the Nursing and Midwifery Council, after the concerns he had with her alleged failures as a registered manager. He explained that he has been discussing the issue with his legal team regarding next steps. Mr Oduyelu indicated that he planned for the service to take in 'low dependency' service users, some of whom would have dementia, Alzheimer's and Parkinson's disease and some of whom would need time to recuperate. Once the service could cope with low dependency service users, it would then consider higher dependency service users, including people coming from hospital with a need for specialist

rehabilitation.

50. He explained that he plans to complete a course to consolidate his knowledge of the care sector – a City and Guilds level five diploma on management in care. He has identified the college and he intends to complete the course.

51. Ms Campbell worked as a dementia and care lead with a care provider called 'Anchor'. She also has experience of domiciliary care and in providing support to adults living with learning disabilities. Ms Campbell met with Mr Oduyelu on 3 May 2021 and began working with him then as a consultant proving ongoing work to Nightingale House, as and when required and assisting to address the actions identified in the previous inspections. She saw this role as an ongoing piece of work as a quality manager or governance lead role – with systems being put in place and embedded. She confirmed that she had read the inspection report from 6 May 2021 and accepted that Nightingale House had problems. She sourced the care quality system to provide the policies and procedures for My Oduyelu after the inspection of 6 May 2021, as well as the care management system and had worked on an environmental improvement plan for him, following her own 'walkaround' the home. Ms Campbell estimated that the work would take about six months to complete before the home could consider taking in service users. Three months was needed to complete the improvements to the environment and three months to recruit suitable staff.

52. Ms Campbell explained that Mr Oduyelu has shared his vision with her and it was to run a luxury care home that is one of the best in the area. Mr Oduyelu was planning to write her job description the week after the hearing

The Tribunal's conclusions with reasons

53. Dealing with the factual matters which remained in dispute, as set in the Scott schedule. We noted the broad position from Mr Oduyelu that there was acceptance of the failures which led to breaches of the Regulations in March 2020, but matters had improved in the meantime to such an extent that they were no longer an issue by the time of the May 2021 inspection.

54. Allegation 1 remains on ongoing issue which has yet to be rectified. A fire risk assessment has not been carried out since October 2019. There is no clear evidence that the issues have been rectified. Ms Chamberlain and Ms Govett continued to have significant concerns about the risk posed by the fire prevention methods which are currently in place, including doors which are not compliant with regulatory requirements.

55. In respect of allegation 2, Ms Chamberlain noted that the wate temperature appears to have been rectified. Therefore, we find that there is no risk posed from the water temperature as of today.

56. We concluded that there was sufficient evidence presented to prove that it is more likely than not that the leak in bedroom 17 remains an issue. Mr Oduyelu seems to accept that the bedroom is inadequate and not fit for purpose, to such

an extent that it is featured in his latest improvement plan, with a view to starting again with the space.

57. Allegation 4 is found proved. We accepted Ms Jones' evidence on the discussion with Ms Martin as to the concerns with this service user's risk of choking and the lack of assessment and direction for staff. Ms Martin did not attend the hearing to provide an explanation of how her account differed from this, if at all.

58. Allegation 6 is found proved. We received clear oral evidence from Ms Cattermole on what she observed, including the need to intervene to prevent a fall. We concluded that on the balance of probabilities and in the absence of documentation (which remains at Nightingale House) to demonstrate proper planning and reasoning for the techniques being used on the two service users, that their freedom of movement was being restricted, placing them at risk of falls.

59. Allegation 7 is found proved. It was admitted in part and we cannot accept a set of circumstances where documentation was not being completed properly gives any reassurance that service users were not at risk of receiving adequate fluids and food. Allegation 8 regarding an unsecured wardrobe is found proved as an ongoing issue, in light of the evidence from Ms Chamberlain and Ms Govett, as well as the updated improvement plan.

60. Allegation 9 is proved on the basis that at the time of the follow up inspection, Ms Martin and the deputy manager were unaware of an updated action plan and the action plan that was in place by that date was deemed unacceptable to the Respondent. Allegation 10 is found not proved in respect of the service user not receiving a bowl of water for their hands – we do not consider that the evidence on this point is clear.

61. Allegation 12 is proved on the basis of the direct observations of Ms Jones and Ms Cattermole which were unchallenged. Allegation 13 is found proved on the basis of the medication audit and the questions asked of the service user during the inspection. Allegation 14 is found proved, taking into account the evidence from Mr Leigh as to the ongoing concerns from the Council on staffing levels. We also took into account the evidence from Ms Cattermole about one member of staff being left to manage an entire floor of service users on their own.

62. Allegations 15 and 16 are found proved. We had clear evidence about the lack of planning for the 48 hours care of one service user with significant needs and risk. We also had clear evidence that details on service users' behaviour was missing from the documentation. Mr Oduyelu did not supply any documentation to demonstrate that the appropriate planning had been undertaken and recorded.

63. Allegation 17 is found proved. We heard evidence from Ms Cattermole that food options were not made clear to service users.

64. As to allegations 18 and 19, we noted that Mr Oduyelu accepted the issues at

the time but advises that there are no longer issues with cleanliness and poor state of repair. We have found the allegations proved as of today, not least as no evidence was presented to demonstrate that risk assessments have been completed in relation to legionella and the overall state of the building. We took into account the detailed observations from Ms Chamberlain and Ms Govett and have concluded that the issues remain, as of the date of the hearing.

65. Allegation 20 is proved. The crude work carried out to cover the radiators, which were an exposure issue in 2020 was not deemed sufficient in 2021 – there remained a risk that service users, with dementia, would be able to touch the radiators and therefore there is still a risk of burns.

66. Allegation 21 is proved. We were not provided with any documentation from the 'falls folder' to assist with countering the observation from Ms Cattermole that the appropriate analysis and reflection work had not been completed. Allegation 22 is proved – we received clear evidence from Mr Leigh that hand hygiene had been raised as a concern and we received no evidence about steps undertaken to ensure the risk was lowered by appropriate learning.

67. Allegation 23 is accepted by Mr Oduyelu. We also took into account his oral evidence, in which he explained that it would have been 'unwise' to attend the meeting in January 2021. We accepted his explanation that by that point he felt that the Council was overwhelming him with concerns.

68. Allegations 24 and 25 are proved – no documentary evidence was presented to support Mr Oduyelu's explanation that staff had discussed medication changes with the service user's GP or that staff understood the risks of changing medications without discussing it with a GP. We considered the medication audit of 7 March 2020 to be clear and persuasive evidence.

69. Allegation 26 is proved, on the basis of Ms Govett's evidence as to Mr Oduleyu's reaction to the seriousness of the issues discussed during the meeting. Finally, allegation 28 is proved. No evidence was presented to demonstrate that sufficient arrangements had been put in place to ensure that the service user was receiving appropriate personal care during a time when she was refusing baths.

70. We found the four CQC inspectors to be credible witnesses and found that their evidence was supported throughout by the documentation. We were particularly impressed with the oral evidence from Ms Chamberlain and Ms Govett, which was highly relevant to our role in assessing whether the decision to cancel registration remained an appropriate one as of today. We had the benefit of the detailed observations and findings from the inspection of 6 May – just over one month before the hearing. It was quite clear to us that Ms Chamberlain had a view of what she expected to see on the inspection visit of 6 May 2021 and she accepted that there could potentially be conditions in place to assist the home with coming back into compliance with the 2014 Regulations. However, her view remained that not enough had been done by way of improvements and planning to reassure the CQC that significant changes to leadership and governance had been made to such an extent that Nightingale

House was appropriate for any rating other than 'inadequate'. She conceded that it would not be possible for the home to demonstrate full compliance with the full range of regulatory requirements, given that it would need to be operating again as a home to 'test' compliance. However, she expected to see much more in the way of improvement, and crucially assurance to lead the inspectors to conclude, with confidence, that the home could, in the near future, come into compliance, to such an extent that 'requires improvement' would be an appropriate rating.

71. We were impressed with Ms Govett. She was careful and deliberate in her evidence, often taking time to consider the question carefully and demonstrating understanding, to a reasonable degree, of Mr Oduyelu's position. She was clear on points she simply could not accept, such as the suggestion that there had been some sort of concerted effort to ensure the home was closed. This assertion, which was maintained by Mr Oduyelu throughout his evidence, was of concern to the Tribunal panel and was directly relevant to our assessment of him, particularly when it came to the interplay between insight, accountability, willingness to significantly change and understanding of what that change would involve – the 'how' as Ms Chamberlain characterised it. We paid regard to the key point advanced by Mr Harries QC throughout the hearing – that Mr Oduyelu accepted that there had been failings in the part and he was determined to put things right, he simply had to be given time and appropriate direction (in the form of restrictive conditions) to ensure that he continued to improve the service to an acceptable extent. However, we could not ignore the position from Ms Govett, in particular which was that assurance was missing from the inspection of May 2021 – the CQC could not be assured that the service would be well led and governed effectively and that service users would receive safe and effective care.

72. We understood the reason for this. We were very concerned to note that it was only after the inspection of 6 May 2021, during which Mr Oduyelu demonstrated surprise with the summary observations from Ms Chamberlain and Ms Govett, that a decision was made, following the input of Ms Campbell, to ensure that the policies and standard operating procedures for the service were overhauled and updated. We examined with care the various new policies and procedures and found them to be generic and lacking in the 'how'. This is likely to be because significant planning and thought have not been devoted to the service's ethos, strategy, vision, behaviours from staff and quality assurance measures for driving and sustaining continuous improvement and good standards of performance. There was no clear view of when the home could reopen, when the works would complete or the profile of service users which the service could realistically manage. It was interesting to note that Mr Oduyelu articulated a vision he had for the home, confirmed he had discussed it with Ms Campbell and when she was asked about the vision that had been discussed with her, it was materially different from what Mr Oduyelu had articulated. We concluded that this was an example of the lack of focused preparation for the inspection of 6 May 2021 and for the hearing. We found it entirely unsatisfactory to receive an environmental improvement plan on the final morning of the hearing when Mr Oduyelu had nearly completed his oral evidence. He explained that he had stayed up quite late the night before the

finish the plan. The CQC had taken time to review it when it was presented to them and it did not change the CQC's view – it did not provide the requisite level of assurance and confidence that the service would be capable of coming into regulatory compliance in the near future. The Tribunal did not understand why this work had not been completed in advance of the hearing. It is a plan which the CQC was waiting on – Ms Govett had expected to receive a copy, which she was still waiting for by the time of the hearing. There was no satisfactory reason given as to why it was being worked on during the hearing, especially when Mr Oduyelu knew of the CQC's intention to complete a follow up inspection as early as January 2021 and given that Ms Campbell had completed an improvement plan after her initial walk around on or around 4 May 2021.

73. The point was made that a number of the environmental improvements which were required are easy to remedy. We agree; a number of them appear easily remediable and yet, they have still not been remedied as of the hearing. The legionella risk assessment was still outstanding. The repeat fire risk assessment was still outstanding. We found the lack of urgency and knowledge about what was required for the fire risk remedial work to be highly concerning, especially given the detailed report from October 2019, which set out what was required and the indication from Mr Leigh that a key reason for the decision to move the service users out of the home in March/April 2020 was the risk to the safety of the service users, following the medication audit of 7 March 2020, the rejection of assistance from the Council's support team and the relatively long standing issues with fire risk, appropriate equipment and evacuation planning.

74. Overall, we considered the evidence from the four inspectors called by the Respondent was persuasive and clearly demonstrated the rationale for the outcomes of the two inspections in March 2020 and the follow up inspection in May 2021. The inspectors applied their process correctly and completed their work in a diligent manner. We have not accepted the general assertion by Mr Oduyelu that there was a determination to ensure that Nightingale House was closed down. We did not receive any direct evidence from Mr Atreed-James and we did not speculate as to the reasons for that. We accepted the explanation from Ms Govett that he was contacted to provide a statement and did not respond. We consider that most of his findings were accepted by Mr Oduyelu and corroborated by the evidence of Ms Jones, Ms Cattermole and Ms Govett. In the end, nothing material turned on the absence of his evidence. Finally, we approached with significant caution the suggestion from Mr Oduyelu that Mr Atreed-James said certain things to Ms Martin upon his attendance at the two visits of March 2020. Ms Martin was not in attendance at the hearing to answer any questions on this point or to set out the contents of any discussion with the inspectors. That point was not covered in her witness statement, which was lacking in relevant detail, in any event. Put shortly – we did not consider that the absence of evidence from Mr Atreed-James and the limited evidence from Ms Martin inhibited our ability to reach a decision in this appeal.

75. We considered the decision tree and enforcement policy used by the Respondent in its management review meetings, which then had an additional

layer of decision making from a national panel which was constituted in response to the Covid-19 pandemic to consider evidence and recommendations and make a final decision on enforcement action. In the case of Nightingale House, through a series of positive indicators being engaged, the decision tree necessarily placed the decision in the more serious end for the purposes of the ultimate decision maker, the national panel.

76. The Tribunal reminded itself that we are looking at matters afresh. We do that by taking into account all of the evidence in the hearing bundle, the two supplementary hearing bundles, the improvement plan submitted by Mr Oduyelu on day four of the hearing, the October 2019 fire assessment report, and the oral evidence provided during the hearing, as well as applying the requirements in sections 3, 4 and 17 of the 2008 Act and the 2014 Regulations. We have paid regard to the Enforcement Policy (February 2015) and the Enforcement Decision Tree documents (January 2017) which set out the principles applied by the Respondent in decisions of this kind. We have considered at all times the principle of proportionality, which we must consider, amongst other factors, pursuant to section 4 of the 2008 Act.

77. We have also borne in mind Nightingale House's regulatory history, noting that it had periods of inconsistency, with a time when it was rated 'good' in each key question and good overall (2018), as well as times of requiring improvement. We could not ignore the fact that the service has been in consistent breach of Regulation 17 (good governance) since the inspection from 2020, noting that for the purposes of this decision, we are concerned with the outcomes of the inspections of 5 March 2020, 17 March 2020 and 6 May 2021. Regulation 17 sets out the fundamental requirements of good governance which broadly cover the ability of the registered person (in this case, Mr Oduyelu) to access, monitor, improve, mitigate and constantly evaluate and improve the quality of services, risks and practices of the service. We consider that compliance with this regulation is fundamental to protection and promotion of the health, safety and welfare of people in care homes who receive accommodation and nursing or personal care.

78. We took into account that the timescale for improvement has been approximately 14 months. In this case, we have significant concerns that the service has not been able to demonstrate embedded improvements to such an extent that it was found to have no breaches on the subsequent inspection of May 2021. We noted the range of breaches in May 2021 – Regulations 10, 11, 15 and 17. We accept that Mr Oduyelu had to contend with not having any service users placed at Nightingale House due to the impact of the conditions in place and the decision of Southend Borough Council. We considered carefully the evidence provided that demonstrated the commitment to improvement – the evidence is important, not only in demonstrating commitment, but also in assisting the Tribunal to assess the sustainability of the improvements and to provide confidence that the risk of repetition is at a low level. One of the key difficulties the Tribunal faced was that clear documentation, tailored to the needs of the service, considered alongside the vision and values for the service was lacking. The improvement plan, submitted towards the end of the hearing, was simply not sufficiently robust and planned

to provide the necessary assurance to us. We would have wished to see a clearly articulated strategy for the future of Nightingale House – the range of service users the home would cater for, the staff to service user ratio, the behaviours expected of the staff, the recruitment strategy, a quality assurance programme, some form of risk register – as examples of what should have been in place. We noted with concerns that Ms Campbell is still waiting on a job description, which had not been put in place for her, despite starting in her role on 3 May 2021. To the Tribunal panel, that made it unclear as to what her role would be and the lines of accountability. We accept that Mr Oduyelu has a clear connection to Nightingale House and a vision of what he would like the service to provide – he was emotional at points in the hearing, which we attributed to his desire to put things right. However, we had to balance that desire against the other evidence we heard. More than one witness described Mr Oduyelu as being passive and reactive. We took into account Ms Govett's view that regulation is not about a regulator such as the CQC directing a service in what is required to ensure it is not in breach. A well-led service, meeting the requirements of Regulation 17, should be able to respond in a proactive manner. We could not ignore the evidence form Mr Leigh that from at least 2018, the Council was having to ensure that it supervised the service with repeated visits and interventions to make sure that changes were being made. We concluded that the evidence provided by Mr Oduyelu, including the improvement plan and the suite of policies and procedures (which were purchased and compiled after the inspection of May 2021) fell short of sufficient evidence to persuade us that Nightingale House is now in a position to make further improvements and to sustain them to such an extent that it will no longer be in breach of the 2014 Regulations and no longer pose a risk to service users who requires the services it offers as a regulated activity.

79. We concluded that Ms Campbell was a credible and impressive witness who clearly had commitment to assisting Mr Oduyelu. We considered that her role and responsibilities were not particularly clear to her and, in turn, to the Tribunal. This was probably not helped by the fact that there was no contract in place between Ms Campbell and Mr Oduyelu and Ms Campbell was still waiting on a job description – a job description that Mr Oduyelu told Ms Govett he would supply to her by 14 May 2021 and on which she is still waiting (along with a number of other requested documents). We would have liked to hear from Mr Martins, given that it was Mr Oduyelu's intention for him to take on the registered manager role, longer term. We considered the impact which the loss of an effective registered manager had on the service in light of the continued breaches of Regulations 12 and 17, as well as the limited information about what the service would look like and how it would operate effectively. As such, it would have been helpful to have heard from Mr Martins about what he had been told of his role and what he would bring to the service, particularly given the fact that none of that detail was set out in his brief witness statement.

80. We did have concerns with Mr Oduyelu's evidence. On the one hand, he accepted the various concerns of the Respondent, but on the other, he complained about the changing of the goalposts, the fact that other care homes in the area are not treated in the way that his was treated, the fact that the CQC involvement was because of the actions of a disgruntled ex-employee and the

fact that various social workers were attending to make life difficult for him in the latter part of 2019 – which appears to be part of a real sense that Southend Borough Council wished to make life difficult for him. We have rejected these assertions – there was no coherent evidence to support them. We concluded that Mr Oduyelu's understanding of the seriousness of the regulatory intervention in March 2020 and the steps to be undertaken from then onwards is limited. With a limited understanding of the importance of good, effective governance, we have concluded that his ability to provide safe and effective care to services users is constrained, to such a degree that there are no workable, measurable and realistic conditions which we could formulate to meet the level for risk of repetition. Mr Oduyelu's level of insight has not reassured us on risk.

81. We have considered carefully the decision of the Respondent from 29 October 2020. We have concluded, without hesitation, that at the time when the decision was made, it represented a proportionate decision. However, our role does not end there, we are required to consider the developments since the point of the decision, which include the corrective efforts made by Mr Oduyelu since then, as well as the further inspection of May 2021. The Tribunal has considered all of the material extremely carefully, applying the principle of proportionality, which requires us to examine the reasonableness of a response against the nature of the concerns it must meet. We have concluded that the decision to cancel the registration of Nightingale House to provide a regulated activity remains a proportionate decision which meets the requirements of section 4 of the 2008 Act.

Decision

The appeal is dismissed.

The Respondent's decision of 29 October 2020 to cancel the registration of Nightingale House is confirmed.

Judge S Brownlee
Care Standards & Primary Health Lists Tribunal
First-tier Tribunal (Health, Education and Social Care)

Date issued: 06 July 2021