# First-tier Tribunal Care Standards

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

**NCN: [2022] UKFTT 235 (HESC)**
**[2022] 4489.EA**

**Heard on 22 and 23 June 2022 via video**

**BEFORE**
**Tribunal Judge – Ms S Iman**
**Specialist Member - Ms J Everitt**
**Specialist Member – Ms D Forshaw**

**BETWEEN:**

**Ede Care Ltd**

**Appellant**

**-v-**

**Care Quality Commission**

**Respondent**

## DECISION

### The Appeal

1. This is an Appeal against the decision of the Care Quality Commission (the "CQC") to cancel the registration for Ede Care Ltd ("the Appellant") as a service provider for the Regulated Activity of providing personal care, under s.28(3) of the Health and Social Care Act 2008 ("the Act"). The Notice of Proposal was served on 13th August 2021. The Notice of Decision was served on 2nd December 2021 and the appeal was lodged on 31st December 2021.

### Hearing

2. The hearing took place on 22 – 23 June 2022. This was a remote hearing which was not objected to by the parties. The form of remote hearing was by Kinly CVP video. The Tribunal considered that the issues could properly be determined by a remote hearing. Overall, no participants experienced connectivity issues that were not resolved nor to such an extent that their engagement with the hearing was impacted. Ms Hooper did have some connectivity issues at the start of the hearing which were resolved but she listened to proceedings for a short while via telephone, but once resolved, re-joined by video and gave her evidence through video link. Mr Ogbeide towards the end of the proceedings had a few sporadic connectivity issues which were resolved by him reconnecting to the platform. Mr Ogbeide in particular took time

at the end of proceedings to thank the Tribunal regarding how the hearing had been conducted.

3. As a starting point, we considered the Tribunal's ability to understand Mr Ogbeide, bearing in mind, on his own account, English is his second language. The Tribunal observed Mr Ogbeide throughout his oral evidence and carefully reviewed the various documents he submitted. The Tribunal concluded with confidence, that we were able to follow his oral evidence and representations throughout proceedings. Mr Ogbeide also confirmed that he was able to fully understand and participate in proceedings.

4. Mr Ogbeide also explained to the Tribunal that he had suffered a paralysis some years ago which required him to move around and stretch. Therefore, reasonable adjustments were made for Mr Ogbeide to be able to move around whilst giving his evidence. The Tribunal also indicated that it would be happy to give additional breaks should they be required. Mr Ogbeide did not request additional breaks but did move around during the proceedings.

**Attendance**

5. Mr Friday Ogbeide attended in his capacity as Nominated Individual for Ede Care Limited and represented himself. The Appellant did not call any witnesses.

6. Ms Briony Molyneaux represented the CQC and the CQC's witnesses were Mandy Hooper, (Inspector) and Ms Victoria Rose (Inspection Services Manager).

**Late Evidence**

7. The Tribunal received the Scott schedule in advance of the hearing.

8. The Tribunal also requested and received the following late evidence in order to have sight of the relevant documents that were submitted by Mr Ogbeide to the CQC. The Tribunal request also extended to include some documents that were exhibited by Mandy Hooper in her witness statement but had not been included in the electronic bundle provided. These documents were as follows;

a) Factual Accuracy Check for the Draft Inspection Report
b) Exhibit MH2 Spreadsheet Community Professional (Redacted)
c) Exhibit MH2 Spreadsheet people who use services ( Redacted)
d) Exhibit MH2 Spreadsheet Staff ( Redacted)
e) Exhibit MH6 Application Form for Staff Member A
f) Exhibit MH7 Application for SM B
g) Exhibit MH8 Application for SM C
h) Exhibit MH9 Application for SM D pdf 1
i) Exhibit MH9 Application for SM D pdf 2
j) Exhibit MH9 Application for SM D pdf 3
k) Exhibit MH9 Application for SM D pdf 4
l) Exhibit MH9 Application for SM D pdf 5
m) Exhibit MH19 email exchange with Northumberland City Council

n) Document SB from Appellant
o) Document AC from Appellant
p) Certificate of Employers Liability Insurance
q) Governance Ede Care Limited
r) Health and Safety policy
s) Impacts of Covid-19 on Ede Care Limited
t) Job offers letter Ede Care Limited
u) Lone working policy in Ede Care Limited
v) Medicines management policy
w) Policy number 03-3717 Safeguarding Vulnerable Adults
x) Rejection letter template
y) Renewal Pack pdf
z) Document titled SB start date
aa) Service User Daily visit report
bb) Staff Induction and Training Agreement
cc) Vaccination Cards
dd) Representations form V4 – Notice of Proposal
ee) Risk Assessment for Ede Care Limited Template
ff) Ede Care Limited staffing recruitment and retention
gg) Ede Care Limited Risk assessment carried out 15 July 2021
hh) Ede Care Limited Risk Assessment and Incidents carried out 15 July 2021
ii) Ede Care limited Policy of Consent
jj) Ede Care limited Medication Chart
kk) Response form for recipients of Section 64 letter

9. The was no objection from either party regarding the admission of the late evidence and it appearing to the Tribunal to be necessary to the proper determination of the appeal to admit it. The Tribunal admitted the above evidence pursuant to Rule 2 and Rule 15 of the First Tier Tribunal (Health, Education and Social Care Chamber 2008) Rules as the evidence was relevant to the issues for determination and it was in the interests of justice to do so.

**Background**

10. The Appellant was granted registration following a successful application, made on 2nd January 2020, for it to provide a domiciliary care service to people in their own homes, this would include providing care to people with Learning Disabilities, Autism, Dementia, Physical and Sensory Disabilities, Mental Health needs and included both older and younger service users.

11. The Registered location for the Service is at "Ede Care Ltd, Harlow Enterprise Hub, Kao Hockham Building, Edinburgh Way, Harlow, Essex, CM20 2NQ". The Nominated Individual is Mr. Friday Ede Ogbeide. The registration is subject to two conditions. Firstly, the regulated activity must be managed by an individual who is registered as a manager of the activity at or from all locations. Secondly, the regulated activity may only be carried on at or from the location.

12. The service was made dormant at the request of the Appellant on 11 November 2020 as it was not carrying out the regulated activity as Mr Ogbeide was in Nigeria.

13. On 8th December 2020 the Appellant contacted the CQC requesting he resume service. This request was permitted, and therefore the service came out of dormancy and was therefore able carry on the regulated activity of personal care.

14. An inspection was undertaken on 30th June 2021 and it was the view of those involved on behalf of the CQC, that there were serious and wide-ranging breaches of the Regulations.

15. At the Inspection the CQC found the Appellant to be in breach of the requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulations) as follows:

    a. Regulation 12 Safe Care and Treatment;
    b. Regulation 17 Good Governance.

16. On 13 August 2021 the CQC served the Appellant with a Notice of Proposal (NOP). Mr Ogbeide was given the opportunity to make written representations in respect of the proposal within 28 days of the NOP. Written representations together with 29 supporting documents were received on 01 September 2021.

17. Further, Mr Ogbeide submitted a response to the CQC's Section 64 request together with 11 supporting documents on 25 October 2021. These were further considered and on the 02 December 2021, the CQC served the Appellant with a Notice of Decision (NOD), cancelling registration.

**Legal framework**

18. The statutory framework for the CQC's main objective as prescribed by statute is to protect and promote the health, safety and welfare of people who use health and social care services (section 3(1)of the Act).

19. The CQC must have regard to the need to protect and promote the rights of people who use Health and Social Care Services (section 4(1(d) of the Act). The CQC must also ensure that action taken in relation to Health and Social Care Services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed (section 4(1)(e) of the Act).

*20.* Cancellation of registration is allowed for under section 17 of the Act; specifically, section 17(1)(c) on the ground that: ' *... the regulated activity is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements.'.*

21. On consideration of the appeal the Tribunal may confirm the decision or direct that it is not to have effect (section 32(3) of the Act). Under section 32(6) of the Act the Tribunal also has power to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates, to direct that any discretionary condition is to cease to have effect or to direct that any appropriate discretionary condition have effect.

**Issues**

22. The key question for the Tribunal is whether the CQC 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 Act.

**The Appellant's position**

23. The appeal that is brought can be summarised on the following grounds, that the decision of the CQC to cancel registration is wrong. The CQC has acted partially in that it gave undue weight to the information provided by the Inspector and insufficient weight to the information provided by the Appellant which included information that the Appellant did not have any clients or staff at the time of the Inspection.

24. The CQC and Inspectors then proceeded to "manipulate things" motivated by racism and discrimination, once they realised that an inspection had occurred in error i.e. that it was illegal and/or was based on ex staff and ex-service users and unlawfully continued to proceed to cancellation.

**The CQC's position**

25. The CQC maintains that the appeal is also wholly without merit. The Appellant was in breach of the Regulations and the decision to cancel registration was entirely correct. It is refuted that the CQC manipulated matters and it also expressly refuted that the CQC has acted in a partial or unfair manner.

26. The Appellant made written representations in response on 01 September 2021 and on 25 October 2021 and these were duly considered by the CQC. The written representations did not demonstrate that the Appellant had made changes to the service to address the CQC's concerns. The CQC remained (and remains) satisfied that the matters set out in the NOP were accurate. In all the circumstances, the CQC acted fairly and reasonably in reaching its decision to cancel the Appellant's registration.

**Evidence**

27. We considered all the evidence that was presented in the hearing bundle 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.

28. The Tribunal heard from Ms Mandy Hooper who is employed as an Inspector for CQC. The Tribunal heard that she has held this role since June 2011. The Tribunal also heard that she is the CQC Equality, Diversity and Human Rights lead for Hub 1 Essex.

29. In her evidence she explained that she contacted Mr Ogbeide by telephone on 28 June 2021 to give appropriate notice of the inspection and to make sure someone would be there to meet with her as per the inspection guidance.

30. In her evidence she explained that she spoke with Mr Ogbeide about the

service and he informed her that they were providing the regulated activity of personal care to two people who lived in Northumberland. Mr Ogbeide informed her that he had provided care to people in Essex, however, this had been very short term as only end of life care had been provided. She explained that she told Mr Ogbeide that as he was providing care to people outside of Essex, she would need to check that the inspection could go ahead.

31. Ms Hooper contacted her inspection manager, Ms Rose on 28 June 2021 to explain that the Appellant was providing the regulated activity to two people living in Northumberland in order to ascertain if this was acceptable. It was agreed that they would continue with the inspection.

32. Ms Hooper explained that she called Mr Ogbeide back to say that the inspection would go ahead, and they agreed the date of the inspection to be 30 June 2021. She explained that she followed this up with an email confirming on 29 June 2021.

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33. Mr Ogbeide later returned three spreadsheets on 29 June 2021 with contact details of two people who used the service, details of staff members who Ms Hooper could contact.

34. Ms Hooper maintained that at no time, either in writing or in conversation during the inspection, did Mr Ogbeide tell her that Ede Care Limited did not have any service users.

35. On the day of the inspection, she was met by Mr Ogbeide at the office premises. When she arrived at the office, there were three desks, one of them separated by a room divider. There was one other person working at a desk .She was not introduced to this person. Mr Ogbeide said the office was used by other people who came and went. When asked about confidentiality and discussing people and their care during the site visit with other people listening, Mr Ogbeide suggested they whisper.

36. Mr Ogbeide also told Ms Hooper that the filing cabinet was locked up and that when he makes phone calls he would usually go into the corridor to make them.

37. Ms Hooper explained that she looked at two people's care plans and risk assessments which Mr Ogbeide showed her on his computer. There was a standard template care plan tool that the Appellant used for assessing and recording people's care needs. In respect of Patient A, under the section Falls and Mobility, there was no information or risk assessment recorded. When asked for the information Mr Ogbeide stated that "it should be there" but was unable to locate the information. Ms Hooper explained that she did not see any information as to how Person A should be supported with step transfers or how they would be supported from lying or sitting to standing and therefore, by failing to assess risk, this left the person at risk of injury from falls.

38. Ms Hooper also explained that there was no information recorded regarding skin integrity and there was no information recorded as to the person's bathing routine, moving and handling risks, any equipment used and guidance to staff about personal care. The failure to assess and record clear, precise and detailed information meant that Person A was at risk of harm.

39. The environmental risk assessment said Person B was independently mobile with “wheeled Zimmer frame on the ward in hospital.” When asked if they used one at home, Mr Ogbeide said Person B didn’t have a Zimmer frame as they came to the door and didn’t need it. Mr Ogbeide then said that they did have a Zimmer frame at home but did not use it that much. There was other equipment listed on the form. Ms Hooper pointed out that when she telephoned the relative on 2 July 2021, they told her the Mr Ogbeide had not visited the person’s home or carried out a virtual visit to review the risks. This failure to risk assess the use of equipment and the environment placed people and staff at risk of unsafe care and treatment.

40. Ms Hooper also noted that the medicine record for Person A did not record the medications that Person A took, how ,when or why they took the medicines prescribed. When asked to see the medicine administration record (MAR) she was advised there wasn’t one as it was in Person A’s home.

41. Mr Ogbeide advised Ms Hooper that when he attends Person A’s house, he checks the MAR and signs to say he has checked it. Ms Hooper confirmed in her oral evidence that she spoke to the relative for person A on 2 July 2021 and they told her that the Appellant had not visited the home to assess or monitor Person A’s needs.

42. In the records for Person B, it said that they required support and prompt around medicines and without support and prompting their long-term health could be affected. The relative of Person B told Ms Hooper that they were not introduced to the care worker, who just turned up and had conveyed, “she didn’t know what she was doing. Mum’s care was to make sure she took her tablets, did this but nothing recorded, no notes of anything .”

43. Ms Hooper explained that not having adequate information and up to date records of the prescribed medicines people took placed them at risk of harm.

44. Ms Hooper explained that she was told during the office visit that Mr Ogbeide called and visited the client, charted all the evidence in the MAR, made sure the name was on there, that medicines had not expired, that they were given and that the client signed as well when medicines were given so that there were two signatures . However, the relatives of Person A and Person B said that he had not visited to assess or monitor people’s needs.

45. Mr Ogbeide told her that audits were undertaken to check staff members competency and that they were done whilst visiting the service user at home. However, after speaking with relatives of Person A and Person B, it was established that Mr Ogbeide had not visited people at home and therefore no checks had been completed of how competent the staff were which left people at risk of harm.

46. Ms Hooper emailed Mr Ogbeide on 1 July 2021 to request a copy of the MARs for Person A and Person B to be sent and audits and competency checks by 5 July 2021,but these were not provided.

47. Ms Hooper also explained that in her opinion Mr Ogbeide did not provide staff employed by the Appellant with the training and knowledge to ensure safe care. Mr Ogbeide was reliant on staff members having had training at their other employments and of the nine certificates provided, six were dated 2017 and out of date.

48. In January 2021, one staff member had completed a course covering twelve essential standards all in one day. (Mr Ogbeide said later in his evidence it was two members of staff having completed 6 standards each). Mr Ogbeide had not checked they had fully understood and were competent in these areas. He was unable to provide her with relevant evidence of training for staff or certificates of their own training in the essential standards in order to provide safe care.

49. For Staff member A and Staff member B no employment application form or references were available to be viewed at the office as Mr Ogbeide could not find them . The Appellant sent two emails with the application forms after the visit. On review of these documents, they had not been fully completed, for example, there was a lack of current employer details and employers contact details.

50. When Ms Hooper asked to see the references requested and received for Staff member A and Staff member B's suitability and good character, the Appellant was unable to produce them. No notes were recorded of any interviews with the staff. Risk assessments had not been carried out in relation to the employment of relatives or any potential conflict of interest given i.e. that one staff member was Mr Ogbeide's son and the other his daughter -in-law.

51. Mr Ogbeide told Ms Hooper he was in the process of recruiting two new staff members. On the two application forms, one for Staff member C and Staff member D, the sections employment and references had been left blank. Both staff members were under 18 and no risk assessments had been completed to ensure they were fully supported in their role. Mr Ogbeide explained that both staff members were completing their online training but they had not yet been interviewed.

52. Ms Hooper said that she had asked Mr Ogbeide about the people he had been caring for since being registered. She had been told that they had been supporting two people who required end of life care, but they were now deceased. When asked about notifications to the CQC of those people's deaths, Mr Ogbeide told the inspector that he had shredded all the information pertaining to those people's care. He thought he should not hold on to people's records.

53. The record keeping shown to Ms Hooper on both the computer and in the filing cabinet system was disorganised in her opinion and Mr Ogbeide found it difficult to find information in both. Ms Hooper considered that Mr Ogbeide did not have a proper process in place to store information or a policy that referenced and followed the Records Management Code of Practice for Health and Social Care 2016.

54. When asked to see completed assessments for any staff who were in the high risk COVID -19 categories, Mr Ogbeide advised that he had completed them but could not find any information in the filing systems or on his computer. When requested that these be sent, Mr Ogbeide later sent a risk assessment policy but no evidence of risk assessments being completed for individual staff.

55. Mr Ogbeide advised that staff work in other places, agencies and care homes and that risk assessments for the staff working in other places had been done but these were not provided. There was in Ms Hoopers opinion, no process for following the current government testing of staff. Mr Ogbeide advised company policy was to make sure staff tested negative, that PCRs were done every month and that emails were sent by staff to verify they had done them.

56. When asked about the use of a LFT Mr Ogbeide advised he had never used these tests and didn't really know what they were. These were not in the policy and procedure document. Mr Ogbeide advised that the COVID-19 policy was written in January 2021 and had not been reviewed

57. When asked about rota arrangements in place, Mr Ogbeide advised that at the moment, Staff member D was working all the hours, four times a day and seven days a week for Person A. When asked what happens if Staff member D is not working or is sick , Mr Ogbeide advised that another member of staff would be asked to do it.

58. Mr Ogbeide advised that Staff Member C was caring for Person B for one hour a day . Ms Hooper later found out when talking with relatives that neither of the staff were caring for people as described by the Appellant. Governance systems were not in place to effectively monitor and manage the service and keep people safe. Ms Hooper explained that she called the wife of Person A who told her that her husband had died two weeks ago and the funeral was on Tuesday the following week. Ms Hooper was shocked and apologised profusely for the intrusion. The relative said that Mr Ogbeide had not been to the house so didn't complete a face-to-face assessment and she had not met him.

59. Ms Hooper explained that Mr Ogbeide appeared to be frustrated with her questions about care plans and management arrangements specifically.

60. During the feedback meeting with him on 22 July 2021, he accused Ms Hooper of treating him less favourably because of his race. He was offered the opportunity on more than one occasion to make a complaint but has not made a formal complaint through the complaints process. Ms Hooper strongly refuted any allegations that she had manipulated or acted in a racist manner and indicated that she was merely doing her job as she would usually do and explained that it had caused her upset that it had been alleged that she had acted in such a manner.

61. The Tribunal also heard from Ms Rose Inspection Manager. Her role involves management of inspections assigned to inspectors based on risk and CQC's return to inspection priorities as well as overseeing any enforcement activity that might be taken to support providers in order to improve care services to

people receiving them. Prior to this role, Ms Rose was employed as an inspector by CQC from June 2015 to July 2020.

62. She explained that she first became involved with the regulation of the Ede Care Ltd as Inspection Manager on 29 June 2021 following a call from inspector Ms Hooper to discuss whether the planned inspection should go ahead.

63. Ms Hooper advised Ms Rose that Mr Ogbeide had informed her that he was providing a regulated activity of personal care to two people, but both resided in Northumberland. Ms Hooper informed her that Mr Ogbeide had been keen for the service to be inspected so he could receive a rating as he had explained that they had struggled to obtain local authority care contracts due to having not been inspected. Ms Rose also explained that Ms Hooper informed her that she told Mr Ogbeide she would need to seek manager advice as to whether the inspection could proceed given that the service was being provided out of area.

64. Ms Rose agreed that they should continue with the inspection as planned given that the Appellant was carrying on the regulated activity . Although it was doing so out of area, the Appellant was still responsible for those service users.

65. On the 1 July 2021 Ms Hooper contacted Ms Rose to advise that a Management Review Meeting (MRM) was required following the inspection.

66. On the 2 July Ms Hooper forwarded an email that she had received from the Mr Ogbeide expressing unhappiness following a request for additional information about staff employed. Ms Hooper had concerns that staff had not been recruited safely in line with employment guidance, care plans were poor, there was little in place to manage the risk or spread of Covid-19 and the provider was sharing the office place with separate businesses, so confidentiality was not able to be maintained.

67. On the 2 July Ms Hooper contacted Ms Rose and requested a call. Ms Rose explained that she called her directly and Ms Hooper was in a distressed, tearful state. She informed Ms Rose that she had contacted the names given to her from Mr Ogbeide, with regards to the two people in receipt of personal care, only to find that both had not received care for some weeks and one was very distressed by the call as their relative had passed away two weeks before. This had caused Ms Hooper some considerable upset.

68. On the 2 July Mr Ogbeide in an email alleged that that inspector Mandy Hooper had been aware that they had not carried out a regulated activity from the first call to announce the inspection. Mr Ogbeide explained that he was unhappy with the inspection.

69. On the 22 July 2021 Mandy Hooper and Ms Rose attended a call with Mr Ogbeide to feedback the concerns found at inspection. Mr Ogbeide alleged that Mandy Hooper's decision to inspect and find concerns at the service was based on racism and would not discuss the concerns found.

70. On the 26 July 2021 Mr Ogbeide wrote to Ms Rose to state he had been unable to access the complaint form. She responded with further information of how he could submit a complaint. However, Ms Rose explained to the Tribunal that Mr Ogbeide has not made a formal complaint.

71. Ms Rose explained that following the review meeting there remained significant concerns as Mr Ogbeide had failed to take appropriate measures to improve systems and processes in place to support people with safe care and treatment should they take on future care packages. Mr Ogbeide failed to understand the extent of the concerns raised by people who had been in receipt of the service and Mr Ogbeide believed that the inspector has fabricated these concerns.

72. Ms Rose explained that Mr Ogbeide's lack of understanding of the importance for robust governance processes and monitoring of people in need of care provision would leave people at significant risk of harm should the notice of decision not be upheld.

73. Ms Rose explained that the matter regarding the process for placing a provider into dormancy is only a policy decision to assist with where inspections and resources should be focused. However, the right to inspect remains even if a provider is in dormancy. Notwithstanding, Ede Care limited was not dormant as there had been an application to remove it from dormancy and therefore it was registered as active.

74. Ms Rose explained that Ms Hooper was an experienced inspector and that she was very active as an Equality and Diversity Lead and she was clear that in her opinion, having reviewed the material, she did not believe that a safe and effective service was being provided. Mr Ogbeide had failed to demonstrate any progress or an ability to work with the regulator.

75. Ms Rose also explained that breaches of regulation 18 and 19 were also evidenced at the time of the inspection but they were not so significant/serious breaches in themselves to meet the enforcement threshold of cancellation. They formed part of the picture and taken together with the breaches to regulation 12 and 17 provided a complete picture of the breach.

76. The Tribunal also heard from Mr Ogbeide and had regard to his written statement and the written representations and documents that were submitted by him to the Care Quality Commission as part of the process following the inspection.

77. Mr Ogbeide explained that his organisation was effectively dormant at the time of the inspection because he was not providing care at the time of the inspection. He was unclear where the inspector obtained her findings as clients had withdrawn their services from Ede Care Limited and it no longer had clients. Mr Ogbeide maintained throughout his evidence that the inspection was *illegal*.

78. Mr Ogbeide explained that on the 29 June 2021 he received a call from Ms Hooper. She introduced herself and asked him about the situation at Ede Care Limited because of the pandemic. Mr Ogbeide informed her of the problems the organisation had faced since the outbreak of the pandemic.

79. Mr Ogbeide told Ms Hooper that they had no users as they had published and shared a large number of flyers but that there was no single call regarding possible work because of the pandemic.

80. Mr Ogbeide in his evidence was clear that he informed Ms Hooper at the outset that the service had had two end of life clients who passed on before the service had started caring for them and since then, there had been no other clients which is why he had approached Northumberland Local Authority.

81. Mr Ogbeide maintained that he advised Ms Hooper that in the month of May that they had had two clients from Northumberland and that after around ten or eleven days, they were given 48 hours notice to discontinue the care package because his staff withdrew from Ede Care Ltd because they did not have sufficient hours of work for them.

82. Mr Ogbeide explained that Ms Hooper initially sympathised with him and after his explanation she indicated that she would be calling often to ask him about the condition/situation of his organisation for inspection at an appropriate time in the future. To his surprise, an hour following the initial discussion he received a phone call from Ms Hooper informing him that she would be attending the next day 30 June 2021 to conduct an inspection.

83. Mr Ogbeide explained that later that day he called Ms Hooper to remind her that Ede Care Ltd had no clients and staff but she insisted that he should write the details of the clients that were in Northumberland.

84. On 30 June 2021 Ms Hooper indicated to Mr Ogbeide that she did not have all the information she needed and she requested he write the details of the clients and staff, which he did, but that he informed her that she would not be able to obtain sufficient information from them because they were ex-clients. Mr Ogbeide maintained that at no point did he tell the inspector that they were supporting two clients in the Northumberland area at the time of the inspection.

85. Mr Ogbeide stated that Ms Hooper asked him a series of questions and due to her manner, which he perceived as harassing, he wanted to ask Ms Hooper to leave the office but as he was being professional, he left her to continue her illegal investigation.

86. Mr Ogbeide also explained that in respect of one of the patients, the care plan received from the council was the one that they started with because it was described as an urgent start. He explained that this particular patient only needed support to get out of bed, washing, dressing, using the toilet and medication prompting and needed just one carer which was provided. The patient's wife cooked and supported with his medication because she had been caring for her husband and Ede Care Ltd provided for just 10 or 11 days before the carer withdrew without notice.

87. The second patient had only one hour of care every day. She moved about herself without support. During the assessment, it was established that this patient did not need assistance in mobilising and Mr Ogbeide does not know why the inspector thought otherwise. He explained that this patient was cared

for only 10 days before leaving the care package and during their time of caring for her, there was no risk of any kind and she moved about herself.

88. In respect of Covid testing Mr Ogbeide stated that they cared for the patients just for few days and the two staff tested themselves. Before they were due for the second test, they withdrew from the organisation. He maintained that Ede Care does have COVID-19 policy and procedures in place. The Tribunal noted that in the written representations, the factual accuracy report and the Section 64 response about the COVID concerns, Mr Ogbeide stated he was attaching the Infection Control Policy, but in the Notice of Decision the CQC state clearly this has not been found in the documents attached.

89. Mr Ogbeide maintained that they had just two end of life clients in April 2020 and that the first one passed on before they arrived on the first morning and they did not support her at all. Ms Hooper was asking for their care plan a year later and he told her that he did not have their care plan because, there was no care plan prepared for just the half day she was a service user. The care plan that was in use was the one distributed by the LA and due to it being a year since the care was provided, this had been shredded.

90. The second end of life patient spent two days as a service user and passed on. They were unable to draw up a care plan within two days and therefore used the care plan from the Council.

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91. Mr Ogbeide explained that all Ede Care Ltd staff were inducted and were given the policy and procedures to read and were inducted on the infection control policy. He explained that the common man on the street would know what to do regarding testing for Covid-19.

92. Mr Ogbeide maintained that the staff were well trained and competent in administering medication but regarding the two clients that were supported, their medication was administered by their family.

93. Mr Ogbeide in his evidence explained that there had been no complaint lodged by the service users to the Care Manager which was evidence in itself of the good service he provided which was to the relatives' satisfaction.

94. Mr Ogbeide maintained that he understands his responsibility as a care provider, that he is fully aware of what is required to assess, review, and monitor our services and that Ede Care Limited had the relevant policies in place.

95. Mr Ogbeide stated that at the time of the inspection, they were in the process of recruiting two members of staff, they were trained on six courses each and it was not the case that one member of staff trained on twelve courses. They were still waiting for their DBS check to come through but they had not commenced working as there were no clients.

96. Once Ede Care Limited was given 48 hours notice to no longer provide care packages by the Local Authority, they also stopped any risk assessments.

97. Mr Ogbeide explained that he did understand what DNACPR meant and that this was a term that would be familiar to anyone and therefore he was insulted

when asked by the inspector if he knew what it was, which is why he said that he did not know what it was.

98. Mr Ogbeide also explained that he had no clients at the time of the inspection but he was actively participating in bidding to secure contracts with Local Authorities so that Ede Care Limited would be able to provide care.

99. Mr Ogbeide clarified in his evidence that he had not visited the sites himself but that his team leader visited them and was the carer also. He said he told Ms Hooper we have visited them. My staff visited. We cannot start a care package without visiting. He did not have time to visit. Mr Ogbeide explained at length that he believed the negative outcome from the CQC was racially motivated. In his response to the Tribunal, he explained that he thought he did make a complaint on the telephone regarding Ms Hooper's conduct and racism.

100. Mr Ogbeide requested £2,000,000.00 in compensation for the damages but it was explained to him that the jurisdiction of this Tribunal related only to the Notice of the Decision and whether it should be upheld or nullified.

**The Tribunal's conclusions with reasons**

101. We have carefully considered the written and oral evidence and submissions dealing with the issues which remained in dispute as set out in the Scott schedule. The Tribunal reminded itself that the evidential burden rests with the CQC. We are grateful to all of the witnesses who attended to give oral evidence at the appeal hearing, which assisted us significantly in reaching our decision.

102. We found both CQC inspectors to be credible witnesses and found that their evidence was supported throughout by the documentation. We were impressed with their oral evidence which was relevant to our role in assessing whether the decision to cancel registration remained a proportionate one as of today. We had the benefit of their detailed observations and findings from the inspection, as well as their comments on points made by Mr Ogbeide in his written representations, Section 64 response and the documents he submitted with them. We took into account Mr Ogbeide's notice and grounds for appeal, his witness statement, exhibits to it and his position on the numerous allegations in the Scott schedule.

103. We found Ms Hooper be a credible witness who reacted with genuine shock to having her integrity questioned. We did not conclude that she acted in the manner suggested by Mr Ogbeide. She came across as a highly experienced, professional and fair witness, who provided a consistent account of what she witnessed during the inspections in June 2021. Furthermore, we considered the oral evidence of Ms Rose on this point, who was vehement in her position that Ms Hooper is professional and an active Equality and Diversity Lead. We concluded that there was no merit to Mr Ogbeide's claims regarding racism, manipulation and discrimination in respect of any of the witnesses and that Ms Hooper was a highly professional, attentive and diligent witness who acted with integrity in the giving of her evidence.

104. Furthermore, The Tribunal did not consider that the inspection was illegal as

alleged by Mr Ogbeide. We accepted the position that Ede Care limited was not listed as *dormant* at the time of inspection for the purposes of registration. We also accepted the evidence of Ms Rose that even a registered provider listed as dormant could also be inspected as dormancy was only a policy decision.

105. The Tribunal noted that on 8 December 2020, Mr Ogbeide after placing the registered provider in dormancy due to being away in Nigeria, requested to come out of dormancy in order to provide the regulated activity of personal care. Therefore, Mr Ogbeide had an understanding of the process surrounding dormancy . The service therefore came out of dormancy and remained active thereafter. It was subsequently flagged for inspection in June 2021 as over 12 months had passed since its registration and it had remained unrated during that time.

106. The Tribunal also had regard to the evidence of Mr Ogbeide that he was actively looking to secure contracts with the relevant local authorities in order to provide further care, therefore the Tribunal had regard to the fact that at any point if he was successful in securing further contracts he would have been able to provide care to other service users due to his active registration status.

107. The Tribunal found that Mr Ogbeide was evasive and lacked clarity and credibility in several areas during his answers to the Tribunal. For example, Mr Ogbeide provided evidence to the Tribunal surrounding his trip to the Northeast. Initially the Tribunal understood his explanation to be that he had made the trip to assess the needs of the service users and draw up care plans. Following further questioning by Ms Molyneux it became clear that he had gone only to check the mileage of the distance. The Tribunal also had to question Mr Ogbeide several times in order to obtain clarity over exactly how many service users he had provided care for and when.

108. The Tribunal also did not accept Mr Ogbeide's assertion that in the first call he explained that he had no clients or staff to Ms Hooper. Ms Rose in her evidence explained that Ms Hooper had advised her that Mr Ogbeide was very much wanting the inspection. His provision had not been inspected before and therefore a positive rating would assist in securing contracts with Local Authorities. The Tribunal considered that this aligned with Mr Ogbeide's own evidence that he was struggling in securing contracts for Ede Care Limited. Furthermore, we were unable to establish any motive for Ms Hooper to fabricate her evidence. Mr Ogbeide had explained in his evidence and in his written representations that this was due her being motivated by racism and discrimination and her wanting to damage Ede Care Ltd but the Tribunal considered that no evidence was provided to substantiate this.

**Regulation 12 (Safe Care and Treatment)**

109. The Tribunal concluded that Regulation 12 had been breached. The Tribunal accepted the evidence of Ms Hooper that the care plans she viewed were inadequate. Although the plans themselves were not seen by the Tribunal we were in receipt of what Ms Hooper had recorded when she had viewed those notes. The Tribunal accepted her evidence that there were deficient individual

risk assessments and care plans for Persons A and B and that they were not thorough in respect of mobility needs, medication needs and risks assessments.

110. The Tribunal accepted that her summary of what she observed on the computer when looking at these plans was accurate and accepted her evidence that the failure to risk assess the use of equipment and the environment placed people and staff at risk of unsafe care and treatment and therefore we concluded that the care plans were inadequate.

111. Mr Ogbeide explained that detailed mobility care plans were not in place for Persons A and B due to degrees of independence and because the care packages lasted only 10-11 days for one patient. The Tribunal accepted the evidence of Ms Rose that any care plan provided by the Local Authority should be superseded within 24 hours by an updated care plan following the provider having conducted the relevant risk assessments, which had not been done in this case.

112. The Tribunal considered the blank template care plan that was forwarded by Mr Ogbeide to the CQC which includes risk assessment forms for moving and handling in respect of mobility, equipment and a care plan that prompts recording support details regarding mobility needs.

113. However, Mr Ogbeide was unable to satisfy the Tribunal in his evidence, both oral and written, that he had a good understanding of why his previous care plans had been deemed inadequate by the CQC and had placed servicer users at risk of harm and how he would ensure that going forward new service users will have their needs risk assessed and their care plans set up before they start receiving care, or as soon as practicable if care was urgently required.

114. Mr Ogbeide in his evidence accepted that he had not visited the premises himself in order to carry out risk assessments. His evidence was that his team leader, who became the carer, visited. Therefore, the Tribunal accepted that he completed environmental risk assessments of people's property without visiting the properties either physically or virtually to review the risks. This placed people at risk of unsafe care and treatment through potentially inaccurate environmental risk assessments. Further, in his evidence Mr Ogbeide was unable to clearly articulate how he would undertake a timely environmental risk assessment of a new service user's property based on a physical or virtual visit, in respect of any proposed service provided by him.

115. The Tribunal had regard to the document titled Ede Care Risk Assessment Ltd dated 15 July 2021 regarding the Covid-19 pandemic. However, it was not clear what risks had been assessed, as the document made broad general references. There was no information on what risks had been identified and how these would be mitigated. The document did not include information on weekly staff testing, individual staff risk assessments, staff working at more than one care service, or how the registered provider would check for changes to relevant government guidance.

116. Though, Mr Ogbeide. was confident in his evidence to the Tribunal that he understood what the testing requirements were, he was in our view unable to

provide a clear explanation as to what testing would be required and what appropriate measures and processes should or indeed now would be put in place and therefore the Tribunal was not satisfied that he had a good understanding around Covid- 19 testing protocol or the concerns raised at the inspection had been addressed.

117. The Tribunal accepted the evidence of the inspector in respect of the inadequacies in administration of medication. No information was available on the care plans as to what medicines people were taking, the dose, the times or any specific instructions in how to take them. It was identified that staff had been supporting people with their medicines but this was not managed safely as staff had not received up to date medicines training and competency checks had not been completed.

118. Ms Hooper explained that Mr Ogbeide stated he had carried out audits of medicines administration records (MAR) to check staff had completed MAR correctly when he visited people at home, but relatives informed her that he had not visited people's homes.

119. Mr Ogbeide maintained that the two staff he had oversight of were given medication training before starting working with him. The Section 64 response states that the training is through 'Social Care TV'. Mr Ogbeide maintained that his staff were competent to provide people with medicines support and would be competent going forward .

120. Mr Ogbeide's position was that the two patients being referred too did not need support with medicines as their relatives provided that support where needed during the few days Ede Care Limited provided them both with a care service. The Tribunal noted that this was contrary to the statements of the staff to Ms Hooper who confirmed that the relatives of Patient B stated that the carer made sure she took her tablets but nothing was recorded.

121. Mr Ogbeide supplied a blank template medication chart ('Ede Care Ltd Medication Chart') with his representations and his Section 64 response which clarifies it is a "record of daily medication administration." However, the chart does not prompt to record the date and time of each administration of each medicine, nor record what dose is being administered. The only date requested is when each medicine starts and stops.

122. The Tribunal had regard to the blank care plan template ('Risk Assessment for Ede Care Ltd GOOD TEMPLATE') which was provided as part of the Section 64 response. Its index includes *5.Health and medical requirements"* but no such section is identified in the body of the care plan, nor is there a care plan section for medication support. The care plan template includes, from page 16, a section titled "Medication Risk Assessment Form." However, the commission pointed out to Mr Ogbeide that this prompts for information regarding the person's medication needs without prompting for assessment of risks and how the service would mitigate the risks.

123. Mr Ogbeide was unable to satisfy the Tribunal in his evidence as to his understanding and acceptance of why these medication administration concerns had been deemed as breaches and failures by the CQC. We

concluded there had been a failure to carry out audits of medicines administration records (MAR) to check if staff had completed the MAR's correctly and were appropriately trained. Mr Ogbeide was unable to demonstrate to the Tribunal that he was able to have a system in place for the safe administration of medicines for people using the service. Mr Ogbeide was asked about his understanding around auditing of medicines administration and again was unable to provide a clear and comprehensive explanation to the Tribunal as to how and when these would be undertaken and what they would involve both previously and also looking forward.

124. Mr Ogbeide was also in his evidence very clear that he ensured his staff were competent, but in addition to online training there was no evidence to suggest that additional staff checks were being done to ensure they had fully understood and were competent in these areas.

125. The Tribunal having reviewed the documentation accepted that the care plans were deficient in a number of areas and the appropriate environmental risk assessments had not been undertaken. The Tribunal were also concerned that Mr Ogbeide had stated that he had attended some of the service users home who had reported to the inspectors that he had never attended.

126. The Tribunal questioned Mr Ogbeide in respect of his understanding around audit and risk assessment, equipment and moving and handling. We considered that his answers were very confused and that he was unable to demonstrate a good understanding of managing risks through audits, care plans and assessment. The Tribunal concluded that, due to the lack of understanding demonstrated by Mr Ogbeide, the ongoing risk remained significant as he did not appear to understand the skills required for the provision of safe care and treatment.

**Regulation 17 Good Governance**

127. The Tribunal concluded that Regulation 17 had been breached. The Tribunal accepted the evidence from the inspectors in respect of their findings during the inspection. The Tribunal accepted that Mr Ogbeide failed to ensure people's information was kept confidential in line with GDPR requirements as the office was shared with others who were not related to the Service Provider and there was no reassurance that when discussing personal details or storing documents, those concerned were having their confidentiality adequately protected.

128. The Tribunal did not accept Mr Ogbeide's assertion that the individual in the room was working in some capacity for Mr Ogbeide and his organisation. Mr Ogbeide explained to the Tribunal that Ms Hooper would have realised this if she had taken the time to ask. We accepted Ms Hoopers account regarding this conversation, as mentioned above the Tribunal found Ms Hooper' evidence around this genuine and retained a high level of explanation. The Tribunal therefore accepted that Mr Ogbeide advised that they whisper when discussing service users. As stated above the Tribunal consider that Ms Hooper had no reason to fabricate this or any other aspect of her conversations with Mr Ogbeide.

129. Mr Ogbeide in his evidence to the Tribunal was unable to satisfy the Tribunal that he had an understanding of good governance and what it would require. For example, the Tribunal noted that a number of template documents had been forwarded to the Tribunal as examples of policies, there was a distinct lack of evidence around how these policies would be implemented and Mr Ogbeide was unable to satisfy the Tribunal that he had a good understanding of how they would be implemented going forward.

130. It was clear to the Tribunal that it had been difficult for the inspector to locate the relevant documents and policies required and we considered that this coupled with a lack of recording and monitoring processes meant the service fell far below the expected levels of good governance required.

131. Mr Ogbeide had indicated in his evidence that he had been supporting two people from Essex Local Authority who required end of life care and were now deceased, and therefore he had shredded all the information pertaining to those people's care. This meant that there were not the proper processes to place to store information.

132. In his written representations he stated that the information was shredded as it was more than one year since their deaths. There was no policy supplied nor an explanation given as to how the policy of shredding after a year aligned with the Records Management Code of Practice referenced in the Notice of Decision which states retention for eight years. Mr Ogbeide was unable to satisfy the Tribunal that he had an understanding as to why it was important to keep records following the death of patient and the systems that would be required to be put in place.

133. The Tribunal accepted that the contact details of two users had been provided to Ms Hooper by Mr Ogbeide. However, they had not been in receipt of care for some weeks which was established when Ms Hooper made telephone calls to their relatives. This was distressing for one of those people who had recently been bereaved. The Tribunal accepted that this distress could have been avoided if the governance systems were adequate and/or open and transparent.

134. Mr Ogbeide stated that he had an updated quality assurance process. The Tribunal considered the document 'Governance - Ede Care Ltd' dated 16 July 2021. Mr Ogbeide was unable to demonstrate to the Tribunal that he had a clear understanding of why his previous process had been considered inadequate and the systems that would be put in place for the practical implementation of this policy.

135. The Tribunal were concerned that Mr Ogbeide considered that due to the fact there had been no complaints made to the "care manager" by the relatives this demonstrated that he was providing a service that was satisfactory to the relatives. There was no understanding demonstrated regarding how to monitor service provision and seek relatives' views.

136. The Tribunal concluded that there was extremely limited evidence of having systems in place for effective, comprehensive and sustained auditing and the breaches of Regulation 17 had not been rectified.

**Regulation 18 Staffing**

137. The Tribunal concluded that Regulation 18 had been breached. Mr Ogbeide maintained that before he employs staff, he ensures that they have at least six months of experience in the care industry and has some important care training certificates. He also indicated in his written evidence that some had been trained to *our satisfaction* before giving them clients. The Tribunal noted that Application forms for Staff members A and B were not fully completed and important areas such as 'current employer' were incomplete and there was no record of any employer references for either staff member.

138. The Tribunal considered that Mr Ogbeide was unable to produce references for staff in the process of being recruited. Ms Hooper also explained that out of the 9 certificates presented to the CQC at the inspection, 6 were out of date and there were no checks to ensure when the training had been undertaken and if staff members had understood the training and were competent.

139. Mr Ogbeide was asked by the Tribunal regarding his processes of staff training and his use of Bank staff. He again failed to clearly explain to the Tribunal a good understanding of his responsibilities in respect of training staff working for him and further what the nature of the training he would undertake with the staff going forward. In response to the Tribunal he repeatedly said that "Ede Care would undertake the training" but was unable to provide clear explanations of what that would entail and involve.

140. The Tribunal accepted the evidence of Ms Rose regarding that ensuring that Bank staff were adequately trained would fall within the responsibility of the service provider that they were working for. The Tribunal considered that Mr Ogbeide was unable to provide a clear explanation as to how and when he uses retention/bank staff and what checks he undertakes. The Tribunal were not satisfied that the Appellant provided staff with the requisite training and knowledge required to ensure safe care or systems in place to assure competence.

141. Having regard to the documentation submitted, the Tribunal accepted that there was some evidence that the Appellant had made changes to its paperwork and policies, but these have not been tried and tested to ascertain if the management systems are effective and safe. Further, the Tribunal were concerned at the lack of knowledge around the policies and their implementation as demonstrated by Mr Ogbeide in his evidence.

**Regulation 19 Fit and Proper Person employed**

142. The Tribunal concluded that Regulation 19 had been breached. In addition to the matters set out above pertaining to ensuring staff were adequately trained or had the requisite knowledge, the Tribunal had regard to the fact that no risk assessments had been carried out dealing with any potential conflict of interest, which was likely to be relevant, as staff included Mr Ogbeide's son and daughter-in-law.

143. Two prospective new staff were in the process of being recruited yet their

forms had no information pertaining to employment history or references, and importantly, given both were under age 18 no risk assessments were undertaken to show they were fully supported in their role. Therefore, the Tribunal accepted that there was no assurances that staff members were sufficiently fit and proper persons for their roles.

144. Overall, we considered that the evidence from the Inspectors called by the CQC was persuasive and clearly demonstrated the rationale for the outcomes of the inspection. The inspectors applied their policy and process correctly and completed their work in a diligent manner.

145. 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 and the oral evidence from all the witnesses, most importantly, Mr Ogbeide. We have applied the requirements in sections 3, 4 and 17 of the Act and considered the requirements set out in Regulations 12, 17, 18 and 19. We have considered at all times the principle of proportionality, which we must consider, amongst other factors, pursuant to section 4 of the Act.

146. We have carefully considered the decision of the CQC issued on the 02 December 2021 pursuant to cancellation. We have concluded, without hesitation, that at the time when the decision was made, it represented a proportionate response and Regulations 12 and 17 cited at the time were breached and also breaches of Regulations 18 and 19 were also evidenced. However, our role does not end there, we are required to consider the developments since the point of the decision, which include any corrective efforts made by Mr Ogbeide.

147. 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 that response must meet. The Tribunal considered whether conditions attached to the registration would be adequate but due to the serious nature of the breaches and the continued and wide-ranging failures, conditions were not considered appropriate or workable. We have concluded that the decision to cancel the registration of Ede Care Limited to provide regulated activities remains a proportionate decision which meets the requirements of Section 4 of the Act for the reasons set out above.

**Decision**:

The appeal is dismissed

The decision dated 02 December 2021 to cancel the registration of Ede Care Limited is confirmed.

**Judge Iman**

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

**Date Issued: 03 August 2022**