Care Standards

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

[2016] 2684.EA
[2016] 2685.EA

Heard on

28 July 2016 at Stoke IAC
29 & 30 September 2016 at Stafford Magistrates Court

Before

Mr H Khan (Tribunal Judge)
Ms M Harris (Specialist Member)
Mr J Cohen (Specialist Member)

Miss Eunice Chulu

and

Smart Care Plus Limited

Appellant (s)

-v-

Care Quality Commission

Respondent

Decision

The Appeal

1. Smart Care Plus Limited & Miss Eunice Chulu ("the Appellants") appeal to the Tribunal against an Order dated 14 April 2016 made pursuant to Section 30 of the Health and Social Care Act 2008 to urgently cancel the registration of the Appellants as a service provider and as a Registered Manager with immediate effect.

Restricted Reporting Order

2. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the service users so as to protect their private lives.

Attendance

3. Miss Chulu appeared in person and represented Smart Care Plus Limited. The Appellants had one witness, Mr P Matsikure.

4. Ms Laura Hackney (Solicitor) represented the Respondent. The Respondent's witnesses were Mr Francis Burrows, Inspection Manager for the North Staffordshire and Stoke-on-Trent Team (Adult Social Care Directorate), Ms Yvonne Allen, Inspector, Ms Helen Nicholls, Inspector for the North Staffordshire and Stoke-on-Trent Team (Adult Social Care Directorate) and Karen Capewell, Strategic Manager, Hospital, Independence and Safeguarding Services.

Late Evidence

5. The Tribunal was asked to admit additional evidence by the Appellant. This included various certificates of training completed by the Appellants staff, details of the Immigration Objection Outcome Notice and a reference for TM. The Respondent did not object to the admission of this evidence. We admitted the late evidence as its admission was agreed between the parties and it was relevant to the issues in dispute.

6. As there were a number of individual items that we were asked to admit and their admission was agreed, we do not propose to particularise each and every item but we shall refer to them specifically where relevant.

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

Events leading up to the issue of the Notice

8. Smart Care Plus Limited has been a registered social care provider since 31 October 2014. It was registered under the provisions of the Health and Social Care Act 2008 to provide the regulated activity of personal care.

9. The Registered Manager at Smart Care Plus Limited was Miss Eunice Chulu. Miss Eunice Chulu is also the sole director of Smart Care Plus Limited.

10. In March 2015, complaint was received from a whistleblower by the Respondent in relation to immigration issues and staff working conditions. Those concerns were passed to Stoke-on-Trent City Council (LA) as part of their safeguarding duties. Officers from Stoke-on-Trent's Adult Safeguarding Teams inspected the Appellant on 19 May 2015. There were concerns raised by the LA which included staff leaving the premises when the inspectors arrived, names on staff lists/rota being different to the names of the individuals, names on timesheets not corresponding to the staff rota, some staff not having any employment files, visas on files not matching the individuals and one individual submitting a timesheet despite the Registered Manager saying she did not work there and was off sick.

11. The Respondent's Inspectors undertook inspections on 16 December 2015 and warning notices were served on 12 February 2016 on the grounds that the provider had not taken appropriate measures to assess, monitor and mitigate risks posed to people who use the service by employing staff members with positive (i.e. endorsed) Disclosure and Barring Service (DBS) check.

12. A Large Scale Enquiry (LSE) was commenced by Stoke-on-Trent City Council on 11 March 2015. A number of organisations were involved in the LSE including Immigration Officers, the Police, the Respondent, Stoke-on-Trent Council, Cheshire East Council and Staffordshire County Council.

13. A further inspection was undertaken on 11 & 12 April 2016 by the Respondent. The Respondent's Inspectors accompanied Immigration Officers and the Police. Miss Chulu was arrested on 11 April 2016 but released later that day.

14. On 13 April 2016 as Miss Chulu did not provide satisfactory responses to the Respondent's concerns, an application was made for the urgent cancellation of Smart Care Plus Limited's registration and also for the cancellation of the registration of Miss Chulu as Registered Manager.

15. The application for urgent cancellation was made under section 30 of the Health and Social Care Act 2008. Miss Chulu was given notice of the application on 13 April 2016 and she appeared in person at the hearing on 14 April 2016.

16. On 14 April 2016 an order was granted and the registration certificate of Smart Care Plus Limited as a service provider and the registration certificate of Miss Eunice Chulu as Registered Manager was cancelled with immediate effect. This is an appeal against that order.

17. The Respondent submits that the decision made on 14 April 2016 was right in the circumstances and that there remains a serious risk to a person's life, health or well-being should the order cease to have effect. The Respondent's concerns can be summarised under the following headings:

a) Service users not receiving care
b) Inadequate DBS checks
c) Inadequate assessment of risks for those with a positive DBS check
d) Incomplete staff lists and service user lists
e) Inaccurate staff rota
f) Confidential information not held securely

18. The appeal was received by the Tribunal on 11 May 2016. Directions were given for the filing and serving of the evidence. The matter was heard on 28 July 2016 at the Stoke IAC. However due to insufficient time, the matter was then relisted for 29th & 30 September 2016 at Stafford Magistrates Court.

19. The Appellant submitted an appeal to the Tribunal under the Memorandum of Understanding provisions on the 25 July 2016, and the appeal was expedited in accordance with the Memorandum of Understanding.

Legal framework

20. The statutory framework for the registration of providers of regulated services is set out in the Health and Social Care Act 2008. Section 32 provides a right of appeal to the Tribunal against any decision made pursuant to Chapter 2 of the Act or an order made by a justice of the peace under section 30 and specifically provides as follows:

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

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

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

(b) it appears to the justice that unless the order is made, there will be a serious risk to a person's life health or well-being, the justice may make the order and the cancellation has effect from the time when the order is made."

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

23. The burden of proof is on the Respondent. The standard of proof is the balance of probability that a person will be at serious risk of harm if the order is not made.

Evidence

24. We took into account all the evidence that was presented in the bundle and at the hearing. We heard lengthy evidence about the various issues including those which did not directly relate to the issues that the Tribunal needed to determine. We have summarised the evidence insofar as it relates to the relevant issues before the Tribunal. We wish to make it clear that what is set out below is not a reflection of everything that was said or presented at the hearing.

25. Mr Francis Burrows submitted that there was a serious risk to a person's life, health or well-being as domiciliary care, such as that provided by the Appellant, involved going into individual's homes. Service users are dependent upon such care for their health and well-being as the care provided is of a personal and intimate nature as well as providing assistance with the taking of their medication.

26. He submitted although all the concerns raised were serious, the most serious individual concern was the service users not getting the care on the 11 April 2016.

27. He confirmed that the Appellant provided services which included attending upon individuals who had dementia and included those who could not verbally communicate. It was important from the Respondent's perspective that providers knew who was going into the homes of such vulnerable individuals and that they had been appropriately vetted.

28. Mr Burrows was concerned that the DBS checks were inadequate and that there was an inadequate assessment of risks for those who had a positive DBS check. The employee list had 47 members of staff and out of those 47 there were 15 members of staff with no record of DBS checks in place and one that was outdated.

29. He explained that at the inspection in December 2015, concerns were raised with the Appellants in respect of three members of staff who had a positive DBS. These were:

LB -who had a conviction for false declaration in order to obtain benefits in 2011

TM - who had a police caution for assault occasioning actual bodily harm in 2008

SR - who had a conviction for Battery in 2010

30. As a result of those concerns, warning notices were served and Ms Chulu had stated that monthly supervisions and regular spot checks would take place and service user feedback would be obtained. However, at the inspection in April 2016, no evidence of these being carried out could be provided.

31. Furthermore, he maintained that the risk assessments which were provided in response to a warning notice were generic and showed no evidence of any in-depth discussions in respect of assessing the risk to the service users. He was also concerned that the two members of staff out of the three identified with a positive DBS (LB and TM) were promoted to supervisory positions. There was no assessment of risk for these positions.

32. He submitted that the DBS checks and character references would allow a provider to build up a picture of the individuals. He referred to the “mum" test i.e. what checks would someone undertake before employing someone to look after their mum.

33. In his view, a positive DBS, i.e. one which reveals a conviction could be managed so long as there was a risk assessment with a good level of detail. In these cases there wasn't. Furthermore, he submitted that the Respondent would not approve of individuals with violent convictions/cautions from working with such vulnerable individuals unless there was an appropriate risk assessment in

place. The convictions/cautions in the present case were for those involving violence and/or dishonesty. He was concerned that those individuals had also been paired together to visit vulnerable individuals in their homes.

34. He submitted that character references were also important. They helped build a picture of a person and considered that person's ability to provide a reliable and compassionate service. In terms of individuals who lived abroad and sought to work in the UK, the Respondent would expect those who employed them to obtain references, carry out risk assessments and other checks such as ability to work in the UK at the outset.

35. The nature of the work was that such staff were visiting vulnerable service users in their homes so the Appellants had to take measures to ensure that they knew who they were employing.

36. In his view, it was important that user information was kept confidential. This information included details of service user's medical conditions, medications being taken as well as their personal financial details. The inappropriate disclosure of such information could lead to the targeting of such vulnerable individuals.

37. We also heard from Yvonne Allen. She reiterated some of the concerns that were raised by Mr Burrows. She outlined the chronology of events including the inspections which were set out in her statement.

38. She described how on 11 & 12 April 2016, an inspection was planned out of hours with external agencies following their risk-based approach to inspection planning. Intelligence had been received from external agencies which led them to believe that service users were at risk of not receiving safe care and support, particularly in the morning of 11 April 2016 due to plans to arrest a number of staff who worked at the service. The Respondent needed to assess if the service was effectively led to ensure service user needs could still be met despite this disruption.

39. On the morning of 11 April 2016, she described how they entered the Appellants premises with the police. They were able to see the state of the premises prior to the police conducting a search or taking any materials. They were also given the opportunity to inspect any documents prior to these being seized by the police.

40. Ms Allen described how most service users did not receive their care on 11 April 2016. There were service users contacting the office to ask why nobody had been. There were no staff available and no explanation was given as to why the care was not provided.

41. She denied that the Respondent's staff had informed the Appellant's staff that they should not undertake visits. Furthermore, she had asked the Registered Manager for an exact list of service users receiving care and details of the current staff. However different lists for staff were provided. In addition, the staff rota did not correspond with the staff list. In her view, there should be

systems in place to ensure the service is maintained as planned in the absence of the Registered Manager.

42. Ms Allen accepted under cross-examination by Ms Chulu that confidential information was in a locked room. However, her concerns stemmed from the fact that the information was strewn across the room and this included confidential medical and financial information relating to the service users as well as staff.

43. Ms Allen was also concerned about the employment of individuals with cautions/convictions for fraud and assault type offences without a sufficient or detailed record of the circumstances of the offence or an appropriate risk assessment demonstrating how such risk would be mitigated. This was, in her view, particularly important for a domiciliary care service because individuals were going into a vulnerable service users homes often without any other persons present. In her view, the possibility of serious harm to service users life, health or well-being without effective risk mitigation in place was serious and immediate.

44. She described how they had looked at files relating to 5 staff that they worked with at the inspection on 16 December 2015 along with one other. Of the six files they looked at, three staff members had serious conviction(s)/caution(s) and one had a less serious traffic offence.

45. She described how some staff did not have appropriate employment checks in place. For example, out of 47 members of staff there were 14 members with no record of references at all whilst 9 staff members had only one reference when two references were required.

46. She described inconsistencies with the staff rota. For example, a staff member known as William provided care to service user DP on Tuesday, 12 April 2016. However, there is no record of William on the staff list. Furthermore, she described service users Mr and Mrs H who both require continued support. However, it was not clear as to which staff were delivering care to them and when this care was being delivered.

47. Ms Helen Nicholls confirmed that she was also present at the inspection on 11 & 12 April. She had spoken to four service users on the morning of 11 April 2016. All four confirmed they had not received a morning care call. One of the service users was very distressed and tearful because the carers had not visited to help them take the medicine they needed to help manage their diabetes

48. She also confirmed that she entered the room where the confidential records were kept immediately after the police entered. She observed that no files were touched by the police, or anyone else, until they were all in the room. On entry, they found the office was already in a state of disarray as staff and service user records were kept in unlocked filing cabinets and on the office floor. The service user’s records and the staff records were not separated as far as she could tell.

49. Furthermore, she had problems contacting the staff. She attempted to contact staff member JC whose name had been on the rota. However, JC ended the call after Ms Nicholls had given her name. However, on the second attempt, JC informed her that she had terminated her employment with the Appellant but could not confirm the date she had left. Further calls were attempted to two other members of staff (TV and MM) and either she got no answer or was asked to contact another member of staff (LB) who also did not answer. This meant that they were unable to identify who was responsible for the safe running of the service in the Registered Manager's absence.

50. She then identified that three of the four staff members whose names appeared on the rota as providing care on 11 April 2016 did not have the appropriate documented evidence about their suitability to work with vulnerable people on file. This included out of date DBS checks and missing references. She also denied telling staff that they should not work or that the service was being closed down.

51. Ms Capewell confirmed that she was the chair of the LSE enquiry that was undertaken into the Appellant. The LA had become involved when initial concerns were raised by a whistleblower. The concerns raised by the whistleblower related to the Appellant's employment of those working illegally in the UK, breaches of confidentiality and working conditions for staff.

52. She described how she had coordinated a response along with the other LA's and set out how the LAs had taken the decision to make alternative care arrangements for their residents.

53. Furthermore, she confirmed that it was the contingency plan of the LA's Social Services which meant that care was delivered to the majority of service users on 11 April 2016. She had anticipated that the Appellants systems might not ensure that care was delivered and that a contingency plan would be required. She was concerned that the Appellant did not provide any care given that the service users were vulnerable individuals.

54. She set out the background of the service users from her LA which had been provided services by the Appellant. They were both very vulnerable and required care and were among the more serious cases being dealt with by her LA. If there hadn't been a contingency plan in place to arrange care on 11 April 2016, the situation would have been considerably worse.

55. Ms Chulu gave evidence at length. She described how she was very passionate about caring. She confirmed that she was arrested on 11 April 2016 but had not been charged with any offence. She had been detained by the Police for most of the day. She was concerned that the Respondent had attended on the same day as the Police and the UK Border Agency.

56. She set out how when she was arrested, three of her mobile phones had been seized, one of which had calls diverted from her work phone. After she was released she had been provided with various explanations by staff as to who was

to blame for the service users not getting any assistance on 11 April 2016. This included the Respondent, the Police and Social Services.

57. On 12 April 2016, she and another carer went to attend to clients but found that they were either being attended or they had been told that Smart Care Plus Limited had "gone bust".

58. However, she accepted that despite it being over five months since the events on 11 April 2016, she still did not know exactly what had happened on the 11 April and why her staff had failed to provide the care.

59. She accepted that the service users had not been provided care from around 7:30am on 11 April 2016. She accepted that the looking back, she could understand why the Respondent had made the application to the Magistrates Court given the risk to the vulnerable service users. She accepted that service users were at serious risk on 11 April 2016.

60. She confirmed the care provided by the Appellant was of a personal and intimate nature and included assistance with essential medication. She wished she "had done things differently". Since the order had been made on 14 April 2016, no services had been provided by the Appellant. She had not had any dialogue with the Respondent and had not made any changes to the process which would prevent this from occurring again

61. She maintained that DBS checks had been carried and references had been obtained. These were kept on the individual staff files. However, she could not explain why the list which was produced by the Police (based on her files) did not record this information as being on the file. She explained that this may be due to work that her administrative staff were doing on the files in the months preceding the 11 April 2016 and therefore the information may have been misplaced. Some of the DBS checks were not in the file was because they had been carried out online although she accepted that there was no document which recorded this.

62. She confirmed that she had taken on an employee, a relative, to deliver care to service users at their home despite her being accused of financially exploiting a service user for around £10,000 in her previous job, an offence for which she was later convicted. The employee was later dismissed after being convicted and Miss Chulu explained that she had consulted the DBS before employing her and dismissed her as soon as she was convicted.

63. She had carried out a risk assessment on both LB and TM and had concluded that they were not supposed to work together. However, he submitted that the staff rota setting out that LB (who had a conviction for false declaration in relation to benefits) and TM (police caution for assault) were working together was incorrect and was a work in progress. Their names had been entered together for the sake of filling the staff rota. The staff rota was changed regularly and reliance should not be placed on those entries showing they worked together.

64. However, she accepted that although she had emphasised that they should not work together, she could not confirm that they had not worked together during the three weeks that she was on holiday. Furthermore, she was supervising them regularly. In her view, neither LB nor TM had exhibited any signs of posing a risk to service users.

65. She also did not understand why JC had said she left the company when she was shown on the staff rota as working on the 11 April 2016 and her entry on the CRM 2000 system also showed her working on the day.

66. She confirmed that she had been fined £10,000 by Immigration Enforcement for employing Chisanga Katonga, who had not been entitled to work in the UK. Ms Chulu submitted that service users and staff records were kept securely in a room. That room was locked.

67. Mr Matsikure confirmed that he underwent to induction process. In his view, the Appellants were providing the best quality of care to the service users and they had received good feedback. He confirmed that he would not put TM and LB to work together on the staff rota.

The Tribunal's Conclusions with Reasons

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

69. Ms Chulu presented herself as being passionate about providing care to the service users. However, we reminded ourselves that we were considering her position as a Registered Manager and Smart Care Plus Limited as the service provider.

70. We had concerns about Miss Chulu's evidence. Ms Chulu relied on assertions which were not supported by the evidence that was presented. For example, she explained that there was a staff rota which set out what time the staff were to get to the service users and who was responsible for the care that was to be provided. However, she conceded that the information put on the rota was incorrect as the staff could not physically get to the locations within the times estimated and the names on the staff rota, listed as working, was simply incorrect. We therefore preferred the evidence of the Respondent in this case as it was clearly set out and corroborated by the evidence before us.

71. We concluded that there was a serious risk to a person's life, health or well-being due to the service users not receiving care on 11 April 2016. We agreed with the Respondents submissions that this presented a serious risk.

72. In our view, Miss Chulu sensibly accepted that there was a risk to the service users on 11 April 2016 and accepted that she would have taken the same action as the Respondent. In our view, the Appellant's staff did not display any concern for the well-being of its service users despite being fully aware that some of them would struggle with their personal care and needed assistance to take

their essential medication. There should have been a clear process in place which would have allowed the service to operate if, as here, the Registered Manager was unavailable. The service users should never have been placed at such risk.

73. Accordingly, we did not need to make further detailed findings given that she accepted there was a serious risk to a person's life, health or well-being on the 11th April 2016.

74. We should add that for the sake of completeness that we rejected her submissions that the Respondent's Inspectors should have attended on another day as they knew that she was going to be arrested on 11th April 2016 and that there would be an impact on the delivery of care. We concluded that had the various agencies not worked together and formulated a contingency plan for the provision of care, the outcome which arose as a result of the Appellants employees abandonment of their responsibilities would have been considerably worse. In our view, it was sensible planning by the Respondent to anticipate that there was going to be a potential impact on the service and to make provision for it.

75. We then considered the position as it was at the date of our decision. We concluded that there remains a serious risk to a person's life, health or well-being. Our reasons for reaching our conclusion was that all the Appellants employees ceased to undertake any of their duties to provide care after around 7:30am. It was still not clear as to why all the staff ceased to provide a service despite it being over 5 months since the incident. The fact that Ms Chulu still did not know what happened left us concerned as she could not take any steps to prevent this from happening again. Furthermore, in reaching our conclusion, we took into account the fact that Ms Chulu did not have in place a plan/process that would prevent this from occurring again.

76. We were also concerned that at one stage Ms Chulu speculated that her staff may have ceased to provide a service as they were aware that social services would have a backup plan in circumstances such as this. We found this unacceptable as it relied on an assumption that the Appellants employees were not sure of as it had not been communicated to them. If Social Services had not put in place a plan to provide care for the service users, the consequences could have been far more serious.

77. There has also been no dialogue between the Appellant and the Respondent and no assurances had been given by the Appellants as to how exactly this would be prevented in the future. We agreed with the Respondents view that if the Appellant was allowed to reopen tomorrow, then there remained a serious risk to a person's life health or well-being. In short, the Appellant had not come up with satisfactory explanation supported by evidence as to what would be different had that situation occurred now rather than in April 2016.

78. Although we concluded that the issue around the failure to provide care to service users would, on its own, be sufficient for us to reach the conclusion that there was a serious risk to a person's life, health or well-being, nevertheless, we

considered the other issues and found them also to be sufficient, when looked at as a whole, to satisfy the statutory test.

79. We concluded that the issues around keeping confidential documents and inaccurate records (on staff and service users) would also present a serious risk to a person's life, health or well-being. The failure to keep records secure about service user's financial and medical information could result in their exploitation, particularly when combined with the lack of proper DBS checks and the matching of two employees to work together who both had a positive DBS for dishonesty and violence.

80. In our view, service users are entitled to know exactly when care staff are going to arrive and who is going to deliver the service. Accurate records allow the monitoring of such service and provide for accountability. This is important when it comes to aspects of personal care and the timely administration of essential medication, for example for the treatment of diabetes.

81. We were also concerned about the staff rota, For example, it paired two individuals who had a combination of conviction/caution for dishonesty and violence together. It was not acceptable that those individuals were paired together despite the Appellant insisting she had told everyone not to put them together and the risk assessment saying likewise. Furthermore, these two individuals were in supervisory positions with influence over who is placed on the rota to work together. In our view, this put vulnerable service users at an increased risk of exploitation as identified by the Appellants own risk assessment.

82. We were troubled to hear Miss Chulu state that the names were just added to the staff rota to fill in the blanks. That contradicted with earlier evidence from Miss Chulu who stated that no one was put on the rota without it being confirmed they were able to work. The outcome, nevertheless, was the same in that the records were inaccurate. The Appellants could not be relied on as by their own admission they were incorrect. This casual approach to record keeping may go some way to explain why the Respondent could not ascertain who was providing care to whom on the 11th April 2016.

83. Furthermore, we concluded that although records were kept in a room which was locked, the information itself was not kept securely as it was strewn across the floor and staff and service user information was mixed together. This meant that some staff with positive DBS records had access to confidential information regarding service user's financial and medical information.

84. We were also concerned that the Appellant could not produce accurate service user's lists. This in part contributed to the confusion on 11 April 2016. There was no way of ascertaining who the Appellant was providing a service to so that appropriate steps could be taken to maintain that service. Whilst a service was provided to the vast majority of service users by Social Services as part of the contingency plan, the failure to maintain an up-to-date list of service users could have resulted in far worse consequences had social services not stepped in. We would have expected the Appellant to have an accurate list of service users so that it was clear to all what service had been provided and where an

unexpected event occurred, the record would allow others, within the same organisation, to continue to provide that service.

85. In our view, it was the Registered Managers responsibility to ensure that records were kept accurately and properly. The service appeared to operate in a culture where accurate record keeping did not appear to be an expectation. The nature of the Appellants work requires accurate recording of information in order to deliver the service and were concerned that we were asked to disregard what was presented on the Appellants own records on the grounds that it was inaccurate.

86. We also concluded that the lack of proper recruitment processes would also present a serious risk to a person's life, health or well-being. We agreed with Mr Burrows, that DBS checks and character references allow an employer to build up a picture of an employee. We concluded that there were incomplete records about whether or not a DBS check had been carried out. The list that we were presented with had significant omissions and we were not impressed with the unsupported explanation put forward that this was due to the DBS being checked online. We would have expected there to be a central list with a complete record of everyone who had a DBS check and confirmation that character references had been taken. The list that was produced from the Appellants own files recorded that 14 members of staff had not been provided with a single reference.

87. The nature of the work that was undertaken by the Appellant involves attending upon individuals who had dementia including those who could not speak. It was extremely important that staff who were working with such individuals were properly vetted prior to starting that role.

88. The failure to check records properly was clearly demonstrated by the fact that the Appellant had been fined £10,000 by the UK Border Agency for employing an adult subject to immigration control. Although she had appealed the amount she had to pay, she did not appeal the basis for imposing the penalty. In our view, employing and sending individuals into the homes of service users, without appropriate background check, presented a serious risk.

89. Although this preceded the order, we were also particularly concerned about the employment of a close relative to provide care in circumstances where the Registered Manager was aware that she had been accused of taking a considerable sum from a service user, an offence for which she was later convicted. These were serious allegations and service users should not have been put at risk whilst this was being investigated.

90. We also considered the risks as they were presented at the date of hearing. No work had been undertaken and no reassurances were provided as to changes in process which would have led us to reach a different conclusion. There has been no dialogue with the Respondent and accordingly, in our view, we concluded that there remained a serious risk to a person's life, health or well-being if the cancellation orders cease to have effect.

Decision

The appeal is therefore dismissed.

The order made on 14 April 2015 is confirmed and registration of the service provider, Smart Care Plus Limited and Miss Eunice Chulu as Registered Manager is cancelled.

Judge H Khan
Lead Judge Primary Health Lists/Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 19 October 2016