Report to the Board of the Care Quality Commission ("CQC") on CQC's Regulation of 14 Colne Road Care Home, London N21 2JD

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Annex – Terms of Reference

Sir Paul Jenkins QC (Hon)
& David Noble QSO

Chapter 1
Summary

1.1 On 1 November 2015 there was an incident at 14 Colne Road, a residential care home in North London for younger adults with learning disabilities. It was operated by Hillgreen Care Ltd ("Hillgreen")

1.2 It may have been an incident of the utmost gravity but the precise details of what happened may prove difficult to determine.

1.3 In July 2017 a newspaper published a story headed: "CQC covered up suspected rape in care home".

1.4 In September 2017 I was asked by the Chair and Chief Executive of the Care Quality Commission ("CQC") to investigate and report to the CQC Board on CQC's regulation of 14 Colne Road and to make recommendations. (My Terms of Reference are at the Annex)

1.5 I have examined an abundance of material from CQC's systems and from other sources. I have interviewed those involved in the inspection processes themselves, their managers, lawyers and more senior officials at CQC to establish what happened, to explore what might be improved and to test my emerging findings. I commend the frank, open, constructive and helpful approach of every person I interviewed.

1.6 I met the devoted mother of the young man at the heart of the matter. She is, if I may say so, an immensely impressive person, not least because of her fortitude, her tenacity and her compassion.

1.7 I first make four general, overarching points.

1.8 First, not everything was perfect in the regulation of 14 Colne Road and Hillgreen. Nor was everything perfect in the CQC's policies and practices in place at the time; far from it. But I have found no evidence whatsoever that there was any "cover-up" at CQC.

1.9 Second, there was a strong, clear focus at CQC on ensuring that people were safe; and to do so in ways which were most expeditious and effective. As a direct result of CQC enforcement activity, 14 Colne Road was closed several

months before the police concluded their investigation into the incident itself and the CPS decided not to prosecute. But, once everyone was safe, competing safeguarding priorities coupled with underdeveloped or unclear policies and processes contributed to a lessening of further enforcement momentum.

1.10 Third, CQC is an organisation committed to continuous improvement. Since November 2015 it has changed, or is in the process of changing, its approach significantly and in ways which are relevant to the issues under investigation. These changes are driven partly by the lessons they themselves have taken from their own rigorous examination of their regulation of Hillgreen and partly by the drive for continuous improvement. Most of the recommendations I make are, in consequence, already in hand. I have seen my task as ensuring that all the issues arising from the incident have been identified and that the changes are the correct ones being implemented in the correct way.

1.11 Fourth, the focus of my investigation has, given my terms of reference, inevitably, been on social care. This has not been a CQC-wide investigation. Nevertheless some recommendations clearly have a read-across to other sectors. CQC will want to reflect on the extent to which there may be other implications across the entirety of their work.

1.12 I make the following recommendations, under four broad headings: general; information; inspection; enforcement.

General

1.13 These are generic, over-arching recommendations which cut across many CQC activities. Where necessary they are also reflected in specific recommendations below.

Recommendation 1 - Consistency

1.14 CQC should ensure consistency of approach across all its activities in the application of policies.

Recommendation 2 - Training

1.15 CQC should ensure there is a strong and consistent focus on excellence in training.

Recommendation 3 - Risk

1.16 CQC should ensure that inspectors are properly trained to understand and manage the risks of challenge by providers and are properly supported when dealing with such risks.

Information

Recommendation 4 – Data

1.17 CQC should adopt a more proactive approach to the collection, retention and deployment of information about providers and services. Such information should be retained as far as possible in a single, readily accessible form. It should also be wide-ranging but there should be a specific focus on:

1.17.1 Small and medium size providers: CQC must collect, retain and deploy information on all providers, including those with fewer than twenty services;

1.17. 2 Data capture from other agencies: CQC should work with other agencies to acquire their relevant data recognising, however, that there may be data sharing constraints;

1.17.3 Data within CQC: CQC should adopt a more proactive approach to data sharing within the organisation;

1.17.4 Information about provider and service risk: CQC should ensure that provider and service risk information is retained in an accessible way even after specific risks have been resolved.

Recommendation 5 - Escalation

1.18 CQC should improve escalation systems to ensure information, including about specific provider and service inspections and enforcement issues, is better transmitted through the CQC hierarchy.

Inspection

Recommendation 6 – Inspection oversight

1.19 CQC should improve inspection oversight to ensure a more consistent approach, especially in relation to ratings.

Recommendation 7 – Inspection reports

1.20 CQC guidance on inspection reports should ensure clarification and improvement in relation to the following:

1.20.1 References to incidents;

1.20.2 References to ongoing enforcement activity;

1.20.3 References to state of services at the time of publication;

1.20.4 References to a provider's claims to special expertise and how those are to be monitored.

Enforcement

Recommendation 8 – Enforcement oversight

1.21 CQC should improve enforcement oversight to ensure a more consistent approach to both decision making and monitoring of progress.

Recommendation 9 – Victims and next of kin

1.22 CQC should proactively keep victims and next of kin informed of enforcement activities.

Recommendation 10 – Representations

1.23 CQC should establish a dedicated resource to consider representations from providers.

Recommendation 11 - Criminal enforcement

1.24 CQC need to keep closely under review their evolving approach to criminal enforcement.

Recommendation 12 - Criminal enforcement – legacy issues.

1.25 CQC should consider whether the legacy from their lack of preparedness to use their powers of prosecution when newly acquired in 2015 has been properly examined to identify incidents which should be considered against current prosecution criteria.

Recommendation 13 - Primacy in investigations

1.26 CQC should establish a protocol with NPCC and any other relevant prosecuting authorities to ensure clarity about who is the lead prosecutor for offences which CQC can prosecute.

Recommendation 14 - Legal resources

1.27 In the light of apparent capacity, capability and recruitment concerns, CQC should consider reviewing the strength and grading of their legal resources available to assist and guide enforcement activities.

Finally:
1.28 As I explain in paragraph 1.10 above, many of these recommendations have either been implemented or implementation is in hand. In the main text of my report, I cross-refer to this in more detail.

1.29 In addition to my thanks to those who have given evidence (paragraphs 1.5 and 1.6 above), I must single out for particular praise and thanks Vince Ricot. Vince has been with me from the outset of this investigation, providing invaluable support and assistance. His diligence, professionalism and all-round cheerfulness have kept me going. I am very grateful.

1.30 I am sorry that this investigation has taken much longer than I anticipated. Unfortunately I have been rather too closely involved with several CQC rated services in the healthcare sector over the last three months. At least my investigation has given me some understanding of the workings of CQC's rating system. I am, sadly, not yet in a position finally to validate the efficacy of the system in the healthcare sector.[1]

[1] Sir Paul Jenkins sadly died before he was able to complete this report. The postscript (section 6) explains how the investigation and report was concluded.

Chapter 2
Introduction

2.1 On 1 November 2015 there was an incident at 14 Colne Road, London N21 2JD, a residential care home in the London Borough of Enfield ("Enfield") for younger adults with learning disabilities. It was one of several then operated by Hillgreen.

2.2 It may have been an incident of the utmost gravity but the precise details of what happened may prove difficult to determine.

2.3 In July 2017 a newspaper published a story headed: "CQC covered up suspected rape in care home".

2.4 In September 2017 I was asked by the Chair and Chief Executive of CQC to investigate and report to the CQC Board on CQC's regulation of 14 Colne Road and to make recommendations. My Terms of Reference are in the Annex

2.5 Two uncertainties have hovered over my investigation from the outset.

2.6 First, following the incident Enfield initiated a Safeguarding Adults Review (SAR) of the care and management of the alleged assailant, P[2]

2.7 The history of Hillgreen as a provider, of P, of the involvement in his care of various local authorities, and of the role played by the police, the Crown Prosecution Service and the courts is long and complex. Much of the detail is now found in the published SAR. That detail complements my narrative.

2.8 But I have not thought it necessary independently to validate much of it for my purposes. My Terms of Reference require me to focus primarily on the regulatory activities of CQC and I set out in this report only such of the more general history as is relevant to my task or may otherwise be helpful to understand my findings and recommendations.

[2] I refer to the alleged assailant as he is referred to in the Enfield SAR to preserve his anonymity. The Enfield SAR was published, dated 12 March 2018, so cross reference to it has now been possible. *https://new.enfield.gov.uk/services/adult-social-care/adult-social-care-information-safeguarding-adults-review-p.pdf*

2.9 Second, the investigation and consideration of criminal proceedings relating to 14 Colne Road. At the time of finalising my report this is continuing. I have been anxious to avoid including in my report anything which might impede a fair trial. For this reason the report refers throughout to "the incident". At times, therefore, my report lacks some of the detail which might have provided a more comprehensive narrative in Chapter 4. This is not intended to diminish the seriousness of what is alleged to have occurred.

2.10 Neither of these uncertainties has impacted adversely or at all on my consideration of the issues or on my recommendations.

Chapter 3
My approach

3.1 I have tried to produce a narrative and analysis which, whilst sufficient fully to understand my findings and conclusions, is also reasonably concise.

3.2 It is important nevertheless to acknowledge the abundance of helpful material which has been available to assist me in this investigation. This abundance is perhaps unsurprising given the seriousness of the alleged incident, the history, the level of regulatory activity and the other investigations undertaken since 1 November 2015. It is also an indication of the constructive way in which people at every level at CQC have responded to this investigation.

3.3 The CQC systems have delivered up volumes of emails, notes of Management Review Meetings (MRM), inspection reports, evidence reviews, legal advice, interactions with the police, inter-agency exchanges and discussions.

3.4 I have seen numerous timelines produced for various regulatory and enforcement purposes and, indeed, to assist me.

3.5 Various narratives and analyses have already been produced by others to help people understand what happened and what might have been done better.

3.6 I was able to observe an experienced inspector and an "expert by experience" on an unannounced inspection of a residential home for adults with learning difficulties. I am grateful to everyone at CQC and the home who helped with this visit including, in particular, the residents who took time to speak to me.

3.7 I have interviewed the Victim 7's mother[3]. She is, if I may say so, a remarkable person.

3.8 I have interviewed those involved at CQC in the regulation of 14 Colne Road and in the oversight of such regulation. I have interviewed CQC lawyers and those in the senior management structure of CQC dealing with adult social care and inspection more generally. All the witnesses I interviewed have gone to considerable and commendable lengths to assist me and their evidence has been invaluable. Without exception, I found those whom I interviewed to be frank, open and completely credible witnesses. I have endeavoured to weave their evidence through my narrative and analysis but only so far as it is strictly relevant.

3.9 Many changes have been made, are underway, or are planned, by CQC since the incident, some in response to what happened and some as part of the CQC's commitment to continuous improvement. I have examined these and discussed them both with those responsible for proposing and developing them and with those who will be tasked with making them work on the ground.

3.10 Towards the end of the investigation I was introduced properly to the work of the Enforcement Oversight Board and its formidable programme of work. It has 27 work streams. Work stream number 10 addresses the changes already underway in consequence of CQC's response to Hillgreen. Work stream 10 has, itself, 10 strands.[4]

3.11 It is important to emphasise that I have not been conducting a disciplinary investigation. Rather, I have gathered and explored this mass of material to ascertain not only what happened but, critically, also to enable me to deliver in

[3] I use the reference which the Enfield SAR used when referring to the victim as Victim 7 to preserve his anonymity.

[4] This EOB work programme, Hillgreen Checklist and other documents taking forward post-14 Colne Road activity are living, changing documents so these are not appended to the report.

a comprehensible way, what I regard as the most important part of my Terms of Reference: “to make recommendations to CQC’s Board in relation to any areas for change, improvement or development identified in the course of the investigation including, in particular, in relation to regulatory risk management.”

3.12 In what follows next, I have endeavoured to set out the crux of what happened in narrative form, drawing on evidence, including oral evidence, but to do so only as far as is necessary for my purposes.

3.13 To assist readers, I signal as I go through this narrative those areas which give rise to the concerns and recommendations explained and set out in detail in chapter 5 below.

Chapter 4
The narrative

4.1 This narrative is broadly chronological but, for ease of comprehension, not entirely so. I divide it up into the following parts:

- Before the incident
- The incident
- The first inspection and the immediate aftermath
- The first inspection report
- Subsequent inspections
- Civil enforcement
- Criminal enforcement

4.2 Given this narrative is only broadly chronological and notwithstanding my comment about the plethora of timelines produced so far, I think it helpful therefore to start this narrative with one more.

4.3 These are some of the key dates to keep in mind through what follows:

- 1 November 2015: the alleged incident

- 2 November 2015: the police are notified of the incident

- 4 November 2015: Hillgreen report the incident to CQC's National Customer Service Centre (NCSC); it is not picked up

- 5 November 2015: the alleged assailant is moved from 14 Colne Road

- 9 November 2015: CQC notified of the incident by Enfield

- 19 November 2015: triggered by the incident, CQC carry out an unannounced inspection of 14 Colne Road

- 25 November 2015: CQC are informed that the deputy manager of 14 Colne Road is an illegal immigrant on the sex offenders' register

- 3 December 2015: a co-ordinated plan was agreed to ensure up to date information was available on all Hillgreen locations

- 18 December 2015: Enfield convene the first of several Provider Concern meetings

- 18 December: CQC send Hillgreen a section 64 letter requiring information about recruitment and visa verification processes (reply received on 29 December)

- 7 January 2016: CQC, Enfield and the police meet to consider possible approaches to prosecution and initiate a Safeguarding Adults Review

- 13 and 19 January 2016: CQC become aware that the acting manager at 14 Colne Road may initially have been told by managers at Hillgreen not to notify the police of the incident

- 22 January 2016: CQC carry out a second unannounced inspection of 14 Colne Road

- 29 January 2016: CQC inspection report, based on 19 November 2015 inspection, published

- 29 January 2016: CQC initiate formal enforcement procedures against Hillgreen

- 2 February 2016: CQC issue an Urgent Notice of Decision to impose conditions on Hillgreen

- 12 February 2016: CQC issue a Notice of Proposal to close 14 Colne Road

- 7 March 2016: CQC carry out a third unannounced inspection of 14 Colne Road; following this inspection the alleged victim was moved from 14 Colne Road

- 11 March 2016: Hillgreen provide representations to CQC in response to the Notice of Proposal to close 14 Colne Road

- 17 March 2016: following the inspection on 7 March, CQC issue a further Notice of Decision to impose conditions on Hillgreen

- 25 July 2016: CQC and police meet to discuss progress; the police agree to share evidence with CQC

- August 2016: at some point the last resident was moved from 14 Colne Road

- 25 August 2016: following notification that the police will not prosecute Hillgreen for wilful neglect and, having handed all witness statements to CQC, CQC commence consideration of prosecution

- 5 September 2016: two Hillgreen individuals invited for interview under caution by CQC;

- 24 October 2016: CQC issue a Notice of Decision to adopt the Notice of Proposal to remove 14 Colne Road as a registered location

- 23 December 2016: CQC notified that the CPS have decided there is no realistic prospect of conviction of the alleged perpetrator of the incident

- 11 January 2017: one of the two Hillgreen individuals invited for interview under caution on 5 September 2016 formally declines to be interviewed

- 31 January 2017: At a CQC MRM it was agreed to collect further evidence but pursuing the fitness of directors put on hold until a decision was made on whether to take forward prosecution in relation to Regs 12 and 13.

- 28 March 2017: A further MRM noted that the Police had confirmed that their cases had been reviewed by CPS and insufficiency of evidence meant that prosecutions would not be brought. Noted that CQC had taken action against individual locations based on identified risks and 4 of the 7 locations had closed.

- 7 August 2017: Winding up order for Hillgreen sought by HMRC

Before the incident

4.4 I heard evidence about the extent to which CQC and other agencies had been involved with Hillgreen before the incident. I was made aware, from amongst other sources the SAR commissioned by Enfield, of the extent of the information held about P, his history and his needs by agencies other than the CQC.

4.5 Inevitably, given their role as the regulator of providers, CQC's information was the most limited, confined largely to inspection reports. It emerged during the SAR that CQC had been made aware of an alleged rape by P in 2009; it was the trigger for his move from another Hillgreen location to 14 Colne Road. It is not, however, the part of the regulator's role to retain information on service users although CQC records showed they did raise concerns at the time.

4.5 **Recommendation 4** (paragraphs 5.36 to 5.45) is about CQC's approach to the collection, retention and deployment of information, including from other agencies. I would emphasise, however, that it is not part of CQC's role as the regulator of providers systematically to collect or retain information on users.

4.6 Before the incident, the most recent CQC inspection of 14 Colne Road was in February 2014. That inspection noted improvements since an inspection in 2013 and found that, under the previous rating system, the service met the

standards required. In particular, it was noted that people's care and welfare were in accordance with the relevant standard. The next inspection of 14 Colne Road was in due in December 2015.

4.7 The CQC inspection manager with responsibility for 14 Colne Road at the time of the incident had taken over his area in April 2015, assuming responsibility for some 270 services, of which two were run by Hillgreen: 14 Colne Road and 2a Oxford Gardens. Prior to that, the previous inspection manager covering 14 Colne Road had responsibility for two inspection areas, encompassing some 500 services.

4.8 The inspection manager with responsibility for 14 Colne Road at the time of the incident had been aware of some concerns about a Hillgreen location in a different part of London from his work as an inspector in 2012. He recalled in his evidence to me that he had found inappropriately placed people and a home which was tatty and with bare rooms.

4.9 But on taking over his new portfolio in April 2015, the new inspection manager's initial focus was inevitably and rightly, in my view, on those amongst his 270 locations where there was an evident risk. He discussed his new patch with the previous inspection manager but he could not recall any mention of Hillgreen or 14 Colne Road. That inspection manager confirmed to me that, whilst he had been running a Notice of Proposal ("NoP") to remove the registration of a Hillgreen location at Middleton Road, that was not a location in the patch which included 14 Colne Road inherited by his successor. He also noted that, following a further inspection, the Middleton Road location was found to have improved and the NoP withdrawn.

4.10 At the time of the incident, the inspection manager was quite new in post; the inspector with responsibility for 14 Colne Road was not only new in post but was also new to CQC. She acquired her portfolio of 40 services at the end of her induction training on 1 September 2015. Initially 14 Colne Road was her only Hillgreen service but she subsequently acquired 2a Oxford Gardens, an all-female service, from a male colleague.

4.11 Although new in post and new to CQC, the inspector had fifteen years' experience working in adult social care before joining CQC, including as a registered manager for domiciliary care agencies and residential care homes. This was fortunate, given what I heard about her induction training.

4.12 The new inspector said in evidence to me: “the training does not equip you to do the job and is not really effective”. She said most of the training was “on the job” rather than in the specifics for the role. For example, she had no direct training in how to look at medicines management: “that was something you learned on the job”. I return to this in more detail in Chapter 5. It is, however, important to bear it in mind through the rest of this narrative.

4.13 Before moving on to the next stage in the narrative, I flag up that **Recommendations 2 (Training – paragraph 1.15) and 4 (Data – paragraph 1.17)** are relevant to what happened before the incident. Of particular relevance is the analysis in paragraphs 5.36 to 5.45 and specifically the recommendation in paragraph 1.17.1 about the collection, retention and deployment of information about small and medium sized providers like Hillgreen. Also of relevance is the recommendation in paragraph 1.17.4 about retaining service and provider risk data once the risk has been dealt with.

The incident and immediate period after it 1st to 12th November 2015

4.14 This is set out in paragraph 1.4.5 of the Enfield Safeguarding Adults Review[5] and it is not necessary for the purposes of this report to set out the details of the incident again here.

4.15 On 9 November, Enfield contacted CQC about the incident at 14 Colne Road. Enfield were the host authority for 14 Colne Road but had not themselves used Hillgreen services for some time, a fact unknown to the inspector, the inspection manager or CQC at all. I observe in passing that this is an example of the sort of information I have in mind when making **Recommendation 4** (better data sharing - paragraph 5.36).

4.16 Later that day the CQC inspector for 14 Colne Road contacted the service about the incident. It was only then that CQC were told of the earlier notification to NCSC. It was also then that the inspector was told that P had already been moved from 14 Colne Road.

4.17 On 12 November CQC attended an initial information sharing meeting with Enfield. Information held by local authorities about P started to be made available to CQC. This was the first in a series of meetings over the following

[5] https://new.enfield.gov.uk/services/adult-social-care/adult-social-care-information-safeguarding-adults-review-p.pdf

months involving various agencies. For the reasons set out below (paragraph 4.33) I do not need to go through these in detail. This part of the process worked well.

4.18 I conclude this part of the narrative relating to the incident itself, by noting two things.

4.19 First, a police investigation into the incident began shortly after they were informed about it. I return to the impact this had on CQC's activities below (paragraphs 4.41 - 42) but note here that the police investigation was well under way by the time of the first CQC inspection on 19 November 2015. I also deal with the inter-relationship between the police and CQC on prosecution matters in **Recommendation 13** (Primacy) in paragraphs 5.119 – 5.122 below.

4.20 Second, following that police investigation and over a year after the incident itself, CQC were notified on 23 December 2016 that the Crown Prosecution Service had concluded that there was no realistic prospect of securing a conviction of the alleged perpetrator.

The first inspection and the period immediately thereafter

4.21 On 19 November CQC carried out a comprehensive inspection of 14 Colne Road. This inspection was brought forward from that planned for December because of the incident. I queried why a more immediate inspection had not taken place. The inspector told me "that since the police were investigating the incident, from CQC's point of view it was in hand and people were safe. The decision was made to bring it [the inspection] forward only if it can be done, but there was always the thought that the police investigation would supersede anything CQC do".

4.22 The CQC inspector had only been an inspector since 1 September 2015. As I have already noted she did, however, have fifteen years' experience working in adult social care, including as a registered manager of various residential care homes and was already well-regarded by her inspection manager. Nevertheless given the seriousness of the incident and recognising that her pre-CQC experience was primarily in elderly care not learning difficulties, at her request, the inspection manager arranged for her to be accompanied by a more experienced inspector.

4.23 I have already referred to concerns about the induction training she had received (paragraphs 4.12 and 4.13 linking to **Recommendation 2** – training).

4.24 By the time of this first inspection P had been moved from the service with the consequent elimination of the risk he presented to other service users at 14 Colne Road. Further, P's care plan was thus no longer available to the inspector on her inspection visit to 14 Colne Road. The police were also, by then, actively investigating the incident (paragraph 4.19 above).

4.25 The inspection did not focus on the incident although the inspector did allude to "a safeguarding incident that had taken place within the home" on page 7 of the inspection report.

4.26 In the evidence I heard there was some divergence of view about whether the approach taken to the incident during the inspection and in the subsequent report were correct. I return to this important issue in the next part of my report when dealing with **Recommendation 7** – inspection reports (paragraphs 5.56 – 5.76).

4.27 Before moving on in the narrative, it is important to note two points which are relevant both here and in the later narrative about the first inspection report.

4.28 First, Victim 7's mother told me how her distress over the incident and the way she and her son had been treated was compounded by the absence of any detailed reference to the incident in the report. This is entirely understandable even if the absence of any detailed reference is otherwise to some extent explicable in the light of CQC orthodoxy at the time.

4.29 Second, it was said in evidence to me that the failure to be more explicit contributed to the less than intensive involvement of senior management in the case. I deal with these points further below when making **Recommendation 5** – escalation. (see paragraph 5.46 – 5.51)

4.30 Moving on from the inspection itself, it is of relevance to my investigation to note that the inspection manager was on jury service from 16 November to 10 December 2015. As was apparently usual, he had been asked by his Head of Inspection to arrange cover. This was more challenging than usual, given the indeterminate length of jury service. In the end, line management of the inspector responsible for 14 Colne Road changed four times between 16

November and 11 December 2015. Although I was told it was usual to leave an inspection manager to arrange cover, I heard a degree of inconsistency about when Heads of Inspection should intervene if there were problems. I do not find anything adverse flowed in this case from the number of line managers. But this is one, albeit small, example of inconsistency of approach. (see **Recommendation 1** – consistency. Paragraphs 5.20 – 5.25)

4.31 In addition to the inspection manager's jury service, much else was going on in the period between the initial inspection on 19 November 2015 and the publication of that inspection report on 29 January 2016.

4.32 As I explained in paragraph 3.12 my intention is set out the crux of what happened and in sufficient detail but only insofar as is necessary to make my analysis and recommendations readily comprehensible.

4.33 I reiterate this point here because, over this period, there were numerous meetings, some multi-agency, including with the police, some internal to the CQC. Although my Terms of Reference require me to look at liaison between CQC and other authorities, I do not set all these meetings out in detail here because, in general terms, information sharing in the aftermath of the incident was good. This is in contrast to information sharing and information retention more generally (see paragraphs 5.36 – 5.45 below)

4.34 It is worth noting, however, that Victim 7's mother was involved in some early meetings. Sadly as things moved forward she was not kept well-informed. **Recommendation 9** (paragraphs 5.78 – 5.84) deals with how contact by CQC with victims and next of kin should be improved.

4.35 On 25 November 2015 CQC were informed by the immigration authorities that the deputy manager of 14 Colne Road at the time of the incident was an illegal immigrant who was also a registered sex offender. Hillgreen were, apparently, cooperative with the immigration authorities who decided not to penalise them.

4.36 Notwithstanding his jury service, on 3 December 2015 the inspection manager began work to look beyond 14 Colne Road to Hillgreen more generally and to ensure up to date information was available for all their locations. I flag up here **Recommendation 4** (paragraphs 5.36 – 5.45) and the need (i) systematically to collect and retain data about all providers and not just those with twenty or more services (paragraphs 5.42 – 5.44) ; and (ii) to

retain risk data on services and providers even once the risks have passed (paragraph 5.45).

4.37 Briefing on the incident was provided for the CQC Adult Social Care directorate weekly risk update on 14 December 2015. The briefing did not reach the Board report. Neither did a similar update provided on 23 December. The 23 December briefing referred to an "emerging issue of major concern" mentioning "a number of serious concerns" about Hillgreen. Specific mention was made, amongst other things, of the alleged rape at 14 Colne Road and the fact that the deputy manager was on the sex offenders register and did not have a valid visa. A later version was eventually reported to the Board on 29th January 2016.

4.38 In this regard, I refer to **Recommendation 5** (paragraphs 5.46 – 5.51) and the need to ensure a satisfactory and consistent approach to escalation of issues of concern within CQC.

4.39 At a Provider Concern meeting on 18 December, Enfield agreed to meet Hillgreen. The meeting took place on 23 December. They also agreed to advise all placing authorities to stop new placings at Hillgreen services and to consider exit strategies for all people currently placed with Hillgreen.

4.40 Also on 18 December and following the discovery about the deputy manager's status, Hillgreen were asked formally by CQC, under section 64[6], for information about their recruitment processes and visa verifications. Most of the information request was provided by Hillgreen on 29 December 2015.

4.41 Amongst the various meetings both within the CQC and involving other agencies, there was a meeting on 7 January 2016 involving the CQC, Enfield and the Metropolitan Police. At this meeting the police revealed they had uncovered a further allegation against P of an assault on another service user at 14 Colne Road. It was also at this meeting that discussion started about who had responsibility for what in terms of possible prosecutions. Eventually the police took the lead not only on the alleged rape but also on the possibility of establishing wilful neglect by Hillgreen. The police eventually abandoned this latter line of investigation in August 2016.

4.42 I have explained in paragraph 4.19 that the presence of the police and the fact of their investigation were factors in the treatment of the incident during

[6] Health and Social Care Act 2008

the inspection. The meeting on 7 January is the first time the importance of establishing who is in charge of what really comes to the fore in the context of enforcement. I deal with this issue in **Recommendation 13** (Paragraphs 5.119 – 5.122)

4.43 On 8 January CQC Inspection Managers met the Nominated Individual at Hillgreen. This was described to me as "very informal" and intended to "seek reassurances". From the notes, it appears it was mainly to discuss recruitment policies and staff checks. It was also at this meeting that Hillgreen appear, for the first time, to have intimated to CQC that the police had not been involved immediately, supposedly because of uncertainty about whether the incident was consensual.

4.44 Subsequently, on 19 January 2016 CQC learned that the unregistered acting manager of 14 Colne Road had initially been instructed specifically by senior managers at Hillgreen not to report the matter to the police.

The first inspection report

4.45 The inspection report which resulted from the 19 November inspection was subject to peer review and was sent to Hillgreen for comment in the usual way. The report was published on 29 January 2016.

4.46 Although a brief reference was made in the report to the incident, there was no detail. Under "Is the service safe?" it was noted that: "The service, at the time of the inspection, was also working with the local authority on a safeguarding incident that had taken place within the home."

4.47 Victim 7's mother told me that she found the absence of any more specific reference to the incident particularly upsetting.

4.48 Nor were any of the issues which might have contributed to the incident alluded to in the report.

4.49 No specific reference was made to either the status of the deputy manager at the time of the incident[7] nor to the suggestion that senior managers had initially instructed the acting manager not to report the incident to the police. Failings in staff recruitment checks were mentioned. There was a

[7] There is no suggestion that the deputy manager's status was a relevant, contributing factor.

generic reference to the absence of safe systems and processes to ensure the safe recruitment of staff. There was a similarly generic reference to the absence of appropriate systems to check whether applicants were legally entitled to work in the United Kingdom.

4.50 The overall rating given was “Requires Improvement”.

4.51 **Recommendation 7** (paragraphs 5.56 – 5.76) addresses the issues about what might properly be included in inspection reports

Subsequent inspections

4.52 On 22 January 2016 a second inspection of 14 Colne Road took place. It was triggered by serious concerns raised by Enfield as part of a food safety inspection carried out on 19 January. 14 Colne Road was rated inadequate on safety and leadership. The safety finding was based on various food hygiene issues, rat and mice infestations and the failings of staff adequately to deal with these issues. The leadership failures stemmed primarily from the absence of a registered manager, lack of adequate systems for monitoring care quality, fire safety and staff training concerns.

4.53 The report following this inspection, when finally published on 26 October 2016, alluded briefly to enforcement action “we are in the process of taking”. For ease of comprehension is jump slightly ahead to note here that the civil enforcement action which started on 29 January 2016 (see paragraph 4.55 below) led to the removal of the last residents from 14 Colne Road in August 2016 and the removal of its registration in October)

4.54 On 7 March 2016 a third inspection took place. It was focused on concerns about the management of service users with epilepsy. The report, published on 19 April 2016, rated 14 Colne Road as inadequate for safety. It was following this inspection that Victim 7 was moved from 14 Colne Road.

4.55 It is worth noting here that with Victim 7’s removal to a more suitable service not owned by Hillgreen, only one resident was left at 14 Colne Road. That resident was placed by Hackney and CQC pressed them about their plans. But it was August before Hackney moved that person from 14 Colne Road.

Civil enforcement

4.56 On 29 January 2016 CQC, having identified from all the information then to hand including from the first two inspections a level of risk which was high/extreme, sent an urgent letter of intent to Hillgreen. In the letter Hillgreen were informed that urgent suspension or cancellation of the registration of 14 Colne Road was under consideration. A response was required by 1 February at the latest.

4.57 It is worth noting that stretched internal legal resources meant this legal work was dealt with by external private solicitors.

4.58 On 1 February CQC reviewed the action plan from Hillgreen provided consequent upon the letter of intent of 29 January. It was decided urgent suspension was not required, there being no immediate risk of harm. It was recognised that Hillgreen had taken steps to address the matters of concern. But urgent conditions were imposed and Notice of Proposal to close was still deemed appropriate.

4.59 The Notice of Proposal to close 14 Colne Road was issued on 12 February. This, together with the urgent conditions imposed, was the start of the twin-track civil enforcement process: conditions imposed which were intended to lead to improvement; a proposal to close in the event of failure to improve.

4.60 The urgent conditions imposed on Hillgreen required, amongst other things, various improvement actions and a steady supply of information about progress. Initially Hillgreen complied. Information was provided in a timely fashion on several occasions in February. However neither of the action plans following the first and second inspections were received on their due dates, 23 February and 25 February. Other information received was inadequate.

4.61 On 11 March 2016, Hillgreen provided CQC with their representations in response to the Notice of Proposal to close 14 Colne Road. On 11 April these representations were allocated for consideration, as was the practice, to a Head of Inspection from another area.

4.62 These continued to be held and reviewed until at least 26 July 2016 at which an MRM recorded an action point to follow up with the Head of Inspections the outstanding review of the representations in order to progress to Notice of Decision to close 14 Colne Road. This Notice, to remove the location from being a registered address, was finally issued, on completion of the review of representations, on 24 October 2016. **Recommendation 10**

(paragraphs 5.85 – 5.92) in relation to the proper and expeditious handling of representations within CQC is particularly relevant here.

Criminal enforcement

4.63 To reiterate, CQC acquired their powers to prosecute on 1 April 2015, some seven months before the incident. Did CQC recognize quickly enough that the power to prosecute brings with it not only additional tools but also the need to operate aspects of its regulatory function in different ways? All the evidence I heard suggested they were not fully prepared for this significant change but this was in the context of all the other substantial changes going on at the same time within CQC and with the way it conducted its functions.

4.64 In terms of this narrative, CQC and the police were two of the key participants in taking (criminal) action against Hillgreen but, as the Enfield SAR makes clear, both commissioning (or placing) local authorities and the host local authority for 14 Colne Road, also bore significant responsibilities in ensuring that individuals placed in that setting were properly safeguarded regardless of the possibility of subsequent criminal sanctions.[8]

4.65 I was told that a full CQC criminal investigation has since been carried out independent of the original inspection team. Following its conclusion, and upon consideration of the evidential and public interest tests, a decision has been taken to prosecute the company Hillgreen Care Limited for two offences under the Health and Social Care Act (Regulated Activities) Regulations 2014. **Recommendations 11** (paragraphs 5.93- 5.115) and **12** (paragraphs 5.116 – 5.118) are relevant to the handling by CQC of this, and other prosecutions.

Chapter 5
Analysis and recommendations

5.1 In this part of my report I make a series of recommendations. Beneath the headline recommendations I set out my thinking behind each one and my analysis linking them to the narrative and to what I believe emerges from that narrative and from the other evidence I have heard. Before turning to the detailed recommendations and the underpinning analysis, I make five

[8] Topic 7"Making safe placements" notes in particular that "Where risk of sexual offending is a factor, placing authorities must satisfy themselves that they are providing the least restrictive environment *that is compatible with the safety of others."*

overarching points. To some extent these points surface again in specific recommendations but they are of more general import.

Validation and assurance

5.2 The CQC is an organisation with a strong culture of continuous improvement. Couple that with a strong desire to learn when things appear to have gone wrong and there might be a risk that an investigation such as this is otiose. And in one sense it is; I have identified little which needs changing beyond that which has already happened or is in hand. But, of course, it is right that CQC should seek independent assurance both that the improvements they have identified as necessary are the right ones and that they have missed nothing. Where, however, I agree that the CQC are on the right track I will be brief, concentrating rather on those areas where I continue to have concerns.

Organisational change

5.3 “Every time something goes wrong, there is pressure to change. But this constant change has a huge impact, especially in adult social care with so many venues”. So said a very senior CQC official in evidence to me.

5.4 CQC was described to me by another senior CQC witness as an organisation on a journey to maturity. Incidents like the one at 14 Colne Road are important in terms of understanding what still needs to improve. But I was also told by several witnesses that the way CQC reacted to such incidents was disruptive of progress. This was not always said critically; it was often merely an explanation of why progress was not always as steady as planned and programmed.

5.5 Whatever the reason, CQC is an organisation where change can appear to be almost endemic. As I have said, change is driven by the need and desire continuously to improve; it comes from new responsibilities, in response to changes to the way the organisation was configured and operated as happened in 2013/14, the acquisition of prosecution functions in 2015, for example; and it comes in response to inquiries and investigations such as this.

5.6 Many of those I interviewed from every level of CQC spoke of the impact of constant change. I heard of times when there were specialist enforcement teams; I heard of substantial changes to methodology; of major

reorganisations; of new areas of responsibility imposed from outside. And so on and so on.

5.7 Few suggested these changes could or should have been avoided. But it is important to emphasise the impact constant (or even episodic but substantial) change has on the organisation and on those who work there. Those I spoke to in senior roles with responsibility for the changes relevant to my investigation were all acutely conscious of the impact of constant change. I make the point partly to ensure the impact on front line staff is never overlooked and partly to emphasise the importance of adequate training, development of new skills and the time needed to assimilate change alongside busy day jobs.

Cultural or Behavioural change

5.8 The CQC acquired their powers to prosecute in 1 April 2015.

5.9 It is worth reflecting on the surrounding context at this time. The acquisition of these new enforcement powers occurred at the same time as the organisation itself was changing quite substantially. I was told that there had been a complete change in the inspection methodology from compliance based inspections to more in-depth specialist inspections of Providers, which involved a completely new set of assessment frameworks; the rating system was introduced following that. The prosecution powers introduced then were not seen as unimportant but were part of a much larger change mechanism. However, when the powers were brought over to CQC I was told that there were no inspectors with experience in running these types of prosecutions. For inspectors in CQC at the time the change was huge since many had changed teams as well as the sector they were inspecting and now had additional criminal enforcement powers and responsibilities. All the changes implemented took time to embed and form a core part of the organisation.

5.10 One of the themes running through the evidence I heard is that CQC has taken time fully to adapt to the acquisition of those powers. This is true in relation to the policies and procedures needed. But it is also true culturally. It is worth expanding on the cultural point briefly here; it runs through much of what follows.

5.11 Several witnesses told me that they and, they believed many others, felt their role was to ensure services were safe and to work with those that were not safe to help them improve. “Punishment” had not been their focus before

2015 and was still something many found almost counter-cultural. Even senior CQC witnesses accepted this was a commonly held view.

5.12 I found clear evidence that this was changing. People recognise that punishment and deterrence have a part to play in ensuring safe, good services. But it is important to bear in mind this general cultural (or behavioural) point CQC's approach to operating its powers of prosecution moves to maturity.

Risk

5.13 My Terms of Reference have a particular focus on regulatory risk. I deal with this below in various contexts. But I make a more general point at this stage. I have already alluded to the sense of constant change and to the cultural issues around punishment. In one sense both are linked to a lack of confidence on the part of some when faced with new responsibilities and with the unfamiliar.

5.14 Those, more senior, staff who are designing the changes I have referred to are alert to the need to build skills and confidence. It is important for them also to understand the extent to which risk aversion in relation to enforcement activity is fuelled by lack of confidence and experience. Witnesses did not put it this way. But it was, perhaps unsurprisingly, obvious for example when dealing with challenging providers and their lawyers. Ensuring that everyone understands that enforcement is merely one element of an effectively performed inspection function, is crucial to removing this risk aversion. I have heard evidence that CQC has been reinforcing this approach.

Consistency of approach

5.15 I heard evidence which showed uncertainty about the correct approach which should have been taken at the time of the incident and in the following months. This uncertainty stemmed, in part, from guidance which was unclear and training which was perceived to be less than adequate.

5.16 But I also heard from several witnesses about inconsistency of approach to various issues both across sectors and across regions. I make the specific **Recommendation 1** to assist in tackling these inconsistencies.

5.17 But it is important for CQC to recognise more generally that the good work they have done, and continue to do, to establish clear guidance and best practice will be less effective if there is not a greater degree of rigour in ensuring consistency of application across sectors and regions.

5.18 With these general points in mind, I turn to the specific recommendations and the evidence and analysis underpinning them.

5.19 I make them under four broad headings: general; information; inspection; enforcement.

General

5.20 These are generic, over-arching recommendations which cut across many CQC activities. Where necessary they are reflected in the specific sub-recommendations which follow:

Recommendation 1 - Consistency

1.14 CQC should ensure consistency of approach across all its activities in the application of policies.

5.21 It was clear from the evidence to me that, at the time, there was a lack of clarity (and therefore consistency of approach) about whether an inspection was a "snapshot" of the service on the day of the inspection or a "video" of the state of that service based on the inspection and other information available to inspectors. It is clear that CQC has taken action to clarify this.

5.22 Similarly, there was uncertainty about the extent to which information made known to CQC (and its inspectors) after the inspection could be reflected in the report. Guidance to inspectors needs to be clearer that inspection reports must accurately reflect the state of the service as close as possible to the time those reports are published.

5.23 I heard evidence about the role of the Management Review Meeting Panels. In each ASC region these reviewed weekly all proposed inadequate ratings; all proposed fit and proper person enforcement actions; and "high seriousness" enforcement according to the decision tree.

5.24 If 14 Colne Road had been looking likely to be an "inadequate" rating then this system might have been fine. It appears to have been fine after the 2nd inspection and all the enforcement that followed thereafter. But what about the first inspection? How was consistency of rating ensured across ASC (and CQC more generally) in relation to ratings not caught by the MRM Panel review system, even on a sample basis?

5.25 Also in the evidence I heard there was no consistent view on how, at the time of the incident, incidents of, as yet unproven, criminal activity should be dealt with in inspection reports. In relation to the first inspection report (November 2015, published January 2016) information about the incident was not included because, it was said, guidance at the time advised against it because of the risk of identification of those concerned (this was a small home with 5 residents at the time of the inspection). Guidance to inspectors must make clear how to deal with unproven but apparently serious incidents in inspection reports and civil enforcement activity and CQC needs to satisfy itself that this guidance is properly understood and being applied in practice.

Recommendation 2 - Training

1.15 CQC should ensure there is a strong and consistent focus on excellence in training.

5. 26 As I have explained, the inspector with responsibility for 14 Colne Road at the time of the incident was new to inspection and new to CQC. Fortunately before she joined CQC she had fifteen years' experience working in social care, including as a registered manager at domiciliary care agencies and residential care homes. Fortunately too, witnesses who knew her professionally told me she was highly able, confirming the clear impression I had when I interviewed her.

5.27 I asked her about her induction training. In summary she told me: "the training does not equip you to do the job and is not really effective". She told me her induction training lasted twelve weeks and was a mixture of classroom and online based training at home. New inspectors were encouraged to shadow inspections. She commented that, whilst most of those training with her had a background in adult social care, albeit from "the other side", it was tough for those without such a background.

5. 28 The new inspector said she felt she had been given the tools to use but there was no direct training soon how to use them all. She said there was more training given around safeguarding and mental capacity. She said most of the training was "on the job" rather than in the specifics for the role. For example, she had no direct training in how to look at medicines management: "that was something you learned on the job".

5.29 I have not interviewed those who have joined CQC more recently. So I record the new inspector's views on her training in 2015 with that caveat. But I draw attention to it because, whether induction training is now better or not, there was a consistent theme throughout my investigation that training at the time was not excellent. This was particularly so in relation to the new powers of prosecution acquired by CQC in April 2015. I was repeatedly told there was no training provided at all. I return to criminal enforcement below (**Recommendations 11 and 12**).

5.30 I merely note here that the success of CQC's preferred approach to criminal enforcement depends heavily on excellent training and new support arrangements (in particular the recruitment of a cadre of Enforcement Review Officers). I heard evidence that CQC has this in hand.[9] It is for this reason that I have said that evaluation of this approach, to ensure that it delivers significant improvement, is kept under a constant spotlight at senior levels in CQC.

Recommendation 3 - Risk

1.16 CQC should ensure that inspectors are properly trained to understand and manage the risks of challenge by providers and are properly supported when dealing with such risks.

5. 31 I was consistently told that much of the cautiousness on the part of inspectors was because providers were frequently aggressive in response to suggestions of possible failings. They had to respond to vigorous lawyers who were ever ready to threaten legal challenge. They face tribunals who, it is felt, too often side with the providers.

[9] There has already been training from Legal Services focussing primarily on Criminal prosecutions, evaluated as being very successful. This training day has now been recorded and is now available to all inspectors through the electronic delivery system. The contract to deliver the Regulatory Skills Training programme is about to be let.

5.32 In summary it was felt there was often an imbalance in the system between the power of providers and the interests of service users.

5.33 The most obvious example I came across were the concerns inspectors had about changing draft reports once they had been sent to providers for comment. At best, further changes delayed matters; at worst they provoked legal threats. This was not the only explanation for the anachronistic first report when published. The guidance was not helpful either. But, as we see below (**Recommendation 7** paragraphs 5.57 – 5.76), the guidance has changed. Inspectors now have good guidance on how to ensure their reports are detailed and up to date as near as possible to publication.

5.34 But, and this is the point of this recommendation, better guidance is unlikely to be enough absent proper training of inspectors to use it and use it in a way which appropriately confronts aggressive providers and their lawyers.

5.35 Finally, I draw attention to the point I make in the penultimate paragraph dealing with **Recommendation 9** (paragraph 5.83). The imbalance (between providers and users) to which I refer above is reinforced by the current Department of Health and Social Care rules restricting public reference to ongoing enforcement activity.

Information

Recommendation 4 - Data

1.17 CQC should adopt a more proactive approach to the collection, retention and deployment of information about providers and services. Such information should be retained as far as possible in a single, readily accessible form. It should also be wide-ranging but there should be a specific focus on:

> **1.17.1 Small and medium size providers: CQC must collect, retain and deploy information (beyond the regional boundaries within CQC) on all providers, including those with fewer than twenty services;**
>
> **1.17.2 Data capture from other agencies: CQC should work with other agencies to acquire their relevant data recognising, however, that there may be data sharing constraints;**

1.17.3 Data within CQC: CQC should adopt a more proactive approach to data sharing within the organisation;

1.17.4 Information about provider and service risk: CQC should ensure that provider and service risk information is retained in an accessible way even after specific risks have been resolved.

5. 36 An example of data which might usefully have been shared with CQC and, indeed with other placing authorities, was the fact that Enfield had refused to use Hillgreen services for some time, including those within their Borough; and the reasons for that refusal. (See paragraph 4.15 above)

5.37 As I explain in the narrative section (paragraph 4.36) on 3 December 2015, and in direct response to the incident and other emerging information, CQC started to look across all Hillgreen services to ensure up to date information about all their locations was available. The work was initiated by the inspection manager who had 14 Colne Road and one other Hillgreen location in his area.

5.38 The inspection manager told me he had some previous involvement with a Hillgreen location from his time as an inspector in south London several years before the incident. He recalled inappropriately placed people and tatty, bare premises. But when, as an inspection manager, he assumed responsibility for part of north London in April 2015 the only information made available to him was existing inspection reports for individual locations. He acquired responsibility for some 270 locations, including two operated by Hillgreen: 14 Colne Road and 2a Oxford Gardens. He took over the area from an inspection manager with responsibility for over 500 services and inevitably handover discussions focused on those locations where inspection reports showed there were problems. Neither Hillgreen location fell into this category. There was no information available to him about Hillgreen generally; nor was any such information collected or held by CQC.

5.39 There is no suggestion that, if CQC had held comprehensive information about Hillgreen, it might have played any part in avoiding the incident. Others had more complete information: Enfield did not use Hillgreen locations because of safety concerns but Hackney, who placed P with Hillgreen, did not know this. CQC needs actively to engage more with placing and host authorities to ensure a comprehensive sharing of relevant data is achieved across the regulated sector.

5.40 But it cannot be satisfactory that comprehensive information, from within CQC, about a provider such as Hillgreen is only produced on an ad hoc basis and in response to a potentially grave incident.

5.41 CQC does capture and hold comprehensive information about major providers. It does so partly to assist in managing the risks of major provider collapse which might, for example, leave large numbers of vulnerable people without care.

5.42 The failure of small and medium sized providers may not risk a major care problem. But such providers can present their own risks. I was told of an instance where such as provider (not, I emphasise, Hillgreen) with too few registered managers moved them from location to location in response to CQC enforcement activity.

5.43 The SAR makes a similar recommendation (under Topic 19 "Evaluating different settings managed by the same provider") when it states: "Where there are concerns about management oversight of particular services, the Care Quality Commission should be proactive in making connections with other settings managed by the same provider in order to satisfy themselves that these failings are specific to one setting and not occurring across the whole organization."

5.44 There is a strong and cogent case for ensuring proper oversight of small and medium providers. CQC accept this and I was told that the Head of Inspection ASC is working on how providers who have more than two but fewer than twenty locations are to be monitored by CQC. This work is essential to ensure that information about small and medium-sized providers with registered locations spanning more than one CQC region is communicated to all those responsible for inspecting those different locations. CQC urgently needs to resolve this, whether by establishing relationship managers for all providers with two or more sites, or by some other means.

5.45 Finally, on these sub-recommendations: Risk registers are, rightly, transient documents. Risks should not linger long on such registers. If they do they merely lead to complacency. But risks, even those which are effectively addressed, may be indicative of more deep-seated problems. This information should be retained as part of the data held about all providers (small, medium and large).

Recommendation 5 – Escalation

1.18 CQC should improve escalation systems to ensure information, including about specific provider and service inspections and enforcement issues, is better transmitted through the CQC hierarchy.

5.46 This issue first surfaces in paragraph 4.29 above but runs throughout the narrative. In essence it is said that escalation within CQC ensures serious issues are dealt with better. It is said that a more explicit reference to the incident and/or an "inadequate" rating would have had this effect. It is not clear to me that this is entirely correct, at least as far as the incident was concerned.

5.47 Briefing on the incident was provided for the CQC Adult Social Care (ASC) Directorate Weekly Risk Update on 14 December 2015. That briefing did not reach the Board report. Neither did a similar update provided on 23 December. That later briefing referred to an "emerging issue of major concern" mentioning "a number of serious concerns" about Hillgreen. Specific mention was made, amongst other things, of the alleged rape at 14 Colne Road and the fact that the deputy manager was on the sex offenders register and did not have a valid work visa. A later version was eventually reported to the Board in January 2016.

5.48 I was told that the system of escalation was risky because so many apparently high risk incidents were put forward to go into Board reports. A senior CQC witness told me there should be a clearer understanding of the purposes of escalation. Escalation to Board level should really be quite limited: essentially so the Board are not caught unawares. The bulk of high risk cases did not fall into this category. Escalation for these cases should be to the level immediately below the Board. That was where any necessary additional action should be triggered; where triage of cases to the Board should take place.

5.49 On any view, it seems to me that an explicit reference to the incident (given the degree of gravity that is at the heart of this particular case) should be the trigger for senior concern and Board notification. When the notification did reach the Board in January 2016 it is not clear to me that it triggered any more vigorous response. But I accept that even the explicit reference to that incident might not trigger that "serious concern and Board notification" when

coupled with a “requires improvement” rating and also with an indication that service users were now safe.

5.50 The facts of the instant case may not therefore be particularly helpful as a guide through the “escalation issue”. I was told work was in hand to ensure more robust language was used in internal reporting. I was told that work to ensure a triage system of the sort indicated in paragraph 5.48 above is in hand. In general I think the understanding that CQC now have of the issue and the work in hand will result in the required improvements to escalation and its effect.

5.51 Just one final caveat on this topic. More robust language will help. Clarity about the different reasons for escalation to Board and to senior managers will help. But inevitably ratings will continue to be a pivotal issue. The work on consistency of ratings is of importance here too. (**Recommendation 6** below)

Inspection

Recommendation 6 – Inspection oversight

1.19 CQC should improve inspection oversight to ensure a more consistent approach, especially in relation to ratings.

5.52 CQC have this work in hand.

5.53 I heard evidence from inspectors, inspection managers and Heads of Inspection which suggested there was a lack of consistency, particularly with ratings. In the instant case for example, I heard witnesses who thought, on the approach in place at the time, the “requires improvement” rating for the first inspection report was acceptable. But I heard from others who felt strongly that it was not.

5.54 But I also heard convincing evidence of the work underway to ensure greater consistency. I heard of risk management meetings where ratings profiles were examined to identify trends. I also heard of more cross-regional work and the use of peripatetic inspectors.

5.55 But the person in the lead on this work acknowledged CQC could still do more. And they must. It barely needs spelling out that the headline ratings are

likely to be what potential service users look at first. Many, I suspect, will barely look beyond a "good" rating.

Recommendation 7 – Inspection reports

1.20 CQC guidance on inspection reports should ensure clarification and improvement in relation to the following:

1.20.1 References to incidents;

1.20.2 References to ongoing enforcement activity;

1.20.3 References to state of services at the time of publication: "A video not a snapshot";

1.20.4 References to a provider's claims to special expertise

5.56 CQC have much of this work in hand.

5.57 CQC say: "We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care."

5.58 To state the obvious, it is important that inspection reports give an accurate and current picture. It is important because "performance ratings help people choose care". But it is also important because inspections ratings can prompt escalation within CQC and trigger further, more intense, regulatory activity.

5.59 The inspection on 19 November 2015, prompted by the incident, resulted in an inspection report published on 29 January 2016. 14 Colne Road was rated as "requires improvement".

5.60 Between the inspection on 19 November and publication of the report just over two months later, CQC became aware that the deputy manager was an illegal immigrant on the sex offenders' register. They became aware that the senior managers had instructed staff at 14 Colne Road not to report the incident to the police.

5.61 None of these facts were mentioned in the report in anything but the most oblique and general terms. The only reference to the incident itself – the trigger for the inspection – were the words: "The service, at the time of the inspection, was also working with the local authority on a safeguarding incident that had taken place within the home."

5.62 Further, an inspection of 14 Colne Road carried out on 22 January, seven days before the publication of the first report, eventually resulted in a rating of "inadequate".

5.63 To the uninformed observer, it might appear to be quite extraordinary that so much information relating to a service was not included in an inspection report. Or that an inspection carried out a week before the publication of the first report eventually concluded 14 Colne Road was inadequate.

5.64 And yet it was not extraordinary. As I mention in the preceding section dealing with ratings consistency, the evidence I heard was divided about this report and the approach taken. But I heard sufficient, cogent evidence to convince me that the approach adopted was far from aberrant.

5.65 As far as the incident itself was concerned, the inspector and other, more experienced witnesses I interviewed, were clear that they would not have expected to touch on such an incident in their inspection activity: it was as yet unproven and the police were actively investigating. To do so also risked identifying those concerned.[10] In practical terms, P's removal had removed the risk of further harm. As the inspector put it to me: "The police were investigating the incident, from CQC's point of view it was in hand and people were safe". In practical terms, the fact that P had been moved by the time of the first inspection also meant his care plan was no longer available for consideration by the inspection team at 14 Colne Road.

5.66 The inspector also told me she had initially included information about the deputy manager's immigration status and P's history but that these were removed during a management review of her draft "because information received after the inspection cannot be included in the report". The inspector also told me that "you can't include information about enforcement or notification [of decisions/proposals] in the report".

[10] It should be remembered there were only five residents at 14 Colne Road at the time of the incident.

5.67 The inspection manager told me that, with the benefit of hindsight, the inspection should have looked at the incident. The additional inspector who took part in the inspection thought it was strange that the inspection did not look at the incident and, in particular, whether placements were appropriate. He acknowledged, however, that this would have been difficult because of the live, ongoing police investigation.

5.68 But, critically in terms of resolving what was CQC orthodoxy at the time, the paper prepared by the Chief Inspector of Adult Social Care on issues arising from Hillgreen noted that the absence of any explicit reference to the alleged sexual assault or serious safeguarding concerns arising from the incident "reflected the existing practice at the time which was very cautious in referring to incidents under investigation by the police, safeguarding or CQC".

5.69 Whatever the CQC orthodoxy at the time, this was one of a number of areas where the inspector and others felt they had insufficient guidance and training.

5.70 Apart from the incident itself, the report did not mention in detail the other issues known at the time of publication: the status of the deputy manager and the initial instruction not to involve the police. There were, at best, oblique references.

5.71 The guidance has now changed and I spoke to inspectors who were comfortable with the new position: the reports should be "videos not snapshots" of the day of inspection.

5.72 But I also spoke to a senior CQC official who recognised that the new guidance might not, on its own, be enough. She acknowledged that inspectors were now much more confident about looking not just at what they found during the inspection. She, however, acknowledged that confidence was building but "there is still some way to go".

5.73 I also record, in relation to this recommendation, that the Enfield SAR (under Topic 18) makes a point, not clearly identified in the inspection reports, that Hillgreen was holding itself out as being able to provide placements to persons such as P who posed a risk to others and/or had complex needs. As the SAR notes: "Placing authorities are often paying a premium for these services and must be sure that the person is getting the service they are paying

for" - to which I would add that other service users and their families will also be relying upon that enhanced level of service to ensure that those other service users are properly safeguarded. The SAR concludes that "CQC will monitor this as part of their regulatory function".

5.74 The nature and extent of this "monitor[ing]" by CQC will need to be fully understood, and (to the extent possible) it will need to be reflected in both inspection practice and enforcement decision-making.

5.75 More specifically, the SAR recommends (under Topic 7 "Making safe placements") that "Regulators should also take note of the compatibility of service users when inspecting providers to offer assurance that groupings are appropriate and that high-risk individuals are not housed alongside particularly vulnerable individuals without adequate safeguards." I heard evidence about cases in the past where inspectors or inspection managers have challenged local authorities and providers about inappropriate placements which presented risks to others. Equally, it is not part of CQC's role as the regulator of providers systematically to collect or retain information on users.

5.76 I have not seen CQC's responses to these CQC-specific recommendations in the Enfield Safeguarding Adults Review[11] but they will require very careful consideration and explanation by CQC how its inspections can deliver them.

Enforcement

Recommendation 8 – Enforcement oversight

1.21 CQC should improve enforcement oversight to ensure a more consistent approach to both decision making and monitoring of progress.

5.77 CQC have this in hand. There have been significant changes to the management and oversight of criminal investigations and prosecutions. The Enforcement Oversight Board's programme of work covers enforcement oversight of both the civil and criminal strands. This, coupled with the changes to both the structure and staffing of the Legal Services team responsible for

[11] As my terms of reference include consideration of CQC's liaison with other public authorities in connection with relevant inspection findings I recommend that CQC establishes a process by which recommendations from SARs that have wider than just local impact on CQC policies and practice, are considered and responded to centrally.

criminal enforcement and the Case Management Review Panel system indicate that CQC has made considerable changes to the management of criminal investigations and prosecutions work since Hillgreen. Evaluation of the impact of these changes and a continuing focus on this oversight work needs to continue.

Recommendation 9 – Victims and next of kin

1.22 CQC should proactively keep victims and next of kin informed of enforcement activities.

5.78 CQC have this in hand.

5.79 Conventionally contact with service users and their kin has been in the hands of placing authorities and those with responsibility for services in their area. In the case in hand, Enfield did involve Victim 7's mother to a certain extent in the period immediately after the incident. But gradually, contact and involvement decreased. She attended early safeguarding meetings, for example the strategy meeting on 10 December 2015. But as matters moved this involvement grew less and less. Victim 7's mother told me she had heard nothing for considerably over a year before the incident came to prominence in July 2017.

5.80 One of the areas where both the police and prosecuting authorities generally have improved their approach quite radically in recent years is when it comes to keeping victims of crime informed about the progress of investigations and about charging decisions.

5.81 At the time of the incident, the CQC's approach was not entirely satisfactory. This cannot be put down just to the fact that powers to prosecute were new and their implementation underdeveloped. In this context those who suffer, whether as users or next of kin like Victim 7's mother, as a result of failings by providers may legitimately have a direct interest in civil enforcement. They may want a service improved and preserved or closed. They will want to know what is happening. They are entitled to know what is happening.

5.82 I accept that there are issues about the extent to which it is possible to be fully transparent about ongoing enforcement activity. But, as one witnesses

said, charging decisions are made public, why not the fact of enforcement activity?

5.83 The answer at the moment lies partly in the fact that CQC are prohibited from sharing details of current enforcement activity with service users or their families. I was told that the Department of Health and Social Care have recently declined CQC's request for this to change. There was a strong feeling amongst some of my senior CQC interlocutors that this was an example where the current regulatory requirements did not get the balance between the interests of providers and those of service users' rights.

5.84 Finally, the CQC lead on this strand of work acknowledged that communication with victims and kin could be challenging, not least because the complexities of both civil and criminal investigation mean progress can appear very slow to those awaiting action. Managing victims' expectations can be difficult. It was often difficult for victims to understand that there will not always be a prosecution even when something appears to have gone wrong. CQC acknowledged to me that inspectors needed to be properly trained so they had the confidence to have these difficult conversations.

Recommendation 10 – Representations

1.23 CQC should establish a dedicated resource to consider representations from providers.

5.85 Civil enforcement was not faultless in this case. There were what I regard as comparatively minor glitches. But ultimately it was civil action which led to the closure of 14 Colne Road. And it did so considerably before any criminal process could possibly have been concluded. It is important to remember this important conclusion when considering the issues around criminal enforcement in this case

5.86 I have spoken of two periods when there appears to have been a loss of momentum in the enforcement processes. The first was over the spring and summer of 2016. What happened?

5.87 CQC pursued a twin track approach to civil enforcement in relation to 14 Colne Road. They issued Notices of Decision to impose conditions intended to try and to facilitate improvements in the service. But to guard against the

possibility that satisfactory improvements were not forthcoming, they also pursued, in parallel, a Notice of Proposal to close the location. This was a good and sensible way of proceeding. As Hillgreen's compliance with the improvements processes deteriorated, the proposal to close came to the fore.

5.88 The Notice of Proposal to close 14 Colne Road was issued on 12 February 2016. Hillgreen responded with formal representations on 11 March 2016. As was the practice at the time, consideration of those representations was passed to a Head of Inspection from another area. This was intended to ensure they were considered by an independent mind with no preconceived ideas about the service or the provider.

5.89 Consideration of representations can be time consuming. To state the obvious it is essential that it is done properly and expeditiously: people's safety is at stake; so too businesses and users' homes. I heard evidence that, at the time Hillgreen's representations were received, there was a significant backlog of over seventy such representations, divided up between the thirteen Heads of Inspection in ASC. No protected time was given to deal with the representations.

5.90 Hillgreen's representations were allocated on 11 April 2016. The Head of Inspection in this case saw that service users were no longer at risk at 14 Colne Road and gave priority to other, more immediately risky locations. As with every person I met who had faced these sort of difficult prioritisation decisions, safety came first. Rightly so, in my judgment.

5.91 What is clear is that the steady growth in enforcement activity made this model unsustainable. CQC have recognised this. A new centralized system is being delivered as a high priority by the Enforcement Oversight Board (EOB).

5.92 I heard that early evidence from the working of this central representations team has both cleared a backlog of 84 cases and has made substantial progress towards reaching the policy turnaround time of 20 working days[12]. This represents a significant improvement on the approach applied to the Hillgreen representations. CQC must monitor this performance

[12] I was told the team are currently running a case completion date of 30 days (delays often occur because the Provider has submitted a factual accuracy challenge or because there is to be a return inspection in a short period of time and this might lead to changes and the representations being withdrawn).

to establish whether the team should become a permanent change to the process.

Recommendation 11 - Criminal enforcement

1.24 CQC need to keep closely under review their evolving approach to criminal enforcement.

5.93 This is an area where there are (at least) 2 different possible approaches towards improving the CQC's performance in this area. CQC has adopted one of those approaches, arguably after having had some limited but unsatisfactory experience with the other. I deal with this in more detail below.

5.94 CQC acquired their additional powers of prosecution in April 2015, some seven months before the incident. It is difficult to conclude from the evidence I heard that they were ready although (as I note in paragraphs 4.63 & 5.5-5.11 above) the context of all the other policy and organisational changes occurring at the same time is relevant to understanding this stated lack of readiness.

5.95 For ease of reference, I note here the three relevant offences under regulation 12 Safe care and treatment, regulation 13 Safeguarding service users from abuse and improper treatment, and regulation 20 Duty of candour; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[13].

5.96 Given my terms of reference, I have not examined why CQC were not better prepared in April 2015. Rather I look at lessons to be drawn from the criminal enforcement activity following the incident, focusing in particular on the work that has been going on since then to place criminal enforcement on a much more sound footing. In part this work was already under way but the incident and its aftermath have undoubtedly been a catalyst for very substantial change and progress.

5.97 For the moment, however, I turn briefly first to what emerged in evidence from the incident and its aftermath. As guided by my terms of reference, this is primarily what guides my thinking on the overall direction CQC are taking.

[13] CQC Enforcement Policy document dated February 2015 provides a helpful list in Table 2 of the regulations for which breaches constitute criminal offences. http://www.cqc.org.uk/sites/default/files/20150209_enforcement_policy_v1-1.pdf

5.98 It was a failure to prosecute anyone apparently responsible for 14 Colne Road which was at the heart of the newspaper report of an alleged cover-up by the CQC. I have rejected the notion of a cover-up as completely without foundation. It is nonsense.

5. 99 But that is not to say the consideration of possible criminal enforcement was straightforward or faultless. Indeed given the lack of preparedness for the new powers it would have been surprising if it had been.

5.100 What were the main problems?

5.101 First there was a lengthy wait for the police to decide to do nothing about any suggestion of wilful neglect by Hillgreen. This was also during the period of civil enforcement activity, a point relevant to the CQC's current focus on retaining prosecution responsibilities in the hands of those inspectors who are also charged with civil enforcement. Each is time-consuming; both, heavily so. Even with additional support from Evidence Review Officers (see paragraph 115 below), running both in parallel will take substantial time for those inspectors and teams involved. CQC workloads need to allow for this.

5.102 Second there was uncertainty about what to do until the CPS concluded that there was to be no prosecution of P over the incident itself. Problems lingered even after the CPS decision. Absent a conviction of P there was a continuing concern about difficulties of proving abuse for the purpose of establishing a breach of Regulation 13: failing to protect from abuse.

5.103 Finally, after much preliminary work gathering evidence, there was an undoubted loss of momentum as competing priorities consumed the CQC's limited legal resources.

5.104 Touching first on the most straightforward issue, there was undoubted confusion about which prosecuting authority – the police or CQC – had the lead and on what. In the jargon, primacy. Who had the lead? I deal with this separately in **Recommendation 13** (paragraphs 5.119 – 5.122 below).

5.105 The concern, that absent a conviction of P, there was no probative evidence of abuse was eventually resolved, as it always should have been, by quick, straightforward legal advice. I return to legal advice below (paragraph 5.115 and **Recommendation 14** paragraphs 5.123 – 5.126 below)

5.106 As to the rest, the issue about which approach to the management of criminal enforcement should be adopted (para 5.93 above) is whether criminal enforcement is better left in the hands of the inspectors responsible for those failing services (with appropriate support) or better passed to specialist enforcement inspectors.

5.107 There was a strong and consistent message from many of those I interviewed, up to and including some Heads of Inspection that criminal enforcement might be better dealt with by specialist enforcement inspectors. It is too complex. It is incredibly time-consuming. It requires too much engagement with scarce and, in the past, occasionally unhelpful legal resources. It doesn't arise often enough to put training into regular practice. Initially I found these arguments convincing.

5.108 To some extent my witnesses also acknowledged that their discomfort in handling prosecutions had been compounded by what many felt was the precipitate reaction of CQC to the initial media reports.

5.109 I have seen something of the work involved in criminal enforcement. There is much that resonates in these concerns. Inspectors are hard pressed but there is a rhythm to their work which enables them to keep people safe and help improve care. That rhythm is at a completely different pace from prosecution work which requires intensive, concentrated, lengthy focus on a single service. Even as prosecutions increase, there will likely be too few to enable training to be put into immediate effect.

5.110 Some expressed concerns that their role, focusing primarily on improvement, meant it was important to work constructively with providers as far as possible. They felt this was difficult if they had responsibility for criminal enforcement. This was, to my mind, part of the cultural or behavioural mind-set I encountered: we joined CQC to improve care not to punish. (see paragraphs 5.10 – 5.12 above – preliminary remarks).

5.111 I make two points about this particular concern.

5.112 First, the same witnesses accept they should have control of civil enforcement. Yet, as the instant case clearly demonstrates and notwithstanding the apparent outrage of those who write headline-grabbing articles, civil enforcement is *highly effective*; it is highly effective making

service users safe; it is highly effective closing down services; and it is highly effective closing down those services far more quickly than even the most vigorously expedited prosecution could hope to do. 14 Colne Road was closed several months before the CPS reached their decision on the incident itself, a decision frankly much less complex in my opinion than a decision on the prosecution of a provider under the regulations.

5.113 Second, it is important for CQC not only to acknowledge this cultural issue exists (as CQC senior managers do) but to address it carefully in training and in implementing the changes which have been agreed to the enforcement function (in particular the criminal enforcement).

5.114 The new approach does away with the role of enforcement inspectors, and indeed I heard other evidence that this model had not provided confidence or consistency of approach across the regions in which they were deployed. Instead, criminal enforcement, as with civil enforcement, will rest with the inspecting inspectors and their inspection line management. It is self-evident that "investigation" and evidence-gathering are essential ingredients of an inspector's role. From this it follows, that enforcement of breaches should be an integral part of their function, and this includes both civil and criminal enforcement. There is evidence that, from a relatively low base in 2015, criminal enforcement in terms of both investigations and prosecutions has continued to grow within CQC[14].

5.115 I heard evidence about the support personnel and processes which CQC has been delivering following Hillgreen to ensure that inspectors have the skills and confidence needed (together with management oversight and legal support) to deliver the full range of enforcement actions, both civil and criminal. This was assisted by a significant restructure of legal services and the creation of dedicated legal support for, and management of, the criminal prosecutions work. Case Management Review Panels in operation since late 2017, the addition of 10 Enforcement Review Officers (being recruited in May/June 2018) to assist with the burdens of disclosure etc., and the training now being made available to inspectors, all indicate that CQC have addressed the defects in their approach at the time of the incident[15]. There is more still to do (see for example **Recommendation 13** below).

[14] By June 2018 I was told that there are, for example, 247 live Regulation 12 investigations within the Legal Services team case management system

[15] I am aware that the Executive Team had a seminar (March 2018) on CQC's role as a prosecutor and regulator at which 3 priorities for further action were identified

Recommendation 12 - Criminal enforcement – legacy issues.

1.25 CQC should consider whether the legacy from their lack of preparedness to use their powers of prosecution when newly acquired in 2015 has been properly examined to identify incidents which should be considered against current prosecution criteria.

5.116 I heard much evidence of the lack of preparedness by CQC for the transfer of prosecution powers from HSE in April 2015, although I note that there was, by June 2015, a specific legal advice note to assist inspectors in dealing with specific incident reports post 1 April 2015. Senor officials at CQC recognized the comments from inspectors and inspection managers about, for example, the lack of training which was provided. I heard varying views on the exact extent of this lack of readiness and I am aware that CQC have not only put in place sensible systems now, but have also looked at some of the lingering legacy issues from that period.

5.117 As far as my terms of reference are concerned, such lack of preparedness played a part in what happened; if the inspectors had been better trained they might well have been more sure-footed. But resources were a bigger issue for 14 Colne Road.

5.118 As I have noted I heard statements that in April 2015 CQC was unprepared to some extent for the new powers and responsibilities. One particular claim related to consideration of the notifications received from the HSE under their RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) notifications in the first 6 months from April 2015. However, I found no evidence to suggest that the way those reports were assessed was any different from the way CQC assess them now. They state “We assess the information in the same way that we do for information obtained from any other source, carrying out initial enquiries such as contacting the provider, reviewing information that we already hold (inspection reports or notifications) or contacting other stakeholders (CCGs, Police, Local Authorities) where necessary. Our Inspectors then apply the enforcement decision tree to determine the most appropriate action to take.” CQC (through the EOB) will, nevertheless, wish to reflect on whether they need to consider whether any other possible legacy issues remain.

Recommendation 13 - Primacy in investigations

1.25 CQC should establish a protocol with the National Police Chiefs' Council (NPCC) and any other relevant prosecuting authorities to ensure clarity about who is the lead prosecutor for offences which CQC can prosecute.

5.119 Why is establishing who leads on what important?

5.120 It would help clarify for the benefit of the police what offences and powers CQC have. The inspector in charge of 14 Colne Road told me "the police do not understand the work CQC does as a regulator". This was despite "several meetings with them to explain this".

5. 120 CQC have a narrower range of both offences and powers. One of the complicating factors in this case, for example, was the possibility of a charge of wilful neglect. This is not an offence which CQC can prosecute. I was told, however, the police seemed initially unaware of this possible offence and it appeared to CQC to play no part in the early police investigation. It was raised by CQC with the police who, eventually, decided not to prosecute. But whilst this matter was with the police, the CQC could do very little given the overlap with offences which they could prosecute.

5.121 Also if, as in this case, a potentially serious crime may be at the heart of matter, the police will tend to dominate. I was told by the inspector involved with 14 Colne Road that "inspectors are very cautious about treading on police toes". The police involvement at that time was one of the factors which deterred the inspector from either referring explicitly to the incident in her report or from initially pursuing possible regulatory offences. Clarity would enable CQC more easily to assert primacy when needs be.

5.122 I was told that the National Enforcement Oversight Lawyer has responsibility for negotiating a Memorandum of Understanding with the National Police Chiefs' Council covering these issues. CQC need to ensure that this MOU is concluded swiftly.

Recommendation 14 - Legal resources

1.26 In the light of apparent capacity, capability, recruitment and retention concerns, CQC should consider reviewing the strength and grading of their legal resources available to assist and guide enforcement activities.

5. 123 I make this recommendation with some degree of tentativeness. A lawyer recommending more, better paid, lawyers is not necessarily an attractive proposition. All the more so at a time of serious funding constraints when many might, quite cogently, argue that resources should be focused on front line staff whose job it is to make people safe.

5. 124 I preface this tentative recommendation by noting the recent restructure and change in focus of the legal team at CQC. This has been widely welcomed. Also because CQC has not yet reached a "steady state" in terms of its prosecution case load, it is not yet possible to be sure what the long-term legal resource requirement is. It is clear that the team continue to experience pressures meaning that work is not turned around as quickly as it should.

5.125 Separately from the numbers but part of the problem in terms of resourcing, is the issue of grade compression and pay competition with other public service legal teams inherited from the previous structure. The grade compression means both that Legal Managers, who manage Senior Lawyers are the same grade. This combination of pay banding and competition issues is not sustainable in the long term, for recruitment or retention.

5.126 I was told that CQCs People Directorate is currently exploring the issue of reward and retention within CQC, and I express my tentative recommendation that these specific difficulties in the Legal service be examined.

Chapter 6 Postscript

6.1 Sir Paul Jenkins QC was appointed in September 2017 to investigate and report to the Care Quality Commission Board on the Commission's regulation of 14 Colne Road, London and to make recommendations.

6.2 By the time of his sad and untimely death in February 2018 Sir Paul had conducted interviews, had met the mother of P, held numerous other conversations with staff of CQC, and had written in draft the vast majority of

the report which follows. He had also written to the Chair and Chief Executive of CQC in December 2017 (aware of his forthcoming hospitalisation) stating, among other conclusions, that "My first conclusion is that there is no evidence whatsoever of any cover-up of the sort alleged by the Times or otherwise"

6.3 Having worked with him over a number of years and, being similarly independent of CQC, I agreed to complete the remaining 2 interviews he had planned (one, a second interview) and to conclude the investigation and report under his terms of reference.

6.4 The public interest in concluding this investigation and report expeditiously in the current circumstances seemed, to me and to those who commissioned me at CQC, to outweigh the interest in restarting the whole exercise afresh, with the associated further substantial delay and duplication of interviewing work that this would have entailed.

6.5 I have seen documents which were not available to Sir Paul before February 2018 (in particular the Enfield Safeguarding Adults Board "Safeguarding Adults Review" March 2018) and I have pursued the enquiries he indicated were to be the subject of further investigation, in particular further actions CQC has taken in light of their own internal review of their handling of 14 Colne Road since December 2017.

6.6 I reiterate the thanks Sir Paul gives to all those who assisted in the preparation of this report through interviews, the supply of documents etc. and in particular, to Vince Ricot who continued to support me with the same "diligence, professionalism and all-round cheerfulness". Finally, I am also very grateful to Sir Paul for the typically logical and thorough way in which he carried out his investigation. This made completion of his work simpler than I feared. He is much missed, not least for his wisdom and compassion.

David Noble QSO **June 2018**

Annex: Terms of Reference

1) To investigate and report to the Board of the Care Quality Commission ("CQC") on CQC's regulation of 14 Colne Road Care Home, as operated by Hillgreen Care Ltd., from 1st November 2015 including:

a) CQC's inspection processes and reports in relation to 14 Colne Road (including, if necessary before 1st November 2015) and its liaison with

other public authorities in connection with relevant inspection findings;

b) the application of CQC's enforcement policies and procedures in relation to its regulation of 14 Colne Road, including in relation to prosecution;

c) management oversight, regulatory risk escalation and decision making at CQC in connection with 14 Colne Road and Hillgreen Care Ltd. Where relevant to 14 Colne Road;

d) the application of CQC's relevant governance systems in connection with 14 Colne Road and Hillgreen Care Ltd.

2) To make recommendations to CQC's Board in relation to any areas for change, improvement or development identified in the course of the investigation including, in particular, in relation to regulatory risk management.