IN THE UPPER TRIBUNAL **Appeal No. UA-2023-001326-V**
ADMINISTRATIVE APPEALS CHAMBER **[2024] UKUT 286 (AAC)**
ON APPEAL FROM:
Appellant: JLA
Respondent: Disclosure and Barring Service

Between:

JLA

Appellant

- v –

DISCLOSURE AND BARRING SERVICE

Respondent

Before: **Upper Tribunal Judge Rupert Jones**
Tribunal Member John Hutchinson
Tribunal Member Josephine Heggie

Hearing date: 22 July 2024
Decision date: 12 September 2024

Representation:
Appellant: Appeared in person
Respondent: Remi Reichhold, Counsel instructed by DLA Piper on behalf of the DBS

DECISION

The decision of the Upper Tribunal is to allow the appeal of the Appellant.

The decision of the Disclosure and Barring Service taken on 6 June 2023 to include the Appellant's name on the Adults' Barred List was based upon material mistakes in findings of fact in relation to the first finding of relevant conduct and a mistake on a point of law in relation to the second finding of relevant conduct. The decision of the DBS is therefore remitted for a new decision under section 4(6)(b) of the Safeguarding Vulnerable Groups Act 2006 based upon the findings we have made for the purposes of section 4(7)(a). The Appellant is to remain on the list pending the fresh decision being made pursuant to section 4(7)(b) of the Act.

The Upper Tribunal makes anonymity orders directing that there is to be no publication of any matter or disclosure of any documents likely to lead

members of the public directly or indirectly to identify the Appellant, witnesses, complainants or any person who has been involved in the circumstances giving rise to this appeal. The anonymity order and directions are made rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008.

Introduction

1. The Appellant (also referred to as 'JLA') appeals to the Upper Tribunal against the decision of the Respondent (the Disclosure and Barring Service or 'DBS') dated 6 June 2023 to include her name on the vulnerable Adults' Barred List ('ABL') pursuant to paragraph 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 ("the Act").

2. Permission to appeal to the Upper Tribunal ('UT') was granted by the Judge on 14 February 2024 in respect of the grounds raised by the Appellant in the notice of appeal. In summary, the grounds of appeal were that each of the findings that the Appellant committed relevant conduct were based on mistakes of fact. The UT Judge also granted permission on a ground of appeal that there was an arguable mistake of law – the DBS made an irrational and / or disproportionate decision to bar the Appellant from working with vulnerable adults.

3. The Tribunal held a in-person oral hearing of the appeal at Leeds Tribunal centre on 22 July 2024. The Appellant appeared and participated in person by giving oral evidence and making submissions.

4. The Respondent (the DBS) was represented at the hearing by Remi Reichhold of counsel. We are grateful to him and the Appellant for the quality of their written and oral submissions.

Rule 14 Anonymity Orders and directions

5. In a letter dated 21 October 2023 from its legal representatives, DLA Piper, the DBS made an application for various orders under Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008 ('the UT Rules'). The Appellant consented to and supported that application at the outset of the hearing.

6. The Tribunal made the following orders at the beginning of the hearing for the following reasons.

7. We made an order that there is to be no publication of any matter likely to lead members of the public directly or indirectly to identify the Appellant or any person who had been involved in the circumstances giving rise to this appeal (witnesses or complainants) pursuant to rule 14(1)(b) of the Tribunal Procedure (Upper Tribunal) Rules 2008. We were satisfied that the Appellant, should not be identified, directly by name or indirectly, in this decision but referred to as 'JLA' (or 'the Appellant'). Having regard to the interests of justice, what is just and fair and in accordance with the

overriding objective, and the individuals' right to privacy under Article 8 of the Convention, we were satisfied that it was proportionate to make such an order and give such a direction.

8. Identifying the Appellant herself may also lead to the identification of any complainants or witnesses who are either vulnerable themselves or have an expectation of privacy. Revealing the identity of any of the witnesses or complainants to the public would be likely to cause the complainants and the witnesses (residents, carers, healthcare assistants or nurses in residential care homes) emotional or psychological harm as they themselves were vulnerable, the potential victims of harmful conduct, or they had an expectation of privacy. The Appellant has not been prejudiced by anonymising the witnesses – she has been aware of their identities throughout and has been able to identify them to answer their evidence and allegations.

9. Identifying the Appellant may lead to the identification of all the parties, complainants and witnesses who are to be anonymised / not identified by virtue of the other orders being made and who may otherwise be identified or linked to the Appellant by virtue of the evidence in the case.

10. Further, the Appellant is the subject of misconduct allegations which took place in a care home. We are satisfied that identifying her at this stage may lead to serious and disproportionate harm to her reputation and employment prospects (an interference with the right to private life under article 8 of the ECHR) when the barring decision of the Respondent is not published generally to the world. There is an expectation of privacy and legal prohibition that the name and identity of the Appellant as appearing on a barred list (and whomever is included on the barred lists) is not publicised to the world or generally (but is known by the Appellant, the DBS, and any other party who may seek to conduct a DBS check upon her eg. a prospective or current employer).

11. We rely on the further reasons explained in *R (SXM) v Disclosure and Barring Service* [2020] EWHC 624 (Admin), [2020] 1 WLR 3259. In that case the victim wanted to know the outcome of the referral to DBS. The Administrative Court held: (a) disclosure was not consistent with the statutory structure; (b) refusing to disclose was neither unreasonable nor disproportionate; and (c) there was no positive obligation to disclose under the Article 8 Convention right. The public interest in the protection and safeguarding of vulnerable groups is sufficiently protected by the barring decision itself and identification of the Appellant's name only to prospective employers or those otherwise entitled to obtain information regarding him from the DBS.

12. We therefore make an order prohibiting the disclosure of any information that would be likely to identify the Appellant, complainants or witnesses in the terms set out in the letter on behalf of the DBS dated 21 October 2023.

13. We also make an order under rule 14(1)(a) that no documents or information should be disclosed in relation to these proceedings that would tend to identify the Appellant or any person who had been involved in the circumstances giving rise to this appeal. Any documents sought to be disclosed would need to be redacted for identifying information as specified in the letter dated 21 October 2023.

14. We make a further order under rule 14(1)(b) and (2) prohibiting the publication or disclosure of any information or document which may lead members of the public to identify any of the individuals (witnesses and complainants) relied on in the Respondent's bundle of evidence and the Appellant herself. Identifying the Appellant herself may also lead to the identification of any complainants or witnesses. The individuals listed in the Respondent's bundle of evidence are to be referred to in the manner set out within the letter dated 21 October 2023.

The Background

15. In broad summary, the background is as follows (page references in square brackets, [], are references to the hearing bundle prepared by the DBS).

16. The Appellant is a 39-year-old woman. At the material time, she was working as a Senior Care Assistant, providing support for vulnerable adults at a private care provider ("the Employer") which operated at least one residential care home. The Appellant states that she had over 17 years of experience in the care sector [5] [14].

17. The Appellant started work for the Employer in May 2020 [5], initially as a (bank) care assistant [51]. In around 2021, the Appellant became a Senior Care Assistant [5] and [60].

18. The Employer's referral to DBS arose, primarily, out of concerns about the care provided (or not provided) to a service user ("X") during the night of 18-19 September 2022.

19. X was a recently-admitted resident at one the Employer's care homes. X was 78 years old at the time, with various long-term conditions [73]-[75]. Notably, X had a catheter and her Care Plan stipulated that she needed regular assistance for associated continence issues [84].

20. The Appellant was subject to the Employer's disciplinary procedure, which encompassed an initial investigation meeting with the Appellant [121]-[124] and five of her colleagues [104-120]. A second investigation meeting was held with the Appellant to put allegations to her which had been made by some of her colleagues [125]-[127].

21. On 30 September 2022, the Employer invited the Appellant to attend a disciplinary hearing, which she did not attend [182]. On 4 October 2022, the

Employer rescheduled the hearing [184], but again the Appellant did not attend [100].

22. The Employer concluded that (among other things) the Appellant had failed, during the night shift of 18-19 September 2022, to take necessary action after having been made aware that X had cut her catheter tube ("the Catheter Incident"). The Employer found the Appellant to have committed gross misconduct and dismissed her with immediate effect [98]-[99].

23. The Appellant had, previously in August 2021, been issued with a formal written warning in relation to breaching the Employer's social media policy (by taking a photo with a TV celebrity visiting the home and posting it to social media) and its PPE (personal protective equipment) policy, having had her mask removed when the photo was taken [128].

24. On 24 October 2022, the Employer referred the Appellant to the DBS [41]-[48].

The Barring Process

25. On 19 November 2022, DBS sent the Appellant an "early warning" letter [29]-[31]. The Appellant wrote to DBS on 20 January 2023, stating that "I have just received a clear DBS for a job I applied for last" and asked about "time scales" of DBS's enquiries [33].

26. On 20 March 2023, DBS sent the Appellant a "Minded to bar" letter [34] with attachments [40]. The Appellant did not make any representations to DBS.

The Respondent's barring decision dated 6 June 2023

27. The Final Decision Letter from the Respondent dated 6 June 2023 notified the Appellant that it was including her on the Adults' Barred List.

Findings of Relevant Conduct

28. The Final Decision letter [139] states that, upon consideration of all the available information, the DBS was satisfied that:

> "On 18 September 2022 you failed to contact the District Nurse Team and report that a service user ([X], aged 78) had cut her catheter tube as per care plan guidance, and following the service user reporting that she felt like her bladder was burning and was in pain, you failed to take any action in response to this concern.
>
> On a date leading up to 6 July 2021 you breached PPE policy by removing your facemask to take a photo with a visitor outside of the home."

29. The DBS concluded that both of these findings amounted to "relevant conduct" within the meaning of the Act which "endangered a vulnerable

adult or was likely to endanger a vulnerable adult". The allegations of relevant conduct were both found proven.

30. The DBS also explained why it was satisfied that in all the circumstances a barring decision - to include her on the Adults' Barred List - was appropriate and proportionate [139]. The Appellant did not exercise her right to ask DBS to review its decision.

The Final Decision Letter

31. The two findings of relevant conduct made by the DBS are as summarised above. The letter set out the following details specifically:

"…

- On 18 September 2022 you failed to contact the District Nurse Team and report that a service user (..[X].., aged 78) had cut her catheter tube as per care plan guidance, and following the service user reporting that she felt like her bladder was burning and was in pain, you failed to take any action in response to this concern.

- On a date leading up to 6 July 2021 you breached PPE policy by removing your facemask to take a photo with a visitor outside of the home.

Having considered this, DBS is satisfied you engaged in relevant conduct in relation to vulnerable adults. This is because you have engaged in conduct which endangered a vulnerable adult or was likely to endanger a vulnerable adult.

We are satisfied a barring decision is appropriate. This is because we are of the view that you failed to realise the seriousness of a situation where a service user had cut their catheter, where you failed to take the appropriate action of reporting the incident to the district nurse, when it was your responsibility as the senior on shift to do so. You failed to read the care plan, despite this being part of your role to do so, with the care plan providing clear instructions on what to do if there were issues with the service users catheter. The actions you instead instructed a member of staff to carry out resulted in the service user's bed becoming wet and requiring changing regularly.

One of the reasons given as to why you failed to call the District Nurse for support was that you couldn't be bothered to wait for them, thereby showing a lack of care for the service user, and failure to place their needs above that of your own. You also failed to take any action when it was reported to you that the service user was in pain, stating this had previously been reported on a previous occasion. However, this shows a lack of concern for how they were currently feeling at that time.

As a result of your lack of action this placed the service user at risk of potential infection and suffering abdominal pain. It is acknowledged that you had extensive previous experience in caring roles with no known previous concerns, and acknowledged on reflection that you should have contacted the District Nurses immediately.

However, you reasoned that you did not know how to deal with the situation as it was a bank holiday, however the District Nurse Team were available 24 hours a

day, and you failed to take any action to ensure the appropriate support could be provided to the service user. You admitted that you had failed to read the service users care plan, stating you didn't have time to as they had only come into the service a few days prior. However, it was part of your role to do this so that you were aware of the service users care requirements.

Had you read this you would have seen clear guidance that any issues concerning the catheter should be reported by the senior on shift, which was yourself, to the District Nurse.

Had you followed this guidance in place this would have ensured the service users' needs were met in a timely manner, with the District Nurse only contacted when your colleague commenced their shift the following morning. The actions you instructed a staff member to take resulted in the service users bed becoming wet and requiring changing, and placed the service user at risk of physical and emotional harm. We are satisfied that it is likely that if you were to be in a Regulated Activity position with vulnerable adults you would fail to read care plans in a timely manner, leaving you without the full knowledge of their care requirements. We are satisfied that it is likely that you would fail to correctly assess the seriousness of a situation, would fail to act upon concerns raised that a service user was in pain, and would fail to access/provide the required support for a service user. A repetition of this conduct is assessed as an unacceptable risk of physical and/or emotional harm to vulnerable adults that cannot be ignored.
…"

32. On 6 June 2023, DBS sent its "Final Decision" letter to the Appellant, notifying her of its decision that it was appropriate and proportionate to include her in the ABL. The Appellant was also informed that she could ask for permission to make late representations to DBS.

33. She did not do so [138] (albeit the Appellant's letter to the UT dated 11 August 2023 refers to making "late representation" [14]).

34. On 22 August 2023, the UT received a letter from the Appellant, purporting to "request […] permission to make late representation" about DBS's decision [14-16].

The appeal to the Tribunal

35. It is understood that the Appellant was advised to complete and return a UT10 Form (a Notice of Appeal), which was filed on 14 September 2023 (8 days after expiry of the 3-month time limit for appeal under r.21(3) of the UT Rules) [2] [214].

36. On 16 February 2024, the UT Judge extended time for the late appeal and admitted the Appellant's Notice of Appeal and application for permission to appeal pursuant to r.5(3)(a) and r.21(6) of the UT Rules [214].

37. The UT Judge granted the Appellant permission to appeal on two grounds:

> a. "…that there were mistakes of fact in the DBS Decision for the reasons outlined"; and
>
> b. "…there being a mistake of law: –
> i) that the decision to bar the Appellant was disproportionate and / or;
> ii) the decision that the Appellant presented a risk of committing relevant conduct in the future was based on a mistake of fact or was irrational or unreasonable." [214]

Appellant's Grounds of Appeal

38. In her Grounds of Appeal (the "Reasons for Appealing" section enclosed within her notice of appeal), the Appellant submitted that the barring decision was based on material mistakes of fact or mistakes of law (the decision was irrational and/or disproportionate which amounts to an error of law). She stated:

> 'I had been working in the Care industry with vulnerable adults for over 17 years at the time of this investigation and I have an unblemished record. I have worked in a number of roles and for various companies, all of which I have done with the upmost pride and professionalism which I am sure any of my previous employers will confirm.
>
> I was employed by [the Employer] in May 2020 as a Carer (bank Staff) and was then asked If I wanted the role as Senior Care Assistant in 2021. I declined at the time as I didn't want the responsibility however the manager asked if I could take on the role part time until they found someone to fill the role which I agreed to. The role was never filled and after a period of time, HR advised that I would have to come off being Bank Staff and be contracted to the role of Senior for [the Employer]. I was never asked to complete any form of application form. I was taken by my manager [S] and advised I would need to interview but she stated she would fill out the paperwork so it didn't matter and no interview was ever completed.
>
> I carried on in the role for several months and despite numerous requests for training in various areas, including Care Plans I was never given any formal training in the role of Senior. I requested training also as part of my yearly appraisal and again although this was promised, it never happened. I was told by my manager that she would personally complete some Care Plan training with me but against despite several requests this never happened.
>
> The allegation on the 18th September related to me not contacting the District Nurse Team regarding a service users catheter tube being cut are not as have been stated. On the night in question I was working along with another Senior Carer, [LS], who had been asked to come in specifically to work on Care Plans as I had not been trained to do them. Following the incident with regards the catheter, I spoke with [LS] and asked her advice on what I should do as the following day was

a bank holiday and I wanted to check that services were the same as on a normal day. [LS] advised me to "leave it until morning" to contact the District Nurse as they wouldn't come out at that time and that it was extremely busy. [LS] had been a senior for much longer than myself and was fully trained and therefore I took her advice. On reflection, I now see that I should have made the call at the time to the District Nurse however I took the word of a more experienced colleague which again on reflection was naive of me.

On nights, working for [the Employer] I had two buildings to cover with approximately 83 residents, many with challenging behaviour. Every other team had two Seniors, however due to staffing issues I was always on my own covering the two buildings with very limited staff. In view of this and the fact that the service user had only been with us a couple of days I had not had chance to read her Care Plan. The amount of work was unmanageable and despite this being told to management on numerous occasions, this issue was never addressed. I spent most of my time having to cover the floor assisting staff with care needs due to the majority being agency staff and not knowing the job which more often than not took me away from my Senior role.

It is stated that it was my role to read service user Care Plans, but I would like to again re-iterate that I had no formal training of any kind for my role as Senior and no training on Care Plans. On the night in question, another Senior was working additional hours updating and reading Care Plan and that Senior advised me to leave the call until morning.

The allegation that I "couldn't be bothered" is completely untrue. The member of staff who alleged this had also made allegations that I was asleep when on duty which let to an internal investigation and was found to be untrue and evidence proved this. I would therefore suggest that this member of staff is untrustworthy and has been proven to be a liar. I have worked in a care role for many years and I disagree strongly that I would ever put my own needs above any service user and show a lack of care.

Whereas on reflection I should have contacted the District Nurse immediately, I feel a lack of training, unmanageable workload and naively taking advice from another Senior more experienced than me are the reasons why this didn't happen, not because I showed a lack of care or neglect to a Service User.

With regards the allegation from the 6th July 2021. This incident was dealt with at the time internally by the company where I was given a written warning. My PPE was removed whilst on my unpaid break whilst having a cigarette and was outside in the staff car park.

As I hope you can appreciate, these allegations have caused me significant upset. I am no longer in a role which I have done for 17 years with no Issues and which I pride myself on as giving everything to the sector. I have a passion for care work and the fact that I can no longer do this has had a massive impact on my life. I am still on medication as a result of the actions and allegations made by [the Employer] and have suffered significant financial issues being out of work because of the impact.

At this time because of what has happened I have no intension of going back into the Care Sector however I would like there to be that opportunity for me maybe

some time in the future as Care work has been a big part of my life for so long and something that I am extremely good and passionate about.

I respectfully request that you consider allowing me permission to make representations against the allegations as documented above.'

The evidence in the appeal

39. The DBS relied on written evidence from witnesses and notes or transcripts of interviews contained in the bundle of evidence it filed and served which contained 225 pages. It included all the evidence relied upon by the DBS in making the barring decision and in defending the appeal as well as the material provided by the Appellant.

40. The witnesses relied on by the DBS included those from the Employer, and colleagues or managers from the care home JLA worked in at the relevant time together with the record of interviews conducted by the Employer with JLA and statements taken from her colleagues.

41. As we note below, none of the witnesses on behalf of the DBS made formal witness statements containing statements of truth, nor gave oral evidence nor were cross examined. Their evidence was therefore untested hearsay. This is a matter to take into account when considering its reliability and the weight it is to be given.

42. The Appellant relied upon her written submissions and notice of appeal sent to the DBS and oral evidence given to the Tribunal as well as the interviews she had with the Employer.

43. It goes without saying that all subsequent written and oral evidence of the Appellant was not available to the DBS when making its barring decision.

44. The relevant evidence [with paragraph numbers and page numbers in square brackets] is referred to in the discussion section below. Therein, we make findings of fact and draw conclusions based upon it.

The Appellant's oral evidence

45. The Appellant gave evidence in chief in response to questions from the Tribunal and was cross examined by Mr Reichhold in relation to all of her evidence. He suggested that both of the findings of relevant conduct did not contain mistakes of fact and there was no mistake of fact in any of the matter relied upon in the DBS barring decision. He put the relevant pieces of documentary evidence to the Appellant and suggested her account was neither reliable nor truthful. The Appellant denied the allegations of relevant conduct in material respects - to the extent that they were based on all material facts found in the Final Decision Letter.

46. Again, we make findings of fact in relation to this evidence and give our reasons in the discussion section below. In summary, we have come to the conclusion and find that the Appellant's oral evidence was substantially reliable and credible for the reasons we give within the discussion section below.

Law

47. The full relevant statutory provisions and authorities are set out in the Appendix to this decision. Therefore, we only draw attention to the most relevant law at this stage.

48. There are, broadly speaking, three separate ways under Part 1 of Schedule 3 to the Act in which a person may be included in the Children's Barred List ('CBL') or ABL, which can generally be described as: (a) Autobar (for Automatic Barring Offences), (b) Autobar (for Automatic Inclusion Offences) and (c) Discretionary or non-automatic barring.

49. The third category applies in this case. The appeal concerns discretionary barring where a person does not meet the prescribed criteria (has not been convicted of specified criminal offences), but paragraphs 3 and 9 of Schedule 3 to the Act applies.

50. Paragraphs 3 and 9 of Schedule 3 to the Act, set out the provisions in relation to inclusion on the CBL or ABL. They provide that, following an opportunity for and consideration of representations, DBS "must" include a person on the List if: (i) it is satisfied that they have "engaged in relevant conduct"; (ii) it has reason to believe that they have been (or might in future) be "engaged in regulated activity relating to children/vulnerable adults"; and (iii) it is satisfied that it is "appropriate" to include them.

51. Therefore, pursuant paragraph 3(3) or 9(3) of Schedule 3, the DBS must include the person in the children's or adults' barred lists if:
(a) it is satisfied that the person has engaged in relevant conduct, and
(aa) it has reason to believe that the person is or has been or might in future be, engaged in regulated activity relating to children / vulnerable adults, and
(b) it is satisfied that it is appropriate to include the person in the list.

52. An activity is a "regulated activity relating to children" for the purposes of paragraph 2(8)(b) of Schedule 3 if it falls within one of the subparagraphs in paragraph 1 of Schedule 4 to the Act; that provision broadly defines "regulated activity" and includes, in relation to children, "any form of teaching, training or instruction of children, unless the teaching, training or instruction is merely incidental to teaching, training or instruction of persons who are not children". An activity is regulated activity relating to vulnerable

adults if it falls with paragraph 7. This includes the provision to an adult of healthcare, personal care or social work.

53. 'Relevant conduct' is defined under paragraphs 4 and 10 of Schedule 3 to the Act as set out in the Appendix. Paragraphs 4(1) and 10(1) of the same, sets out the meaning of "relevant conduct". It includes: (i) "conduct which endangers a child / vulnerable adult or is likely to endanger a child / vulnerable adult"; (ii) "conduct which, if repeated against or in relation to a child / vulnerable adult, would endanger that child / vulnerable adult or would be likely to endanger him". Paragraphs 4(2) and 10(2) of the same, provides that conduct "endangers a child / vulnerable adult if" among other things it: (i) "harms" a child / vulnerable adult ; or (ii) puts a child / vulnerable adult "at risk of harm".

54. Section 4 of the Act provides:

> **4 Appeals**
> (1) An individual who is included in a barred list may appeal to the [Upper]1 Tribunal against– [...]
> (b) a decision under [paragraph 2, 3, 5, 8, 9 or 11]3 of [Schedule 3]4 to include him in the list;
> (c) a decision under [paragraph 17, 18 or 18A]5 of that Schedule not to remove him from the list.
> (2) An appeal under subsection (1) may be made only on the grounds that [DBS] has made a mistake–
> (a) on any point of law;
> (b) in any finding of fact which it has made and on which the decision mentioned in that subsection was based.
> (3) For the purposes of subsection (2), the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact.
> (4) An appeal under subsection (1) may be made only with the permission of the [Upper] Tribunal.
> (5) Unless the [Upper] Tribunal finds that [DBS] has made a mistake of law or fact, it must confirm the decision of [DBS].
> (6) If the [Upper] Tribunal finds that [DBS] has made such a mistake it must–
> (a) direct [DBS] to remove the person from the list, or
> (b) remit the matter to [DBS] for a new decision.
> (7) If the [Upper] Tribunal remits a matter to [DBS] under subsection (6)(b)–
> (a) the [Upper] Tribunal may set out any findings of fact which it has made (on which [DBS] must base its new decision); and
> (b) the person must be removed from the list until [DBS] makes its new decision, unless the [Upper] Tribunal directs otherwise.

55. As underlined above, an Appellant may appeal against the barring on the ground that the DBS has made a mistake:

a. "on any point of law" (section 4(2)(a) of the Act).
b. "in any finding of fact which it has made and on which the decision … was based" (section 4(2)(b) of the Act).

56. However, for these purposes “the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact” (section 4(3))

57. The only issues in this appeal therefore are whether there were any material mistakes of law or fact relied upon by the DBS in including the Appellant on the ABL.

58. In *Khakh v Independent Safeguarding Authority* [2013] EWCA Civ. 1341 the Court of Appeal stated:

> “18 …A point of law…includes a challenge on Wednesbury grounds and a human rights challenge. But it will not otherwise entitle an applicant to challenge the balancing exercise conducted by the ISA [now DBS] when determining whether or not it is appropriate to keep someone on the list. In my view that is plain from traditional principles of administrative law but in any event it is put beyond doubt by section 4(3) which states in terms that the decision whether or not it is appropriate to retain someone on a barred list is not a question of law or fact. It follows that an allegation of unreasonableness has to be a Wednesbury rationality challenge i.e. that the decision is perverse.”

59. At para 23 the Court said of the DBS duty to give reasons:

> “23.I would accept that the ISA must give sufficient reasons properly to enable the individual to pursue the right of appeal. This means that it must notify the barred person of the basic findings of fact on which its decision is based, and a short recitation of the reasons why it chose to maintain the person on the list notwithstanding the representations. But the ISA is not a court of law. It does not have to engage with every issue raised by the applicant; it is enough that intelligible reasons are stated sufficient to enable the applicant to know why his representations were to no avail.”

60. Despite the exclusion of ‘appropriateness’ from the Upper Tribunal’s appellate jurisdiction, it is “empowered to determine proportionality” - *B v Independent Safeguarding Authority [2012] EWCA Civ. 977 - s*ee the appendix for further details.

61. In *CM v DBS* (2015) UKUT 707 the following proposition was cited with approval:

> ‘We therefore reject the argument that our jurisdiction is limited to what is often termed *Wednesbury* unreasonableness – that the actions of ISA are so unreasonable that no reasonable body of a similar nature could have reached that decision. The Upper Tribunal will have in all cases the duty to ensure that proper findings of fact are made. This will include both considering any alleged factual errors in the ISA decision and also whether ISA has both identified all relevant evidence and given an appellant a chance to make representations on all relevant evidence. Conversely ISA must ignore irrelevant evidence. In cases of dispute it will be for the Upper Tribunal (and of course the courts on further appeal) to indicate what is relevant.’

62. The jurisdiction for the Tribunal to consider a challenge based on a mistake of fact was considered in *PF v DBS* UKUT [2020] 256 AAC where a three-judge panel stated at [51]:

> a) In those narrow but well-established circumstances in which an error of fact may give rise to an error of law, the tribunal has jurisdiction to interfere with a decision of the DBS under section 4(2)(a).
> b) In relation to factual mistakes, the tribunal may only interfere with the DBS decision if the decision was based on the mistaken finding of fact. This means that the mistake of fact must be material to the decision: it must have made a material contribution to the overall decision.
> c) In determining whether the DBS has made a mistake of fact, the tribunal will consider all the evidence before it and is not confined to the evidence before the decision-maker. The tribunal may hear oral evidence for this purpose.
> d) The tribunal has the power to consider all factual matters other than those relating only to whether or not it is appropriate for an individual to be included in a barred list, which is a matter for the DBS (section 4(3)).
> e) In reaching its own factual findings, the tribunal is able to make findings based directly on the evidence and to draw inferences from the evidence before it.
> f) The tribunal will not defer to the DBS in factual matters but will give appropriate weight to the DBS's factual findings in matters that engage its expertise. Matters of specialist judgment relating to the risk to the public which an appellant may pose are likely to engage the DBS's expertise and will therefore in general be accorded weight.
> g) The starting point for the tribunal's consideration of factual matters is the DBS decision in the sense that an appellant must demonstrate a mistake of law or fact. However, given that the tribunal may consider factual matters for itself, the starting point may not determine the outcome of the appeal. The starting point is likely to make no practical difference in those cases in which the tribunal receives evidence that was not before the decision-maker.

63. The Court of Appeal has further considered the mistake of fact jurisdiction recently in *DBS v RI* [2024] EWCA Civ. 95 and confirmed that *PF* represents the correct interpretation of the UT's fact-finding jurisdiction at [28]-[29]:

> '28.I agree with the observation that there is no longer any point of legal principle raised by this appeal which requires determination by the court, but I do not accept that the parties are in agreement as to the interpretation and scope of the mistake of fact jurisdiction. Far from it. In their further supplementary skeleton argument on behalf of *RI* Mr Kemp and Mr Gillie write:-
>
> > "The Upper Tribunal is entitled to make a finding that an appellant's denial of wrongdoing is credible, such that it is a mistake of fact to find that she did the impugned act. In so doing, the Upper Tribunal is entitled to hear oral evidence from an appellant and to assess it against the documentary evidence on which the DBS based its decision. That is different from merely reviewing the evidence that was before the DBS and coming to different conclusions (which is not open to the Upper Tribunal)."
>
> 29.That is in my view an accurate description of the mistake of fact jurisdiction and corresponds with the guidance given by the Presidential Panel of the Upper Tribunal in *PF,* approved by this court in *Kihembo.'*

64. *PF* should also be read in the light of the judgment in *DBS v AB* [2021] EWCA Civ 1575 where Lewis LJ, for the Court of Appeal, stated at [43] and [55]:

> '43. By way of preliminary observation, the role of the Upper Tribunal on considering an appeal needs to be borne in mind. The Act is intended to ensure the protection of children and vulnerable adults. It does so by providing that the DBS may include people within a list of persons who are barred from engaging in certain activities with children or vulnerable adults. The DBS must decide whether or not the criteria for inclusion of a person within the relevant barred list are satisfied, or, as here, if it is satisfied that it is no longer appropriate to continue to include a person's name in the list. The role of the Upper Tribunal on an appeal is to consider if the DBS has made a mistake on any point of law or in any finding of fact. It cannot consider the appropriateness of listing (see section 4(3) of the Act). That is, unless the decision of the DBS is legally or factually flawed, the assessment of the risk presented by the person concerned, and the appropriateness of including him in a list barring him from regulated activity with children or vulnerable adults, is a matter for the DBS.
>
> 55. Section 4(7) of the Act provides that where the Upper Tribunal remits a matter to the DBS it "may set out any findings of fact which it has made (on which DBS must base its new decision)". It is neither necessary nor feasible to set out precisely the limits on that power. The following should, however, be borne in mind. First, the Upper Tribunal may set out findings of fact. It will need to distinguish carefully a finding of fact from value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness. The Upper Tribunal may do the former but not the latter. By way of example only, the fact that a person is married and the marriage subsists may be a finding of fact. A reference to a marriage being a "strong" marriage or a "mutually-supportive one" may be more of a value judgment rather than a finding of fact. A reference to a marriage being likely to reduce the risk of a person engaging in inappropriate conduct is an evaluation of the risk. The third "finding" would certainly not involve a finding of fact.
> Secondly, an Upper Tribunal will need to consider carefully whether it is appropriate for it to set out particular facts on which the DBS must base its decision when remitting a matter to the DBS for a new decision. For example, an Upper Tribunal would have to have sufficient evidence to find a fact. Further, given that the primary responsibility for assessing the appropriateness of including a person in the children's barred list (or the adults' barred list) is for the DBS, the Upper Tribunal will have to consider whether, in context, it is appropriate for it to find facts on which the DBS must base its new decision.'

65. Therefore, the UT has a full jurisdiction to identify and make findings on the evidence heard as to whether there has been a mistake of fact. An assessment of risk however is generally speaking for the DBS, as the expert assessor of risk, and what is and is not a fact should be considered with care.

66. Only if a risk assessment is made by the DBS in error of fact, eg. based on an incorrect fact, or made in error of law, for example, that a risk assessment relied upon by the DBS is irrational (one that no properly

directed decision maker could reasonably have arrived at on the evidence before it), can the barring decision on which it is based be disturbed on appeal.

67. Thus, the role of the Upper Tribunal on an appeal is to consider if the DBS has made a material mistake on any point of law or in any finding of fact – one upon which its barring decision was based. The UT cannot consider the appropriateness of barring (see section 4(3) of the Act) - the appropriateness of including a person in a list barring them from regulated activity with children or vulnerable adults, is a matter for the DBS.

68. If the Upper Tribunal finds that DBS made a mistake of law or fact, as described in section 4(2), section 4(6) requires the Upper Tribunal to either:

(a) direct DBS to remove the person from the list, or
(b) remit the matter to DBS for a new decision.

69. After *AB* the usual order will be remission back to the DBS unless no other decision than removal is possible on the facts found (for example that there is a finding that the Appellant has not committed any relevant conduct such that they do not satisfy the statutory condition for inclusion on a barring list).

DBS's submissions

70. Mr Reichhold made oral and written submissions on behalf of the DBS in resisting the appeal, which we set out below. He submitted that it appeared from the Appellant's Grounds of Appeal ("the Grounds") that her primary contention was that DBS made one or more mistakes of fact in relation to the Catheter Incident [5]-[6].

71. However, he acknowledged that the Appellant had also been granted permission to appeal in relation to mistake of law [214]. To that end, he addressed both grounds.

A. No material mistake of fact

72. Mr Reichhold submitted that it is not entirely clear, however, how and on what basis, the Appellant seeks to challenge the relevant DBS findings. In broad terms, the Appellant states in the Grounds that things are "not as have been stated" [5]. Mindful that the Appellant is unrepresented, and doing the best he could from the Grounds [5-6], he identified the following four factual challenges in relation to the Catheter Incident:

a. The Appellant claims that the allegation/finding that she "couldn't be bothered" (to take the necessary/appropriate action) is untrue; the Appellant challenges any conclusion that she would put her own needs above a service user's needs and/or have a "lack of care" toward a service user ("the Insufficient Interest Challenge").

b. The Appellant claims (now) to have acted in line with alleged advice from a more senior/established/trained colleague ("LS") ("the Acted on Advice Challenge").

c. The Appellant claims to have asked for (but not been provided with) further/ formal training from the Employer, specific to her role at the relevant time, and regarding "care plans" in particular ("the Insufficient Training Challenge").

d. The Appellant claims that work demands were "unmanageable", leaving her no time to read X's care plan ("the Lack of Time Challenge").

73. Mr Reichhold noted that by contrast, there does not appear to be any material challenge, on the facts, to the second finding of relevant conduct - findings arising from the photograph with the celebrity and the associated failure to comply with the Employer's PPE and social media policies.

i. Insufficient Interest Challenge

74. The DBS made a finding that, upon being made aware that X had "cut" the Catheter tube, the Appellant failed to contact the District Nurse Team (which was the action she accepts that she should have taken). The Appellant did not challenge this finding in the notice of appeal nor during the hearing.

75. The DBS also made a finding that, upon (shortly later) being made aware that X was reporting that she was in pain (with a reference to a "burning" feeling in her bladder), the Appellant still failed to take adequate action. There, appeared to be no challenge to that finding by the Appellant in the written grounds of appeal although there was during her evidence.

76. Mr Reichhold argued that the challenge appeared, instead, to be focused on the reason why the Appellant failed to take the actions that she ought to have taken. There appear to be two relevant aspects to that challenge.

77. First, there is a challenge to the finding by DBS that "one of the reasons" why the Appellant failed to contact the District Nurse Team was a lack of sufficient care for X and/or a failure to place X's needs above her own [139].

78. Mr Reichhold submitted that the DBS made no material mistake in relation to this factual finding. He contended that there was, and still is, a sufficient body of evidence to support it:

a. There is the record of the account provided, close to the time (when memories would likely be fresher), of the carer who first raised the Catheter Incident ("KF") [114]. According to KF's account, he responded to X having pressed an emergency buzzer; ran to see X; X's bed was wet; it became clear that X had cut the Catheter tube with scissors; KF then ran to inform the Appellant; the Appellant delayed for about 15 minutes before attending

to X; the Appellant decided the District Nurse Team would not be contacted (saying that it was not an emergency) and gave some instructions to KF (to put a pad on X and tuck the Catheter tube into it); KF thought the situation was dangerous and that it was important to alert others so that they could come and change the Catheter; KF spent time reassuring X, who was "very apologetic" and appeared "worried". KF added that, later (at around 1.10am), in addition to X reporting that they were in pain (see paragraph 80(a) below), X activated the emergency buzzer again and, on attending to X, KF saw that X's bed was wet again, following which KF needed to provide further reassurance to X [114-116].

b. There is the record of the account provided, close to the time, by LS (who appears to have worked with the Appellant during only two shifts) [118-119]. According to LS's account: KF came into the office and said that X had cut the Catheter tube; on hearing this, the Appellant, who was sat close to LS, said "for gods sake" [118]; the Appellant said that she was not going to "ring it through"; LS told the Appellant "you will have to ring it through"; the Appellant responded that she "can't be arsed" as she would have to "wait up for them", and that she "can't be bothered". LS added that she had "presumed" that the Appellant, despite her complaining, would "ring it in" nonetheless [118].

c. There is the record of the account provided, close to the time, by another colleague who appears to have come on shift the following morning and, finally, made the call to the District Nurse Team [104] ("B"). According to B's account: the Appellant said that she had not called the nursing team because it was a bank holiday and had instead waited until the morning (with the intention that they would be called after 8am when the day staff came in) [104]-[105].

d. There is also the account provided, close to the time, by the Appellant herself [121]. The Appellant accepted she was made aware that the Catheter tube had been cut. She appears to have accepted that she decided the District Nurse Team would not be contacted, expressing a view that it was "too late in the day" for the equipment to be replaced and that instead contact would be made by phone "in the morning" [122]. She later added, when asked why no one was called until around 7am the next morning, that she was "not too sure how to deal with that especially being the bank holiday, didn't think, didn't know what to do" [123]. The Appellant appears to have understood that there was a risk of "infections and stuff" from the situation having been left as it was [123]. The Appellant also appears to have accepted that she could have called "S[]" (her manager) but had not done so [121-124].

79. Second, there is a challenge to the finding by DBS that the Appellant had, in still not taking any adequate action after having been informed that X was reporting being in pain/discomfort, demonstrated a "lack of concern" for how X was feeling [139].

80. Mr Reichhold submitted that the DBS made no material mistake of fact in this regard and that there is ample evidence to support that finding:

a. There is, again, the account provided by KF [115]: KF reported to the Appellant that X's bladder was "burning" and that X was "in pain"; the Appellant responded by saying that X "says that all the time and […] has to get over it" [115]; the Appellant did not attend to X again (and, in that sense, ignored X); X had not complained of anything similar before to KF (although this was only KF's second night during which X had been present). KF also indicated that when he told the Appellant about the "burning" bladder, she came out of the lounge, "didn't seem very interested in what [he] had to say [and] went straight [b]ack into the lounge" [114]-[117].

b. The Appellant appears to have accepted that she was told by KF that X was complaining of experiencing a "burning" bladder, discomfort and/or pain [123]; and that she took no further action. The Appellant's explanation for taking no further action was that X had "been complaining" about such things before; that it was "not anything new" and had been reported before [123]. She is also recorded as having mentioned that she was, at some point, told that it was "something to do with being constipated" [123].

81. Mr Reichhold submits that the following is also notable:

a. The Appellant did not attend the Employer's disciplinary hearing (i.e. to contest the core allegations or to provide her own account in support of an alternative factual position). That was despite a second hearing being scheduled [184] after the Appellant did not attend the first. Nor, it seems, did the Appellant seek to challenge the decision to dismiss her (whether by appeal to her Employer or subsequently in the Employment Tribunal).

b. The Appellant did not provide any written representations to DBS (i.e. to contest the core allegations or provide her own account in support of an alternative factual position). It should be noted that the Appellant was corresponding with the DBS at around that time [33].

c. It is recalled that the Appellant has also not filed any evidence, or made written submissions, in support of this appeal, or to challenge DBS's submissions.

d. Although the Appellant has made some reference to not feeling able or strong enough to challenge allegations/decisions [14], there is, to date little, if any, evidence to support such a claim. Moreover, there is evidence that, in January 2023, just a few months after her dismissal in October 2022, she was fit enough to have applied for, and/or intending to seek, work [33].

82. Mr Reichhold noted that set against all of that, there is the Appellant's position set out in her grounds of appeal:

a. According to the record of the Appellant's second investigation meeting with the Employer [125], the Appellant: denied LS's account of the conversation during which the Appellant was reported to have said that she "couldn't be arsed" to "ring it through" (claiming the conversation "did not happen") [125]; claimed to have gone to check on X "straight away" (but qualified that she couldn't say how long it actually was, and that it was "minutes") [126]; accepted that she was aware residents may be in pain or harmed if there was a delay in checking on them; denied the alleged conversation during which someone told her that X was experiencing a "burning" bladder, discomfort and pain, and during which the Appellant said X says that all the time and needed to get over it (but accepted that she had said that X had mentioned such symptoms to her, adding that "seniors" agreed that X had been having "ongoing pains anyway" [126]); asserted that "clearly somebody has got it in for me" and that it is "their word against mine" [126]. The Appellant did, however, accept that she "should have rung it in", that it was a "bad choice on my part" and added: "hold my hands up to it" [127].

b. In the Grounds of Appeal, the Appellant raised a number of matters relating to the wider context in which she says the Catheter Incident took place. Notably, the Appellant claimed – seemingly for the first time – that she asked LS for advice about what to do in relation to the Catheter Incident and that LS advised her to "leave it until morning" [5] (as the district nurses wouldn't come out at that time and it was busy). The Appellant now claims that, given LS's greater seniority and/or training, the Appellant had simply been following LS's advice. The Appellant contends that, on reflection, she realises that she was wrong to do so and should have contacted the District Nurse Team immediately, but that, in not doing so, she was guilty of no more than naïvety [5].

c. In the Grounds of Appeal, the Appellant claims that the "can't be bothered" conversation is untrue. She argues that the staff member making that allegation (LS) also made the allegation that the Appellant had been asleep on duty (an allegation that the Appellant claims has been proved untrue) and has, as a result, been shown to be "untrustworthy" and "proven to be a liar" (see below in relation to the sleeping allegation). More generally, the Appellant denied putting her own needs above those of service users [5-6].

83. Mr Reichhold therefore submitted that the DBS made no material mistake of fact in its findings of relevant conduct.

84. He argued that it is striking that, according to the evidence, the Appellant did not (at the time) raise with the Employer this new counter-allegation that she was merely following LS's advice. The evidence (e.g. [118-120]) indicates that LS's contemporaneous account is entirely inconsistent with the Appellant's new claimed version of events. It is submitted that it is highly improbable that the Appellant would not have mentioned such an obviously relevant factor in either of her formal interviews with the Employer (when it

would have been clear she was facing serious allegations and her job was on the line) [121-123] [125-127].

ii. Acted on Advice Challenge

85. Mr Reichold contended that this appears to be a wholly new argument, raised for the first time in the Grounds, and, in effect, amounts to a significant change of position. Again, he submitted that it is highly improbable. He argued that if true, the Appellant would have raised it at the time, in one or both of her interviews with the Employer, or during the disciplinary process (or on appeal), or in representations to DBS. It is inconsistent with other more contemporaneous evidence.

86. For these reasons, he submitted that DBS made no material mistake of fact.

iii. Lack of Training Challenge

87. Mr Reichhold submitted that the DBS made no material mistake in relation to the Lack of Training Challenge (which again was raised in the Grounds for the first time). There is a record of various training apparently provided to the Appellant by the Employer [63-67]. It includes training relating to "care plans" and "care planning" (amongst others). It also includes training relating to "continence care in social and community care" completed by the Appellant on 25 October 2021 [64].

88. Further, and in any event, he argued that any such mistake of fact would not be material in all the circumstances. No further or specialist training was required. The Appellant had many years of experience working in similar environments. The Appellant had others, such as "S[]" (her manager) she could turn to for guidance.

89. The evidence indicates that X's care plan was readily available and that the Appellant simply failed to read it. The care plan, including the most relevant section [84], would be straightforward for an experienced practitioner to understand.

90. In a section specifically on "continence management" [84], it states: X "requires support from the district nurse team in ensuring her catheter is managed and changed regularly"; staff are "to ensure that [X] is always kept clean and dry and any issues concerning her catheter are to be reported to the senior on shift so the district nurses can be contacted"; and, again, that "any concerns [in relation to the Catheter] are to be reported to the senior member of staff so that district nurse team can be contacted" [84]. It flags risks of a hazard relating to continence as "high", and the severity of such a hazard as "high". It emphasises that the aim is to support X in a dignified and respectful manner with continence. The evidence also indicates that other colleagues were expressing concern about the situation and seeking an intervention from the district nurse team (e.g. KF [115]).

iv. Lack of Time Challenge

91. Mr Reichhold also contended that the Lack of Time Challenge appears to be a new argument, raised in the Grounds for the first time.

92. He submitted that the DBS made no material mistake of fact. The evidence indicates that, in reality, the Appellant would have had sufficient time to read X's care plan. Any suggestion to the contrary is improbable. Reading a service user's care plan is, surely, an essential part of the role that the Appellant was entrusted to carry out. It is mentioned, expressly, and in several prominent places in the job description document (including the very first bullet point setting out the "purpose" of the role and as a key part of the "main objective") [60]. Indeed, the Appellant's responsibility went further than merely reading plans, she was expected to ensure they were regularly reviewed [60].

v. Other matters

93. Mr Reichhold noted that wider allegations were made relating to the Appellant sleeping at work and spending an inappropriate amount of time at work on her phone (talking, watching videos and/or on social media).

94. In relation to the sleeping at work allegation:

a. According to the record of her first interview with the Employer the Appellant: confirmed that she goes to the "quiet lounge" for breaks; claimed "always" to tell staff; denied sleeping there for longer than permitted, maintained that she would set her alarm and that others must be lying about the duration [123-124].

b. However, other interview records contradict the Appellant. HW said that the Appellant would be: "absent" most shifts for 1-3 hours [110] and that the Appellant would not notify her; and that the Appellant was found in the lounge "[l]aying there looking like she is asleep or on her phone to someone" [111]. HW added that, on 14 September 2022, the Appellant was asleep between 1.40am and 5.30am [111]. KF said that he had seen the Appellant go to the lounge with a giant teddy (which he presumed would be used as a pillow) and stayed there for 2 hours; indicating that she tended, more generally, to say she would be up there for 20 minutes but then stay for a "couple of hours" (KF said the Appellant "never used to until maybe a month two months ago") [116]. BF said that the Appellant did "[n]ot specifically" tell staff that she was to take her break [108].

c. According to the record of her second interview, the Appellant denied being asleep for several hours on 14 September 2022. The Appellant

referred to text messages sent during that timeframe (seemingly between at least 02.07am until 03.14am) [97]. While the text messages appear to prove that the Appellant was not asleep for the whole period, they do not prove that she was not asleep for other parts of it (or that she was otherwise working and available in line with the requirements of her employment).

d. The Employer appeared to accept that the Appellant could not have been asleep for the whole of the period in question on 14 September 2022, but referred to wider allegations about sleeping and connected issues. The Employer seems not to have made clear/conclusive findings on such wider matters but expressed concerns about the Appellant going to the lounge, being unreachable, and sleeping at any time while on shift. The decision to terminate the contract appears to have been based on other findings (i.e. those relating to the Appellant's failures regarding the Catheter Incident and not reading X's care plan).

e. In the Grounds, the Appellant contends that the sleeping allegation was found to be untrue and, moreover, that the "member of staff" who alleged this is "untrustworthy" and a proven "liar" [5].

f. DBS did not find proved the allegation that the Appellant had been asleep between 1.40am and 5.30am on 14 September 22. It took into account the inconsistencies in accounts. It concluded there was insufficient evidence to prove that particular allegation [150]. There was no wider allegation about sleeping more generally while on shift or failing to be available.

95. In relation to the time spent on her phone (talking/watching videos/social media):

a. According to the records, a number of sources claimed that the Appellant spent considerable time on her phone at work. HW said that the Appellant "quite regularly" used her phone [111]. KF witnessed the Appellant on her phone at least 5 times, including around the time he told her about X's "burning" bladder [115]. KF added that he had witnessed the Appellant, later that day, scrolling through Instagram on her phone. It is recorded that KF said he heard the Appellant, during every shift ("without a doubt") listening to videos on her phone in the office [115-116]. LS indicated that she had seen and heard the Appellant playing videos on her phone, for an hour and a half or so, in the office around the time of the Catheter Incident [119].

b. According to the note of her second interview with the Employer, the Appellant claimed not to watch TikTok at all [127]. No further questions appear to have been put to her about watching other videos (including via other platforms).

c. The Appellant does not appear to have addressed this matter (since being dismissed); but DBS has not raised it as a specific allegation.

96. Mr Reichhold submitted that these wider matters may nevertheless be relevant to the Appellant's overall credibility and/or in relation to aspects of the account she presents in the Grounds (such as whether the Appellant's role was so demanding that she had no time to read X's care plan).

B. No mistake of law

97. Mr Reichhold relied on the fact that the Appellant did not appear to have set out, expressly, any specific mistake(s) of law. However, bearing in mind the grant of permission in this respect, he submitted that:

a. On the DBS's core findings, the Appellant's conduct unarguably constituted "relevant conduct" within the meaning of the Act, as conduct likely to put a vulnerable adult at risk of physical and/or emotional/psychological harm (or indeed was likely to cause such harm). It is also noted that the Appellant has left open the possibility of undertaking care work in the future [6].

b. The DBS expressly carried out a proportionality assessment, including the impact of the barring decision on the Appellant, and her ECHR rights [140] [163].

c. It was appropriate and reasonably necessary to include the Appellant in the ABL, as the legitimate and important aims of DBS, and the wider safeguarding regime, could not be adequately met by other less-restrictive means. Those important aims outweighed, and continue to outweigh, the Appellant's rights.

98. By comparison to the present case, the Tribunal may wish to consider the UT's approach in *JA v DBS* [2024] UKUT 60 (AAC). In that case, the appellant care worker was included in the children's barred list and the ABL on the basis that JA "slept on shift during your waking night shift, leaving service users in your care without support for up to 1 hour" (at §1). It was argued on the appellant's behalf that the barring decision was disproportionate. The UT disagreed, and concluded that:

"23. […] We consider that DBS made a proper assessment of JA's Convention right under Article 8. This was the only occasion on which JA had fallen asleep on duty. She had been subject to numerous spot checks in the past and had always been awake at the time of the visits, although she told us that it was usual for the managers to ring the door bell. In those circumstances, it may seem harsh to ban her from any work in regulated activity with children and vulnerable adults. But the legislation allows only two options: to bar or not to bar. Unlike other regulators, DBS has no power to suspend a care worker for a period or to impose conditions on her working in the sector.

24. When JA fell asleep, it was not just something that could have happened to anyone. She did not suddenly find herself overcome by illness or fatigue. She was not exhausted after a long run of night shifts. She was not inexperienced at adjusting to staying awake throughout the night. She was a seasoned night worker,

she knew it was her responsibility to stay awake, and she had her own experience as well as her employer's policy to rely on to help her remain watchful. Although she could call on her fellow carer, it was her duty to ask for help. Her co-worker was entitled to sleep and was not responsible for overseeing or checking on JA. JA was the first line of protection for the residents should anything happen. Despite that, she set herself up to fail without taking even the simple precaution of having a mug of coffee to keep her awake. In those circumstances, we consider that it was proportionate for DBS to exercise its protective role as it did and include her in the lists."

99. Mr Reichhold therefore submitted that the DBS's decision was proportionate, and that it was not irrational or unreasonable (in the Wednesbury sense) to conclude that there is a risk of the Appellant engaging in relevant conduct in the future.

Discussion: Findings of Fact and Analysis of grounds of appeal

100. We have examined all the evidence in the case with care, both that which was before the DBS and that provided by the Appellant as part of her appeal (most of which was not available to the DBS at the time it made its Decision).

101. The evidence that was before the DBS when it made its Decision obviously did not include all the factual representations and evidence we received from the Appellant during the hearing. The Appellant's factual representations and evidence denying many of the allegations, were in similar terms to the grounds contained in the notice of appeal dated 14 September 2023.

102. We make findings of fact on the balance of probabilities as set out below. In light of these, we consider whether the DBS made mistakes of fact in accordance with the approach set out in *PF v DBS* and *DBS v RI*. The burden of proof remained on the DBS when establishing the facts and making its findings of relevant conduct in its barring decision. Thereafter on the appeal to the UT, the burden was on the Appellant to establish a mistake of fact (see *PF* at [51]):

> 'The starting point for the tribunal's consideration of factual matters is the DBS decision in the sense that an appellant must demonstrate a mistake of law or fact. However, given that the tribunal may consider factual matters for itself, the starting point may not determine the outcome of the appeal. The starting point is likely to make no practical difference in those cases in which the tribunal receives evidence that was not before the decision-maker.'

103. Furthermore, the UT stated in *PF*:

> ‘In determining whether the DBS has made a mistake of fact, the tribunal will consider all the evidence before it and is not confined to the evidence before the decision-maker. The tribunal may hear oral evidence for this purpose…. In reaching its own factual findings, the tribunal is able to make findings based directly on the evidence and to draw inferences from the evidence before it...The tribunal will not defer to the DBS in factual matters but will give appropriate weight to the DBS’s factual findings in matters that engage its expertise.’

104. The Appellant relied upon her notice of appeal and the submissions of fact she made therein as set out above. She supplemented this with oral evidence of fact given during the appeal hearing. As noted above and below, her oral evidence was consistent with the factual representations she made in the notice of appeal.

105. We also note that the Appellant attended the hearing of the appeal, gave evidence and was cross examined. This is in contrast to the witnesses relied upon by the DBS who did not. Their evidence consisted of written notes of answers given to questions from the Employer and it was untested by cross examination so that potentially less weight is to be given to the written evidence of those DBS witnesses. As is made apparent below, their reliability and credibility has been impugned by the Appellant. Therefore, we have had to balance our assessment of their reliability and credibility against our assessment of the Appellant’s reliability and credibility having heard her give oral evidence.

106. We are satisfied that the Appellant was a reliable and credible witness in the oral evidence that she gave the Tribunal. We set out our reasoning for this conclusion in the section below when addressing Grounds 1 and 2 and the alleged mistakes of fact in relation to the findings of relevant conduct.

Ground 1

<u>Material mistake of fact: first finding of relevant conduct – Finding 1</u>

107. The first finding of relevant conduct against the Appellant relied upon by the DBS in its decision to bar is that:

> “On 18 September 2022 you failed to contact the District Nurse Team and report that a service user ([X], aged 78) had cut her catheter tube as per care plan guidance, and following the service user reporting that she felt like her bladder was burning and was in pain, you failed to take any action in response to this concern.”

108. In summary, the Appellant’s response in her oral evidence in chief was as follows.

109. She was full of remorse about the catheter incident and tearful throughout giving evidence. She stated she felt ashamed and had failed

herself. She displayed a good level of insight and acceptance as to the mistakes she had made.

110. She accepted she had made mistakes by: a) not reading the care plan for X which included instruction to contact the District Nurse for concerns about X's catheter; b) not contacting the District Nurse for advice, instruction and assistance with what to do on learning that X's catheter had been cut; c) not calling her manager [S] who was on call at night for advice; d) following LS's advice as to how to act in response to the Catheter Incident.

111. There was no dispute that her mistakes constituted relevant conduct – her failures to act fell below the standard of reasonable conduct and exposed X to a risk of physical harm as explained by the DBS in the barring letter:

> 'This is because we are of the view that you failed to realise the seriousness of a situation where a service user had cut their catheter, where you failed to take the appropriate action of reporting the incident to the district nurse, when it was your responsibility as the senior on shift to do so. You failed to read the care plan, despite this being part of your role to do so, with the care plan providing clear instructions on what to do if there were issues with the service users catheter. The actions you instead instructed a member of staff to carry out resulted in the service user's bed becoming wet and requiring changing regularly.
> …
> As a result of your lack of action this placed the service user at risk of potential infection and suffering abdominal pain. It is acknowledged that you had extensive previous experience in caring roles with no known previous concerns, and acknowledged on reflection that you should have contacted the District Nurses immediately.
>
> However, you reasoned that you did not know how to deal with the situation as it was a bank holiday, however the District Nurse Team were available 24 hours a day, and you failed to take any action to ensure the appropriate support could be provided to the service user. You admitted that you had failed to read the service users care plan, stating you didn't have time to as they had only come into the service a few days prior. However, it was part of your role to do this so that you were aware of the service users care requirements.
>
> Had you read this you would have seen clear guidance that any issues concerning the catheter should be reported by the senior on shift, which was yourself, to the District Nurse.
>
> Had you followed this guidance in place this would have ensured the service users' needs were met in a timely manner, with the District Nurse only contacted when your colleague commenced their shift the following morning. The actions you instructed a staff member to take resulted in the service users bed becoming wet and requiring changing, and placed the service user at risk of physical and emotional harm…'

112. However, we accept the Appellant's oral evidence about the following matters which a) provide mitigation for her failures; and b) reveal mistakes of fact in the findings relied upon by the DBS.

113. First, the Appellant stated that she had asked LS – another senior care assistant who was also on duty that night but who had more experience than her – for advice on what to do about the cutting of X's catheter. She stated that LS had advised her there was no need to contact the District Nurse until the next morning. The Appellant therefore instructed the staff to put pads under X and regularly change them throughout the night. The following morning the Appellant came back into work to conduct the handover and inform the District Nurse of the situation but her manager [B] told her there was no need as he would deal with it.

114. The Appellant's oral evidence was consistent with her grounds of appeal on this issue from September 2023:

> Following the incident with regards the catheter, I spoke with [LS] and asked her advice on what I should do as the following day was a bank holiday and I wanted to check that services were the same as on a normal day. [LS] advised me to "leave it until morning" to contact the District Nurse as they wouldn't come out at that time and that it was extremely busy. [LS] had been a senior for much longer than myself and was fully trained and therefore I took her advice. On reflection, I now see that I should have made the call at the time to the District Nurse however I took the word of a more experienced colleague which again on reflection was naive of me.

115. We accept that the Appellant took advice from a colleague who was more experienced but of equal rank and relied upon it, however inadvisably. As above, she accepted that this was only mitigation and she had failed to follow the care plan and call the District Nurse.

116. Second, we accept her evidence that she did not say to her colleague that she 'couldn't be bothered' to contact the District Nurse or senior manager once she had been informed that X had cut her catheter her or that it could wait until the morning. We accept her evidence that she has 17 years' experience in care work and was concerned for all her clients / service users. This again is consistent with her written grounds of appeal:

> The allegation that I "couldn't be bothered" is completely untrue. The member of staff who alleged this had also made allegations that I was asleep when on duty which let to an internal investigation and was found to be untrue and evidence proved this. I would therefore suggest that this member of staff is untrustworthy and has been proven to be a liar. I have worked in a care role for many years and I disagree strongly that I would ever put my own needs above any service user and show a lack of care.

117. Third, we accept her account that she did not delay before going to see X and instructing that pads be put underneath her and regularly changed and that she did not fail to take action when hearing that the service user

was in pain. We reject the allegation that she unreasonably delayed before visiting the service user X and accept that she went quickly – at least within a few minutes as she suggests. We accept that she did take action on being told of the service user suffering from the cut catheter – by instructing that pads be used. We also accept her account, that however misguided, the Appellant believed that the service user had been reporting a burning sensation since she arrived at the home a couple of days before so that the Appellant did not consider anything additional needed to be done.

118. We accept the Appellant's evidence that the written accounts of the two witnesses relied upon by DBS are not reliable. The DBS relied upon written notes of the accounts given by KF and LS in investigatory meetings: KF claimed that the Appellant did not go up to see X for 15 minutes and LS said she could not be bothered to call the District Nurse. The notes record the following:

> 'KF
> It was around 10pm, X was pressing emergency buzzer, I ran upstairs into her room saw that her bed was wet, odd as she has a catheter, she held it up and it was snipped, I grabbed the scissors, didn't take them with me but moved them away, resident's item, moved away from her on top of the wardrobe ran downstairs to tell JLA, said X sniped her catheter, she said what do you mean, said she has cut the catheter, she said she will go up in a minute, 15 mins passed before she went up, she then instructed me to put a pad on her and tuck the catheter tube in her pad, didn't want the bed to get wet, before I went up to do this, she did say I am not ringing through to district nurse's as not an emergency, I thought not connected to the bag surely it needs replacing, she said it's not an emergency. I went upstairs and helped change sheets and clothing and made sure she was dry and comfortable, sat with her for a few minutes reassured her, she was apologetic, said it was fine…'

> 'LS
> I was sat in the office on the main computer, X was in, KF went up to her, she had cut her catheter, KF came back down and said she has catheter, JLA sat behind me, said for gods sake, KF said its snipped, bed wet, after 10 minutes, JLA went up to see her told KF to change her bed and put a pad on her, JLA said not ringing it through as not an emergency, said you will have to ring it through, JLA said I can't be arsed to ring it through as have to wait up for them, I said it will do something to her, JLA said I can't be bothered, KF put her pad on her and changed her bed I went across to the other building and presumed she would ring it, didn't know where she was when I came back…'

119. We reject those parts of the account by KF suggesting JLA delayed for 15 minutes before going to see service user X and reject the suggestion of LS that she said she could not be bothered to ring the District Nurse. We are not satisfied these allegations are reliable on the balance of probabilities for a number of reasons.

120. First, the witness accounts are untested hearsay. The evidence consists of notes of interviews with each of the witnesses but not any formal statements or documents authored by them – let alone witness statements

containing statements of truth. The absence of any cross examination of the witnesses means that less weight should be given to their accounts in this case.

121. Second and importantly, as the Appellant emphasises, KF went on to make another allegation against her which both the Employer and the DBS found not to be proved. KF alleged that the Appellant had been asleep on duty for around four hours during night shift (around 1am to 5am) on 14 September 2022. This allegation was found unproved by the Employer during disciplinary proceedings and the DBS in its barring decision process document. This was partly because the Appellant had produced text messages that she had sent at around 2-4am during the time she was alleged to have been asleep.

122. As the Employer stated in its outcome letter dated 7 October 2022:

> 'In addition, it was reported that you were asleep on the 14th September between 1-5am. You submitted evidence prior to the meeting to counter this allegation. The text messages you provided were from the night of 14th September and shows that you sent text messages between 2-4am. By your own admittance you stated that you have been going to the quiet lounge which is off the main unit where you are not reachable…'

123. The DBS found in its barring decision process document:

> 'KF reported that for a period of 1 to 2 months that she had seen [JLA] disappearing for period of from around 2 hours to 6 hours, and that she goes away for a period of time longer than her allocated break and that she doesn't inform staff she is doing this, and that she regularly uses her phone whilst on shift. KF also stated having to find [JLA] if a resident requires medication. Although this is consistent with the account from HW of witnessing [JLA]disappearing for a significant period of time, this however this does not confirm that [JLA] was going off to sleep during this period, or of what she was doing. This is also inconsistent with the account from BF, who although had not worked with [JLA] much, had not witnesses her going off for a significant period of time. (Flag 15).
>
> [JLA] admitted that she gone to the quiet lounge off the main unit but that she had informed staff of this and that she was only taking her hour break that she is entitled to. (Flags 9, 10, 17). As a Senior Care Assistant [JLA] was required to be alert and available at all times, and therefore sleeping at any time during her shift would be unacceptable. (Flag 9).
>
> Although there have been two staff members who have reported that on an occasion [JLA] disappears off the floor for a number of hours, there has also been a colleague who has not witnesses this, and has reported [JLA] being on the floor for most of her shift. Given that there have been inconsistent accounts from two staff members who were working together on the shift on 14/09/2022 around whether [JLA] had disappeared from the floor for a number of hours or not, and that [JLA] has provided evidence of her being awake at a point during the period that she was alleged to be sleeping, there is therefore insufficient evidence to

prove on the balance of probabilities that on the night shift of 14 September 2022 [JLA] was asleep on shift between 1.40 - 5.30 am.'

124. We do not consider it appropriate for the DBS to attempt to undermine the Appellant's credibility or reliability based upon an allegation that it has found unproven as part of its barring decision process document and was not contained in its barring decision letter.

125. Third, the Appellant gave contemporary account in interviews with the Employer denying these specific allegations and was consistent in those denials throughout notice of appeal and oral evidence to us. During the disciplinary interviews (investigation meetings) with her Employer on 21 and 27 September 2022 she stated:

'21 September 2022

TM It has been reported that on the night of 18/09/22 service user [X] cut her catheter tube using a pair of scissors at approximately 10pm, what can you tell me about this?

JLA One of the carers went up said she had managed to cut it, asked what with, said scissors, spoke to her asked why, said her catheter was full, explained that wasn't the right way to go, too late in the day for the tube to be replaced, asked the carer to remove the scissors going to phone in the morning Braiden said its alright, I will do it

TM Did you call the district nursing team? If not, why did you not? If yes, did you record this anywhere?

JLA [B] said he would ring , he picked up the phone and did it

TM If she cut the catheter at 10pm, what time did you know about it?

JLA Maybe 12 ish,

TM How come no one was called until 7am

JLA Not too sure how to deal with that especially being the bank holiday, didn't think, didn't know what to do

TM What is the risk of [X's] catheter tube not being intact?

JLA Infections and stuff

TM Anyone that you could have contacted

JLA Could have tried ringing [Senior manager S] but didn't

TM It was reported that [X] was experiencing 'burning', discomfort and pain with her bladder what was done about this?

JLA She has been complaining of that before, not anything new, already had those sensations, already reported before

TM What was done about it

JLA I got told something to do with being constipated…

27 September 2022

TM We spoke to you previously regarding service user [X] cutting her catheter tube using a pair of scissors. It has been reported that when asked whether you would ring it through you said that you wouldn't as it wasn't an emergency and that you could not be arsed to ring it through as you would have to wait up for them, what can you tell us about this?

JLA That conversation did not happen, I don't know who would say that, that was not said

TM Did any conversation happen

JLA No, about it happening how it happened and I asked for the scissors to be removed

TM It has been reported that when the incident was reported to you, you did not check on the resident immediately and went up after 15 minutes, why did you delay in checking the resident?

JLA I did go and check on her straight away, can't say how long it was, it was minutes

TM What could have been the repercussions of not checking on the resident in a timely manner?

JLA That she could be in pain, could cause harm

TM It was reported that when you were told that KH was experiencing 'burning', discomfort and pain with her bladder, you said that KH says that all the time and she needs to get over it, what can you tell us about this?

JLA Clearly somebody has got it in for me, that discussion didn't happen, I said she has mentioned that to me, Seniors agreed that she had been having ongoing pains anyway…'

126. We also accept the explanation given by the Appellant in oral evidence as to why KF and LS had reason to make unreliable allegations against her. She explained that LS may have felt responsible for giving the Appellant the wrong advice about how to care for service user X and was seeking to deflect blame and place it upon the Appellant. Second, she explained that KF and LS were in a personal relationship.

127. Mr Reichhold relied upon the fact that the Appellant had not raised matters she now relied upon at an early stage. She only mentioned that she had asked LS for advice in her notice of appeal a year later in September 2023 and not during the disciplinary interviews in September 2022. Further she had not attended the disciplinary hearing with the Employer nor made representations to the DBS in advance of the barring decision as invited to do.

128. We have considered carefully whether these matters undermine the Appellant's reliability and credibility. However, we have decided that they do not.

129. First, we were impressed by the fact that the Appellant was ready and willing to make concessions against her own interest in her evidence and in her notice of appeal. As we have explained above, she accepted she had made mistakes in relation to her care for service user X. She accepted that she had not read the care plan and did not do so generally – that she needed training and did not want to be a senior health care assistant as she did not want the responsibility. She was remorseful and insightful. She accepted much of the DBS's case on the first finding of relevant conduct.

130. Second, in coming to this conclusion, we have taken into account the Appellant's character and previously unblemished 17 year career in the care sector. This is relevant to her propensity to commit relevant conduct and her reliability or credibility when giving evidence. We also take into account that JLA gave oral evidence and was tested under cross examination unlike the witnesses relied on by DBS. We have also taken into account the fact that there was no reliance by the employer or findings by the DBS in relation to other allegations made against her which she denied.

131. Third, on balance, we accept her explanations that she gave to Mr Reichhold when cross examined on these points. We accept that the Appellant was suffering from a high degree of anxiety as a result of the allegations and this was reason for her not attending disciplinary hearing with the Employer or engaging with the DBS on the substantive issues at an earlier stage prior to lodging her notice of appeal. It was apparent from her appearance, manner of giving evidence and explanations regarding her mental health that the Appellant had been continuing to suffer from poor mental health since the incident.

132. On balance, we also accept that the Appellant did not mention asking LS for advice at earlier stage before her notice of appeal as she did not want to get LS in trouble. We also accept her explanation that she thinks LS was seeking to put further blame upon her as LS felt guilty for giving the Appellant bad advice at the time and was seeking to deflect responsibility.

Mistakes of fact

133. The Appellant's contemporaneous account and her account during the hearing in relation to Finding 1 included an admission to relevant conduct in respect of Service User X. Nonetheless we accept her denials in relation to a number of material facts relied upon by the DBS in making its Barring Decision. We identify below the facts upon which the barring decision was based but which have not been established on the balance of probabilities.

134. We are satisfied on the balance of probabilities that DBS made the following mistakes of fact in relation to the first finding of relevant conduct upon which its barring decision was based. The following findings and reasoning contained in the final decision letter were made in error of fact:

> [From the finding of relevant conduct itself]…following the service user reporting that she felt like her bladder was burning and was in pain, you failed to take any action in response to this concern
>
> [From the reasoning in the Final Decision Letter]… One of the reasons given as to why you failed to call the District Nurse for support was that you couldn't be bothered to wait for them, thereby showing a lack of care for the service user, and failure to place their needs above that of your own. You also failed to take any action when it was reported to you that the service user was in pain, stating this had previously been reported on a previous occasion. However, this shows a lack of concern for how they were currently feeling at that time.

135. We are satisfied that these findings and reasons were materially mistaken in fact. The Appellant did not fail to take action, did not say she could not be bothered to wait for the District Nurse, did not show a lack of care for the service user and did not show a lack of concern for how the service user was feeling at the time.

136. We turn to consider the headings under which Mr Reichhold categorised the Appellant's mistake of fact challenge to the first finding of relevant conduct:

a. The Appellant claims that the allegation/finding that she "couldn't be bothered" (to take the necessary/appropriate action) is untrue; the Appellant challenges any conclusion that she would put her own needs above a service user's needs and/or have a "lack of care" toward a service user ("the Insufficient Interest Challenge").

b. The Appellant claims (now) to have acted in line with alleged advice from a more senior/established/trained colleague ("LS") ("the Acted on Advice Challenge").

c. The Appellant claims to have asked for (but not been provided with) further/ formal training from the Employer, specific to her role at the relevant time, and regarding "care plans" in particular ("the Insufficient Training Challenge").

d. The Appellant claims that work demands were “unmanageable”, leaving her no time to read X’s care plan (“the Lack of Time Challenge”).

137. We address the four categories in turn.

138. A. We have found that on the balance of probabilities that there was an error of fact in the DBS finding that the Appellant had insufficient interest in helping Service User X. This is for the reasons set out above.

139. B. We accept the Appellant’s evidence on the balance of probabilities that she ‘Acted on Advice’ of LS. Even though this was not sufficient or reasonable, it is some mitigation.

140. C. On balance, we accept that the Appellant’s evidence that she had asked for extra training in relation to care plans. Again, this is only mitigation because she had been provided with training and should reasonably have read the care plans of service users for whom she was responsible.

141. D. On balance, we accept the Appellant’s evidence that the work demands placed upon her by the Employer during much of her time at the home were very difficult. On night shift she was often the only senior care assistant responsible for 84 residents – across two houses - half of whom had behavioural difficulties and the other half were elderly. She was supported by one or two agency care workers, some of whom did not speak English. There was a lot of challenging behaviour that she was called to respond to and little time to read anything. She had told her manager S that she did not understand the care plans and need help understanding them. LS happened to be on shift as a second senior care assistant on the night in question to deal with the care plans. The Appellant was trying her very best to look after everyone under her care and genuinely thought that placing pads under X with hourly checks was the best thing to do after being advised by LS to leave calling the District Nurse to the morning. The Appellant believed that pads would prevent X being soaked and causing her any harm. Working during the time of COVID placed extreme demands upon her.

142. While all of the above is some mitigation, it does not excuse the Appellant’s conduct in failing to read X’s care plan. X had been a resident in the home for two days before the catheter incident, so even if the Appellant had not read the care plan before the Catheter Incident, as she ought to have, she should reasonably have read the plan when the incident was brought to her attention so she knew what was the appropriate action to take. In her oral evidence, the Appellant did not suggest that unmanageable demands were the principle reason for not reading X’s care plan – she simply accepted that she did not read care plans as she had not had training and did not understand them.

143. We are therefore satisfied that the DBS has made materials mistake of fact upon which the barring decision was based and while the Appellant did still commit relevant conduct there was some mitigation for it.

Mistake of fact: second finding of relevant conduct – Finding 2

144. The DBS's second finding of relevant conduct was that:

> On a date leading up to 6 July 2021 you breached PPE policy by removing your facemask to take a photo with a visitor outside of the home.

145. At no stage did the Appellant deny this finding. By way of context, she explained that she had seen a celebrity visitor to the home and on what she described as an unpaid break during the working day she went to get a photograph with them outside the home. It was during the time of COVID restrictions. She stated that did not understand that PPE policy applied during her breaks outside the home. We accept her evidence – albeit that again it is mitigation and does not reveal any mistake of fact in the finding.

146. While there had also been an allegation that the Appellant had then posted the photograph on social media in breach of the Employer's social media policy, this was not relied upon by the Employer.

147. Therefore, there was no mistake of fact in Finding 2.

148. We do note that while the DBS relied on this finding as constituting relevant conduct within the Final Decision Letter, it did not go on to say anything else about it in the letter nor rely on it as a reason for the barring decision. Therefore, it is not clear if it played a material part in the barring decision.

149. Further, it is by no means clear that the finding constitutes relevant conduct as a matter of law. There is no suggestion that any vulnerable adult was actually put at risk of any harm by the Appellant's conduct. The question is then whether, if the Appellant's conduct were repeated in respect of a vulnerable adult, it would put them at risk of harm. This would depend on how close the Appellant was standing to the other person without wearing a facemask or PPE – ie whether if the conduct was repeated in relation to a vulnerable adult there would be a risk of the Appellant passing on or contracting COVID or any other infectious disease which in turn might put all residents at risk of contracting it.

150. There was no evidence relied upon by the DBS or reasoning in the barring decision process document as to why the finding constituted relevant conduct or posed a risk of harm to an actual or hypothetical vulnerable adult. The rationale set out in the barring decision process document was limited to the following (essentially that it was a breach of PPE policy):

'[JLA] admitted that she used her phone and took a photo of a cast member from Emmerdale who had arrived and uploaded this to social media on her break. (Flags 20, 21, 22). [JLA] stated not realising that she was breaching PPE policy by removing this whilst outside to take the photo. (Flag 20).

[JLA] was given a first written warning due to breaching the homes social media policy and PPE policy. [JLA] was described as being very remorseful.

It was stated that at the time of this PPE breach that social distancing and mask wearing was important for all staff to wear masks including outside due to the risks of infection and spreading of covid-19 at this time. (Flag 19)

Given [JLA]'s own admission to removing her mask when taking a photo with a visitor who arrived at the home, it appears on the balance of probabilities that on a date leading up to 6 July 2021 [JLA] breached PPE policy by removing her facemask to take a photo with a visitor outside of the home.'

151. We therefore find that there was a mistake of law in relation to this finding. The DBS failed to provide any reasons or evidence in its final decision letter or barring decision process document as to why the finding of fact it relied upon constituted relevant conduct (ie. if repeated in relation to vulnerable adults would cause a risk of harm).

Remedy – Remittal to the DBS pursuant to section 4(6)(b) & 7 of the Act

152. In light of our findings that there was a material mistake of fact in relation to the first finding of relevant conduct and a mistake of law in relation to the second finding of relevant conduct, we have decided to remit the Appellant's case to the DBS for a fresh barring decision based upon the findings we have made above (see sections 4(6)(b) & (7)(a) of the Act). Given that there has been an admission by the Appellant to much of the first finding of relevant conduct in relation to the catheter incident, and there is no dispute that it constitutes relevant conduct, it would not be appropriate for us to direct the Appellant's removal.

153. The DBS will need to reconsider the appropriateness and proportionality of including the Appellant on the ABL in light of the findings we have made.

154. It is therefore unnecessary for us to decide whether the decision to bar the Appellant was proportionate and whether there was any other mistake of law based upon the findings it relied upon.

155. Nonetheless, we offer some observations upon the proportionality of the barring decision to assist the DBS in re-making its decision.

Mistake of Law - Proportionality

156. The Appellant gave cogent evidence as to the impact that the barring decision has had upon her which we accept.

157. She stated that she had struggled to find work as she had spent her most of her working life in care. After taking a break from care work in 2018-2020 because she had suffered a lot of anxiety and depression, she had specifically gone back in to care work because of COVID. Barring had greatly impacted her life, caused her much mental stress and financially affected her - she nearly lost her home by way of eviction. She had rented her house and had three young people at home. Luckily, she had subsequently been able to go into working for a pharmacy after working for a bank. She was now working towards pharmacy qualifications, her confidence having been shot. Her manager has offered for her to go on a course for the NHS to qualify as a pharmacy technician but she would not be able to do that or progress in her job while subject to the barring decision. She had no intention to go back into care work even though she had loved it - it was not a job she loved anymore. She would not be able to progress in pharmacy work and work in hospitals or prisons or in a dispensing capacity if she stayed on the barred lists and she would like to progress in her career.

158. She did not believe that she presented any risk of harm to any vulnerable adult, had never caused harm and there had never been any other report against her. She had received so many letters and cards from families of those she had cared for. This was a one-off silly mistake - she felt that her reputation had been ruined and she was too ashamed to tell her father about it.

159. Given the findings of relevant conduct that the DBS had made, it was not a "perverse" or irrational decision by DBS to have included the Appellant on the ABL at the time it made its decision. There is a high bar for perversity/irrationality challenges to barring decisions and we are satisfied that the decision to bar was neither perverse nor irrational but one the DBS was entitled to reach at that time. Obviously, the DBS will have to re-decide whether it is appropriate and proportionate to bar the Appellant from regulated activity with vulnerable adults based on the findings we have now made.

160. The decision that it was "appropriate" in all the circumstances to bar JLA is outside our jurisdiction to examine but we will always need to consider the proportionality of any barring decision.

161. We next consider if there was any mistake of law in the barring decision made at the time on the grounds of proportionality. It is accepted that barring represents an interference with a person's private life for the purpose of Article 8 of the Convention but the question is whether it is proportionate.

162. In summary, the proportionality of DBS's decisions to include individuals on the barred lists should be examined applying the tests laid down by Lord Wilson in *R (Aguilar Quila) v Secretary of Stage for the Home Department* [2012] 1 AC 621 at para 45:

> …But was it "necessary in a democratic society"? It is within this question that an assessment of the amendment's proportionality must be undertaken. In *Huang v Secretary of State for the Home Department* [2007] 2 AC 167, Lord Bingham suggested, at para 19, that in such a context four questions generally arise, namely:
>
> a) is the legislative objective sufficiently important to justify limiting a fundamental right?
>
> b) are the measures which have been designed to meet it rationally connected to it?
>
> c) are they no more than are necessary to accomplish it?
>
> d) do they strike a fair balance between the rights of the individual and the interests of the community?

163. These four questions were later developed by Lord Sumption in *Bank Mellat* [2013] UKSC 39 at 20:

> … the question [of proportionality] depends on an exacting analysis of the factual case advanced in defence of the measure, in order to determine (i) whether its objective is sufficiently important to justify the limitation of a fundamental right; (ii) whether it is rationally connected to the objective; (iii) whether a less intrusive measure could have been used; and (iv) whether, having regard to these matters and to the severity of the consequences, a fair balance has been struck between the rights of the individual and the interests of the community.

164. In assessing proportionality, the Upper Tribunal has '*…to give appropriate weight to the decision of a body charged by statute with a task of expert evaluation*' (see *Independent Safeguarding Authority v SB* [2012] EWCA Civ 977 at [17] as set out above).

165. However, we must conduct our own assessment of proportionality afresh rather than simply review the DBS's assessment.

166. We are satisfied that each of questions a)-d) should be answered in favour of the barring decision being proportionate based on the findings that the DBS made at the time (even though those findings are now disturbed because we have found they contained mistakes of fact).

167. On the basis of the findings that the DBS made in its final decision letter, we are satisfied that the DBS was entitled to conclude that it was proportionate and reasonably necessary to bar JLA in order to achieve its (important and) legitimate safeguarding aims.

168. There is no real question that the public interest and legislative objective of safeguarding vulnerable groups is sufficiently important to justify the interference with private life that barring constitutes and that barring is rationally connected to protecting those groups.

169. We are satisfied that when making the barring decision, the DBS correctly concluded that no other measures were in place sufficient to adequately safeguard vulnerable adults from JLA participating in regulated activity and committing further acts of neglect or the like such that it was the least intrusive measure necessary.

170. We are also satisfied that barring was necessary and struck a fair balance between JLA's right to a private life and the interests of the community. The DBS expressly carried out the "balancing act" exercise required and we have done the same. We are satisfied that the DBS was entitled to consider that the Appellant presented a risk of harm to vulnerable adults at the time of the decision based upon Finding 1 as originally made. The decision that the Appellant posed a risk of repeating similar acts at the time of the barring decision was also rational – ie. based on her not reading care plans.

171. However, the assessment of proportionality of barring may be rather different in light of the findings we have now made.

172. As we have set out above, the barring decision will have to be remade on a different factual basis that the Appellant was careless, neglectful or negligent rather than wilful in her actions relating to the catheter incident.

173. It will have to be made on the basis of the substantial mitigation: that she did ask LS for advice – although she should not have followed her advice anyway but that of a District Nurse; that she was an honest witness who made damaging admissions against her own interest; that she was highly remorseful and had insight into her conduct; that she had a previously long and unblemished career; that she was working in very stressful conditions, with difficult and challenging service users, low numbers of staff and in times of COVID; that she had told the Employer did not want to be a manager and was doing her best; there had been a very significant impact upon her as a result of barring both psychologically, financially and professionally; and barring will prevent the Appellant progressing in her current pharmacy career. There is no doubt that the cumulative effect of dismissal in September 2022 and barring in June 2023 have acted as a significant punishment – even if barring is designed as a preventative rather than punitive measure.

174. When reconsidering the issue of proportionality, the DBS will need to look again at applying the third and fourth stages of *Aguilar Quila / Bank Mellat* to this case.

175. When looking at the third stage and the least intrusive measure necessary, the DBS will be mindful that barring is a blunt tool. Unlike professional regulators who have a range of sanctions they can impose for disciplinary misconduct the DBS cannot make suspension or conditions of practice orders that might impose training or supervision requirements. Barring is an all or nothing outcome as far as regulated activity is concerned. In an ideal world it might be that a condition could be imposed that the Appellant be trained on reading and applying care plans if working in the care sector or regulated activity generally, or that she could work in other forms of regulated activity without restriction. However, that type of order is not available under the legislation.

176. The fourth question is whether on the findings now made a fair balance would be struck between the seriousness of the findings of relevant conduct upheld, and any risk of further harm to vulnerable adults that can be rationally derived from it, as against the impact and effect of baring on the Appellant's private life. The risk assessment (of the risk that the Appellant may now pose to vulnerable adults if working in regulated activity) will now need to be reconducted in light of our findings of fact in relation to the relevant conduct and its impact on the likelihood of repeat occurrences. It remains a matter for the DBS to decide whether our findings and its revised risk assessment in light of those findings means that the public interest in safeguarding vulnerable groups outweighs the impact of barring upon the Appellant.

177. When reconducting the risk assessment, the DBS should also take into account the following. While, it is concerning that the Appellant admitted that she did not read care plans and wanted training on how to do so, this is something that the DBS might ask the Appellant to address by way of evidence or representations (eg. on further training she has or would take). Therefore, the DBS's further risk assessment may turn on further evidence than that which was before us during the hearing. We urge the Appellant to engage constructively with the DBS on the evidence of insight, remorse and retraining that she has undergone since the original barring decision in June 2023.

178. We accept that it will be for the DBS to re-decide whether barring is necessary and whether it strikes a fair balance has been the Tribunal's finding of relevant conduct, and the DBS's revised risk assessment. This will be balanced against the factual matrix now found as to the interference with / impact upon the Appellant's private life and employment restrictions it imposes on her (not only preventing her from working in care but also progressing in her pharmacy career). If the DBS does decide that barring remains proportionate, that decision will be subject to a right of appeal and the Tribunal would then carry out its proportionality decision afresh.

Conclusion and Disposal

179. For the reasons set out above, the Appellant's appeal should be allowed.

180. We conclude for the purposes of section 4(6)(b) of the Act that there were material mistakes of fact in the first finding of relevant conduct and a mistake of law in relation to the second finding or relevant conduct upon which the ultimate decision to include the Appellant on the ABL was based.

181. We therefore remit the decision of the DBS to include the Appellant on ABL for it to make a new decision in light of our findings of fact for the purposes of section 4(7)(a) of the Act. We also direct for the purposes of section 4(7)(b) that she remains on the list pending the DBS making its new decision.

Authorised for release:
Judge Rupert Jones
Judge of the Upper Tribunal **Dated: 12 September 2024**

Appendix

The lists and listing under the 2006 Act

1. The Safeguarding Vulnerable Groups Act 2006 ('the Act') established an Independent Barring Board which was renamed the Independent Safeguarding Authority ('ISA') before it merged with the Criminal Records Bureau ('CRB') to form the Disclosure and Barring Service ("DBS").

2. So far as is relevant, section 2 of the Act, as amended, provides as follows:

'2(1) DBS must establish and maintain—

(a) the children's barred list;

(b) the adults' barred list.

(2) Part 1 of Schedule 3 applies for the purpose of determining whether an individual is included in the children's barred list.

(3) Part 2 of that Schedule applies for the purpose of determining whether an individual is included in the adults' barred list.

(4) Part 3 of that Schedule contains supplementary provision.

(5) In respect of an individual who is included in a barred list, DBS must keep other information of such description as is prescribed.'

Children's barred list

3. The relevant provisions (paragraphs 1 to 4) of Part 2 of Schedule 3 to the Act, on the children's barred list, mirror those in paragraph 8 to 11 for vulnerable adults which are provided below.

Vulnerable adults' barred list

4. The relevant provisions (paragraphs 8 to 11) of Part 2 of Schedule 3 to the Act, on the vulnerable adults' barred list, provide as follows:

8(1) This paragraph applies to a person if any of the criteria prescribed for the purposes of this paragraph is satisfied in relation to the person.

(2) Sub-paragraph (4) applies if it appears to DBS that—

(a) this paragraph applies to a person, and

(b) the person is or has been, or might in future be, engaged in regulated activity relating

to vulnerable adults.

……

(4) [DBS] must give the person the opportunity to make representations as to why the person should not be included in the adults' barred list.

(5) Sub-paragraph (6) applies if—

(a) the person does not make representations before the end of any time prescribed for the purpose, or

(b) the duty in sub-paragraph (4) does not apply by virtue of paragraph 16(2).

(6) If [DBS] —

(a) is satisfied that this paragraph applies to the person, and

(b) has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, it must include the person in the list.

(7) Sub-paragraph (8) applies if the person makes representations before the end of any time prescribed for the purpose.

(8) If [DBS] —

(a) is satisfied that this paragraph applies to the person,

(b) has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, and

(c) is satisfied that it is appropriate to include the person in the adults' barred list, it must include the person in the list.

9 (1) This paragraph applies to a person if–

(a) it appears to [DBS] that the person [—]

[(i) has (at any time) engaged in relevant conduct, and

(ii) is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, and]

(b) [DBS] proposes to include him in the adults' barred list.

(2) [DBS] must give the person the opportunity to make representations as to why he should not be included in the adults' barred list.

(3) [DBS] must include the person in the adults' barred list if–

(a) it is satisfied that the person has engaged in relevant conduct, […]

[(aa) it has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, and]

(b) it [is satisfied] that it is appropriate to include the person in the list.

[Emphasis added]

10 (1) For the purposes of paragraph 9 relevant conduct is–

(a) conduct which endangers a vulnerable adult or is likely to endanger a vulnerable adult;

(b) conduct which, if repeated against or in relation to a vulnerable adult, would endanger that adult or would be likely to endanger him;

(c) conduct involving sexual material relating to children (including possession of such material);

(d) conduct involving sexually explicit images depicting violence against human beings (including possession of such images), if it appears to [DBS] that the conduct is inappropriate;

(e) conduct of a sexual nature involving a vulnerable adult, if it appears to [DBS] that the conduct is inappropriate.

(2) A person's conduct endangers a vulnerable adult if he–

(a) harms a vulnerable adult,

(b) causes a vulnerable adult to be harmed,

(c) puts a vulnerable adult at risk of harm,

(d) attempts to harm a vulnerable adult, or

(e) incites another to harm a vulnerable adult.

(3) “Sexual material relating to children” means–

(a) indecent images of children, or

(b) material (in whatever form) which portrays children involved in sexual activity and which is produced for the purposes of giving sexual gratification.

(4) “Image” means an image produced by any means, whether of a real or imaginary subject.

(5) A person does not engage in relevant conduct merely by committing an offence prescribed for the purposes of this sub-paragraph.

(6) For the purposes of sub-paragraph (1)(d) and (e), [DBS] must have regard to guidance issued by the Secretary of State as to conduct which is inappropriate.

11 (1) This paragraph applies to a person if–

(a) it appears to [DBS] that the person [—]

[(i) falls within sub-paragraph (4), and

(ii) is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, and]

(b) [DBS] proposes to include him in the adults' barred list.

(2) [DBS] must give the person the opportunity to make representations as to why he should not be included in the adults' barred list.

(3) [DBS] must include the person in the adults' barred list if–

(a) it is satisfied that the person falls within sub-paragraph (4), […]

[(aa) it has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, and]

(b) it [is satisfied] that it is appropriate to include the person in the list.

(4) A person falls within this sub-paragraph if he may–

(a) harm a vulnerable adult,

(b) cause a vulnerable adult to be harmed,

(c) put a vulnerable adult at risk of harm,

(d) attempt to harm a vulnerable adult, or

(e) incite another to harm a vulnerable adult.

5. There are three separate ways in which a person may be included in the barred lists under Schedule 3 to the Act.

6. The first category is under paragraphs 1 and 7 of Schedule 3 to the Act, where a person will be automatically included in the lists without any right to make representations ('autobar'). This is where they have been convicted of certain specified criminal offences or made subject to specified orders set out within Regulations 3 and 5 and paragraphs 1 and 3 of the Schedule to The Safeguarding Vulnerable Groups Act 2006 (Prescribed Criteria and Miscellaneous Provisions) Regulations 2009 ('The Regulations').

7. The second category is under paragraphs 2 and 8 of Schedule 3 to the Act, where a person will be included in the lists if they meet the prescribed criteria. The person who is proposed to be barred has a right to make representations to the DBS ('autobar with representations'). There are prescribed criteria where a person has been convicted of certain specified criminal offences or made subject to specified orders but nonetheless is entitled to make representations as to inclusion on the list. The prescribed criteria are set out within Regulations 4 and 6 and paragraphs 2 and 4 of the Schedule to The Safeguarding Vulnerable Groups Act 2006 (Prescribed Criteria and Miscellaneous Provisions) Regulations 2009.

8. If a person falls within the prescribed criteria under the Regulations, they satisfy subparagraph (1) of the following paragraphs and therefore under paragraphs 2(6), (2)(8), 8(6) or 8(8) of Schedule 3 to the Act, the DBS will include the person in the children's or adults' barred list if it:

a) is satisfied that this paragraph applies to the person,

b) has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to [children or adults], and [so long as the person has made representations regarding their inclusion]

c) is satisfied that it is appropriate to include the person in the children's barred list, it must include the person in the list.

9. In contrast, this appeal concerns the third category ('discretionary barring') where a person does not meet the prescribed criteria (has not been convicted of specified criminal offences nor made subject to specified orders as set out within the Regulations and the Schedule thereto), and therefore paragraphs 3 and 9 of Schedule 3 to the Act apply.

10. It is the third category under which the DBS made the decision to bar the Appellant.

11. Under paragraphs 3(3) and 9(3) of Schedule 3 the DBS must include the person in the children's and adults' barred list if:

(a) it is satisfied that the person has engaged in relevant conduct, and

(aa) it has reason to believe that the person is or has been or might in future be, engaged in regulated activity relating to children or vulnerable adults, and

(b) it is satisfied that it is appropriate to include the person in the list.

12. 'Relevant conduct' is defined under paragraphs 4 and 10 of Schedule 3 to the Act as set out above.

13. The difference between the sets of criteria in the second and third categories is where a person meets the prescribed criteria for automatic inclusion with representations (has been convicted of a specified offence or made subject of a specified order), the DBS is not required to decide if the person has been engaged in relevant conduct. This is because the statutory scheme appears designed so that a specified criminal conviction which satisfies the prescribed criteria, renders the need to make any findings about a person's conduct otiose.

The Right of Appeal and jurisdiction of the Upper Tribunal

14. Appeal rights against decisions made by the Respondent (DBS) are governed by section 4 of the Act. Section 4(1) provides for a right of appeal to the Upper Tribunal against a decision to include a person in a barred list or not to remove them from the list. Section 4 states:

'4(1) An individual who is included in a barred list may appeal to the [Upper] Tribunal against—

(a) . . .

(b) a decision under paragraph [2,] 3, 5, [8,] 9 or 11 of [Schedule 3] to include him in the list;

(c) a decision under paragraph 17[, 18 or 18A] of that Schedule not to remove him from the list.

(2) An appeal under subsection (1) may be made only on the grounds that DBS has made a mistake —

(a) on any point of law;

(b) in any finding of fact which it has made and on which the decision mentioned in that subsection was based.

(3) For the purposes of subsection (2), the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact.

(4) An appeal under subsection (1) may be made only with the permission of the Upper Tribunal.

(5) Unless the Upper Tribunal finds that [the DBS] has made a mistake of law or fact, it must confirm the decision of DBS.

(6) If the Upper Tribunal finds that DBS has made such a mistake it must—

(a) direct DBS to remove the person from the list, or

(b) remit the matter to DBS for a new decision.

(7) If the Upper Tribunal remits a matter to [the DBS] under subsection (6)(b)—

(a) the Tribunal may set out any findings of fact which it has made (on which DBS must base its new decision); and

(b) the person must be removed from the list until DBS makes its new decision, unless the Upper Tribunal directs otherwise.'

[Emphasis added]

15. Thus section 4(2) of the Act provides that a person included in (or not removed from) either barred list may appeal to the Upper Tribunal on the grounds that the DBS has made a mistake of law (including the making of an irrational or disproportionate decision) or a mistake of fact on which the decision was based. Although not provided for by statute, the common law requires that any mistake of fact or law, normally referred to as 'errors', must be material to the ultimate decision ie. that they may have changed the outcome of the decision – see [102]-[103] of the judgment in *R v (Royal College of Nursing and Others) v Secretary of State for the Home Department* [2010] EWHC 2761 (Admin) ('*RCN')*:

'102.During oral submissions there was some debate about the meaning to be attributed to the phrase "a mistake ….in any finding of fact within section 4(2)(b) of the Act". I can see no reason why the sub-section should be interpreted restrictively.

In my judgment the Upper Tribunal has jurisdiction to investigate any arguable alleged wrong finding of fact provided the finding is material to the ultimate decision.

103. In light of the fact that the Upper Tribunal can put right any errors of law and any material errors of fact and, further, can do so at an oral hearing if that is necessary for the fair and just disposition of the appeal I have reached the conclusion that the absence of a right to an oral hearing before the Interested Party and the absence of a full merits based appeal to the Upper Tribunal does not infringe Article 6 EHCR. To repeat, an oral hearing before the Interested Party is permissible under the statutory scheme and there is no reason to suppose that in an appropriate case the Interested Party would not hold such a hearing as Ms Hunter asserts would be the case. I do not accept that this possibility is illusory as suggested on behalf of the Claimants. Indeed, a failure or refusal to conduct an oral hearing in circumstances which would allow of an argument that the failure or refusal was unreasonable or irrational would itself raise the prospect of an appeal to the Upper Tribunal on a point of law. Further, any other error of law and relevant errors of fact made by the Interested Party can be put right on an appeal which, itself, may be conducted by way of oral hearing in an appropriate case.'

16. It flows from this that an appeal to the Upper Tribunal can only succeed if the DBS made a mistake in fact in making a finding upon which the decision is based or made a mistake in law in any way in making its decision – see section 4(5) of the Act.

Mistake or error of fact

17. Some mistakes of fact will amount to errors of law, for example, if it is demonstrated that the DBS took into account evidence that was irrelevant, or failed to take into account evidence that was relevant or made a finding that was unreasonable – no reasonable tribunal could have arrived at upon the evidence before it. These are all errors of law that might be committed in relation to a factual finding.

18. However, by virtue of section 4(2), mistakes of fact which are not also errors of law may also constitute a ground upon which the Upper Tribunal may interfere with a DBS finding upon which a decision is based. This type of mistake of fact might arise if the DBS recorded or interpreted evidence before it inaccurately or incorrectly or relied upon evidence which was inaccurate or incorrect as a matter of fact.

19. So long as the DBS takes account of the relevant evidence, provides rational reasons and makes no errors in the facts relied upon for rejecting a barred person's account on the balance of probabilities, this is unlikely to give rise to an arguable mistake of fact. In other words, an appeal before the Upper Tribunal is not a full merits appeal on the facts – see [104] of the *RCN* judgment below.

20. The Upper Tribunal must begin by examining the DBS decision and deciding whether it made any mistakes when finding the facts (such findings will have been made based on the documentary material available to it). However, the Upper Tribunal may also make its own fresh findings of fact having heard all

potentially relevant evidence and witnesses during the appeal process by which it may determine whether the DBS made a mistake of fact which was material to the making of its decision.

21. The extent of the jurisdiction for the Upper Tribunal to determine mistakes of fact by the DBS and make its own findings of fact was outlined in *PF v Disclosure and Barring Service* [2020] UKUT 256 (AAC) at [51]:

'Drawing the various strands together, we conclude as follows:

a) In those narrow but well-established circumstances in which an error of fact may give rise to an error of law, the tribunal has jurisdiction to interfere with a decision of the DBS under section 4(2)(a).
b) In relation to factual mistakes, the tribunal may only interfere with the DBS decision if the decision was based on the mistaken finding of fact. This means that the mistake of fact must be material to the decision: it must have made a material contribution to the overall decision.
c) In determining whether the DBS has made a mistake of fact, the tribunal will consider all the evidence before it and is not confined to the evidence before the decision-maker. The tribunal may hear oral evidence for this purpose.
d) The tribunal has the power to consider all factual matters other than those relating only to whether or not it is appropriate for an individual to be included in a barred list, which is a matter for the DBS (section 4(3)).
e) In reaching its own factual findings, the tribunal is able to make findings based directly on the evidence and to draw inferences from the evidence before it.
f) The tribunal will not defer to the DBS in factual matters but will give appropriate weight to the DBS's factual findings in matters that engage its expertise. Matters of specialist judgment relating to the risk to the public which an appellant may pose are likely to engage the DBS's expertise and will therefore in general be accorded weight.
g) The starting point for the tribunal's consideration of factual matters is the DBS decision in the sense that an appellant must demonstrate a mistake of law or fact. However, given that the tribunal may consider factual matters for itself, the starting point may not determine the outcome of the appeal. The starting point is likely to make no practical difference in those cases in which the tribunal receives evidence that was not before the decision-maker.'

22. The more recent judgment of the Court of Appeal in *Disclosure and Barring Service v AB* [2021] EWCA Civ 1575 ('AB'), addressed the Tribunal's fact-finding jurisdiction when remitting cases to the DBS having allowed an appeal:

'55. The Upper Tribunal also made findings of fact and made comments on other matters. Section 4(7) of the Act provides that where the Upper Tribunal remits a matter to the DBS it "may set out any findings of fact which it has made (on which DBS must base its new decision)". It is neither necessary nor feasible to set out precisely the limits on that power. The following should, however, be borne in mind.

First, the Upper Tribunal may set out findings of fact. It will need to distinguish carefully a finding of fact from value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness. The Upper Tribunal may do the former but not the latter. By way of example only, the fact that a person is married and the marriage subsists may be a finding of fact. A reference to a marriage being a "strong" marriage or a "mutually-supportive one" may be more of a value judgment rather than a finding of fact. A reference to a marriage being likely to reduce the risk of a person engaging in inappropriate conduct is an evaluation of the risk. The third "finding" would certainly not involve a finding of fact.

Secondly, an Upper Tribunal will need to consider carefully whether it is appropriate for it to set out particular facts on which the DBS must base its decision when remitting a matter to the DBS for a new decision. For example, Upper Tribunal would have to have sufficient evidence to find a fact. Further, given that the primary responsibility for assessing the appropriateness of including a person in the children's barred list (or the adults' barred list) is for the DBS, the Upper Tribunal will have to consider whether, in context, it is appropriate for it to find facts on which the DBS must base its new decision.'

Appropriateness

23. On an appeal, the Upper Tribunal ('UT') must confirm the DBS's decision unless it finds a material mistake of law or fact. If the UT finds such a mistake, it must remit the matter to the DBS for a new decision or direct the DBS to remove the person from the list.

24. Under section 4(3) of the Act, the decision whether or not it is "appropriate" for an individual to be included in a barred list is "not a question of law or fact". Section 4(3) of the Act therefore provides that the appropriateness of a person's inclusion on either barred list is not within the Upper Tribunal's jurisdiction on an appeal. Unless the DBS has made a material error of law or fact the Upper Tribunal may not interfere with the decision - *RCN* at [104]:

'104.I am more troubled by the absence of a full merits based appeal but I am persuaded that its absence does not render the scheme as a whole in breach of Article 6 for the following reasons.

First, the Interested Party is a body which is independent of the executive agencies which will have referred individuals for inclusion/possible inclusion upon the barred lists. It is an expert body consisting of a board of individuals appointed under regulations governing public appointments and a team of highly-trained case workers. Paragraph 1(2)(b) of Schedule 1 to the 2006 Act specifies that the chairman and members "must appear to the Secretary of State to have knowledge or experience of any aspect of child protection or the protection of vulnerable adults."

The Interested Party is in the best position to make a reasoned judgment as to when it is appropriate to include an individual's name on a barred list or remove an individual from the barred list. In the absence of an error of law or fact it is difficult to envisage a situation in which an appeal against the judgment of the Interested Party would have any realistic prospect of success.

Second, if the Interested Party reached a decision that it was appropriate for an individual to be included in a barred list or appropriate to refuse to remove an individual from a barred list yet that conclusion was unreasonable or irrational that

would constitute an error of law. I do not read section 4(3) of the Act as precluding a challenge to the ultimate decision on grounds that a decision to include an individual upon a barred list or to refuse to remove him from a list was unreasonable or irrational or, as Mr. Grodzinski submits, disproportionate. In my judgment all that section 4(3) precludes is an appeal against the ultimate decision when that decision is not flawed by any error of law or fact.'

25. The fact that the appropriateness of barring is not to be examined as an error of fact in the light of section 4(3) of the Act was recently reiterated in *DBS v AB [2021] EWCA Civ 1575*. The Court of Appeal explained the nature of the Upper Tribunal's jurisdiction at [67]-[68]:

'67. The context, and the nature of the statutory scheme, is that it creates a system for the protection of children and vulnerable adults. It provides for an independent body, the DBS, to determine whether specified criteria are met and, in the case of paragraph 3 of Schedule 3 to the Act, that it is appropriate to include a person's name in the children's barred list or the adults' barred list. There is a safeguard for individuals in that they may appeal to the Upper Tribunal on the basis that the DBS has made an error of law or fact. The Upper Tribunal cannot consider the appropriateness of the decision to include or retain the person's name in a barred list when deciding if the DBS had made such an error. If the DBS has not made an error of law or fact, the Upper Tribunal must confirm the decision of the DBS (section 4(5) of the Act). Only if the DBS has made an error of law or fact, can the Upper Tribunal determine whether to remit or direct removal of the person's name from the list (section 4(6) of the Act).

68.The scheme as a whole appears, therefore, to contemplate that the DBS is the body charged with decisions on the appropriateness of inclusion of a person within a barred list. The power in section 4(6) of the Act needs to be read in that context. The context would not readily indicate that the Upper Tribunal is intended to be free to decide for itself questions concerning the appropriateness of inclusion of a person in a barred list. It is unlikely, therefore, that section 4(6) of the Act was intended to give the Upper Tribunal the power to direct removal because it, the Upper Tribunal, thinks inclusion on the list is no longer appropriate. It is more consistent with the statutory scheme that the power is to be exercised when the only decision that the DBS could lawfully make would be to remove the person from the barred list.'

26. Therefore, the DBS is empowered and required to make a judgement as the expert body appointed by Parliament, whether the relevant conduct is such that, in all the circumstances, makes it "appropriate" to include the individual in the CBL. In so doing it will normally take into account a risk assessment, that it performs in relation to the individual it proposes to bar. However, the DBS concedes that the rationality and proportionality of any risk assessment it conducts can be challenged as having been made in error of law.

Mistake or error of law

27. A mistake or error of law includes instances where the DBS have got the particular legal test or tests wrong (applied or interpreted the law incorrectly), or failed to consider all the relevant evidence or made a perverse, unreasonable or irrational finding of fact, or failed to explain the decision properly by giving sufficient or accurate reasons, or breached the rules of

natural justice by failing to provide a fair procedure or hearing (in the rare circumstances where it considers oral representations).

28. A mistake of law will also include instances where the decision to bar was disproportionate.

Proportionality

29. The UT is not permitted to carry out a full merits reconsideration of, or to revisit, the appropriateness of R's decision to bar; but it does have jurisdiction to determine proportionality and rationality in relation to the DBS's judgment as to the risk that a barred person poses and whether they should be included on the list, according appropriate weight (in so doing) to the DBS's decision as the body particularly equipped, and expressly enabled by statute, to make safeguarding decisions of this specific kind (e.g. B v Independent Safeguarding Authority (CA) [2012] EWCA Civ 977, [2013] 1 WLR 308 ; *Independent Safeguarding Authority v SB (Royal College of Nurses intervening)* [2012] EWCA Civ 977; [2013] 1WLR 308 ('B').

30. Maintenance of public confidence, in the regulatory scheme and the barred lists, will "always" be a material factor when seeking to balance the rights of the individual and the interests of the community (e.g. B). Where it is alleged that the decision to include a person in a barred list is disproportionate to the relevant conduct or risk of harm relied on by the DBS, the Tribunal must, in determining that issue, give proper weight to the view of the DBS as it is enabled by statute to decide appropriateness - see the Court of Appeal's judgment in B at paragraphs [16]-[22] (ISA formerly assuming the role of the DBS):

'16. The ISA is an independent statutory body charged with the primary decision making tasks as to whether an individual should be listed or not. Listing is plainly a matter which may engage Article 8 of the European Convention on Human Rights and Fundamental Freedoms (ECHR). Article 8 provides a qualified right which will require, among other things, consideration of whether listing is "necessary in a democratic society" or, in other words, proportionate. In *R (Quila) v Secretary of State for the Home Department* [2011] 3 WLR 836, Lord Wilson summarised the approach to proportionality in such a context which had been expounded by Lord Bingham in *Huang v Secretary of State for the Home Department* [2007] 2 AC 167 (at paragraph 19). Lord Wilson said (at paragraph 45) that:

> "… in such a context four questions generally arise, namely: (a) is the legislative object sufficiently important to justify limiting a fundamental right?; (b) are the measures which have been designed to meet it rationally connected to it?; (c) are they no more than are necessary to accomplish it?; and (d) do they strike a fair balance between the rights of the individual and the interests of the community?"

There, as here, the main focus is on questions (c) and (d). In *R (SB) v Governors of Denbigh High School* [2007] 1 AC 100 Lord Bingham explained the difference between such a proportionality exercise and traditional judicial review in the following passage (at paragraph 30):

> "There is no shift to a merits review, but the intensity of review is greater than was previously appropriate, and greater even than the heightened scrutiny test … The domestic court must now make a value judgment, an evaluation, by reference to the circumstances prevailing at the relevant time … Proportionality must be judged objectively by the court …"

17. All that is now well established. The next question – and the one upon which Ms Lieven focuses – is how the court, or in this case the UT, should approach the decision of the primary decision-maker, in this case the ISA. Whilst it is apparent from authorities such as *Huang* and *Quila* that it is wrong to approach the decision in question with "deference", the requisite approach requires

> "… the ordinary judicial task of weighing up the competing considerations on each side and according appropriate weight to the judgment of a person with responsibility for a given subject matter and access to special sources of knowledge and advice."

Per Lord Bingham in *Huang* (at paragraph 16) and, to like effect, Lord Wilson in *Quila* (at paragraph 46). There is, in my judgment, no tension between those passages and the approach seen in *Belfast City Council v Miss Behavin' Ltd* [2007] UKHL 19 which was concerned with a challenge to the decision of the City Council to refuse a licensing application for a sex shop on the grounds that the decision was a disproportionate interference with the claimant's Convention rights. Lord Hoffmann said (at paragraph 16):

> "If the local authority exercises that power rationally and in accordance with the purposes of the statute, it would require very unusual facts for it to amount to a disproportionate restriction on Convention rights."

Lady Hale added (at paragraph 37):

> "Had the Belfast City Council expressly set itself the task of balancing the rights of individuals to sell and buy pornographic literature and images against the interests of the wider community, the court would find it hard to upset the balance which the local authority had struck."

These passages are illustrative of the need to give appropriate weight to the decision of a body charged by statute with a task of expert evaluation.

…….

22. This brings me to two particular points. First, there is the fact that, unlike the ISA, the UT saw and heard SB giving evidence. However, it cannot be suggested that it was unlawful for the ISA not to do so. It had had at its disposal a wealth of material, not least the material upon which the criminal conviction had been founded and which had informed the sentencing process. The objective facts were not in dispute. Secondly, Mr Ian Wise QC, on behalf of the Royal College of Nursing, emphasises the fact that the UT is not a non-specialist court reviewing the decision of a specialist decision-maker, which would necessitate the according of considerable weight to the original decision. It is itself a specialist tribunal. Whilst there is truth in this submission, it has its limitations for the following reasons: (1) unlike its predecessor, the Care Standards Tribunal, it is statutorily disabled from revisiting the appropriateness of an individual being included in a Barred List, *simpliciter*; and (2) whereas the UT judge is flanked by non-legal members who themselves come from a variety of relevant professions, they are or may be less specialised than the ISA decision-makers who, by paragraph 1(2) of schedule 1 to the 2006 Act "must appear to the Secretary of State to have knowledge or experience of any aspect of child

protection or the protection of vulnerable adults". I intend no disrespect to the judicial or non-legal members of the UT in the present or any other case when I say that, by necessary statutory qualification, the ISA is particularly equipped to make safeguarding decisions of this kind, whereas the UT is designed not to consider the appropriateness of listing but more to adjudicate upon "mistakes" on points of law or findings of fact (section 4(3)).'

31. In summary, questions of the proportionality of DBS's decisions to include individuals on the barred lists should be examined applying the tests laid down by Lord Wilson in *R (Aguilar Quila) v Secretary of Stage for the Home Department* [2012] 1 AC 621 at para 45:

…But was it "necessary in a democratic society"? It is within this question that an assessment of the amendment's proportionality must be undertaken. In *Huang v Secretary of State for the Home Department* [2007] 2 AC 167, Lord Bingham suggested, at para 19, that in such a context four questions generally arise, namely:

a) is the legislative objective sufficiently important to justify limiting a fundamental right?

b) are the measures which have been designed to meet it rationally connected to it?

c) are they no more than are necessary to accomplish it?

d) do they strike a fair balance between the rights of the individual and the interests of the community?

32. In assessing proportionality, the Upper Tribunal has '*…to give appropriate weight to the decision of a body charged by statute with a task of expert evaluation*' (see *Independent Safeguarding Authority v SB* [2012] EWCA Civ 977 at [17] as set out above).

Burden and Standard of proof

33. The burden of proof is upon the DBS to establish the facts when making its findings of relevant conduct in its barring decision. Thereafter on the appeal to the UT, the burden is on the Appellant to establish a mistake of fact. The standard of proof to which the DBS and the Upper Tribunal must make findings of fact is on the balance of probabilities, ie. what is more likely than not. This is a lower threshold than the standard of proof in criminal proceedings (being satisfied so that one is sure or beyond reasonable doubt).