IN THE UPPER TRIBUNAL **Appeal No. UA-2023-000295-V**
ADMINISTRATIVE APPEALS CHAMBER **[2024] UKUT 250 (AAC)**

The Upper Tribunal has ordered that there is to be no disclosure or publication of any matter likely to lead members of the public to identify JW or the service user concerned (Miss X)

Between:

JW

Appellant

- v –

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Citron, Ms Jacoby and Mr Graham

Decided following an oral hearing at Field House, Breams Buildings, London EC4 on 22 May 2024

Representation:

Appellant:	by Ms Wafa Shah of counsel, instructed by Duncan Lewis Solicitors
Respondent:	by Mr Tom Tabori of counsel, instructed by DBS Legal

DECISION

The decision of the Upper Tribunal is to ALLOW the appeal. The Respondent made a mistake on a point of law or in a finding of fact it made and on which its decision of 12 December 2022 (reference DBS6191 00984617743) to include JW in the children's and adults' barred lists was based. The Upper Tribunal REMITS the matter to the Respondent for a new decision, which must be based on the findings of fact set out at paragraphs 4.i, 14, 15, 34 and 35 of the "Reasons" section below. The Upper Tribunal DIRECTS that JW remains included in the two barred lists until the Respondent makes its new decision.

REASONS FOR DECISION

This appeal

1. This is an appeal against the decision ("**DBS's decision**") of the Respondent ("**DBS**") dated 12 December 2022 to include JW in the children's and adults' barred lists.

DBS's decision

2. DBS's decision was made under paragraphs 3 and 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 (the "**Act**"). These provide (in very similar terms as regards both children and vulnerable adults) that DBS must include a person in the relevant barred list if
    a. it is satisfied that the person has engaged in relevant conduct,
    b. it has reason to believe that the person is, or has been, or might in the future be, engaged in regulated activity relating to children/vulnerable adults, and
    c. it is satisfied that it is appropriate to include the person in the list.
3. Under paragraphs 4 and 10, "relevant conduct" includes, amongst other things, conduct which endangers a child/vulnerable adult or is likely to endanger a child/vulnerable adult, or which, if repeated against or in relation to a child/vulnerable adult, would endanger them or would be likely to endanger them; and a person's conduct "endangers" a child/vulnerable adult if she (amongst other things)
    a. harms them or
    b. causes them to be harmed or
    c. puts them at risk of harm.
4. The letter conveying DBS's decision (the "**decision letter**"):
    i. found that
        a. on multiple occasions before and including on the morning of 14 June 2022, whilst working as a care assistant in a supported living home, JW prevented a service user (Miss X), a 19-year-old with complex needs, from leaving her room as she wished by holding the door closed, causing her emotional distress; and
        b. on 14 June 2022, JW told Miss X that she did not like working with her and called her violent and unpredictable;

        (we refer to the above as DBS's "**core factual findings**")

    ii. stated that DBS was satisfied that JW engaged in relevant conduct in relation to vulnerable adults, on the basis that she had engaged

in conduct which endangered a vulnerable adult or was likely to endanger a vulnerable adult;

iii. stated that DBS considered that JW had engaged in relevant conduct in relation to children: conduct which, if repeated against or in relation to a child, would endanger that child or would be likely to endanger them;

iv. stated that DBS was satisfied that JW, in preventing Miss X from leaving the room on multiple occasions by holding the door closed, had placed Miss X at risk of physical harm (as well as causing her significant emotional distress), because JW was aware that Miss X was known to engage in self-injurious behaviour when distressed;

v. cited a number of aspects of JW's representations to DBS which, DBS found, indicated significant lack of insight and empathy into Miss X;

vi. found that JW's poor problem-solving and coping skills directly contributed to her behaviour towards Miss X, as JW maintained that she held the door closed on Miss X as a means of dealing with her challenging behaviour;

vii. acknowledged that JW had worked in care settings for 25 years.

Jurisdiction of the Upper Tribunal

5. Section 4(2) of the Act confers a right of appeal to the Upper Tribunal against a decision by DBS under paragraphs 3 and 9 of Schedule 3 to the Act (amongst other provisions) only on grounds that DBS has made a mistake
    a. on any point of law; or
    b. in any finding of fact on which the decision was based.
6. The Act says that "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)).

The grant of permission to appeal

7. In response to case management directions permitting JW (following disclosure by DBS of documents held by it) to amend her "reasons for appealing" as set out in her application form for permission to appeal, JW's solicitors submitted a "perfected grounds of appeal" document on 4 August 2023. This made a number of factual assertions:
    a. at paragraphs 7 to 10, it asserted facts about JW's background
    b. at paragraphs 12 to 26, it asserted facts about the "background" to the "barring incident"

c. at paragraphs 27 to 34, it asserted facts about the "barring incident" itself;

It then recited relevant law. At paragraph 41, under the heading "Grounds", it said that

d. JW accepted that the "primary finding of fact" made by DBS was accurate

e. JW's appeal was on the basis that

(i) DBS failed to show that JW engaged in relevant conduct; and/or

(ii) DBS's decision was disproportionate, irrational and/or perverse in all the circumstances;

The document then set out enumerated grounds as follows:

f. ground 1: mistake of fact and error of law: primary finding of fact of creating a risk or causing emotional and physical harm – paragraphs 43 and 44; paragraph 44 contains 13 bullet points under the heading "Holding the door closed", and one under the heading "Telling Miss X that she did not like working with her and called her violent and unpredictable", all making factual assertions

g. ground 2: secondary findings of fact re: risk posed

h. ground 3: error of law: the structured judgement process is flawed

i. ground 4: proportionality of the barring decision.

8. Permission to appeal was given by the Upper Tribunal (Judge Citron) in a decision (the "**permission decision**") issued on 5 October 2023. The reasons given in the permission decision were as follows:

> "The grounds of appeal essentially rest on factual assertions by JW, to the effect that the key finding of fact on which DBS's decision was based failed to take into account relevant and important contextual facts such as:
>
> • it was not JW's role to provide care for Miss X (see paragraphs 15 and 23 of the "perfected" grounds of appeal)
>
> • only two female staff were permitted to change Miss X's pad (see paragraph 28 of the "perfected" grounds of appeal)
>
> • Miss X had caused serious physical injury to other members of staff (see paragraph 25 of the "perfected" grounds of appeal)
>
> • JW held the door closed to protect herself and Miss X (see paragraphs 29 and 44 of the "perfected" grounds of appeal)
>
> It seems to me arguable that factual assertions of this kind could be proved by JW on the balance of probabilities, and that, if they were so proved, that DBS made a mistake in the finding of fact on which the decision was based, and/or on a point of law, by omitting important and relevant context."

The evidence before the Upper Tribunal

9. JW provided a witness statement, dated 20 December 2023, with several "exhibits"; she also gave oral evidence at the hearing, and was cross examined by Mr Tabori.

10. On the day before the hearing, JW's solicitors submitted a witness statement (dated that day, 21 May 2024) of Lisa Fletcher, who had worked at the same care home as JW, and in particular had worked with Miss X there. We were told that the reason for the lateness (case management directions had required details of the evidence JW intended to adduce, by late December 2023) was the difficulty in getting hold of Ms Fletcher.

11. We decided, at the hearing, to admit Ms Fletcher's late evidence, and permit her to give oral evidence (via video link); our natural concerns about unfairness to DBS by reason of "ambush" were assuaged by the fact that Ms Fletcher's statement largely repeated material from her already in the bundle (exhibits to JW's witness statement included emails from Ms Fletcher of 6 and 12 December 2023); in substance, the "last minute" development was not the evidence itself, but the fact that Ms Fletcher was making herself available to give oral evidence, and be cross examined; overall, it seemed to us fair and just to allow this to happen, so that relevant evidence could be fairly tested.

12. The documentary evidence in the bundle included:

    a. the barring referral form submitted by the management of the care home to DBS;

    b. a 1-page hand-written document dated 14 June; this was signed by NJ (another care worker in the home) and said:

> "5.30 (roughly) I came to check-in with the wake night (JW) in case of any issues, only to discover JW holding the door to keep Miss X in her room. I did ask JW about it. Her answer was she didn't want to deal with Miss X till day staff arrived. Miss X's behaviours became negative as a result. I did prep her meds and feed as requested but I had to try and settle her from agitation. I am blowing the whistle now as JW's dismissive attitude to Miss X has turned to controlling acts [the next words are difficult to make out] on edge as Mr Y may be affected by this"

    c. 1-page typed investigation minutes, dated 14 June 2022, signed by NJ as "employee" and by the care home's service manager as "investigator"; this says that when NJ went downstairs at the home at 5.30 "to check if there were any issues overnight", he saw JW holding Miss X's door and asking Miss X "to go back to sleep until day staff come in"; when questioned by NJ, JW reportedly said: "I can't be dealing with Miss X until day staff arrive"

    d. 1-page hand-written document dated 15 June 2022 and setting out a list of 12 things that Miss X had "said" or "stated"; it was signed by named individuals as "a true statement of Miss X's wishes"; it include that Miss X had said the following:

        (i) JW had held the door lots of times/more than 10 times

        (ii) JW held the door for some time – more than 1 hour

    e. email exchange of 14 June 2022 between the care home service manager and JW, describing the incident that morning with Miss X, as follows:

> "Miss X woke up at 6 pm, I [JW] went into her and said to her she can't get up as day staff are not here. With that I stood outside her door and didn't let her out. NJ came down and I said I would only let her out if NJ looked after her.
>
> NJ proceeded to go into Miss X, he gave her feed and medication in her wheelchair. NJ came back to the lounge with Miss X in her wheelchair, Miss X was not happy she tried to kick the lamp over. I said to Miss X 'I don't like working with you because you are violent and unpredictable', I went outside as I don't like being abused by Miss X
>
> NJ tried to get us both talking, I put her hair in a ponytail. She proceeded to kick at me in my lower back. No incident form was completed. …
>
> I left at 6.45 when day [staff] arrived".

f. hand-written investigation meeting minutes (4 pages), dated 15 June 2022; this had notes of 11 questions asked of JW by the care home's service manager as "investigator"; the 10th and 11th of these are quoted at paragraph 27 below

g. a hand-written account by JW, dated 15 June

h. the care home service manager's "internal investigation summary report" dated 16 June 2022 (2 pages)

i. disciplinary meeting minutes of 22 June 2022 (4 pages) signed by JW as well as care home's "registered manager" as "chair"; in this, JW is recorded as saying that she did not work with Miss X; she did not understand sign language; she was not allowed to change Miss X's pad, and that Miss X always wants her to; that Miss X became agitated when JW cannot change her pad, which results in Miss X kicking and hitting. It records JW saying that she felt it was a "no win" situation as between her and Miss X, as she was not able to change her pad; she did not want Miss X to get hurt but did not know how to pacify Miss X. It records JW as saying she had not read Miss X's support plan as she had always been told she was not there for Miss X (she was there for Mr Y). It records JW as saying that incidents in which she had held Miss X's door closed had occurred about three times

j. notice of termination of employment for gross misconduct, dated 24 June 2022

k. Miss X's "communication passport", created on 16 November 2021 (15 pages); it explains that a "communication passport" is a "simple and practical guide to understanding and supporting a person's communication"

l. offer of employment letter to JW, dated 23 December 2019, for the role of support worker; and a job description

m. an undated 4-page representation letter from JW

n. DBS's "barring decision summary" document. This found:

   (i) definite concerns with respect to "callousness/lack of empathy" and to "poor problem solving/coping skills"

   (ii) some concerns with respect to "irresponsible and reckless".

Background facts

13. In this section we present some background facts that were not in dispute.

14. Miss X

a. had learning disability;

b. had "capacity";

c. was non-verbal: she communicated using "voca" (voice output communication aids) or sign language;

d. used a wheelchair;

e. mobilised in the home on her hands and knees;

f. had "behaviours" at times and had a "behaviour plan";

g. was PEG-fed;

h. required 2:1 care;

i. generally slept at night.

15. JW was a woman in her early 50s at the relevant time. She was a "waking support worker" at the supported living home. Her shift started at 9 pm.

Review of JW's evidence on disputed matters

16. In this section we summarise JW's evidence on more controversial matters and explain why, on the whole, we accept her evidence. As a backdrop to what follows, we generally found JW to be credible; it seemed to us that she was doing her best at the hearing to tell the truth; there was corroboration in the more-contemporaneous documentation for a good deal of what she said. On some matters, JW's evidence was also corroborated by that of Ms Fletcher (to whose evidence we also accorded weight, as she too presented herself to the hearing for cross examination, and seemed to us generally credible). All this does not, of course, mean that we take as "proven", everything that JW (or indeed Ms Fletcher) had to say: JW obviously had a personal interest in interpreting the events of, and leading up to, 14 June 2022 a certain way; and the events in question had occurred two years before the hearing, allowing memory to fade; we therefore reviewed her evidence critically, and noted with care the extent to which it was corroborated.

JW's role at the home

17. JW's evidence was that her role at the home was principally to support not Miss X, but another service user in the home, Mr Y, whom she had cared for for some time, prior to the incidents in question involving Miss X. JW's evidence was that Mr Y required "1:1" care/support during the night, to prevent him wandering into other people's rooms; and that JW's role was to provide that care for Mr Y.

18. We accept this evidence, noting that it was corroborated by an email from the care home's service manager to staff, of 19 November 2021 (an exhibit to JW's witness statement).

The requirements for Miss X's personal care

19. JW's evidence was that Miss X was supposed to have "2:1" support for all personal care and that personal care was to be provided by female staff; hence, JW was not allowed to change Miss X's pad when she woke in the night wanting it changed, because two female carers were required for that task (and no other female carer was available at the home, at night, at the relevant time). JW's evidence was that she had not been "allocated" as a carer for Miss X (in part because she was not fully trained in managing a PEG tube). JW's evidence

was that, accordingly, she had not seen Miss X's support plan, nor her "communication passport", prior to the events in question.

20. Ms Fletcher corroborated JW's evidence that Miss X required 2:1 personal care from female carers. Ms Fletcher's statement also said this: " … it was deemed and you [JW] were expected to see to Miss X because you were there, and Miss X was supposed to stay in bed all night, on occasions in which Miss X got up or required care, you were on your own and expected to deal with it, there was no support from management and on call would not always answer the call, or could be the other end of the country and haven't a clue who Miss X was or anything about Miss X care."

21. We again accept this evidence, noting that the care home management's own "internal investigation summary report" stated that Miss X required "2:1" care. It seems to us that although JW's principal responsibility was 1:1 care of Mr Y overnight, the management of the care home and JW had fallen into a 'working practice' of JW also checking in on Miss X when she woke at night (even though the management of the care home knew that JW could not administer personal care for Miss X on her own, was not trained in PEG-related matters, and generally had not been equipped to deal with Miss X).

Miss X's occasional "behaviour"

22. JW's evidence was that Miss X was known to grab, pull, kick and spit at staff; that she often expressed herself through violent behaviour; and that she had injured several staff members, included JW. Ms Fletcher gave corroborating evidence to similar effect. We accept this evidence.

The incidents where JW held the door to Miss X's room closed

23. JW's evidence was that, on a small number of occasions including on 14 June 2022, Miss X had woken up in the night or in the early morning (whilst JW was still on shift), and indicated she wanted something; JW went in to see what Miss X wanted; it became clear that Miss X wanted her pad changed; JW indicated that she was unable to do this and Miss X would have to go back to bed and wait until the day shift for her pad to be changed; this upset Miss X and she began to lunge at JW, potentially hitting her; to distance herself from Miss X, JW left the room and held the door shut; she continued to tell Miss X to go back to bed; JW stood holding Miss X's door closed this way for a few minutes.

24. We find it relatively straightforward to accept JW's evidence, up to this point in the narrative. It is similar to what JW was recorded as saying in the 22 June 2022 disciplinary meeting minutes; it is different, in a few details, from accounts given, by JW and NJ, immediately after the 14 June 2022 incident; but we do not see these differences in detail as significant (or as materially damaging to JW's credibility) and, moreover, we think the period of one week (14 to 22 June) in which JW was able to reflect, gather her thoughts, and present a cogent account, does not diminish the reliability of the account.

25. More difficult was what to make of the evidence of what Miss X's response was, to JW holding her door closed for a matter of minutes. JW's evidence was that, by holding the door closed, she was trying to, and did, de-escalate the situation; that she (JW) knew that Miss X was not harming herself (behind the closed door); that Miss X did go back to bed, because she knew JW was not

"engaging". In essence, JW's evidence was her holding Miss X's door closed "worked", in that it calmed Miss X down.

26. We do not wholly accept JW's evidence in this regard; we regard as credible the evidence that, in the 14 June 2022 incident, the door-holding ended with NJ, another care worker, stepping in and managing to calm Miss X (in other words, the door-holding did not "work" to calm Miss X). On the other hand, we do accept that JW's i*ntention* was to de-escalate the situation; and that when she stood holding the door closed, she kept a listening ear out for any signs that Miss X was in danger or self-harming.

27. There was considerable questioning at the hearing on the written note of two of the questions in the "investigation meeting minutes" of 15 June 2022 (signed by JW as well as the care home's service manager) (page 47 of the bundle), as follows:

> "Q10:
>
> service manager: Miss X has said you have held door multiple times?
>
> JW – did do once as JW wasn't allowed to change pad and Miss X kicked off so held door
>
> Q11:
>
> service manager - how often have you held the door?
>
> JW – have held door before
>
> Service manager – have you filled form out
>
> JW – no
>
> JW – third one – Miss X bang bang on door JW tried to put in her room Miss X tried to pull tube and JW held door"

28. DBS's case was that the final entry above was an "admission" by JW that, in one of the door-holding incidents prior to 14 June 2022, Miss X had tried to pull out her PEG as a result of her distress at having her door held shut. JW denied making such an admission: her evidence, as noted at paragraph 25 above, was that holding the door closed "worked" to de-escalate the situation.

29. Our view is that little of any significance can be gleaned from the final entry in the note of "Q11" above, for a number of reasons:

    a. it is unclear what is meant by "third one" – if it means the incident on 14 June, it is odd that no other account (such as NJ's) mentions Miss X trying to pull out her PEG

    b. the wording is somewhat garbled; and in it, the pulling out of the PEG is mentioned *before* JW holding the door closed – it is therefore unclear whether (as DBS interpret it), the door-holding *caused* the attempt to pull out the PEG or (per JW's account) that the door-holding was a *response* to Miss X having become upset (at JW refusing to change to her pad) (and the door-holding had the effect of calming her down)

    c. most significantly, in our view, is that Miss X attempting to pull out her PEG does not appear in the "internal investigation summary report" (16 June) or "disciplinary meeting minutes" (22 June) that were the precursors to JW's employment being terminated (24 June); it seems to

us that, if the final entry on "Q11" was understood at the time to have the meaning DBS now ascribe to it, the point would have featured in those reports, and probably expressly as a reason for JW's employment being terminated.

Our analysis of mistake of fact and/or law in DBS's decision

30. The "reasons" section of the permission decision (reproduced at paragraph 8 above) explained why permission to appeal was given - in short, because it was arguable that DBS had made a mistake in its core factual findings, and/or on a point of law, by omitting important and relevant context. The permission decision gave four examples, based on the large number of factual assertions made in the "perfected grounds of appeal" document submitted by JW, of what these *omitted* relevant and important contextual facts could be. Accordingly, in this section of our decision, we shall address (1) whether important and relevant factual context *was* omitted in DBS's core factual findings; and (2) whether in so doing, DBS made a mistake on a point of law or in a finding of fact on which its decision was based.

31. We note that the reasons given in the permission decision did not refer to the four enumerated grounds in JW's "perfected grounds of appeal" document, but rather stated that JW's grounds "essentially" rested on factual assertions indicating the omission of relevant and important contextual facts. We infer from this that, whilst not expressly restricting permission to the grounds set out in the permission decision's "reasons" section, the permission decision did not find the enumerated grounds to be arguable, but did find there to be an arguable case within the factual assertions put forward by JW in her "perfected" grounds; and that it was fair and just in the circumstances to give permission on the basis of that arguable case, as spelt out in the permission decision.

32. For the avoidance of doubt, we consider it fair and just to decide this appeal on the basis of the issues identified as arguable in the permission decision: the parties had ample opportunity to prepare their cases following issuance of the permission decision, with accompanying case management directions.

33. For completeness, we will also give our decision on the four enumerated ground in JW's "perfected" grounds document.

Was important and relevant context omitted?

34. In our view, the relevant facts as regards the door-holding incidents are as follows: in the incident on the morning of 14 June 2022, and a handful of similar incidents in the preceding weeks,

    a. JW was on waking night shift, with primary duty of caring for Mr Y;

    b. Miss X was generally asleep during the night;

    c. caring for Miss X was not JW's responsibility; she was not trained to help Miss X with her PEG; she had not read Miss X's care documents; nevertheless, the management of the care home had allowed a 'working practice' to develop such that JW would look in on Miss X if she woke during the night;

d. in each of the incidents, Miss X woke (in the middle of the night or in the early morning), wishing to have her pad changed; JW responded by going to look in on Miss X's room to see what was the matter;

e. JW could not help Miss X by changing her pad; it required two female carers to do so;

f. Miss X became upset because JW told her that her pad could not be changed and she had to go back to bed until the morning shift arrived;

g. when upset, Miss X would not uncommonly lunge at and try to hit carers; this happened here; JW responded by leaving the room and holding the door shut for several minutes;

h. JW's motivation in holding Miss X's door shut was both to prevent Miss X from coming after her and to de-escalate the situation; JW kept a listening ear for any indication that Miss X was in danger; the episode on 14 June 2022 ended with another carer, NJ, taking over from JW and managing to calm Miss X.

35. In our view, DBS's core factual finding about JW holding Miss X's door closed, omitted important and relevant context, namely that JW was in a very difficult position given the following combination of factors:

a. there being no way to change Miss X's pad, if she woke in the night, as only one female carer was available

b. JW being expected to look in on Miss X, if she woke in the night

c. JW being ill-equipped to deal with Miss X, as her principal duty was to look after Mr Y

d. Miss X's proclivity to become violent with carers, when she was upset and frustrated.

We would describe this state of affairs as one of management dysfunction: in other words, those responsible for managing the home had organised things such that there was no satisfactory way of dealing with the possibility of Miss X waking during the night wanting to have her pad changed.

Does this omission in DBS's decision amount to a mistake of law or fact?

36. It seems to us that a decision that omits important and relevant context for its core factual findings is potentially making a mistake

a. in a finding of fact on which it is based (see *PF v DBS* [2020] UKUT 256 (AAC) at [39]: "There is no limit to the form that a mistake of fact may take. It may consist of an incorrect finding, an incomplete finding, or an omission. …"); or

b. on a point of law, in that it is failing to take into account something material to the decision.

Whichever way one looks at it (mistake of fact or of law), it seems to us the key question is materiality – might the decision have been different, if the omitted matter had been included in the findings of fact or in the reasoning - or was the decision bound to have been the same?

37. In this regard, we note the following from DBS's "barring decision summary" (pages 105-136 of the bundle), the fullest record of the reasoning behind DBS's decision:

    a. DBS was aware of JW saying that she could not change Miss X's pad: (see page 110 of the bundle, last full paragraph); however, DBS did not understand why this was: see page 112, third full paragraph: "It is not stated throughout the evidence why JW could not change her pad, however, her employer does not appear to have disputed this with her". In contrast, we have found (see paragraph 34 e above) that the reason for this was that two female carers were required to change Miss X's pad. In our view, it was DBS's lack of understanding on this point that led it to doubt JW's credibility (see page 111, first full paragraph) as to the reason for Miss X waking during the night: in contrast, we have found (at paragraph 34 d above) that the reason was that Miss X wanted her pad changed.

    b. DBS was also aware of JW saying that her role was to look after Mr Y (only); but, on page 111, DBS twice state that it did not appear "plausible" that JW "never" expected to provide "any" care to Miss X, "being the waking night staff member". DBS went further, finding (on page 114, bottom paragraph) (based, it seems, on the care home management asking JW in the investigatory interview whether she had read Miss X's care plans) that JW was "expected" to assist Miss X during the night. In contrast, our findings indicate a state of management dysfunction at the home (see paragraph 35 above) whereby the one person available to help Miss X during the night when she wanted her pad changed, could not do so, and was not equipped to deal with Miss X.

    c. DBS found "no evidence that any other staff struggled with Miss X's behaviour" (page 115, last full paragraph). In contrast, we find (see paragraph 22 above) that Miss X's behaviour could be very challenging; it was not JW alone who found Miss X's "behaviour" difficult.

    d. DBS interpreted the final entry in the note of Q11 in the "investigation meeting minutes" of 15 June 2022 as showing that JW had "stated you were aware Miss X was known to attempt to pull out her PEG tube when distressed, *and that she had tried to do so previously when you had held the door closed*" – this is how it was put in DBS's decision letter; in the "barring decision summary", DBS said that JW "*admitted* that on a previous occasion, she knew that Miss X had admitted to pull out her PEG tube *in response to being unable to leave her room*." DBS went further on pages 121 and 122, stating that JW "witnessed Miss X attempting [to pull out her PEG tube] on one occasion *and continued to hold the door shut*" (emphasis added by us in the foregoing quotations). In contrast, we find (see paragraph 29 above)that the note of Q11 is weak evidence and cannot support the inferences DBS draw from it; and whilst Miss X was known to try to pull out her PEG when upset, the note of Q11 does not comprise an "admission" by JW that this had happened specifically *because of* an instance of JW holding her door

closed; and, more generally, JW's motive in holding the door closed was to de-escalate the situation (see paragraph 26 above).

e. DBS refers to JW's failure to "escalate" to her employer, the lack of clarity about her responsibility for Miss X. In contrast, we have found (at paragraph 35 above) there to have been a state of management dysfunction regarding Miss X's care when she woke at night; that situation would have been perfectly evident to the management of the care home; it did not therefore call for "escalation".

38. The contrasts between the contents DBS's reasoning, and our own factual findings, based on all the evidence in front of us, cited above, seem to us sufficient to show that the omission of relevant and important context in DBS's decision *was* a material mistake (whether of fact or of law), in that it affected DBS's reasoning to a significant extent. This is not a case where it can be said that even if DBS's mistakes had not been made, its decision was bound to have been the same.

The grounds enumerated in JW's "perfected ground of appeal"

39. The conclusion just reached is sufficient for us to allow the appeal. For completeness, however, we set out below our views on the enumerated grounds in JW's "perfected grounds of appeal" document:

a. ground 1: It seems to us that DBS's core factual findings amount to "relevant conduct", because they represent conduct which was likely to put a vulnerable adult at risk of harm. Needless to say, this does not mean it is necessarily *appropriate* to include JW in the barred lists – that is a matter for DBS's discretion, based on all the relevant facts;

b. ground 2: it seems to us that the "secondary findings of fact" referred to here ("lack of insight and empathy", "poor problem solving and coping skills", "failure to take responsibility", "future risk of harm") are, for the most part, evaluative judgements that are part and parcel of DBS's decision as to the *appropriateness* of including JW in the barred lists (and, to that extent, outwith the jurisdiction of the Upper Tribunal);

c. ground 3: this largely overlaps with ground 2; for the same reasons, we do not consider it discloses a mistake of fact or of law in DBS's decision;

d. ground 4: in our view, DBS's decision, in light of the facts found by it, was not "off the spectrum" of reasonable decisions that could have been made on those facts; and DBS's decision itself reasonably considered issues of proportionality. We do not consider that DBS's decision, *on the facts as found*, was disproportionate.

Remittal to DBS for a new decision

40. Applying the test in *DBS v AB* [2021] EWCA Civ 1575 at [73], this does not seem to us a case where the *only* decision DBS could lawfully reach in the light of the law and the facts as found by us, would be to remove JW from the barred lists. DBS is the arbiter of "appropriateness" of listing and it is now for it to make a new decision as to whether it is appropriate to include JW in the barred lists, based on all the relevant facts, as we have found them.

41. For similar reasons, it seems to us fair and just in this case that JW remain in the lists, pending DBS's new decision: it would be in no one's interests, we feel, to direct JW's removal, only to have her re-included upon a new decision by DBS. We trust that DBS will make the new decision as soon as it reasonably can.

Zachary Citron
Judge of the Upper Tribunal

Suzanna Jacoby
Roger Graham
Members of the Upper Tribunal

Approved for release on 9 August 2024