Neutral Citation Number [2024] UKUT 427 (AAC) Appeal No. UA-2023-001731-V

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

NG

Appellant

- v -

DISCLOSURE AND BARRING SERVICE

Respondent

Before: Upper Tribunal Judge Stout, Tribunal Member Jacoby and Tribunal Member Hutchinson
Hearing date: 29 November 2024
Mode of hearing: By video (CVP)

Representation:
Appellant: In person (accompanied by a McKenzie friend)
Respondent: Richard Ryan (counsel)

On appeal from:
DBS Reference: POOO6UJQZHS
DBS Decision Date: 18 September 2023

RULE 14 Order

Pursuant to rule 14(1) of the Tribunal Procedure (Upper Tribunal) Rules 2008, it is prohibited for any person to disclose or publish any matter likely to lead members of the public to identify the appellant in these proceedings, or any other individual member of staff or service user referred to in the hearing bundle,

at the hearing or in this judgment. In order to protect the identity of those individuals, the name of the care home concerned must also not be disclosed or published. This order does not apply to any person exercising statutory (including judicial) functions where knowledge of the matter is reasonably necessary for the proper exercise of the functions.

SUMMARY OF DECISION

SAFEGUARDING VULNERABLE GROUPS (65)

DBS included the appellant on the adults' barred list because it found: (i) she had been complicit in locking residents in their rooms overnight; and (ii) she had verbally abused residents. The Upper Tribunal finds that there was no evidence for finding (ii) which was an error of fact and law. The Upper Tribunal further finds that in deciding to bar the appellant for finding (i) DBS erred in law and in fact in a number of respects, including that the barring decision was disproportionate and breached the appellant's rights under Article 8 of the European Convention on Human Rights. The Upper Tribunal directs DBS to remove the appellant from the list.

Please note the Summary of Decision is included for the convenience of readers. It does not form part of the decision. The Decision and Reasons of the Tribunal follow.

DECISION

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

The Disclosure and Barring Service is directed to remove the appellant from the barred list pursuant to section 4(6)(a) of the Safeguarding Vulnerable Groups Act 2006.

REASONS FOR DECISION

Introduction

1. The appellant in this case appeals under section 4 of the Safeguarding Vulnerable Groups Act 2006 (SVGA 2006) against the decision of the Disclosure and Barring Service (DBS) of 18 September 2023 including her in the adult's barred lists pursuant to paragraph 9 of Schedule 3 to the SVGA 2006. This is the unanimous decision of the Upper Tribunal following an oral hearing. The structure of this decision is as follows:

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The Upper Tribunal hearing

2. This hearing was conducted by video at the appellant's request so that her step-father could assist her. She was also assisted by her son with some technical issues with the laptop and video technology. Despite DBS's efforts to send her a hard copy bundle at the judge's (late) direction, this had not arrived and nor did the appellant at the start of the hearing have the electronic bundle available to her. With the help of her son and a second laptop arrangements were made for her to be able to access the bundle.

3. The appellant had not prepared a witness statement, despite a direction to do so, but it was agreed by Mr Ryan for DBS that her submissions in reply to DBS's response could be read as constituting a witness statement and an intention to give evidence at this hearing. At the invitation of the Tribunal, the appellant confirmed on affirmation the truth of those submissions, and also the statement she provided to her employer in the internal disciplinary proceedings, her submissions to DBS in response to the "minded to bar" letter and her grounds of appeal.

4. The appellant was questioned by Mr Ryan for DBS and by the Tribunal.

5. Both parties then made closing submissions, referring to the written submissions they had provided in advance.

DBS's decision

6. DBS was satisfied that, whilst employed as a Care Assistant, the appellant had engaged in conduct that endangered or was likely to endanger a vulnerable adult because it concluded: (i) that she had been complicit in locking a number of residents into their rooms without their consent on the nightshift of 13-14 October 2022; and (ii) had verbally abused residents in her care.

7. The most serious of the allegations against the appellant, found proved by DBS, was that the appellant was complicit in residents being locked into their bedrooms without consent. DBS was critical of the reasons that the appellant has advanced in her representations (and now in her grounds of appeal) for having done this, which included that the home was short-staffed, she had too much to do and rooms were locked in order to keep residents safe from each other as there were violent adults in the home who would otherwise walk into other residents' rooms, and that some of the vulnerable adults asked for their rooms to be locked to stop this happening.

8. DBS adopts a structured judgment process (SJP) when taking its decisions. In this case, DBS identified concerns in relation to the appellant as regards emotional and behavioural factors, including "callousness/lack of empathy" and "irresponsible and reckless" behaviour. DBS considered that she had in her letter of representations demonstrated a lack of empathy towards the vulnerable adults in her care, that she had an irresponsible approach to her caring role with a tendency to blame others, including the vulnerable adults themselves, for her conduct. DBS considered that she demonstrated a lack of insight into the harm that her actions might have caused the vulnerable adults.

9. This led DBS to conclude that there was a significant risk of her repeating this behaviour. DBS specifically considered the appellant's rights under Article 8, noting that a decision to bar would prevent her from seeking future employment working with vulnerable adults, a role that she has performed for a number of years, which could impact her earning potential and personal life and limit her volunteering opportunities. However, DBS decided that a decision to bar was a proportionate interference with her Article 8 rights in this case in view of the risk that it considered she poses to vulnerable adults.

The grant of permission

10. Judge Stout granted permission in this case following the appellant renewing her application for permission to an oral hearing (permission having been refused on the papers by Judge Fitzpatrick). In granting permission, Judge Stout observed as follows. We have added in to these observations the numbering of the grounds as subsequently adopted by DBS in its response to the appeal:-

> 19. I consider it arguable that DBS has erred in law and/or in fact in concluding from this evidence that the appellant has engaged in relevant conduct in relation to

vulnerable adults and/or in concluding that she poses a future risk to vulnerable adults and/or in concluding that the conduct was sufficiently serious as to render barring a proportionate response bearing in mind the extent of the interference with the appellant's Article 8 ECHR rights. The arguable errors arise in particular from the failure to take account of and/or to afford appropriate weight in the Article 8 proportionality assessment to the following matters:-

[Ground 1] - The CQC report confirms at p 55 that the home was short-staffed on the occasion in question and that managers had not complied with the regulation regarding deployment of staff. This supports the appellant's case that there were reasons why keeping residents safe overnight may have required rooms to be locked. Even if eight rooms were locked, that still left four staff (only three of whom provided personal care) with 38 residents to look after so the comment in DBS's decision letter "You have not explained how or why you were so busy when the residents were locked in their rooms" is arguably unjustified.

[Ground 2] - Risk of harm to self or others is a reason why deprivation of liberty by locking a resident in their room may be justified. DBS has failed to take account of or explained the basis on which it rejected the appellant's case that she was trying to keep residents safe through her actions and that, if rooms had not been locked, there may have been a greater risk to residents.

[Ground 3] - As mentioned in the CQC report, there is a process for authorising deprivations of liberty in a care home in relation to an adult who lacks capacity by way of application to the local authority under the Deprivation of Liberty Safeguards (DoLS) regime. The appellant as a junior member of care staff is unlikely to have been responsible for that sort of decision, and there was no evidence before DBS that she was responsible for that decision.

[Ground 4] - DBS has failed to take into account and/or resolve the inconsistency in the facts as to how many residents had been locked in without consent. The CQC report says seven, but the employer's case at the disciplinary hearing was four (p 41). There is also minimal evidence about the individual circumstances of the particular residents involved or the actual risk of harm that was posed to each of them.

[Ground 5] - The CQC report provides ample evidence of poor management practice at the home, which is potentially a significant mitigating factor in the appellant's case.

There is no evidence, for example, that management had provided guidance to the appellant about when doors may be locked or how that should be authorised.

[Ground 6] - No reference has been made to the anonymous statement at p 39 that contradicts the whistleblower in response to whom CQC carried out their inspection, indicating that there was no general practice of locking residents' doors overnight.

20. The second allegation related to verbal abuse of residents. I consider it arguable [Ground 7] that DBS erred in law and/or in fact in concluding that this allegation was proven. There is no evidence in the bundle that the appellant was verbally abusive to residents. There is no statement setting out this allegation, or identifying when it occurred or what the nature of the abuse is said to be. The only evidence is the appellant's response to the allegation, which was to the effect that she accepted she was on occasion "firm" with residents when they were being "very nasty and unwilling to co-operate". There is nothing wrong in principle with a member of staff being "firm" with a resident who is exhibiting challenging behaviours. There is arguably no evidence that the appellant conducted herself in a way that was harmful to a resident.

21. In her UT10 appeal form, and accompanying letter, and at this hearing, the appellant argues that she does have empathy for the people in her care and that she does not pose a risk to vulnerable adults in future. I was impressed with the appellant at this hearing; she came across as a kind and caring individual. I consider it arguable [Ground 8] that DBS erred in fact or in law in inferring from her written representations, which were written with a view to defending herself from charges of misconduct in respect of which the evidence is, in my judgment, weak (see above), that she lacks empathy and/or poses a significant risk of harm to vulnerable adults in future. It is also relevant in this respect that the principal conduct relied on is locking residents in rooms, which is conduct that it is inherently improbable someone would repeat once they understand, as it appeared to me the appellant now does, that locking a resident in a room without a DoLS authorisation in place is a dismissable offence.

22. Finally, as to the finding that the appellant was hostile to the CQC inspector who visited, I am not [at present] persuaded that this is a material element of DBS's reasons for its decision, but if it is then I consider it arguable [Ground 9] that DBS has placed too much weight on it in the proportionality analysis as it has arguably failed to take into account the appellant's explanation for her hostility which was because she perceived the inspectors as being hostile to her, genuinely doubted whether she should let them in at 5am without phoning CQC to check the authenticity of their ID

> cards and had a need to go to a particular toilet at the time that they arrived for medical reasons.

Legal framework

Relevant legal framework for DBS's decision

11. The appellant in this case was included on the adults' barred list using its powers in paragraph 9 of Schedule 3.

12. Under those paragraphs, subject to the right to make representations, DBS must include a person on the relevant list if (in summary and in so far as relevant to the present appeal):

    a. The person has engaged in conduct which endangers or is likely to endanger a vulnerable adult (Sch 3, paragraph 9 and 10(1)(a));

    b. The person has been or might in future be engaged in regulated activity in relation to adults; and,

    c. DBS is satisfied that it is appropriate to include them in the relevant list.

13. "Endangers" means (in summary) that the conduct harms or might harm the vulnerable adult: see Schedule 3, paragraph 10(4).

14. By paragraph 9(2) of Schedule 3 DBS must give the person an opportunity to make representations before including them on the barred list. By paragraph 16(1) a person who is given the opportunity to make representations must have the opportunity to make representations in relation to all of the information on which DBS intends to rely in taking a decision under Schedule 3.

15. By paragraphs 17(2) and (3) a person who does not make representations within the prescribed time may apply to DBS for permission to make representations out of time and if DBS grants permission it must consider those representations and remove the person from the list if it considers it appropriate.

16. A person included in a barred list may apply for a review of their inclusion after the prescribed minimum period of 10 years (paragraph 18), or at any time on the basis of new information, a change in circumstances or an error (paragraph 18A).

The Upper Tribunal's jurisdiction on appeal

17. An appeal to the Upper Tribunal under section 4 of the SVGA 2006 lies only on grounds set out in sub-section (2), i.e. that DBS has, in deciding to include a person on a list or in refusing to remove a person from a list on review, made a mistake: (a) on any point of law; or (b) in any material finding of fact (cf s 4(2)). For the purposes of sub-section (2), the decision whether or not it is appropriate for an individual to be included on a barred list is not a question of law or fact.

18. If the Upper Tribunal finds that DBS has not made a mistake of law or fact it must confirm the decision: SVGA 2006, section 4(5). If the Upper Tribunal finds that DBS has made a mistake of law or fact, it must either direct DBS to remove the person from the list or remit the matter to DBS for a new decision: section 4(6). The Court of Appeal has held that unless the only lawful decision DBS could come to in a case, in the light of the Upper Tribunal's decision, is removal, the Upper Tribunal must remit the case: *AB v DBS* [2021] EWCA Civ 1575, [2022] 1 WLR 1002 at [72]-[73] *per* Lewis LJ. If the Upper Tribunal remits a matter to DBS then the Upper Tribunal may set out any findings of fact which it has made on which DBS must base its new decision and the person must be removed from the list until DBS makes its new decision, unless the Upper Tribunal directs otherwise: section 4(7).

19. A mistake of fact is a finding of fact that is, on the balance of probabilities, wrong in the light of any evidence that was available to the DBS or that is put before the Upper Tribunal; a finding of fact is not wrong merely because the Upper Tribunal would have made different findings, but neither is the Upper Tribunal restricted to considering only whether DBS's findings of fact are reasonable; the Upper Tribunal is entitled to evaluate all the evidence itself to decide whether DBS has made a mistake (see generally *PF v DBS* [2020] UKUT 256 (AAC), as subsequently approved in *DBS v JHB* [2023] EWCA Civ 982 at [71]-[89] per Laing LJ, giving the judgment of the Court, *Kihembo v Disclosure and Barring Service* [2023] EWCA Civ 1547 at [26] and *DBS v RI* [2024] EWCA Civ 95 at [28]-[37] per Bean LJ and at [49]-[51] *per* Males LJ). As the Tribunal put it in *PF* at [39], "There is no limit to the form a mistake of fact may take. It may consist of an incorrect finding, an incomplete finding, or an omission". A finding of fact may be made by inference (*JHB*, ibid, [88]), but facts must be distinguished from "value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness [of including the person on the barred list]": *AB v DBS* [2021]

EWCA Civ 1575, [2022] 1 WLR 1002 at [55] per Lewis LJ (giving the judgment of the court).

20. A mistake of law includes making an error of legal principle, failure to take into account relevant matters, taking into account irrelevant matters, material unfairness and failure to give adequate reasons for a decision. (See generally *R (Iran) v SSHD* [2005] EWCA Civ 982 at [9]-[11].) On ordinary administrative law principles, accordingly, "an allegation of unreasonableness has to be a *Wednesbury* rationality challenge, i.e. that the decision is perverse" (*Khakh v ISA* [2013] EWCA Civ 1341 at [18]).

21. However, a mistake of law also includes making a decision to include a person on a barred list that is disproportionate or otherwise in breach of that individual's rights under Article 8 of the European Convention on Human Rights (ECHR). In *ISA v SB* [2012] EWCA Civ 977, [2013] 1 WLR 308 the Court of Appeal explained the approach to be taken by the Upper Tribunal as follows:

> *(1) The approach to proportionality*
> 14. Although section 4(3) of the 2006 Act inhibits the Upper Tribunal from revisiting the question "whether or not it is appropriate for an individual to be included in a barred list", Ms Lieven concedes, correctly in my view, that the Upper Tribunal is empowered to determine proportionality and rationality. In this regard, the passage from the judgment of Wyn Williams J in *R (Royal College of Nursing) v Secretary of State for the Home Department [2011] PTSR 1193* (see para 8 above) is undoubtedly correct. Thus, the Upper Tribunal cannot carry out a full merits reconsideration. Its jurisdiction is more limited. In this respect, it is narrower than was the jurisdiction of the Care Standards Tribunal under the previous legislation.
>
> 15. 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 Convention for the Protection of Human Rights and Fundamental Freedoms. 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 (Aguilar Quila) v Secretary of State for the Home Department (AIRE Centre intervening) [2012] 1 AC 621* , Lord Wilson JSC summarised the approach to proportionality in such a context which had been expounded by Lord Bingham of Cornhill in *Huang v Secretary of State for the Home Department [2007] 2 AC 167* , para 19. Lord Wilson JSC said, at para 45:

> "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*, para 30 Lord Bingham of Cornhill explained the difference between such a proportionality exercise and traditional judicial review in the following passage:

> "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."

16. 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 Upper Tribunal, should approach the decision of the primary decision-maker, in this case the ISA. Whilst it is apparent from authorities such as *Huang's* case and *Aguilar Quila's case* that it is wrong to approach the decision in question with "deference", the requisite approach requires (per Lord Bingham in *Huang's case* [2007] 2 AC 167 , para 16, and see, to like effect, Lord Wilson JSC in *Aguilar Quila's case* [2012] 1 AC 621 , para 46):

> "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."

There is, in my judgment, no tension between those passages and the approach seen in *Belfast City Council v Miss Behavin' Ltd* [2007] 1 WLR 1420 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 para 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."

Baroness Hale of Richmond added, at para 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, a 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.

17. Ms Lieven's first complaint is that the Upper Tribunal failed to accord appropriate weight to the decision of the ISA. The 16-page decision of the Upper Tribunal was undoubtedly the product of a careful and conscientious consideration. However, it seems to me that the Upper Tribunal did not accord any particular weight to the decision of the ISA but proceeded to a de novo consideration of its own….

20. The assessment of the ISA caseworker was itself a careful compilation produced on a template headed "Structured judgment process" which tabulated "indications" and "counter indications" in adjacent columns. Moreover, examination of that assessment and the decision which it informed suggests to me that the conclusion of the Upper Tribunal that the ISA had failed to take account of "the wealth of evidence" that SB imposes a low risk of reoffending and "gave no weight or at least very little weight, to the issue of [him] as a person" was simply erroneous. The "wealth of evidence" seems to relate to the numerous positive references but it is apparent that these were taken into account in the caseworker's assessment and in the decision of the ISA. The assessment was a fair representation of the many indications and counter indications and specific mention was made of the numerous references and the fact that SB had voluntarily sought counselling.

21. This brings me to two particular points. First, there is the fact that, unlike the ISA, the Upper Tribunal 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 RCN, emphasises the fact that the Upper Tribunal 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 Upper Tribunal 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)(b) 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 Upper Tribunal 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 Upper Tribunal is designed not to consider the appropriateness of listing but more to adjudicate upon "mistakes" on points of law or findings of fact: see section 4(3) of the 2006 Act.
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> 22. For all these reasons I consider that the complaint that the Upper Tribunal did not accord "appropriate weight" to the decision of the ISA is justified.

22. The Court of Appeal's approach in *SB* was approved and followed by the Court of Appeal in *DBS v Harvey* [2013] EWCA Civ 180. In this appeal, DBS has drawn our attention to three later decisions of the Upper Tribunal where at first blush it appears that divergent approaches have been taken to the issue of proportionality (*KB v DBS* [2021] UKUT 325, at [130]-[135], panel chaired by Judge Jones; *WW v DBS* [2023] UKUT 241 (AAC), at [55], panel chaired by Judge Wikeley; and *NV v DBS* [2024] UKUT 42, at [38], panel chaired by Judge Wright). A three-judge panel of the Upper Tribunal is accordingly being listed for early in 2025 to consider the proper approach to the question of proportionality in appeals against DBS decisions in the case of *KS v DBS* (UA-2024-000839-V). It has not, however, been suggested that we should stay consideration of this case pending that decision, and we do not consider it necessary to do so. Pending the decision in *KS*, it seems to us that we should in this case continue to apply the approach laid down by the Court of Appeal in *SB* and *Harvey*, the ratio of those decisions being in any event binding on us. We note that this was also the approach recently taken by the Upper Tribunal chaired by Judge Brunner KC in *MFAG v DBS* [2024] UKUT 330 (AAC) at [24]-[27]. The Upper Tribunal in that case also referred to the decision of the Court of Appeal in *Dalston Projects and ors v Secretary of State for Transport* [2024] EWCA Civ 172 which affirms the "well-established" principle that the question of whether an act is incompatible with a Convention right is a question of substance for the court itself to decide.

23. We do, however, add the following further observations as regards the passage from *SB* that we have set out above.

24. First, the Court of Appeal was in *SB* concerned to emphasise the expertise of the Independent Safeguarding Authority (ISA, DBS' predecessor) and the

importance of weight being given to the views of ISA as the primary decision-maker under the statutory scheme. As was pointed out by the Upper Tribunal chaired by Judge Wikeley in *CM v Disclosure and Barring Service* [2015] UKUT 707 (AAC) at [59]-[64], however, it is not clear that the Court of Appeal in *SB* had its attention drawn to the Practice Statement on the *Composition of Tribunals in relation to matters that fall to be decided by the Administrative Appeals Chamber of the Upper Tribunal on or after 26th March 2014* which sets out the requirements as to the expertise of Upper Tribunal lay panel members. We agree with the Upper Tribunal in *CM* that, once that Practice Statement is considered, the Court of Appeal's suggestion that there is a relevant difference between the expertise of DBS decision-makers and lay panel members of the Upper Tribunal is undermined. To use the Latin phrase, it seems to us that the Court of Appeal's observation on the relative expertise of Upper Tribunal panel members and DBS decision-makers may be regarded as being *per incuriam*.

25. Secondly, DBS as a matter of practice makes its decisions on the papers alone, whereas the Upper Tribunal has the benefit of a hearing with witness evidence. While the Court of Appeal in *SB* rightly noted (at [21]) that it was not an error of law for DBS not to hold a hearing, it also seems to us to be important to remember, when considering the approach we should take, that the hearing before the Upper Tribunal in DBS cases is the "fair and public hearing … by an independent and impartial tribunal" with "full jurisdiction" which secures that the barring scheme under the SVGA 2006 is compliant with Article 6 of the European Convention on Human Rights. The appellant has a civil right to practise her profession and to work with children/vulnerable adults: see *R (G) v Governors of X School* [2011] UKSC 30, [2012] 1 AC 167 at [33]. In that case, which concerned whether Article 6 applied to the employer's internal disciplinary proceedings stage of the process, the Supreme Court proceeded on the assumption that the barring scheme as operated by what is now DBS, together with the right of appeal to the Upper Tribunal, ensured compliance with Article 6: see [84] *per* Lord Dyson, [94] *per* Lord Hope and [101] *per* Lord Brown. (We have not set those paragraphs out in this judgment because there is no need to do so, but we add for the benefit of anyone who troubles to make the cross-reference that the point that the Supreme Court is 'not deciding' in those paragraphs is the more complex argument as to whether, if Article 6 had been held to apply to the employer's internal disciplinary proceedings in that case, the lack of procedural safeguards in the internal disciplinary proceedings, could have been 'cured' by the subsequent decision-making processes of the ISA and appeal to the Upper Tribunal. The Supreme Court's decision seems to us to leave no room for doubt that including someone

on a barred list is a determination of their civil rights and thus one to which Article 6 applies and in respect of which the appeal to the Upper Tribunal must be one where the Upper Tribunal has "full jurisdiction" over fact and law in order to secure compliance with Article 6.)

26. We mention this point about Article 6 because it underscores for us the importance of what the Court of Appeal said in *SB* at [15] (citing *R (SB) v Governors of Denbigh High School*) about proportionality being a matter for objective assessment by the Upper Tribunal. Due weight must be given to the views of DBS given its role as the primary statutory decision-maker, reinforced by the statutory prescription in section 4(3) that the question of whether it is appropriate for someone to be included in a list is not a question of fact or law in this context. However, it is ultimately for the Upper Tribunal as a court of full jurisdiction to determine whether the inclusion of a person on a barred list is or is not proportionate and compatible with their Convention rights.

27. In short summary, therefore, the approach we have to apply to this case to the appellant's proportionality argument is as follows:-

    a. The DBS's decision engages the appellant's Article 8 rights (cf *SB* at [15]) as placing someone on a barred list affects their reputation, their ability to practise their chosen profession and earn a living. It is also likely to impact on their family and personal relationships. The right to practise a profession is a civil right engaging Article 6 of the Convention.

    b. We proceed on the assumption (*cf SB* at [15]) that the legislative object of the barring scheme (protecting children and vulnerable adults) is sufficiently important in principle to justify limiting those rights so that, where there has been conduct that endangers or is likely to endanger children or vulnerable adults, a barring decision is in principle rationally connected to that legislative object.

    c. The questions for us, however, are (*SB,* [15]):

        i. whether the barring decision is in the particular case more than is necessary to accomplish the legislative object; and

        ii. whether a barring decision strikes a fair balance between the rights of the appellant and the public interest in protection of children and vulnerable adults.

d. In deciding whether the DBS' decision is compatible with the appellant's Convention rights as required by s 6 of the Human Rights Act 1998 (HRA 1998), the Upper Tribunal must accord particular weight to DBS' view and take due account of the differences in the jurisdiction of DBS and the Upper Tribunal and the material available to each at the time of taking their respective decisions.

Our approach to the evidence

28. Having considered the documentary evidence in the bundle, the oral evidence of the appellant and the submissions of the parties, we make the following findings of fact, applying the balance of probabilities standard. We do so as a preliminary step to considering whether DBS has made a 'mistake of fact' in any material respect in its decision. It does not necessarily follow that because our findings of fact differ to DBS's findings in its decision that DBS has made a 'mistake of fact'. We consider whether or not it has made a mistake in any material respect when dealing with the specific grounds of appeal and our conclusions.

The facts

29. The appellant is 54 years old. She has been a carer for over 30 years, although her only formal qualification is an induction award. She was at the time of the events that led to DBS making the barring decision engaged as a Care Assistant working in a care home for older people living with dementia, where she was responsible for all activities of daily living including personal care. She worked night shifts. She had been working for that employer since June 2014 and had no history of misconduct or any prior referral to DBS.

30. She was referred to DBS by her employer on 31 January 2023, having been dismissed by her employer with effect from 5 December 2022.

31. The appellant's dismissal was the culmination of an internal disciplinary process followed by her employer. The appellant was dismissed following a disciplinary meeting that she did not attend, although she presented a statement for consideration. In some of her documents, the appellant has referred also to 'appealing' her dismissal, but there is no documentation relating to that appeal and the impression we gained from the appellant's oral evidence was that she felt the dismissal decision was made when she was first suspended such that her references to an 'appeal' are probably to be read as references to what was in fact the disciplinary hearing. However, nothing turns on this for our purposes.

32. According to the employer's documentation, the appellant had been the subject of five allegations as follows: (1) verbal aggression, swearing at residents; (2) sleeping whilst on duty; (3) locking residents bedroom doors; (4) neglect, not changing continence products during the night; and (5) a bad attitude towards CQC on the morning of 14 October 2022.

33. However, not all of these allegations were upheld. The employer's dismissal letter concluded that the appellant should be dismissed summarily for gross misconduct in the light of the following findings:

    a. The allegation of being verbally aggressive and swearing at residents was partially upheld based on the appellant having said in her statement that she was "very firm" with residents;

    b. That the appellant had locked four residents bedroom doors without their request in contravention of their civil rights and causing a serious health and safety risk;

    c. The appellant had displayed a poor attitude to CQC inspectors on the morning of 14 October 2022.

34. The employer's documentation indicates that statements had been obtained by the employer during the disciplinary process from the following people:

    a. CS (Operations Director);

    b. LT (Assistant Manager);

    c. SP (Home Manager); and

    d. CF (HCA ND).

35. Only two of those statements are in our bundle: CS and SP. There is also an anonymous statement dated 18 November 2022.

36. CS's statement detailed that CQC arrived at the home around 4.30am/5am on 14 October 2022, following a whistleblowing alert received on 12 October. She said that CQC had reported receiving *"a very hostile reception"* from the appellant who did not want to let them in, with one inspector saying she had to put her foot in the door to gain access despite having ID. CQC found eight bedroom doors locked, two with bolts on the outside and one person calling for help. The appellant and another member of staff were suspended immediately by the

manager (SP). CS's statement concludes, *"There was no explanation we could give to CQC why the bedroom doors were locked"*. We observe that CS's statement does not include any evidence that either she or CQC spoke to the appellant or LS to ask why doors were locked.

37. SP in her statement for the internal disciplinary proceedings describes how on 14 October at around 4.30am she received a phone call from the appellant informing her that CQC were there *"and they are not very nice"*. SP called LT and they went to the home, arriving c 5am. The appellant greeted them and told them that the CQC inspectors were not happy and were *"very rude"*. The inspectors asked SP if she knew why eight bedroom doors were locked and also said that they believed two staff were sleeping, but they did not see them. SP described then how she spoke to the appellant and the other member of staff (LS) concerned to inform them that they were suspended. SP says that the appellant replied, *"ok boss I will look for another job and then left"*, while the other member of staff started *"shouting … you have someone fall through the ceiling and I fucking get sacked for locking a few room. HH was up in and out of room so locked the doors as CJ was getting agitated and HH was going in and out of rooms"*. SP goes on to describe how LS continued shouting at her and would not leave when asked. Again, there is no evidence in SP's statement that either she or CQC asked the appellant or LS at any point why doors were locked, although, as is apparent, LS on being told she was suspended did provide some explanation. There is no evidence that SP relayed this to CQC.

38. The anonymous statement said that there was no practice of door-locking, but two doors were locked at residents' request. The anonymous statement concludes (sic): *"If I was a wear of the doors being locked I would have gone to the management as they can deal with it. When I was told about this I felt sick in my stomach as I worked the shifts and was not a wear"* (sic). The appellant in her documents (see eg p 75) and also in her oral evidence at this hearing says that she knows who wrote this statement and that she *"encourage this person to go onto days, as she still very young, but she was told to write this, so her name would not be drag through the mud, like mine"*.

39. The appellant in her statement for the disciplinary proceedings described how CQC rang the doorbell at 5am, the appellant asked for ID and said she needed to phone to confirm who they were, but *"NO"* the CQC person said and proceeded to come in. The appellant wrote: *"this woman was very rude how she spoke to me and stand there. I needed to go to the toilet as I have (diverticulitis) she then*

pointed the nearest toilet but as I have problem I always use the same toilet and make sure it is clean before and after I use it. the man who came with her was very polite." In her statement, the appellant then says that she was called into the office and informed by SP that she was suspended. She wrote she *"did not want to start arguing my case as I was tired and stressed, I just said ok boss shrugged my shoulders and went home"*. She then explained that on the night in question, *"Doors were locked, this was for the safety of the residents in these rooms for there on safety as we had some men who were violent and had already wandered into other residents rooms. As most doors can be opened from both sides we cannot stop clients from leaving their rooms and wandering into other rooms and causing distress to other residents. So some doors are locked for their own safety, so I am dammed if I do and dammed if I do not. As there was only two fully qualified … carers on that night. We were run of our feet making sure all things were running well"* (sic).

40. Regarding the allegation of verbal abuse towards residents, in this statement the appellant wrote, *"As for shouting and swearing how does a 4ft10 weighing less than 9st deal with a 5ft6 man weighing over 10 and a half stone who is being very nasty and unwilling to cooperate. I do not shout at residents but I am very firm with them when needs be"* (sic).

41. The notes of the disciplinary hearing (which the appellant did not attend) indicate that CQC found seven doors locked, of which three were at residents' request. It is recorded that CS had reviewed the Handover logs for 14 October 2022 and there were no comments regarding the behaviour of residents wandering around or being violent or requesting doors to be locked. CF's statement is not in the bundle, but it is quoted in part in the disciplinary hearing notes and states that she did not know why doors were locked and was surprised to find they were.

42. DBS also received and considered CQC's report on the home following inspections on 14 October, 20 October and 21 October 2022. (The latter two inspections were after the appellant had been suspended, so she was not at work during those inspections.) CQC gave the home an overall rating of Inadequate. Regarding locking people in rooms the CQC report states as follows:

> People were not protected from risk of harm or abuse. We received significant concerns from a whistle-blower that people were being locked in their rooms at night. When we arrived at 5am, we found seven people had been locked in their room without their consent. Two rooms had been bolted from the outside. One of these

> rooms was on the second floor and the person's care plan confirmed they were unable to use a call bell for help placing them at significant risk of harm.
> The staff member who accompanied us around the building, did not have keys to open these doors and could not explain why they were locked.
> The registered manager said they were unaware this was happening and later during discussions with inspectors gave different reasons why rooms may have been locked. These included reasons such as protecting the person's belongings, or people had asked for the room to be locked so no other people could enter their rooms. We did not find any records to support these decisions.
> The registered manager told us they were unsure why staff had not come to them to raise the concerns above. However, we were concerned a culture of poor practice had developed within the service which meant staff may have recognised these but had not reported concerning unsafe practice by other staff.
> The provider and registered manager had not ensured any checks of the quality and safety of the service during the night were completed. This meant we were unable to determine how often people had been locked in their bedrooms, seriously compromising their ongoing safety and mental wellbeing.
> During the inspection we told the provider they must provide immediate written assurances about actions they would take to keep people safe and ensure they were not locked in their rooms without their consent.
> They provided us with an action plan to keep people safe which included reviewing management presence during the nights over the weekend.
> During the inspection, doors were unlocked, and bolts removed from people's doors once the registered manager arrived on site. All people locked in their rooms had not come to physical harm but were at risk of serious harm to their mental health.
> The registered manager re-issued the providers safeguarding policy to all staff and asked them to sign to confirm they had read and understood the information contained.

43. CQC were also concerned about the lack of full risk assessments and care plans at the home, failure to follow safe manual handling practice, poor record-keeping, failure to complete proper mental capacity assessments, failures by staff to raise concerns about poor practice to management and failure by management to recognise the wider culture of poor practice in the service. CQC noted that staff were *"not deployed effectively to ensure people were kept safe and their needs were met"*, and that on the night in question there should have been five members of care staff on duty, but in fact there were only four, one of whom did not provide personal care (p 55). CQC noted that staffing numbers were determined using a

dependency tool, but that they could not be assured that staffing numbers were being determined on the basis of accurate data because *"people's needs had not been reviewed regularly and they did not consider when people may have periods of heightened anxiety or distress which required intervention from more staff"*. The report further noted: *"Staff did not have the skills or experience to meet the needs of people who were living with advanced dementia"* and *"Staff appeared to lack skills to manage situations where people were becoming distressed or anxious"*.

44. Regarding the Deprivation of Liberty Safeguards (DoLS) regime at the home, CQC's report stated as follows:

> The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
>
> People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
>
> We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
>
> The service was not always working within the principles of the MCA. Staff had a basic understanding of the MCA and could describe basic principles. However, people's rights were not always maintained in line with the MCA. Mental capacity assessments were poorly completed, and information was lacking in detail as to how the determination of capacity had been made.
>
> There were no mental capacity assessments, best interest decisions or applications for DoLS in relation to people being locked in their bedrooms at night. People had not consented to being locked in their bedrooms.

> People's ability to make decisions were not assessed and recorded consistently. Care records stated for One person that they did not have capacity to use the call bell system to call for assistance, but there were no assessment or records to demonstrate how this determination was made and what was required to ensure they could ask for help when needed.
>
> On the second day of inspection, we were informed two of the seven people locked in their rooms had been assessed and had capacity to make the decision they would like their room locked at night when they were in there. We reviewed the capacity assessments for both people. Both had been completed at the same exact time on the same day which did not evidence these assessments were individualised or had been completed properly.
>
> …
> Records showed staff had completed a range of training relevant to needs of people, such as moving and handling people, dementia and Mental Capacity Act 2005. However, these skills were not put into practice when interacting and caring for people. Staff did not demonstrate safe practice when supporting people to move and did not effectively support people with advanced dementia in a way that acknowledged and met their emotional needs. For example, one person was becoming distressed at another person following them.
>
> Both people came into the room that inspectors were using. Staff came and helped both people, however staff assisted them both out of the room together and left them in another part of the building. Shortly after both people came back into the room and one was particularly distressed at not being able to move freely without the other. Staff did not manage the situation effectively.
>
> There was no evidence provided to us during inspection to confirm staff had been trained in supporting people living with advanced stage dementia who may have periods of distress or anxiety. We raised this during our feedback process at the end of the inspection and the registered manager later supplied another training record with this recorded as completed, however we were not assured this training had been effectively utilised based on our observations.

45. The appellant in her handwritten submissions to DBS in response to the Minded to Bar letter provided a more detailed account of the arrival of CQC. She explained why she had not felt able to participate more actively in the employer's

disciplinary process, which was essentially because she felt the outcome was predetermined, as she made clear again orally at this hearing. Regarding the locking of doors, she wrote, *"little is said about the position they put us in"*. She wrote that the staffing that night in addition to herself was: *"a senior"* (LS), the manager's son (not a carer) and his girlfriend (who was pregnant). She said there were 46 residents on site. We now draw together here all the material parts of her submission that deal with why she and the senior member of staff on duty (LS) locked some residents in their rooms that night. These do not follow consecutively in her submission as she moves between topics:

> "little said about how violent 3 of the men were, one had head butted a carer knocking her out for few seconds (she had to have 2 weeks off work", 2 other carers had got black eyes, this was just walking pass them, they would lash out, these men would go into others residents room. One trying to take resident out of they bed, the locking of doors was not to be malicious, lazy or upset anyone. The senior had to think of the safety of the other residents, we were put in this situation, lots of nights we were short staff. I did not ask to be put in this situation, yet I am the one being blame… C door, I'm sorry I cannot remember number was lock from outside, C was ok with his door lock, as due to it being at the end of corridor, lots of walkers would go to his room (go through his cupboards) where C could understand and say "lock the bloody door" to stop others going into room. This was not every night, when C ask, some nights C would stay up all night in lounge …. With M door being lock, she would request it lock, and a lot of the time M would already be in bed before our shift started (day staff would of put M in bed, and she would ask them to lock it, but I think all day staff deny this (more lies). M would also call out for help, she also had a buzzer mat in front of her bed, and alarm call on bed, M new how to use these, but would call out for help, and if carer walk in she say she can't sit up, please can I stress M can sit up on her own, and she also can get herself on to Commode. (I'm not sure about now, as I have no contact with anyone that works they at this time). So she would call out help, and if no one heard her, M would get up, which would set buzzer of, whomever went up, she would say I've been shouting out for help but M at the time could sit up, sit on edge of bed, and get herself onto Commode"
>
> …
>
> (p 76): I am now still asking the same question if a violent man had gone into bedroom and hurt another resident, would I still be in the same position, with everyone asking if you new they were violent, why did you not lock doors, I still say "I'm dam if I do, I dam if I don't"

I also no, as did other staff, the Senior would inform manger, we had to lock so and so doors last night her reply would be 'what I don't know, don't hurt me'

[She then referred to all the breaches of regulations CQC found to have been committed by managers and concluded …]

I just want you all to see what situations we were left in, all we were trying to do was protect the residents, not harm or hurt or cause any distress …

They is no way I would ever hurt a resident, and if staff were ask, they would say I had a very good repour with residents, as I would find they trigger points, what upset them, what cheer them up, what they like, dislike, learn they face impression. I did love my job. But this company has shown its true colours, they will destroy anyone to save themselves…" (sic)

46. Regarding the allegation of shouting at residents, the appellant wrote in her submissions to DBS:

"…this I believe is me shouting up the stairs, maybe I've use wrong word, but asking (that's me shouting) to K to come down stairs if she wanted tea, sandwiches (Iris would say every 20 mins, that she has had no food for days) K would demand her snacks and tea. We found if K had her snacks and tea in bedroom (around 11pm) she would go into other residents room to offer them some, and even wake people up or try and sit them up, so Iris was encourage to come to lounge to have snacks and tea, but CS and AH says this is wrong, so I did say in my 6-7 page statement, if this is wrong, then all staff need to be spoken to, as we are all doing it the wrong way.

Me swearing is all I can think off is when I was in kitchen and said "he getting fucking hard work". Yet again, this was not meant in a bad or horrible way, I just said it without thinking it was not said in front of residents and I remember the staff that were on as I remember saying something like "he goone be [?] but this was not said in a nasty way, but can I please state one of the other girls name that was whistleblow, was accuse of bullying her own Grandad in the home. As I now no whom the whistleblower is. Can I say that I remember having my tea and fag break with her, and telling me in the last 3 homes she had work she had call CQC once, and safeguarding twice on other homes, not until this happen did I realise, but I should of seen the red flat. She has had 4 different care jobs since this has happen (I'm not 100% that she made the call, but got friend to do this).

> …. , I've just remember, me saying I'm firm with residents, this would be me saying to a male residents Stephen you cannot go into this room they is a lady asleep and assisting then to his own bedroom, this I was told was wrong, yet again maybe it's the I have worded things, but again I have heard day staff say this to, but they have not been pull up"

47. The appellant in her grounds of appeal and statement for this hearing seeks to explain why she disagrees with DBS's assessment that she lacks empathy, explaining how she recognised and sought to meet the needs of individual residents. She says that she would never put a resident at risk in her care.

48. She emphasises again, regarding door-locking, that there was a senior on shift who would inform a manager regarding door-locking.

49. She states that the home was short-staffed with 46 residents to 4 carers, one of whom was just a 'helper' (the manager's son, who was not allowed to do personal care).

50. She explains that she was very busy as some residents would stay up until 2 or 3am, while others would go to bed then wake up after an hour or so and be dressed thinking it was morning. The carers had to answer buzzers, do pad changes, provide guidance to the manager's son regarding cleaning and laundry, clean both lounges, wash and fold the laundry for 46 people. She says they were lucky even to sit down let alone eat their lunch.

51. The appellant has explained that the impact on her of the barring decision has affected her earnings, personal life, volunteering, that she had to leave the job she got following her dismissal from the employer who referred her to DBS, that it is now impossible for her to get a job and her savings have all gone. She says that she found caring very rewarding and that the barring decision has taken everything she loves away from her.

The appellant's evidence at this hearing

52. At this hearing the appellant affirmed the truth of her statement to her employer, submissions to DBS, grounds of appeal and her submissions in response to the grant of permission.

53. In addition to the parts of her oral evidence that we have included in our account of the facts above, in answer to questions from counsel, the appellant confirmed

her understanding that the CQC visit was in response to a whistleblower, but that she had not been told at the time why she was being suspended. She was not asked by managers or CQC why rooms were locked. She said the only qualified people working that night were her and the senior LS. HP was a helper not a carer. He was the boyfriend of the other carer, who was pregnant.

54. Regarding locked rooms, the appellant was not sure who was in which room number, but she thought the two rooms that were locked from the outside would have been residents C and M who frequently asked for their doors to be locked and who had on that night. She said that the resident that CQC heard calling out for help would have been M, that M's door was often locked when they came on shift as M would already be in bed and the senior would say that she had requested for it to be locked. She said that the other doors locked were either because residents asked that night or they were residents who were *"at the very end of their dementia, double-incontinent, could not feed themselves, would not call for help"* and who *"could not walk or talk"*. She said *"we would not have known if someone had gone in and attacked them"*. They locked their doors to keep them safe from other residents who were wandering and violent.

55. She said that there were lots of nights when the home was short-staffed; probably about 60% of the time they only had three actual carers on duty when there should have been five. As we understood her evidence, when they were short-staffed they locked doors of those residents they regarded as particularly vulnerable as they felt they could not keep everyone safe otherwise. If someone asked for their door to be locked that was done whatever the staffing situation.

56. She said it was up to the senior what happened on the shift and it was up to the senior to do handover to the manager. She was asked what would happen if there was an emergency and residents had their doors locked. She responded, *"if there was an emergency, they would be the first ones out in my eyes"*, by which we understood her to mean she would go and get them herself. She said that doors were unlocked in the morning unless residents wanted them to stay locked. She said that she believed there were records kept of people wandering as the senior would upload photos to the handheld system.

57. She did not think that the locking of doors was potentially dangerous or that it should be reviewed because she thought the manager knew about it and it was the senior's decision on each shift. She said there used to be signs on the residents' doors that they could use to indicate whether they wanted the doors locked or not, but that these had gone as residents kept taking them. She did not

know there was any particular procedure or policy to be followed in relation to locking room doors. She could not remember being provided with any training about locking doors, or any policy on it, but she thought because signs had used to be up on doors that it was part of the home policy.

58. Regarding the allegations of verbal abuse of residents, she said that she would call up the stairs and when in the kitchen (away from residents) she would say if a resident was *"f-ing hard work"*. She said she remembered saying that and *"putting her head in her hands"* as *"when you see the dementia dipping, they are not going to get better"*.

59. Regarding the allegation of being rude to CQC, she repeated that she spoke to them as they spoke to her, but she was not aggressive. She asked if she could phone to confirm who they were, but the woman said no, told her where to stand, spoke to her *"like she was training a dog"*. She could not remember having written that a resident was *"nasty and unwilling to co-operate"*. When her own statement was put to her, she remembered, but said that she had not dealt very much with that resident as he was very big.

60. In answer to questions from the panel, the appellant confirmed that she now understood that locking residents in should not be done unless requested or it was *"done properly"* with the right processes. She repeated that for those at the end of life doors had been locked for safeguarding reasons. She said door locking was not recorded in care notes, but she understood the senior would tell the manager in the morning. She said she knew now she had presumed too much at the time. She did not know at the time that what was being done was wrong, but she did now. She said now she would follow all proper protocols and *"make sure it was up and running with safeguarding"* and that *"if not I would inform CQC"*.

61. She felt confident about that now and confirmed she would inform CQC even if it meant losing her job. She said that the problem with bolting doors from the outside was that it had *"put her in this situation"*, but she could also understand the safety issue if there was a fire or anything like that. She could not think of any other reason why it was a problem. She was asked what if they needed help but could not call out. She said that those who had requested doors to be locked could call out. She said that the others were really *"at the end of their dementia"* and could not call out anyway.

62. Asked how she felt about the residents, she said "*they were lovely, they were like family, I was there 5/6 nights a week, they were like nan and grandads – the*

workload was hard, we had a lot on … I loved to chat to them about what they lived and what they did in their lives and their family”.

Our analysis and conclusions

63. Before considering the nine grounds of appeal, we set out first our conclusions regarding the evidence we have received.

64. We found the appellant to be an honest and credible witness. Her ‘story’ has been essentially consistent from her first statement to her employer, through all the written documents and at this hearing. What she says about the reasons why residents’ rooms were locked is not contradicted in any significant respect by the evidence provided by her employer to DBS or the CQC report.

65. The senior on duty on her shifts was LS. The employer did not provide DBS with a statement from LS, but SP’s account of LS’s outburst when she told her she was suspended provides support for the appellant’s account that doors were locked because violent residents were wandering that night. CQC’s findings were reached without knowledge of the reasons why doors were locked because CQC did not ask the appellant or LS.

66. We place little weight on the manager’s denial of knowledge of room-locking to CQC. It is evident from the CQC report that the home was very poorly managed in multiple respects. Management would likely have known, even though the appellant at the time did not, that doors should not have been locked without consent without proper capacity assessments and DoLS authorisations in place, which they were not. It was therefore in management’s interests to deny knowledge of why rooms were locked to CQC as that enabled them to present it as the ‘rogue’ action of the appellant and LS. However, it seems to us to be likely that the locking of rooms was something that was at least countenanced by management as otherwise there would not have been the system of signs or locks installed on the outside of doors.

67. In any event, it is not part of the appellant’s evidence that she personally discussed door-locking with SP or any other manager. Her evidence is that she understood that the senior LS did this, and there is no evidence to contradict her account in that respect.

68. Further, the appellant's account that they were that night short-staffed is supported by the employer's documentation and the CQC report. There is no dispute that, although there should have been five staff on duty according to the employer's dependency calculations, in fact there were only four staff, only three of whom could provide personal care. The CQC report further indicates that the employer's dependency calculations may have been inadequate because of the lack of updated care plans and risk assessments so that the employer's calculation of how many staff were required to meet the needs of residents may have been wrong in any event. As such, the appellant's account of being overworked and her belief that locking rooms of the most vulnerable was the only way to keep them safe is also plausible and we accept it.

69. The only aspect of the appellant's evidence that is contradicted by the CQC report is that one of the two doors that were locked from the outside was evidently the door of one of the extremely vulnerable residents at the end of their lives rather than (as the appellant recalled when answering questions in oral evidence) one of the residents who had asked for their door to be locked. This is because the CQC report mentions that this person's care plan records that they cannot call out for help. We find that this particular detail is one that the appellant has misremembered given the passage of time and the fact that she understandably cannot remember which resident was behind which door number. This does not lead us to doubt any of the rest of her account.

70. In the circumstances, we see no reason not to accept all her evidence as we have set it out above in "The Facts" section and we accordingly proceed to consider the individual grounds of appeal on the basis that the factual picture is as set out above.

<u>Grounds 1-6 concerning DBS finding (i): locking residents in rooms</u>

71. We have first considered, by reference to each of the numbered grounds of appeal, whether DBS in its decision-making made any mistake of fact or a mistake of law by leaving out of account any relevant factor or taking into account a relevant factor. We then deal with the question of proportionality at the end.

Ground 1

The CQC report confirms at p 55 that the home was short-staffed on the occasion in question and that managers had not complied with the regulation regarding deployment of staff. This supports the appellant's case that there were reasons why keeping residents safe overnight may have required rooms to be locked. Even if eight rooms were locked, that still left four staff (only three of whom provided personal care) with 38 residents to look after so the comment in DBS's decision letter "You have not explained how or why you were so busy when the residents were locked in their rooms" is arguably unjustified.

72. In response to this ground, DBS argues it has taken into account all relevant factors and no irrelevant factors and that it has not made any mistake of fact. DBS points out that in the SJP and final decision letter it has referred to the fact that the home was short-staffed on the night in question. DBS in its response argues that CQC had identified the locking of rooms as a deprivation of liberty and a health and safety concern and that there was no suggestion by CQC that inadequate staffing or safeguarding of residents was an explanation for the locked rooms. DBS notes at paragraph 26b of its response what CQC says about staffing numbers that night and adds that *"there is no further comment on adequate staff-service user ratios"* in the CQC report. DBS submits that its comment that the appellant had *"not explained how or why you were so busy when the residents were locked in their room"* was justified in context.

73. We find that DBS has made three specific errors of fact and/or law in its consideration of this aspect of its decision as follows:-

    a. It has failed to take into account the relevant fact that CQC did not speak to the appellant or LS and did not therefore have the opportunity to consider their accounts of why residents were locked in their rooms. As such, it does not assist DBS to point out that CQC had not identified these as being possible justifications for locking rooms. So far as CQC was concerned there was 'no explanation' for why rooms were locked because managers had been unable (or unwilling) to provide any.

    b. DBS has failed, even in response to this appeal, to recognise that the CQC report does make *"further comment on adequate staff-service user ratios"* in addition to noting that they were that night short-staffed. As we have noted, CQC was highly critical of management's care plans and risk assessments which had not been kept up to date and therefore could not

in CQC's view provide a proper basis for an assessment of the required staffing levels. This was a relevant factor that DBS left out of account.

c. As such, we consider that DBS's comment that the appellant had *"not explained how or why you were so busy when the residents were locked in their room"* is simply wrong as a matter of fact. The appellant had explained that. She had explained that they were short-staffed, and the extent to which they were short-staffed makes it obvious that the three carers would likely be very busy. That is especially so given that those who were locked in their rooms without their consent were those who were not able to call out for or otherwise demand attention and who thus needed carers to go in and check whether they were all right at intervals whether doors were locked or not (and it has not been suggested that there was any failure by the appellant and her colleagues in that respect). By locking doors, the appellant and her colleagues were left with those residents who were wandering/active and demanding attention.

74. It is convenient to add here, as it is relevant to our assessment of proportionality below, that, as the appellant stated in her representations to DBS (p 72), the home was frequently short-staffed; 60% of the time was the appellant's evidence at this hearing, which we accept. As such, it is likely that the situation that led to doors being locked that night did occur relatively frequently and that, as CQC noted in the SJP (p 101), *"the date in question was not the first occasion it happened"*. While DBS regarded the fact that this was not the first occasion as further evidence of culpability on the part of the appellant, we consider that this is in fact a neutral factor in the evaluation because it is clear that the same difficulties that led to the appellant and LS locking doors on the night in question would likely have been present on other nights.

75. We also add that the fact that CQC found someone calling out from behind a locked door does not in itself indicate any failure of care: at the point that CQC inspected rooms, they had told the appellant and LS to stand downstairs by the front door and thus taken them away from their work. The appellant's evidence was also that the person calling out was likely to be resident M who asked for her door to be locked; the CQC report does not contradict this.

Grounds 2 and 3

Ground 2: Risk of harm to self or others is a reason why deprivation of liberty by locking a resident in their room may be justified. DBS has failed to take account of or explained

the basis on which it rejected the appellant's case that she was trying to keep residents' safe through her actions and that, if rooms had not been locked, there may have been a greater risk to residents.

Ground 3: As mentioned in the CQC report, there is a process for authorising deprivations of liberty in a care home in relation to an adult who lacks capacity by way of application to the local authority under the Deprivation of Liberty Safeguards (DoLS) regime. The appellant as a junior member of care staff is unlikely to have been responsible for that sort of decision, and there was no evidence before DBS that she was responsible for that decision.

76. We take these grounds together. In response to ground 2, DBS submits that it has made no error in because the appellant's explanation that doors were locked for residents' safety was also rejected by the appellant's employer. DBS refers in this regard to the notes in the employer's record of the disciplinary hearing that no record had been found in handover notes of *"comments with regard to the behaviours of residents wandering around or being violent"*. DBS also suggests (paragraph 29 of its response) that *"A colleague of the [appellant] working on the nightshift was also surprised the doors were locked (see CF, middle of [42])"*.

77. However, we consider there are a number of errors of law in its consideration of this aspect of its decision for the following reasons.

78. DBS's final decision letter is written in a way that makes it appear that DBS considers there can never be any justification for locking residents' doors and that this will in all cases be, or risk being, harmful to residents. DBS wrote: *"You blame residents wandering into other rooms for the need to lock them into their bedrooms without their consent. You also blame low staffing levels/being run off your feet for the need to lock residents in their bedrooms without their consent"*. DBS has not, on the face of the decision letter, included anything to indicate an understanding that, provided the correct authorisations are in place, it is lawful to deprive someone of their liberty who lacks capacity to consent if that is in their own best interests to protect them from harm, is a proportionate response to the likelihood and seriousness of the harm and if there is no less restrictive alternative: see paragraph 1.13 of the *Deprivation of liberty safeguards: Code of Practice* (2008).

79. We acknowledge and, indeed, emphasise that someone should never be deprived of their liberty *"for the convenience of professionals, carers or anyone*

else" (see paragraph 1.14 of the Code) and, further, that, in the absence of the proper authorisations under the Deprivation of Liberty Safeguards (DoLS) regime, room locking is unlawful as it breaches residents' rights under Article 5 of the ECHR. However, DBS's concern is, or should be, the risk of harm to the vulnerable adults. As such, the absence of the necessary authorisations should not be regarded by DBS as conclusive proof of harm to the vulnerable adults. If it is said that there were in fact and in principle circumstances that justified the deprivations of liberty in the residents' best interests, DBS needs to engage with that evidence in order to determine what the risk of harm to the vulnerable adults was and the risk that the appellant may pose in future. In this case, DBS did not engage with the appellant's evidence as to the reasons why she was complicit in locking residents in rooms. Indeed, DBS treated those potential justifications for locking rooms as being evidence of the appellant's lack of empathy and irresponsible attitude, when in fact the reasons were, or potentially were, evidence of the opposite, i.e. evidence of the appellant's care for the residents, empathy and responsible attitude.

80. If, and to the extent that, the brief references in the SJP to the appellant's justifications for locking rooms (relied on by DBS in response to this appeal) are to be taken as DBS having considered the appellant's evidence about risk to residents but rejected it because the risks had not been recorded in handover notes, then in that respect too DBS has in this case in our judgment failed to take into account relevant factors. It is clear from the CQC report that this was a home that was being run in general without proper regard to the principles of the Mental Capacity Act 2005 and that its record-keeping was in general extremely poor. CQC also found that staff training was inadequate. There is nothing to suggest that CQC took these factors into account in its decision-making, but they bear directly on this issue. Given the findings of CQC, we do not consider that it was open to CQC in this case (i.e. we find it was irrational) for CQC to treat the absence of records of resident behaviour as a reason for disbelieving the appellant's evidence on that point (if, indeed, CQC did reach that view, which we are not satisfied it did because there is, as we have already noted, nothing to suggest that CQC actually engaged with the appellants' evidence as to the potential justifications for locking rooms).

81. We add this: we said above that it was wrong in this case for DBS to treat the absence of the necessary DoLS authorisations as conclusive proof of harm to the vulnerable adults. That is in substance the effect of DBS's decision, as we read it. However, we observe that in this case DBS's decision letter does not even

acknowledge that it is the absence of DoLS authorisation that means there was a breach of residents' rights. DBS's decision letter does not give any indication that it is aware of the Deprivation of Liberty Safeguards (DoLS) regime at all. While we proceed on the assumption that DBS as the expert regulator is aware of that regime, we are not satisfied that the particular decision-maker(s) in this case were aware of it as the reasoning does not take this relevant factor into account.

82. As such, we find that DBS has made errors of law in failing to take into account the foregoing relevant factors and in reaching irrational conclusions on the evidence before it.

83. Finally, we make clear that we do not intend our findings in relation to this ground of appeal to indicate that we are satisfied that DoLS authorisations would have been granted for the locking of doors that occurred in this case. Indeed, we very much doubt that they would because it seems quite clear from the CQC report and the evidence that the reasons why the appellant and LS felt it was necessary to lock residents' doors were essentially reasons arising from the poor management of the home: inadequate staffing levels, inadequate risk assessments, inadequate training of staff all contributing to the situation in which two carers felt that the only way they could be sure of keeping all residents safe was to lock doors. DoLS authorisations would not be granted in such circumstances, or would only be granted for the very shortest of periods until the situation could be regularised. However, we do accept, for the reasons we have set out above, the appellant's evidence that she personally believed the locking of doors of those without capacity to consent was necessary in their best interests to keep them safe. We also accept her evidence that she was not at the time aware of the procedures that must be followed before any door is locked.

Ground 4

DBS has failed to take into account and/or resolve the inconsistency in the facts as to how many residents had been locked in without consent. The CQC report says seven, but the employer's case at the disciplinary hearing was four (p 41). There is also minimal evidence about the individual circumstances of the particular residents involved or the actual risk of harm that was posed to each of them.

84. Having considered the evidence, we accept DBS's submission that it was not necessary for DBS to resolve this inconsistency in this case. There was not sufficient evidence before DBS, and nor have we received sufficient evidence, to

make any reliable determination as to the circumstances of each individual whose door was locked.

Ground 5

The CQC report provides ample evidence of poor management practice at the home, which is potentially a significant mitigating factor in the appellant's case. There is no evidence, for example, that management had provided guidance to the appellant about when doors may be locked or how that should be authorised.

85. We have in substance dealt with this ground as part of considering Ground 2. We need deal no further with it.

Ground 6

No reference has been made to the anonymous statement at p 39 that contradicts the whistleblower in response to whom CQC carried out their inspection, indicating that there was no general practice of locking residents' doors overnight.

86. Having considered the appellant's evidence about the person who she believes wrote this anonymous statement, we accept that there was nothing unlawful about DBS not placing any particular weight on it.

Ground 7: Finding (ii): verbal abuse of residents in her care:

Ground 7: I consider it arguable that DBS erred in law and/or in fact in concluding that this allegation was proven. There is no evidence in the bundle that the appellant was verbally abusive to residents. There is no statement setting out this allegation, or identifying when it occurred or what the nature of the abuse is said to be. The only evidence is the appellant's response to the allegation, which was to the effect that she accepted she was on occasion "firm" with residents when they were being "very nasty and unwilling to co-operate". There is nothing wrong in principle with a member of staff being "firm" with a resident who is exhibiting challenging behaviours. There is arguably no evidence that the appellant conducted herself in a way that was harmful to a resident.

87. In its response to the appeal, DBS asserted that its conclusion that the appellant verbally abused residents was not in error because it was based on the appellant accepting she was occasionally *"firm"* with residents. At the hearing, Mr Ryan

took the Tribunal to the SJP by way of further explanation as to DBS's reasoning in this regard.

88. Reading the SJP, it seems to us that there was a failure by DBS to give due consideration to the evidence regarding verbal abuse. DBS refers to the whistleblower's allegation that there had been shouting and swearing at residents (by unnamed persons on unnamed dates and in unspecified terms) as if this is capable of constituting evidence that the appellant personally behaved in that way. In our judgment, it is not remotely capable of constituting such evidence.

89. DBS then refers to the appellant's locking of residents' rooms as if that is evidence demonstrating a propensity to verbally abuse residents when in fact there is in our judgment no rational connection between those two very different types of conduct.

90. DBS then concludes that *"being very firm … could constitute verbal and emotional abuse"*. We find this to be an irrational conclusion in this case. The expert panel members agree with the judge's initial view that there is nothing wrong in principle with a member of staff being *"firm"* or even *"very firm"* with a resident who is displaying challenging behaviours. In the absence of any more specific evidence about what the appellant said or did on any particular occasion, DBS's conclusion that this amounted to verbal and emotional abuse was perverse. It was also 'wrong'. It was an error of fact and law.

91. DBS submits that if it did make an error regarding this second finding, it was not material. We disagree. The final decision letter relies significantly on this finding. It forms part of DBS's reasoning in relation to its conclusions that the appellant lacks empathy and has an irresponsible approach to her role.

Ground 8: lack of empathy

I consider it arguable [Ground 8] that DBS erred in fact or in law in inferring from her written representations, which were written with a view to defending herself from charges of misconduct in respect of which the evidence is, in my judgment, weak (see above), that she lacks empathy and/or poses a significant risk of harm to vulnerable adults in future. It is also relevant in this respect that the principal conduct relied on is locking residents in rooms, which is conduct that it is inherently improbable someone would repeat once they understand, as it appeared to me the appellant now does, that locking a resident in a room without a DoLS authorisation in place is a dismissable offence.

92. DBS submits in response to this ground of appeal that it was rational for it to infer from the primary facts that the appellant lacks empathy. I am afraid we disagree. DBS has left out of account many relevant factors and we find its conclusion to be perverse.

93. First, we observe that great caution is required when endeavouring to carry out a psychological assessment of someone based on limited written materials as DBS did in this case.

94. Secondly, DBS has left out of account in its assessment that the appellant's reasons for locking rooms actually demonstrate empathy for residents because her concern was to keep them safe. There was no reliable evidence before CQC that anyone whose room was locked without their consent was even aware of that let alone distressed by it. (We have already dealt above with the evidence about the individual who was calling out.) While a deprivation of liberty is still unlawful even if the individual knows nothing about it (see *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] AC 896 at [35] *per* Baroness Hale), if DBS is going to use the fact that someone has locked a resident in a room as the basis for inferring that they lack empathy, it needs to take account of what actual distress was or may have been caused by that and also of any distress that the individual who did the locking thought they were avoiding.

95. Thirdly, DBS took into account its finding that the appellant had verbally abused residents, but that finding was erroneous in law and fact (see Ground 7).

96. Fourthly, DBS on the face of its decision letter left out of account the wealth of other material in the appellant's written submissions (further expanded on at this hearing) which indicates that she is a caring and empathetic individual who recognised the needs and natures of individual residents and took an interest in their lives.

97. When all these matters are taken into account, we consider that the only rational conclusion is that the appellant is not someone who lacks empathy.

Ground 9: hostility towards CQC inspectors

Finally, as to the finding that the appellant was hostile to the CQC inspector who visited, I am not persuaded that this is a material element of DBS's reasons for its decision,

but if it is then I consider it arguable that DBS has placed too much weight on it in the proportionality analysis as it has arguably failed to take into account the appellant's explanation for her hostility which was because she perceived the inspectors as being hostile to her, genuinely doubted whether she should let them in at 5am without phoning CQC to check the authenticity of their ID cards and had a need to go to a particular toilet at the time that they arrived for medical reasons.

98. DBS submitted in response to this ground of appeal that it had made no error, but that in any event this was not a material element of the decision. We agree that it is not a material element of the decision. It was a make-weight referred to by DBS in the SJP as part of its reasons for concluding that the appellant had verbally abused residents, but that part of the decision has fallen away anyway for the reasons set out at Ground 7. On our reading of the decision letter it does not play a material role in the finding that the appellant lacked empathy or in the reasons why DBS considered it proportionate to bar.

99. However, as the appellant's reaction to the CQC inspectors may have some bearing on proportionality, we make the following observations: first, the final decision letter is wrong to say that *"a number of credible witnesses state that it was [the appellant] who was hostile"*. There are in fact no witnesses who state this, all we have is a second-hand account from CS who was not present and the appellant's own evidence. Secondly, there is a limit to the weight that can be given to anyone's reaction to someone calling unannounced at 5am in the morning. Thirdly, we accept the appellant's evidence that she genuinely thought she ought to phone to confirm the CQC inspectors were who they claimed to be, that the inspectors adopted a hostile approach to staff on arrival because of the reasons for their visit, and that they ordered the appellant to stand in a particular place at a time when she needed to go to the toilet for medical reasons. We consider that all contributed to creating a degree of tension that provides some mitigation for the appellant's hostile reaction.

Proportionality

100. We now stand back to consider the case in the round and whether DBS's decision in this case was a proportionate and lawful interference with the appellant's Article 8 rights or not.

101. We have considered first whether we should adjourn further deliberation at this point in order to give DBS an opportunity to express its views on the question of proportionality in the light of the facts as we have found them to be following this hearing. This could be done by issuing our decision to this point as a decision on a preliminary issue as permitted by rule 5(3)(e). This is an approach that the judge has adopted in another case, but in this case we as a panel do not consider it is necessary to delay resolution of this case further. Although we have received oral evidence from the appellant of which DBS did not have the benefit, in this case her oral evidence has not made much difference to the facts of the case as they appear from the papers. Most of what she said in oral evidence at the hearing she had already said in her submissions to DBS, it was just that in our judgment DBS had not taken proper account of it in the ways that we have identified above.

102. In those circumstances, we consider that we can lawfully to proceed to make our own determination on proportionality in accordance with the legal principles that we set out above. We begin by giving real weight to DBS's view that this was a case in which barring was appropriate in the light, in particular, of the appellant's complicity in locking residents' doors. We recognise that DBS considered that conduct by itself in principle justified barring and we accept and agree with DBS's view that this constituted 'relevant conduct' for the purposes of the statutory scheme, since even if there were justifications for it, locking rooms normally brings with it a potential for harm.

103. However, we do not give DBS's view on proportionality as much weight as we would in most cases because we have found that in reaching that view DBS left out of account many relevant factors and reached perverse or wrong conclusions on the facts of this case in the ways that we have identified above.

104. We further find that the nature and extent of the risk that the appellant poses to vulnerable adults (or children) in future is very limited. She did not verbally abuse residents and her actions in locking doors were motivated by a desire to keep residents safe. It is concerning that she had not at the time understood that room doors should not be locked without consent save where specifically authorised and that authorisation would not be granted unless it was in the resident's best interests to protect them from harm, was a proportionate response to the likelihood and seriousness of the harm and if there was no less restrictive alternative. However, the appellant was not well qualified, she was the junior on shift and she was working in a badly run home where inadequate training was provided. These are significant mitigating factors. Once she had been dismissed

for locking rooms, it was apparent to her that this was a serious offence and something that should not be done. There is no past history of misconduct in the appellant's case which might indicate that she is unwilling or unable to learn lessons. In our judgment she is willing and able to learn, and has done so.

105. We found that DBS's conclusion that the appellant lacks empathy was perverse. The only proper conclusion on the facts of this case is that she is empathetic to those in her care.

106. We do share some of DBS's concerns that the appellant did not take appropriate responsibility for her professional practice. Although she was the junior on shift, she also bears responsibility for decisions that are made and she should also have 'blown the whistle' on the situation in this home. However, we do not consider that this factor of itself means that the appellant poses a significant risk in future. We were satisfied that, as a result of her dismissal, she knows in future that she must take personal responsibility, even if she risks losing her job.

107. In the present case, we therefore find that barring the appellant is more than is necessary to accomplish the legislative objective of protecting vulnerable adults and children. As such, it is disproportionate and unlawful as it breaches the appellant's rights under Article 8 of the ECHR.

108. Were it necessary to go further, we would also find that the barring decision in this case failed to strike a fair balance between the rights of the appellant and the public interest in protection of children and vulnerable adults. The effect on the appellant has been very significant: she has suffered emotional distress, she has been unable to work, and she has suffered financial hardship. The impact on the appellant is in our judgment disproportionate to the level of risk she poses to vulnerable adults and children.

Conclusion on the appeal

109. For the reasons we have given, we find that DBS has made material errors of law and fact in its decision and that the only lawful decision in this case is that the appellant should not be included in the barred list. Under section 4(6) of the SVGA 2006, we accordingly direct DBS to remove her from the list.

Holly Stout
Judge of the Upper Tribunal

Suzanna Jacoby
Upper Tribunal Member

John Hutchinson
Upper Tribunal Member

Authorised by the Judge for issue on 17 December 2024

<u>Annex</u>: Anonymity: Rule 14 Order

1. A Rule 14 Order had previously been made by an Upper Tribunal Registrar, but this only covered the appellant's colleague LS. At the start of the hearing, we asked DBS if they also sought other Rule 14 orders and they confirmed that they sought Rule 14 orders in relation to all staff and service users named or otherwise identified in the documents, and had no objection to one being made in respect of the appellant. The appellant confirmed that she wished a Rule 14 order to be made in respect of her in order to protect her privacy and reputation. The parties considered that it may be necessary also to anonymise the name of the care home in which the appellant worked in order to avoid the possibility of 'jigsaw identification'.

2. In the light of the parties' positions, we have considered whether it was appropriate to make any orders under Rule 14 in this case going beyond the orders already made by the Registrar. We bear in mind that we should not order a restriction on publication simply because both parties seek it: see *X v Z Ltd* [1998] ICR 43, CA.

3. In this case, we were satisfied that the private interests of the appellant, and also other individuals (staff and service users) named in the papers, were such that it was appropriate to protect those interests by anonymising them at the hearing and in this judgment pursuant to a Rule 14 Order. Our reasons for so concluding are as follows.

4. Open justice means that justice must not only be done, it must be seen to be done. In *Cape Intermediate Holdings Limited v Dring* [2019] UKSC 38, [2020] AC 629 the Supreme Court explained the purpose of the principle as follows:

> "42. The principal purposes of the open justice principle are two-fold and there may well be others. The first is to enable public scrutiny of the ways in which courts decide cases – to hold the judges to account the decisions they make and to enable the public to have confidence that they are doing their job properly. …
>
> 43. …the second goes beyond the policing of individual courts and judges. It is to enable the public to understand how the justice system works and why decisions are taken. For this they have to be in a position to understand the issues and the evidence adduced in support of the parties' cases".

5. Article 6(1) of the European Convention on Human Rights (ECHR) provides that: *"Judgment shall be pronounced publicly but the press and public may be*

excluded from all or part of the trial in the interests of…” and then a series of reasons are listed, including: *“the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the Court in special circumstances where publicity would prejudice the interests of justice”*.

6. Numerous cases have emphasised the link between open justice and the right under Article 10 of the European Convention of Human Rights to freedom of expression and have provided guidance on the nature of that right, including stressing the importance of names to the exercise of that freedom (see, in particular, *Khuja v Times Newspapers Limited and ors* [2017] UKSC 49, [2019] AC 161 at [14]-[30]). Section 12(4) of the Human Rights Act 1998 (HRA 1998) requires the Court to have *“particular regard to the importance of the Convention right to freedom of expression”* when considering whether to make any order that might affect the exercise of that right. This is not a case in respect of which there has been any press interest, nor does any seem likely. That does not affect the principles we have to apply, but it does mean there is no one who can realistically be notified as a ‘respondent’ to this application for the purposes of section 12(2) of the HRA 1998.

7. An order anonymising someone who would otherwise be named in court proceedings is an interference with the principle of open justice. As Lord Reed JSC described in *A v BBC* [2015] AC 588 at [23]: *“It is a general principle of our constitutional law that justice is administered by the courts in public, and is therefore open to public scrutiny. The principle is an aspect of the rule of law in a democracy…In a democracy, where the exercise of public authority depends on the consent of the people governed, the answer must lie in the openness of the courts to public scrutiny”*.

8. Ordinarily, it is said that it is not unreasonable to regard a person who brings proceedings as having accepted the normal incidences of their public nature, including the potential embarrassment and reputational damage inherent in being involved in litigation: see *TYU v ILA SPA Ltd* [2022] ICR 287 at [44] *per* Heather Williams QC (sitting as she then was as a Deputy High Court Judge). However, the same is evidently not true of other people named in the proceedings but who have otherwise had no involvement in the proceedings. As Williams J notes later in that paragraph, that is a factor that has been accepted in the authorities as being relevant to the question of whether they should be anonymised.

9. In this particular jurisdiction, the considerations are somewhat different to those in the authorities we have mentioned, because this is an appeal in relation to the

appellant's inclusion on the barred lists, the statutory scheme for which provides for the identity of those on the lists to be kept confidential and only revealed by DBS to those with a legitimate interest in knowing. Generally, that just means prospective employers, as the Divisional Court (Flaux LJ and Lewis J) explained in *R (SXM) v DBS* [2020] EWHC 624 (Admin), [2020] 1 WLR 3259. That case was a judicial review brought by someone who claimed to be the victim of sexual abuse who wanted to be informed by DBS whether the alleged perpetrator had been included on the barred list. The Divisional Court held that DBS had acted lawfully in refusing to disclose that information. It is, of course, not possible to tell from the judgment in *SXM* whether the alleged perpetrator had appealed to the Upper Tribunal or not, since that fact would itself have conveyed to the claimant in that case that the alleged perpetrator had been included on the barred list. It is, though, relevant for us to take into account that not anonymising an appellant in an appeal to the Upper Tribunal goes 'against the grain' of the legislative scheme as it was recognised to be by the Divisional Court in *SXM*.

10. We also consider that, in the context of appeals against DBS decisions, the emphasis that courts and tribunals in other contexts place on it being reasonable to assume that someone who litigates accepts the incidence of publicity that comes with that should perhaps be given less weight. That is because the legislative scheme gives those who are subject to it an expectation that they will not be publicly named and because the right of appeal to the Upper Tribunal is an essential element of that same legislative scheme. As we noted in the section of our judgment dealing with the Upper Tribunal's jurisdiction on appeal and proportionality, the hearing before the Upper Tribunal in DBS cases is the "fair and public hearing … by an independent and impartial tribunal" with "full jurisdiction" which secures that the barring scheme under the SVGA 2006 is compliant with Article 6 of the European Convention on Human Rights. It is important that an appellant should not be deterred from exercising their appeal rights by the fact that an appeal to the Upper Tribunal might bring with it publicity from which they are otherwise protected under the statutory scheme.

11. In this particular case, we are satisfied that the appellant's right to privacy under Article 8 of the European Convention on Human Rights is engaged as the issues in the case are capable of significantly affecting her personal life and reputation. The appellant in her documents and at this hearing has told us of the devastating effect that DBS's decision has had on her personally, in both emotional and financial terms. Inclusion on the list led to her losing the job to which she moved after her dismissal by the respondent and plainly affects her reputation and

access to employment. Revealing the appellant's name would represent a departure from the statutory scheme that was evidently intended by Parliament to strike the appropriate balance between public interest and private rights in this context as explained in *SXM*.

12. As we have noted, although it is often said that a claimant implicitly accepts publicity by commencing legal proceedings, it is hard to see why someone who exercises their statutory right to appeal DBS's decision should be deprived of the privacy they would otherwise have enjoyed if they had not appealed but accepted the barring, or to which they are properly entitled in cases where the barring decision is found by the Tribunal to be unlawful (as we have found it to be in this case). On the other hand, there is no particular public interest in anyone knowing the appellant's name, especially given that we have found that she was wrongly included on the barred list (and if we had dismissed the appeal, the public interest in knowing her name would largely have been served by DBS continuing to reveal it to prospective employers on request under the statutory scheme). We consider that the principle of open justice is very nearly as well served in this case by the public hearing and the publishing of this judgment without her name as it would be with her name.

13. We are therefore satisfied that the appropriate balance in this case between the principle of open justice, Article 10 and the appellant's Article 8 rights, is for the hearing and judgment to be public, but for the appellant to be anonymised.

14. For anonymity to be achieved in practice in this case, it seems to us that this means the name of the home in which the appellant worked must also not be made public as this was a relatively small care home and we consider there is a real risk of the appellant being identified if the care home is identified. It also means in our judgment that the names of other individuals in the case should be anonymised as publishing the names of multiple individuals who all worked at the same time in the same place would in our judgment bring a risk of 'jigsaw identification'.

15. However, we are also satisfied that the other individuals in the case required anonymisation in their own right. Their Article 8 rights are also engaged.

16. The service users are vulnerable adults being provided with intimate personal care in what is effectively their home as a result of medical conditions in respect of which they are entitled to privacy. They have had no involvement in these proceedings and it would have been inappropriate even to tell them of them.

17. As to other staff members, their personal reputations are not engaged to the same degree as the appellant's, but some of them have been the subject of argument and allegations as to their professionalism or credibility. The proceedings relate to matters that occurred at their work two years' ago which those involved would have had no reason to think would become public. These other staff members have not been involved in these proceedings, are probably unaware of the proceedings and have had no opportunity to answer any allegations made against them in these proceedings. These are all relevant factors as the *TYU* case makes clear. There is a real risk of unfairness to these staff members if their names are made public, and revealing their names would do little in this case to further the principle of open justice as their identities are not important to the facts of the case.

18. All these factors mean that, even absent the considerations about the appellant, we would have made Rule 14 Orders requiring the staff members and service users referred to in these proceedings to be anonymised.