**IN THE UPPER TRIBUNAL** **UT ref: UA-2023-001118-V**
**ADMINISTRATIVE APPEALS CHAMBER** **NCN No. [2025] UKUT 036 (AAC)**

On appeal from the Disclosure and Barring Service

# ORDER

**The Order of 4 October 2023 remains in place.**

**Any breach of that Order is liable to be treated as a contempt of court and may be punishable by imprisonment, fine or other sanctions under section 25 of the Tribunals, Courts and Enforcement Act 2007. The maximum punishment that may be imposed is a sentence of two years' imprisonment or an unlimited fine.**

**Between:**

**SB**

Appellant

- v –

**The Disclosure and Barring Service**

Respondent

**Before: Upper Tribunal Judge Wright**
**Upper Tribunal Member Hutchinson**
**Upper Tribunal Member Jacoby**

Decision date: 30 January 2025
Decided after an oral hearing on 10 October 2024

**Representation:**
Appellant: Calum C MacDonald, Financial Conduct Authority, instructed pro bono by Advocate
Respondent: Richard Ryan of counsel instructed by the DBS.

# DECISION

**This decision is given under section 4 of the Safeguarding Vulnerable Groups Act 2006**

**The appeal is allowed.**

**The decision of the DBS made on 12 May 2023 to retain the appellant on the Children's and Adults' Barred Lists involved mistakes on points of law and fact. Pursuant to section 4(6)(b) of Safeguarding Vulnerable Groups Act 2006 the Upper Tribunal remits the matter to the DBS for a new decision. The Upper Tribunal directs that the DBS shall not remove the Appellant's name from the Children's and Adults' Barred List pending the making of the new decision.**

## REASONS FOR DECISION

Introduction

1. This is an appeal by SB against the DBS's decision of 12 May 2023 to retain her name on the Adults' and Children's Barred Lists.

Our decision in summary

2. We allow the appeal by SB and remit her case to the DBS to make a new decision. SB will remain on both barred lists in the meantime.

3. The appeal is allowed because the DBS (i) made a mistake of fact about SB failing to accurately report and record the incident which occurred on 10 August 2022, (ii) erred in law in failing to take into account all the relevant evidence about whether SB had shown insight and remorse for what had occurred on 10 August 2022, and (iii) it further erred law by failing to take into account the character references SB had supplied to the DBS. The appeal is dismissed on all other grounds.

The DBS's decision in summary

4. The core factual basis for the DBS's decision was that SB had failed to follow safeguarding procedures on 10 August 2022 in that she had:

(i) failed to secure a commode/shower chair prior to assisting a service user to use it;

(ii) failed to seek medical assistance and moved a service user who had fallen to the floor without assessing their injuries; and

(iii) failed to accurately record and report the incident.

5. The DBS's decision letter further explained the basis for its barring decision as follows:

> "the evidence showed that it was in the service users care plan, as part of the risk assessment to prevent her from falling forward, to secure the commode and it's reasonable to suggest that you should have known to do this without instruction. You should have checked it was secure, and/or asked your colleague if it was secure before you moved away, and not assume your colleague had done it. Whilst you stated your colleague was the 'lead carer' you still had equal responsibility for the welfare of the service user.
>
> Your comments that you didn't believe the service user was injured or in pain because she hadn't called out is not considered credible. You had worked with the service user for 3-4 weeks and was therefore aware that she was non-communicative and could not indicate her pain or injuries. Despite you seeing the bruising to her face you did not suggest to your colleague you seek medical attention nor did you get an ice pack to help with the swelling. You could not have known, at that point in time, the extent of any injuries caused and should have sought assistance to ensure there were no other more serious injuries which were not visible. It is therefore concerning that you stated you followed your colleagues lead despite having been trained on the appropriate course of action to take

and the obvious need for the service user to receive further attention. You have therefore demonstrated a lack of insight into the harmfulness of your behaviour.

It's accepted that your colleague contacted the office following the incident, however it remains concerning that you did not correct your colleague and provide the true version of events, when the service user's daughter was told of an accident. You had already confirmed you had left the home without providing a clear account of the incident. You therefore failed to report it accurately to others. It is concerning that you have demonstrated an attitude that your behaviour was ok because you were following your colleagues lead, despite knowing this was incorrect.

It is accepted that you did not suffer from panic attacks or anxiety but it remains concerning that you admitted to panicking during the incident, despite receiving training on the correct course of action to take, and that this affected your behaviour; you confirm that you were in complete shock and automatically followed the instructions of your colleague. It's acknowledged that you have since undertaken work in a classroom since September 2022, however there is no evidence that you've encountered any similar situations and been able to demonstrate that you can react without panicking or that you can challenge poor practice when you witnesses it.

The DBS are concerned that your additional representations indicate that you have not accepted responsibility for your actions and have attempted to place all blame onto your colleague. This demonstrates a lack of insight/understanding into the need for you to speak up against poor practices which may place vulnerable adults at risk. You had a responsibility to challenge your colleague, even if she was the 'lead' carer, when you knew what your colleague was doing was wrong, was harmful and was against policy and procedures. The DBS are concerned that you may not report harmful behaviour in regulated activity in the future, if you were subservient, or if you had established relationships/loyalties with colleagues who may perpetrate harmful behaviour.

As such the DBS are satisfied that you carried out neglectful behaviour which caused and had the potential to cause significant harm to a vulnerable adult - you ignored a service user's medical and physical care needs and failed to challenge your colleague's harmful behaviour.

It's acknowledged that you had worked in a care provision role for 6 years and that there had been no concerns about your behaviour during this time. However, given your most recent conduct the DBS are concerned that you don't have the right problem solving skills to deal with stressful situations which often occur within regulated activity. The DBS are satisfied that you failed to recognise the seriousness of the incident and the service user's potential injures despite your experience in care. The DBS are therefore satisfied that vulnerable adults placed in your care are in danger of being subjected to physical and emotional harm through your neglectful behaviour.

> It's also concerning that you have failed to recognise the harmfulness of your behaviour and have focused only on the impact it has had on yourself and your future aspirations.
>
> As such, the concerns the DBS had, have not been sufficiently mitigated and the DBS aren't assured that you would act differently in the future. The likelihood of you repeating your behaviour is therefore considered high, given you have already acted contrary to your training. The potential level of harm, if you repeated your behaviour, is significant and the DBS is satisfied your behaviour indicates the need to impose a preventative mechanism in order to protect vulnerable adults.
>
> It's reasonable to consider that you could be presented with similar situations with children, you are therefore also considered to present a significant risk to children."

Grounds of appeal

6. The grounds on which permission to appeal was granted are as follows.

*Error of fact grounds*

7. In respect of the first core finding (the failure to secure the commode/shower chair), SB accepts that on the balance of probabilities the commode/shower chair was not appropriately tilted or secured and that the service user's care plan stated that it should be. However, it is argued that the DBS erred in failing to make any findings of fact as to the role and responsibility of SB's co-worker that day ("HA"). It is said by SB that HA was the service user's regular carer at the time of the incident and that HA's own evidence was that she sometimes did not secure the service user's chair. SB argues that factual findings as to HA's behaviour were plainly material to an assessment of SB's responsibility and culpability. It is said by SB that the mistake of material fact here was the DBS's failure to make findings of fact: per paragraph [39] of *PF v DBS* [2020] UKUT 256 (AAC).

8. The second mistake of material fact ground of appeal is about the second core finding in the DBS's decision, that SB had failed to seek medical assistance for the service user and had moved her without assessing her injuries. SB argues the DBS here made a material error of fact in finding that the service user was "non-communicative" when it had previously (and SB says correctly) found the service user to be "non-verbal". It is argued this was highly relevant because when the service user fell, she made no noise to indicate pain and, initially, showed no signs of injury, and SB therefore reasonably believed her uninjured and acted as she did (in moving the service user) on that basis. It is argued the DBS rejected this explanation as "not considered credible" on the erroneous basis that the service user "could not indicate her pain or injuries". It is further argued that the statement that the service user's injuries were not assessed is simply incorrect. It is submitted that SB (and HA) both initially believed that the service user was unharmed, they then assisted her to her bed where they performed an injury assessment.

9. In respect of the third core finding – that SB had failed to accurately record and report the incident – it is argued by SB that the DBS made a mistake of fact because she had been placed in an exceptionally difficult situation. Her colleague, HA, initially misled the service user's daughter and another member of staff as to the cause of the service user's injuries, but contradicting HA's account would have meant SB undermining the trust developed in HA's years' long care relationship with the service

user, which SB was reluctant to do before having discussed the incident with her superiors. It is argued that, nonetheless, at no point following the incident, did the SB make any false or inaccurate statements regarding the service user's fall. HA had stated she would phone the employer, Excelcare, to report the incident, and HA did so. It was for this reason that SB did not report the incident herself by phone. However, it is said, SB did provide an accurate report of the incident to Excelcare on leaving the service user's home. It is further argued that the third core finding incorrectly apportions HA's misconduct to SB.

10. A further consideration in respect of the third core finding was raised when permission to appeal was granted. This is that whether SB had failed to record and report the incident might depend on what her then employer's safeguarding policies and procedures required her to do in circumstances where at least two employees were involved in the incident.

*Error of law grounds*

11. The first error of law ground is that the DBS failed to identify and consider the "safeguarding policies and procedures" it is said SB had "failed" to follow on 10 August 2022. It is further argued that the DBS made a further error in failing to consider whether it was a realistic and reasonable approach in all the circumstances for patients to never to be touched and an ambulance called in any situation where there was a fall. SB argues here that so to act would have required her to leave the service user lying face down on the floor (in a position where her breathing would likely be impaired) for an indefinite period despite believing her to be uninjured. This prima, facie, would to be an irrational approach.

12. The second error of law ground (which states it is also an error of fact ground) is that the DBS erred by dismissing evidence of SB's insight and remorse in unqualified terms. SB argues that the DBS wrongly focused only on SB's most recent representations to it and thus ignored other evidence of SB's insight and remorse. This it is said is demonstrated by the fact that the DBS's previous barring decision, of 29 March 2023, "acknowledged that [SB had] accepted responsibility for [her] behaviour and [had] apologised for it". It is argued by SB under this ground in particular, and as a result, that the DBS was wrong to find (i) she had not accepted responsibility for her actions and had placed all the blame onto her colleague; (ii) that she had demonstrated an attitude that her behaviour was ok; and (iii) that she had focused only on the impact the incident had had on herself and her future aspirations.

13. The third error law ground for which SB has permission to appeal argues that the DBS erred in law by failing to consider relevant evidence and made an unreasonable assessment of the risk of future harm posed by SB. The DBS's decision to bar SB it is argued was based on a single unfortunate accident which lasted less than an hour and where SB was not the service user's regular carer, she generally cared for people with less advanced needs, and had not experienced a scenario such as the incident in issue before. It is argued in addition, inter alia, under this ground of appeal that (i) the DBS failed to consider the character references provided by SB, and (ii) that barring her, as an otherwise excellent carer, for a single incident for which she immediately took responsibility and into which she demonstrated insight, was wholly disproportionate.

14. A separate ground of appeal is advanced by SB in respect of her inclusion on the children's barred list. Here it is argued that the DBS failed to explain how "similar situations" could arise in respect of children, and it was therefore irrational and/or disproportionate for the DBS to have included SB on the children's barred list.

15. An overarching error of law ground of appeal is that the DBS did not provide adequate reasons for its decision.

Relevant law

16. Section 2 of the Safeguarding Vulnerable Groups Act 2006 ("the SVGA") provides that the DBS must maintain the adults' and children's barred lists. Subsection (2) of section 2 provides that Part 1 of Schedule 3 applies for the purpose of determining whether an individual is included in the children's barred list. Similar provisions apply under the SVGA in respect of the adults' barred list, but given the final ground of appeal, and the nature of the other grounds of appeal, we consider it is only necessary for us out set out the relevant parts of the SVGA concerning inclusion on the children's barred list.

17. Paragraphs 3 and 4 of Schedule 3 to the SVGA deal with what constitutes "relevant conduct" in respect of children. Those paragraphs, insofar as relevant on this appeal, provide as follows:

> "3(1)This paragraph applies to a person if—
> (a) it appears to DBS that the person —
> (i) has (at any time) engaged in relevant conduct, and
> (ii) is or has been, or might in future be, engaged in regulated activity relating to children, and
> (b) DBS proposes to include him in the children's barred list.
> (2) DBS must give the person the opportunity to make representations as to why he should not be included in the children's barred list.
> (3) DBS must include the person in the children's barred list if—
> (a) it is satisfied that the person has engaged in relevant conduct,
> (aa) it has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to children, and
> (b) it is satisfied that it is appropriate to include the person in the list.
>
> 4(1) For the purposes of paragraph 3 relevant conduct is—
> (a) conduct which endangers a child or is likely to endanger a child;
> (b) conduct which, if repeated against or in relation to a child, would endanger that child or would be likely to endanger him;…
> (2)A person's conduct endangers a child if he—
> (a) harms a child,
> (b) causes a child to be harmed,
> (c) puts a child at risk of harm,
> (d) attempts to harm a child, or
> (e) incites another to harm a child."

18. The Upper Tribunal's appellate jurisdiction is provided for under section 4 of the SVGA, which provides (insofar as relevant) as follows:

> "**Appeals**

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

19. The following decisions set out the bounds of the jurisdiction of the Upper Tribunal in exercising its appellate jurisdiction under section 4 of the SVGA cases. First, the appropriateness of a barring decision is not a matter for the Upper Tribunal on appeal. Second, for an appeal to succeed it needs to be shown, on the balance of probabilities, that the DBS made either a material error of law or a material error of fact in its decision: *R v (RCN and others) v Secretary of State for the Home Department* [2010] EWHC 2761 (Admin) (at paragraph 104) and *PF v DBS* [2020] UKUT 256 (AAC); [2021] AACR 3. Third, if it is argued that a decision to include a person on a barred list is disproportionate to the relevant conduct or risk of harm relied on by the DBS, the Upper Tribunal must afford appropriate weight to the judgement of the DBS as the body enabled by statute to decide appropriateness: *SA v SB & RCN* [2012] EWCA Civ 977; [2013] AACR 24. Fourth, what needs to be considered is not the terms of the decision letter alone but the whole basis for the decision as evidenced on the papers the DBS considered in coming to its decision: *VT –v- ISA* [2011] UKUT 427 (AAC) (at paragraph 36).

20. The primacy of the DBS's role as decision maker under the SVGA has been underscored and reaffirmed by the Court of Appeal in *DBS v AB* [2021] EWCA Civ 1575: see in particular paragraph [43] of that decision. The Court of Appeal in *AB* have also settled that there is a very limited basis on which the Upper Tribunal can direct that a person be removed from a Barred List under section 4(6) of the Act. The duty to direct removal only arises in circumstances where "that is the only decision the DBS could lawfully reach in the light of the law and facts as found by the Upper Tribunal" (*SB* at para. [73]).

21. The decision in *AB* also contains a useful discussion of what constitutes a 'finding of fact', about which it may be argued that the DBS was mistaken, contrasting such a finding with value judgements and the evaluations of the relevance or weight to be given to facts when assessing appropriateness: see para. [55] of *AB*.

22. Finally, following the Court of Appeal's decision in *Disclosure and Barring Service v JHB* [2023] EWCA Civ 982, and paragraph [95] of that decision in particular, as that decision is explained in *Disclosure and Barring Service v RI* [2024] EWCA Civ 95 (at paragraphs [33] and [54]), the Upper Tribunal should be slow to consider the DBS has taken a mistaken view of the facts when no new evidence has been put before the Upper Tribunal which bears on the findings of fact made by the DBS in its decision. Paragraph [54] of RI, however, makes plain that the ratio of *JHB* is confined to "cases where the Upper Tribunal either hears no oral evidence at all, or no evidence which is relevant to the question whether the barred person committed the relevant act – in other words, where the evidence before the Upper Tribunal is the same as the evidence before the DBS". The Court of Appeal in *RI* agreed with the RI (at paragraph [28]) that:

> "The Upper Tribunal is entitled to make a finding that an appellant's denial of wrongdoing is credible, such that it is a mistake of fact to find that she did the impugned act. In so doing, the Upper Tribunal is entitled to hear oral evidence from an appellant and to assess it against the documentary evidence on which the DBS based its decision. That is different from merely reviewing the evidence that was before the DBS and coming to different conclusions (which is not open to the Upper Tribunal)."

Discussion and conclusion

*SB's evidence*

23. Before turning to address the grounds of appeal, we set out first the key aspects of the evidence SB gave at the oral hearing before us.

24. SB told us that she had worked as a teacher in Bangladesh, and as a teaching assistant in the UK from December 2021 until she was barred from working with vulnerable adults and children in March 2023. She had also worked in the care sector in the UK, with older people, for over 6 years. SB told us that she loves working with young people and older people, but has not worked in the care sector since the relevant incident (on 10 August 2022) that led to her being barred by the DBS.

25. In respect of that 10 August 2022 incident and the service user involved in it, VA, SB told us that she had started working with VA on 10 July 2022, but SB then took a week of holiday. SB said the care agency ought to have explained to her what care needs VA had and the agency did not tell SB to read VA's care plan. SB told us she just did what her colleague, HA, told her to do in terms of VA's care, though SB added that HA's communication with her was not good. SB later clarified her evidence by saying she had not seen VA's care plan and assumed HA would tell her about VA's care needs. The care given to VA was given to her in VA's home.

26. SB's evidence to us was that VA did not have any means to speak but she could 'scream' if given too much food, and VA therefore could communicate when in pain or discomfort.

27. Turning to the incident on 10 August 2022, SB was working with HA in providing care to VA. HA had finished feeding VA and VA was then showered and dressed.

They then put a sling on VA whilst she was sitting in the shower chair/commode. The sling was to aid transferring VA from the chair to the bed. HA would usually stand next to VA but on this occasion had moved from her side to make up VA's bed. SB was standing a couple of feet away with her back to VA, putting some cream away. As SB turned around, she saw VA fall from the chair face down onto the floor. SB later told us that she did not know the chair had a tilted position, but it was (in her view) stable. It is common ground that the chair had not been secured in its tilted back position. SB initially told us that as neither she nor HA heard VA scream, they immediately lifted her back from the floor back onto the chair, and then checked VA over when she was in the chair. VA was then transferred to bed. SB then said that it was when VA was in the bed that she and HA "needed to see if she was okay or not on the head or the body". This evidence was seemingly at variance with SB's initial evidence that checks were made on VA when she was in the chair. In either event, SB's evidence was that neither she nor HA had checked VA before moving her from the floor back to the chair.

28. VA had some swelling on her face 15 minutes after the fall. On seeing this, it was SB's evidence that she told HA that they had to tell VA's daughter the truth of what had happened. However, HA told SB they were going to to tell the daughter her mother (VA) had hit her head in the hoist, which was part of the mechanism used to move VA in the sling. SB told us she had said to HA "How can you say this?", but SB then froze. As HA in SB's view had a good relationship with VA's daughter, SB wanted to see if HA would lie to the daughter. HA then suggested she and SB just left VA's home, but SB's evidence to us was that she told HA they could not do that and "no matter what we must tell the daughter the truth". The daughter was in another room downstairs in VA's house, and came into the room. The daughter was crying. When she asked what had happened, HA (wrongly) told the daughter her mother had hit her head on the hoist. SB told us that she was nervous and a new carer for VA, so all she said in answer to the daughter's query was that she (SB) "didn't do this intentionally".

29. VA had fallen, SB told us, at about 9.30am on 10 Augut 2022. At around 10.15am that day, SB said that a third carer came to the property. That carer kept asking what had happened. SB did not answer her as she just froze, but HA told the third carer that VA had fallen into the hoist. It was the third carer who ran to the kitchen to get an ice pack to put on VA's bruised face. SB had not done this, she told us, because she thought HA would do this and she (SB) did not have any information about the kitchen. Nor did SB or HA ring '999'. It was VA's daughter who did this. SB's reason for not ringing '999' she told, us was because she thought VA was fine. We interpose at this stage that SB took this view notwithstanding the bruising to VA's face or the fact that she had fallen flat on her front, face first.

30. SB told us that had a problem with her own phone on the day in question so she could not call her employer's office to report what had occurred. SB's evidence to us was that she had told HA to call the employer's office and explain everything that had occurred and that she (SB) would go to the office later. She went to the employer's (Excelcare's) office at around 1pm-1.30pm that day (10 August) and explained to the staff member there what had happened. The record of SB's statement is at page 74 of the Upper Tribunal bundle. It is a short but accurate description of VA's fall, but wrongly implies or at least suggests by its closing words that when SB and HA saw VA's face was swelling they called the daughter and told her what had occurred. Nothing in that short statement of SB sets out that her

colleague had, at the very least, misled, or at worst, lied to, the daughter about what had occurred.

31. However, SB did tell her manager what HA had (wrongly) told VA's daughter when SB was interviewed by her manager, on her statement, at 1.30pm on 10 August 2022. That interview begins at page 83 of the Upper Tribunal bundle. What SB is recorded as saying in that interview is largely consistent with her evidence to us. SB told her manager that VA had fallen from the chair, face first, onto the floor, and that she and HA had moved VA back into the chair before checking on her. SB also disclosed in that interview that HA had told the daughter that VA had got hurt on the hoist, whereas the hoist was nowhere near and VA had fallen and hit her face on the floor.

32. It was in an interview the next day with the same manager that it was put to SB that she and HA had discussed what to say to the daughter and had agreed, effectively, to lie to the daughter about VA having hit her head on the hoist. SB did not agree in that interview that she had agreed to this lie, and her evidence was to the same effect before us.

33. SB further told us that her manger told her she could resign and that, if she did, she did not need to attend the disciplinary hearing. She resigned in consequence.

34. SB's evidence to us was that she had had no similar issues with those she cared for before 10 August 2022 or had faced any disciplinary proceedings. She has reflected further on the incident and understands further what went wrong. She realises, she told us, that she ought not have picked VA up from the floor and should have reported what had occurred immediately. She knows it was both her and HA's responsibility to care for VA, but she thought HA would take the lead. SB told us she had learnt from the incident and evidenced this by referring to a neighbour who had fallen and for whom she had called an ambulance and then waited until the ambulance arrived. She had become more cautious that nothing should go wrong when working as a teaching assistant. Her dream job is to work with children but the barring decision had limited her career in this respect. SB said she deeply apologised for what had happened to VA. VA was like, and about the same age as, SB's grandmother, and SB said she wanted to save VA otherwise the ambulance was going to come. She considered she had saved VA (by moving her from the floor) because VA's face was down, she might not have been able to breathe and her condition could have worsened if she had been left lying face down on the floor. However, SB later accepted in cross-examination that they should not have moved VA after she had fallen to the floor and that they should have called the ambulance (and VA's daughter) immediately. On the face of it, and consistently with what SB had told her employer on 10 and 11 August 2022, SB accepted that both the need to call the ambulance immediately and not to move VA arose from her (manual handling) training. However, she had been shocked by the fall and as a result those steps were not taken.

35. Further under cross-examination, SB accepted she had worked for 6 years as a carer before 10 August 2022 and was experienced in caring for older people. Moreover, this was the only time she had not read a person's care plan. SB did not have VA's care plan and had been told just to go to VA's house and HA would tell her about VA's care needs. She had asked HA about what exactly they had to do for VA, but HA had not given SB all the information and was quite bossy. In questions from the tribunal, SB told us that care plans for individuals were kept in their homes and

on SB's phone and "it was always suggested if going to a new home to read the care plan". However, in this case SB had assumed HA would tell her what VA's care needs were. SB's evidence was that VA may have had a care plan in her home, but SB had not checked. Nor had she had "the opportunity" to say to HA that she (SB) needed to see the care plan, although this evidence was in our view somewhat undermined by SB's later evidence that she had asked HA what VA's care plan required, evidence which was itself somewhat undermined by earlier evidence of SB that she should have asked about the care plan.

36. We comment at this stage that if SB was (rightly) concerned to know the details of VA's care needs as set out in her care plan, and if (as SB told us) HA was not giving her all the information and was not good at communicating with SB, it was for SB to find out that information for herself by locating the care plan in VA's house and reading it.

37. As for the incident on 10 August 2022 itself, SB clarified that it was VA's face that hit the ground first, the fall made quite a loud bang and HA at one stage had thought VA had died. When Mr Ryan (for the DBS) put to SB that she had accepted in the interview with her manager on 10 August 2002 that she knew (from manual handling training) that she should never support someone up from the floor following a fall, particularly where they have hit their head, and she should have called for medical assistance, SB said she and HA had panicked. Once VA was back in the chair, HA had checked her for injuries, and once VA was in the bed both SB and HA had checked VA for injuries. In questioning from the tribunal, SB told us that she had had first aid training two years before the incident and was herself a first aid trainer. SB accepted that when she saw the swelling on VA's face she needed to tell the daughter so that the next steps to be taken could be identified. However, it had not come into SB's mind that VA might have suffered a head injury as a result of the fall.

38. In relation to the chair and its tilting mechanism, SB said she did not know the chair could tilt and she had not asked HA about this. Moreover, SB accepted that she had not told her colleague that she (SB) had not read VA's care plan. SB further accepted in cross-examination that she a responsibility to challenge HA.

39. In relation to whether SB and HA had agreed to lie to VA's daughter about what had happened, SB's evidence was in some respects equivocal. In cross-examination SB said she had told HA that they needed to tell the daughter, but said they then agreed not to tell the daughter. On SB's evidence, HA then told SB they were going to lie and SB thought HA, as a care worker of more experience, knew best how to handle the situation, though she recognised what HA was doing was wrong. Furthermore, SB said she could not bear to tell VA's daughter the truth about what had in fact occurred because the daughter was so upset.

40. It seems on the evidence before us to us, on the balance of probabilities, that SB did not positively agree to lie to VA's daughter about what had happened, but neither did she take any steps to correct to the daughter the lie that HA had told VA's daughter. This is supported by, and is broadly consistent with, the evidence SB subsequently gave to her employer in her two interviews with her employer on 10 and 11 August 2022.

41. One other area of the evidence we need to address is the "incident reporting procedure". This is referred to within the DBS's Barring Decision Summary document, and appears on page 209 of the Upper Tribunal bundle. What is there set out is:

> "It appears that [SB] subsequently failed to follow policies or procedure on witnessing [VA's] fall in that she failed to seek medical assistance and moved [VA] from the floor to the chair without conducting an assessment of her injuries, she failed to report the fall to her daughter and [the third care worker who arrived at on 10 August 2022 at 10.15am] and she failed to record the fall via the incident reporting procedure." (the underlining is ours and has been added for emphasis)

In the DBS's decision, this 'failure' to report to VA's daughter and the third care worker was described as follows:

> "It is accepted that [HA] contacted the office following the incident, however it remains concerning that you did not correct [HA] and provide the true version of events, when [VA's] daughter was told of the accident. You had already confirmed you had left the home without providing a clear account of the incident. You therefore failed to report it accurately to others."

42. The tribunal raised this issue with the parties. SB's evidence was that she recalled this procedure but it was for HA, as the more senior carer (in the sense of HA having worked with VA for longer), to write this up. SB understood HA had made this record and report. SB told us that one person making such a report on behalf of two carers was fine. SB considered her attending the office and being interviewed at 1.30pm on 10 August 2022 was her 'reporting' the incident. She considered the 'incident reporting procedure' had been followed by HA contacting the office and reporting in the paperwork.

43. Having set out, and to some extent commented on, SB's evidence, we turn to the grounds of appeal.

*Grounds of appeal*

44. We will start with the grounds of appeal on which we consider SB should succeed. We will then explain why the other grounds of appeal are not, in our judgement, made out made.

*Grounds on which the appeal succeeds*

45. The first ground on which the appeal succeeds concerns the third core finding of the DBS. That finding, when read compendiously, is that SB had "failed to follow safeguarding procedures on 10 August 2022 in that she had failed to accurately record and report the incident". This ground covers the mistake of fact grounds described in paragraphs 9-10 above, and at least part of the error of law ground in paragraph 11 above.

46. The critical starting point is that the evidence before the DBS and before us does not set out either the "safeguarding procedures" of Excelcare which SB was expected to follow or the "incident reporting procedure" of the same company that SB was required to meet.

47. The lack of evidence of the written policies and procedures of Excelcare and the error of law ground (that the DBS had failed to identify and consider the safeguarding policies and procedures SB had failed to meet) do not on their own give rise to any material error of law. This is because the DBS's failure to consider those written policies does not alone and of itself necessarily result in a consequence in the decision on SB's case, as that (mere) failure does not necessarily establish conduct

by SB which, for example, endangered, or was likely to endanger, a vulnerable adult (or child).

48. We are satisfied, however, that in relation to the other two core findings of fact made by the DBS that the content of Excelcare's safeguarding procedures can be inferred from the evidence, even though Excelcare's written procedures were not before us. That inference arises, first, from SB not disputing that VA's care plan (as part of Excelcare's safeguarding procedures) required the commode/shower chair to be secured and tilted when VA was sitting in it. And its arises, secondly, from SB's clear acceptance in her interview of 10 August 2022 with her manager at Excelcare, a matter which was not disputed before us, that she was aware from her moving and handling training (training which we consider part of Excelcare's "safeguarding procedures") that she should never support someone up from a fall to the floor, particularly where the person has banged their head, and instead should have called for medical assistance.

49. However, we are not satisfied that any similar inferences as to the content of Excelcare's safeguarding procedures or its incident reporting procedure can be made in relation to the third core finding made by the DBS. We have seen no detail as to the terms of Excelcare's "incident reporting procedure", and nor did the DBS have that information when it made the barring decision. We therefore do not consider it was open to the DBS, insofar as it did so (see the passages from the Barring Decision Summary and the decision letter cited in paragraph 41 above) to find that SB had *failed* to follow Excelcare's incident reporting procedure, or any other "safeguarding procedures", in not reporting the fall to VA's daughter or to the third care worker who attended at VA's home after the incident on 10 August 2022. There was simply no evidence before us showing that SB had been placed under an obligation to report the fall to VA's daughter or the third care worker, and as such we consider the DBS's made a mistake of fact in finding that SB had failed to report the fall to either VA's daughter or the third care worker.

50. We would accept, indeed infer, from the evidence before us that Excelcare had in place on 10 August 2022, in general terms, an incident reporting procedure. Indeed, SB herself accepted that Excelcare had such a procedure, and having such a procedure would plainly be an important part of a care provider's safeguarding procedure. However, without the actual terms of that reporting procedure this acceptance can only be at the level of generality, and looking at what SB told her manager at 1.30pm on 10 August 2022, we consider the DBS made a mistake as to a material fact when it held that SB had "failed to accurately record and report the incident". What SB told her manager on 10 August 2022 was in our judgement an accurate report of the incident. She told the manager on 10 August 2022 that VA had fallen forward out of the chair and hit her head, that SB and HA had moved VA from the floor to the chair and then the bed, and that HA had (wrongly) told the daughter that VA had hit her head on the hoist. That, in our judgement, was an accurate report of the incident.

51. Further, in the absence of the terms of the incident reporting procedure, or the terms of Excelcare's safeguarding procedure's more generally, we do not consider the DBS had a proper factual basis for its finding (insofar as it is a separate finding of fact) that SB had failed to accurately record the incident. The decision letter (see again the passage cited from it in paragraph 41 above) only relies on SB's failure to *report* the incident, which we have dealt with above and deal with further below. The

Barring Decision Summary passage cited at paragraph 41 above does rely on SB having "failed to record the fall via the incident reporting procedure". However, we consider this finding of fact was not properly open to the DBS on the evidence, and it was therefore mistaken. We have so concluded because in the absence of evidence as to the exact terms of the incident reporting procedure, we consider there was (and is) no secure basis for finding that SB, instead of or in addition to HA, was obliged by the incident reporting procedure to record the fall. SB told us, which we have no reason to disbelieve on the evidence before us, that it was for HA as the more experienced care worker to report the incident, including the fall, and HA had done this when HA went to Excelcare's office on 10 August 2022. Insofar as HA when so acting was acting on behalf of SB, there was no evidence before us, or the DBS when it made its decision, that HA did not record the fall via the incident reporting procedure.

52. Part of the DBS's argument before us was about whether SB had agreed with HA to lie about VA having hit her head on the hoist and thus had 'gone along with the lie'. Mr Ryan clarified later that the DBS was not, and had not, relied on SB herself having lied about VA having hit her head on the hoist. That clarification was welcome. There is nothing in the evidence before us to support any finding that SB had said VA had hit her head on the hoist. Moreover it should be noted that Excelcare in its letter of 17 August 2022 acknowledging SB's resignation stated "[w]e appreciate your honesty in this matter". However, we should add that we did not see the relevance of whether SB and HA had (or had not) agreed to lie to the daughter about the fall. We say this because it was no part of the DBS's finding that SB had failed to accurately report and record the incident that she had *agreed* with HA to lie about the fall. Nor was any part of that finding based on what SB had reported (or may not have fully reported) to her manager on 10 August 2022. The DBS's finding about SB's failure to report was limited to SB not reporting the fall to the daughter (and the third care worker), and thereby not correcting HA's lie to the daughter.

53. SB is also entitled to succeed on this appeal because we accept her argument that the DBS erred in law when making its decision by failing to take into account all the relevant evidence about whether SB had shown insight and remorse for what had occurred on 10 August 2022.

54. We set out the core relevant parts of the DBS's decision on which relied SB relied under this ground of appeal, which read:

> "The DBS are concerned that your additional representations indicate that you have not accepted responsibility for your actions and have attempted to place all blame onto [HA]. This demonstrates a lack of insight/understanding into the need for you to speak up against poor practices which may place vulnerable adults at risk."

55. SB also sought to rely on the passage in the decision letter which reads:

> "It is concerning that you have demonstrated an attitude that your behaviour was ok because you were following your colleagues lead, despite knowing this was incorrect."

And:

> "It's also concerning that you have failed to recognise the harmfulness of your behaviour and have focused only on the impact it has had on yourself and your future aspirations."

56. SB points out that in its earlier decision of 29 March 2023 (a decision which the DBS then reviewed and replaced with the decision under appeal) the DBS acknowledged SB had:

> "accepted responsibility for your behaviour and apologised for it."

57. The additional representations were made by SB's then solicitors and are dated 5 May 2023. It is apparent from their content that they were intended to be additional representations and not replacement representations. The representations request at their outset that the DBS take them into account "in conjunction with our previous representation[s]". The additional representations were not therefore intended to amount to the sum total of SB's representations.

58. We assume, which a fair reading of the 5 May 2023 letter might suggest is the case, that the DBS's above characterisation of the content of the additional representations is correct. We also accept that the DBS correctly identified those representations as being additional representations. And we further accept that the DBS was entitled to be concerned that those additional representations on their face may have sought to place all the blame onto HA and did not show SB accepting responsibility for what had occurred.

59. All of that said, however, what the DBS's decision making fails to show is any attempt to weigh those representations against that which SB had previously represented or said about the incident, which had led the DBS to find or conclude as it had in its 29 March 2023 decision. By way of example, the previous representations from the same solicitors of 25 April 2023 (which the DBS were also asked to take into account in the 5 May 2023 representations), state, inter alia, that the unfortunate incident had taught SB to learn from the experience and to make sure protocols were followed without question. That statement did not appear in the 5 May 2023 representations. Moreover, in our judgement the 25 April 2023 representations cannot fairly be characterised as placing all the blame on HA.

60. Furthermore, in a letter of 2 March 2023 SB told the DBS how she had identified her mistakes which should not have happened, that she now had insight into what she had done which was wrong, and she accepted full responsibility for her actions.

61. Moreover, on the same day the incident had occurred, SB told her manager, in answer to a question about whether SB was "comfortable with the decisions that [she] made and the steps [she] took after the fall", SB answered:

> "No, I am very angry and upset and what is done is done, I can only be totally honest with you, we should have called an ambulance at the time so she could get the proper treatment straight way."

And then in answer to a further question as to whether SB would have told anyone about the fall if VA's face had not swollen, SB answered:

> "Definitely, I would have called the office straight after, she is an elderly frail lady, she might have bruised, we had to keep an eye on her I would not have kept this secret. That was not my intention."

62. At the further interview the next day, in the context of SB's manager exploring with her why she had not corrected HA's lie to VA's daughter, SB said:

> "I understand, we have learnt totally different in training, I know it was wrong, I have no words to say other than sorry, I am not thinking about

> myself at the moment, I only hope VA is going to be okay. I didn't sleep last night, thinking, why did we do that…..
>
> ….I should have done the right thing, we should have called the ambulance and daughter immediately, I shouldn't have list[en]ed to HA, I let myself down"

63. The statements made by SB immediately in the aftermath of VA's fall on 10 August 2022 are plainly relevant to whether she had accepted responsibility for her actions (as is her letter of 2 March 2023) and whether she was showing remorse. The statements SB made on 10 and 11 August 2022 are also relevant to whether SB overall thought her "behaviour was ok" and whether she had failed to recognise the harmfulness of her behaviour and had focused only on the impact on herself and her future aspirations. In our judgment, the above highlighted statements SB made in her interviews on 10 and 11 August 2022 do not support the findings or the conclusions of the DBS we have set out in paragraphs 54 and 55 above. Indeed, given the highlighted statements from SB's interviews, we can see why the DBS seemingly accepted in its earlier 29 March 2023 decision that SB had accepted responsibility for her behaviour and apologised for it.

64. For error of law purposes, however, the point is that the DBS had to weigh all of the evidence going to whether SB had accepted responsibility for her actions and had shown remorse, and it failed to do that in its decision. Putting this perhaps another way, the DBS failed to consider the totality of all the relevant evidence concerning whether SB accepted responsibility for her actions on 10 August 2022 and thereby erred in law.

65. We reject the DBS's submission that its consideration of SB's representations and evidence as to her responsibility and remorse was sufficient. It may be, as the DBS argued, that its earlier decision of 29 March 2023 had a more nuanced basis: because, having made the acknowledgement set out in paragraph 56 above, it continued "however your insight appears limited to the impact your behaviour has had on yourself and your career rather than the harmfulness of it". Those concluding words may themselves have failed to take account of SB's evidence in her 10 and 11 August 2022 interviews. However, the DBS's acknowledgement quoted in paragraph 56 above is no more than demonstrative of the evidence from SB which supports her having accepted responsibility for her behaviour, and apologised for it, and it is that evidence of SB which the decision has not sufficiently taken into account. Nor are we persuaded by the DBS's arguments about the quality or depth of the responsibility shown by SB. That judgement had to be made having considered all the relevant evidence, which was not done in SB's case.

66. Nor are we persuaded by the DBS's argument, if we understood it correctly, that its decision was about the risk of future harm being caused by SB and, as part of that, the DBS was not satisfied that SB would in future challenge a colleague's wrong behaviour. We recognise that the assessment of risk is for the DBS. However, in making that assessment it had to take into account all relevant evidence. How SB viewed her role in what had occurred with VA on 10 August 2022 (including whether SB considered she had acted correctly in following and not correcting HA) in our judgment was plainly relevant to that assessment, and that required the DBS to consider all the relevant evidence going to those issues.

67. This point can be put another way. It is clear from the DBS's decision letter that it took into account the additional representations as relevant evidence about SB's insight and understanding about the need for her to "speak up against poor practice" and the need for her to report wrongful behaviour carried out by a worker who was more senior then her. The DBS therefore plainly considered that evidence about SB's acceptance of her responsibility for her actions **was** relevant evidence (which it was). However, having taken that step in its decision making, the DBS was required to consider (and show through its reasons it had considered) all such relevant evidence, and that it failed to do.

68. We consider this is sufficient to dispose of this ground of appeal. SB argued in addition, or in the alternative, that the DBS made a mistaken factual finding that she had "not shown insight and remorse" for her actions on 10 August 2022. An initial concern we have here, which was not addressed in argument before us, is can it be said to be a finding of fact whether someone has "shown insight and remorse". It is at least arguable that this 'finding' is instead an evaluative conclusion based on all relevant evidence. The latter is off limits for the Upper Tribunal: see *SB* at paragraph [55]. Although the discussion in paragraph [55] of *SB* is about the Upper Tribunal exercising the fact finding function located in section 4(7)(a) of the SVGA, it is also relevant in our judgement to deciding whether the DBS made a finding of fact about which it may have been mistaken. The second concern we have is, ignoring the first concern, whether the DBS actually made a finding of fact in its decision that SB had not "shown insight and remorse". None of the passages in the DBS's decision on which SB relies (see paragraphs 54 and 55 above) make such a finding. The passage from the decision letter in paragraph 54 above does refer to SB having a lack of insight, but (i) that is in a more limited context of a need for SB to speak up, rather than her insight more generally, and (b) in any event, is tied to the DBS (legally wrong) view that the sole relevant evidence was that found in the additional representations. It is therefore not a finding of fact (if it can be a finding of fact) that SB had not more generally "shown insight and remorse". Given these concerns, we do not consider we can or should find on the evidence before us (including SB's oral testimony which we have set out above) that the DBS made a mistaken finding of fact that SB had not shown 'insight and remorse'.

69. We should add, however, that the evidence SB gave to us, which we have summarised above, will form part of the evidence the DBS will need to take into account when it makes its new decision on SB's case under section 4(6)(a) of the SVGA.

70. The third, and final, ground of appeal on which the appeal succeeds is the DBS's failure to take into account the character references provided by SB to the DBS. This was part, but a distinct part, of her proportionality ground of appeal. It was not addressed by the DBS in its written submissions. Mr Ryan's argument before us was that the DBS consideration of the character reference was sufficient. We do not agree. There is no consideration of the character references in the decision letter of 12 May 2023. We accept that the decision letter has to be read alongside the record of DBS's decision making process set out in the Barring Decision Summary document (the BDS"). Unlike the decision letter, the character references are noted and summarised in the BDS as it appears at pages 223 and 224 of the Upper Tribunal bundle. However, other than the BDS listing this evidence, at no stage does the BDS grapple clearly (if at all) with this evidence.

71. The character evidence may to some extent be said to be quite general in nature. But where, by way of example, a care coordinator from Excelcare says, on 13 July 2022, that SB (on the face of it in her role as a care worker with Excelcare) was "amazing" and it had been a pleasure having SB in the care coordinator's team, that evidence needed to be addressed as it was evidence of SB's competence as a care worker as testified to by a more senior member of staff. That evidence obviously came before the incident on 10 August 2022 and so could not have taken that incident into account. However, we do not consider it was sufficient for the DBS to address that (and the other character references, which refer to SB's honesty, trustworthiness and reliability), if that is what the DBS was doing, by saying in the decision letter (and the BDS):

> "It's acknowledged that you had worked in a care provision role for 6 years and that there had been no concerns about your behaviour during this time. However, given your most recent conduct the DBS are concerned that you don't have the right problem solving skills to deal with stressful situations which often occur within regulated activity. The DBS are satisfied that you failed to recognise the seriousness of the incident and the service user's potential injures despite your experience in care. The DBS are therefore satisfied that vulnerable adults placed in your care are in danger of being subjected to physical and emotional harm through your neglectful behaviour."

72. We do not consider this is a sufficient explanation encompassing the character references because: (i) it is not clear it is addressing those references, and (ii) it fails to show that the DBS had weighed in its consideration that if, for example, SB had been an 'amazing' member of a care team and would seemingly (on the DBS's assessment) often have had to deal with stressful situations, SB may have developed the right problem solving skills over those 6 years and her reaction to VA's fall may therefore have been a one-off mistake which was not likely to be repeated.

73. We recognise that in SB's oral evidence to us she told us that she had had no similar issues with those she had cared for in her 6 years of caring before VA's fall on 10 August 2022. That evidence may well be relevant to whether SB had in fact developed the necessary problem solving skills over those 6 years to address that which confronted her when VA fell on 10 August 2022, and therefore whether her reactions to the fall were an out of character one-off or evidenced a propensity by SB not to be able to deal properly with care situations such as the one that she was confronted with on 10 August 2022. However, this is not evidence on which the DBS relied in its decision nor is it part of the DBS's reasons for that decision.

74. The above grounds are the grounds of appeal on which SB succeeds. Section 4(6) of the SVGA requires us to either remove SB from the barred lists or remit the matter to the DBS for a new decision. Removing SB from the both barred lists is only available if, per *AB*, we consider that was the only decision available to the DBS on the law and the correct facts. Given we are not allowing the appeal on any other grounds, and therefore the two other core findings remain intact that SB failed to secure VA's commode/shower chair (thus allowing VA to fall) and 'wrongly' moved VA from the floor after she had fallen, we do not consider removal from the lists is or was the only available decision open to the DBS.

*Grounds of appeal which are not successful*

75. We are not persuaded that the DBS made a mistake about a material fact in finding that SB had failed to follow safeguarding procedures on 10 August 2022 by failing to secure a commode/shower chair prior to assisting VA to use it. SB (rightly) concedes that the said chair had not been appropriately secured on that day and that VA's care plan stated that it should have been secured. The latter obligation being imposed by VA's care plan was accepted by SB in her interview with her manager on 10 August 2022. That admittance provides a sufficient evidential basis for the DBS's finding that such a requirement was part of the safeguarding procedures Excelcare had in place for VA on 10 August 2022. Nor does SB argue that the DBS was wrong or mistaken in fact in finding that she, SB, failed to secure the chair. The requirement to do so was in VA's care plan which SB had not read but should have read (see our comment in paragraph 36 above), and her failure to read VA's care plan formed part of her failure to follow safeguarding procedures and her consequent failure to secure the chair. SB was co-caring for VA with HA that day and it was the responsibility of both of them to ensure that the chair was secured in the tilting position. Although SB referred to HA being a more senior carer, that was only in respect of HA having more experience as a carer including, particularly, for VA. It was no part of SB's case before us, and there was no evidence to this effect, that she was required to take a subservient role to HA or only do as HA told her.

76. In all these circumstances, we can find no proper basis for the DBS having made a mistake about a material fact in not making further findings of fact about HA's role in what occurred on 10 August 2022. On the evidence, including the admissions of SB, the DBS was not mistaken in finding as a fact that SB had failed to follow safeguarding procures in that she (along with HA) had failed to secure/tilt the commode chair before VA used it. Insofar as the DBS were required as part of a judgement as to relative culpability to consider HA and SB's respective responsibilities and roles, in our judgement it did so sufficiently in its decision.

77. Nor did the DBS make any material mistake of fact in finding that SB had failed to follow safeguarding procedures on 10 August 2022 by failing to seek medical assistance and by moving VA from the floor without assessing her injuries. Again, the content of the safeguarding procedures and requirements under which SB was working that day can be inferred from her admissions with her Excelcare manager on 10 August 2022. The material safeguarding rules, which SB accepted in the 10 August 2022 interview she knew about from training, including manual handling training, were (i) never to support someone up from the floor, particularly following a fall, and (ii) if someone had hit their head (as VA had), they should not be moved and medical assistance must be called for. On her own evidence, SB (with HA) moved VA from the floor without assessing HA's injuries and had not called for medical assistance.

78. Seen from this correct perspective, whether the DBS made a mistake of fact about whether HA was non-verbal or could not communicate at all is, in our judgement, immaterial. SB relies on VA not making any noise, and being conscious, as the reason VA was moved from the floor. However, the core safeguarding faults were moving VA from the floor and not calling for medical assistance (i.e. an ambulance) while VA was on the floor. SB's assessment of VA's injuries was irrelevant in terms of those two safeguarding requirements, unless SB was being

instructed to make such an assessment by a '999' operator whilst VA was on the floor, which she was not.

79. We further reject the error of law argument made on behalf of SB that the safeguarding policies/requirements of leaving VA on the floor and calling an ambulance in any fall situation were irrational, and thus that they were requirements SB was not obliged to follow or at least could be excused by the DBS from not following in terms of assessing the harm of SB's acts. Much was made on behalf of SB of the harm that might have been done to VA had she been left lying face down while waiting, perhaps for a long time, for the ambulance. However, on the facts SB said she could see VA was conscious and breathing. Perhaps more importantly, what this argument leaves out of account is the role the '999' or ambulance service operator would have taken in enabling SB and HA to assess VA while waiting for the ambulance, and whilst VA remained on the floor, had they followed the safeguarding procedures and called an ambulance.

80. The penultimate error of law argument is that the DBS erred in law in making a disproportionate decision to include SB on both barred lists. The arguments here for SB at times treated 'disproportionate' as a synonym for 'irrational'. That is a mistake. As case law such as the first sentence in paragraph [84] of *In re B (Care Proceedings: Threshold Criteria)* [2013] UKSC 33; [2013] 1 WLR 1991 shows, properly understood, the argument that the DBS made a disproportionate decision is not an argument that the DBS erred in law in the procedure it adopted in coming to its decision that it was proportionate to place SB on both lists. The argument here is that the DBS erred in law on 12 May 2023 because the barring decision was disproportionate. We have to decide for ourselves whether the decision was disproportionate (see the same citation from *In re B*). Following *Bank Mellat v HM Treasury* (No.2) [2013] UKSC 39; [2014] AC 700, and paragraphs [20] and [74] of that decision in particular, this reduces to the fourth criterion in that case, namely whether the impact on SB's (Article 8) rights is disproportionate to the likely benefit of the barring decision. This has to be assessed in the context (i) of the appropriateness of barring not being a matter for us (see section 4(3) of the SVGA), and (ii) there being no less intrusive measures available: the DBS must bar a person if the person has engaged in relevant conduct, the DBS has reason to believe they have engaged (or might in the future engage) in regulated activity with children/vulnerable adults, and the DBS is satisfied it is appropriate to include the person on the lists. In other words, the question we have to decide is whether the decision to bar was a disproportionate interference with SB's rights to work with vulnerable adults and children.

81. We do not consider the DBS's decision was disproportionate. It was not therefore in error of law.

82. An interesting issue may arise as to whether in evaluating whether the barring decision was disproportionate, the Upper Tribunal has to decide this question on the basis of the facts as the DBS found them or the facts which we have found the DBS was not mistaken about. We heard no argument on this issue. The decision of the House of Lords in *Huang v SSHD* [2007] UKHL 11; [2007] 2 AC 167 might suggest that it is for the Upper Tribunal to decide whether the barring decision was disproportionate having established the relevant facts: see paragraph [15] of *Huang*. However, it may be an important consideration that the fact finding arose in *Huang* because the relevant statute enabled what is now the First-tier Tribunal, under

section 65 and paragraphs 21(1) an (3) in Schedule 4 to the Immigration and Asylum Act 1999, to review any finding of fact on which the decision was based when deciding whether the decision against the appeal was brought was not in accordance with the law. The error of law jurisdiction in *Huang* therefore could include reviewing (and redeciding) issues of fact. Under section 4(2) and (7)(a) of the SVGA, however, it may be arguable that 'facts' and 'law' are kept separate from one another. Moreover, the case law on proportionality is clear that the Upper Tribunal is not carrying out a full merits reconsideration (see *B v ISA* [2012] EWCA Civ 977; [2013] 1 WLR 124 at paragraphs [14] and [19]) and the Upper Tribunal must give appropriate weight to the DBS's decision on proportionality (*B v ISA* at [21]), which arguably must be the DBS's decision based on the facts as it found them. Given these features of the legal landscape, it may not be open to the Upper Tribunal to base the search for an error of law based on whether the decision was a disproportionate breach of the barred person's human rights on what the Upper Tribunal has decided are the 'correct' facts. That may be said to usurp the DBS's primary decision making function.

83. However, as we have said, we have had no argument on this potentially important point. We therefore proceed on an assumption and one that most favours the appellant, namely we evaluate whether the barring decision was disproportionate on the basis only of the facts which the DBS was not mistaken about. This assumption, however, does not assist SB.

84. Measuring the effects of the barring decision on SB's Article 8 Convention rights against the importance of barring her from regulated activity, in our judgement the importance of barring outweighs the effects on SB. Putting this another way, we consider the barring decision strikes a fair balance between the rights of the individual, SB, and the interests of the community. The latter includes as a material consideration, per paragraphs [23]-[24] of *B v ISA*, the need for public confidence in the system for regulating those who work with vulnerable adults and children. We did not, however, hear any argument from either party on this 'public confidence' point and our decision does not turn on it.

85. In terms of the severity of the effects of the barring decision on SB, we recognise that it will prevent her for many years from working with children or vulnerable adults. We accept her evidence that it is these areas of work which are her chosen professions. However, it is important to recognise that the barring decision does not mean SB cannot work or make a living at all. It is not therefore, on SB's facts, a decision carrying with it the most serious or gravest of effects in terms of SB's core human rights. In *Dalston Projects Ltd v Secretary of State for Transport* [2024] EWCA Civ 172; [2024] 1 WLR 327, the weight to be attached the person's human rights in the proportionality balancing exercise was put in this way:

> "[21]…. the context will include (1) the importance of the right (e g in *A v Secretary of State for the Home Department* [2005] 2 AC 68 ("the *Belmarsh* case") the rights were personal liberty and the principle of equality, where there was a "suspect" ground, i e nationality); (2) the degree of interference; (3) the extent to which the subject matter is one in which the courts are more or less well placed to adjudicate, both on grounds of institutional expertise (e g they are the guardians of due process but are much less familiar with an area such as the conduct of foreign relations or national security) and democratic accountability (e g

when it comes to social and economic policy, including the allocation of limited resources).

86. As against the interference the barring decision will have on SB's Article 8 rights, we have to accord appropriate weight to the DBS's statutory role as the primary decision-maker and its assessment of future risk based on the (correct) findings it made about SB having failed to secure the chair and having failed to leave VA on the floor and seek medical assistance after she fell.

87. The likely benefit of the barring decision is, putting it very broadly, that it will prevent SB from harming other vulnerable adults and children. That risk of SB harming other vulnerable adults and children, giving appropriate weight to the DBS's view about the same, in our judgement is properly and particularly based on SB's reaction to VA's fall. What happened on 10 August 2022 may have been a one-off event but that is because, on her own evidence, it is something that SB had not encountered before. This is not an issue that was explored in any detail before us (see further what we say in paragraph 74 above). However, our judgement on the evidence which was before us is that, notwithstanding her 6 years of care work and her training, SB did not insist on reading VA's care plan and then panicked/froze when VA fell. As a result, she did not follow that which she later accepted she knew should be done and wrongly moved VA from the floor despite knowing VA had hit her head on the floor. So acting could have had very serious consequences for VA, as moving her head and neck in an unsecure way could have exacerbated any head or brain injury. Given the risk to others evidenced by SB's acting outwith the safeguarding rules she knew about and was expected to work under, the likely benefit to the community as a whole of barring SB from working with vulnerable adults and children did not, in our judgement, amount to a disproportionate interference with SB's Article 8 human rights.

88. We should add that we have given consideration to the character references provided by SB in making the above proportionality assessment. Those references, however, do not address what occurred on 10 August 2022 and SB's breach of Excelcare's safeguarding rules on which we have found the DBS were entitled to rely. Moreover, insofar as the references attest to SB's good work record for 6 years, we have already taken this into account in paragraph 87 above.

89. We also add that we did not find the decisions in *AA v DBS* [2023] UKUT 110 (AC) and *JA v DBS* [2023] 204 (AAC), which were relied on by SB, of any real assistance as to the correct approach to proportionality in SB's appeal. Both *AA* and *JA* would seem to have turned on their own facts. In addition, the comments made in *JA* about proportionality were *obiter* (see paragraph [69] of *JA*) and were not, seemingly, grounded in relevant case law such as *Bank Mellat (No.2)*. As for the *AA* decision, it appears that the Upper Tribunal found there were mistakes of fact in the DBS's decision and those factual mistakes as to relevant conduct meant (see paragraph [65] of *AA*) that "including the Appellant [on either barred list] on the basis of this relevant conduct cannot reasonably be considered to be appropriate". The subsequent discussion in AA about whether it was disproportionate to include *AA* on either barred list may also be viewed as being *obiter*. Insofar as it was not *obiter*, the decision would seem to turn on its own particular facts which involved 'occasional' failure to respect the cared for person's wishes, facts which have little or no read across to SB's failings in this appeal.

90. SB's final ground of appeal concerns the part of the DBS's decision that included her name on the children's barred list. She argues that it was irrational, and thus in error of law, for the DBS to have based this part of its decision on it being reasonable to consider that SB could be presented with similar situations with children and thus (for the DBS) to consider her to also present a significant risk to children. It is said by SB that the DBS have not explained how such "similar situations" could arise with children, and therefore this part of the decision was irrational/and/or disproportionate.

91. We do not consider the DBS erred in law in including SB on the children's barred list. The children's barred list is not just about young children, as SB sought to argue. It includes children up to the age of 18. We do not consider it was irrational (or disproportionate) for the DBS to include SB's name on the children's barred list. Irrationality as an error of law ground is a very high bar. We consider that given the failures we have found the DBS was entitled to find in respect of SB's care for VA on 10 August 2022, and the future risks which those failures evidenced, the DBS was entitled rationally to conclude amounted to conduct which was transferable to children if SB was in the future to work with children: see *MG v DBS* [2022] UKUT 89 (AAC) at paragraph [57-[58]. In this respect we bear in mind that "relevant conduct" includes, per paragraph 3(4)(1(b) of Schedule 3 to the SVGA, "conduct which, if repeated against or in relation to a child, would endanger that child or would be likely to endanger him".

92. It is, moreover, not the case that the issue of transferability is limited to cases involving serious sexual offending or conduct. Nor does transferability depend on the DBS showing (per *OR v DBS* [2023] UKUT 160 (AAC) a risk of harm arising from a "willingness to exploit vulnerabilities and to cross ethical boundaries". That language was obviously appropriate in the *OR* case but it was not seeking to lay down a legal requirement for all cases.

93. The reasoning of the DBS for transferability of risk and placing SB on the children's barred list is short. In the decision letter it reads:

> "It's reasonable to consider that you could be presented with similar situations with children, you are therefore also considered to present a significant risk to children."

In the circumstances, and insofar as SB challenged this reasoning as being inadequate on this appeal, that reasoning when read in context was adequate and was sufficiently based on the evidence.

*Conclusion*

94. For all of these reasons, this appeal is allowed and we give the decision in the terms set out above.

**Authorised issue by**

**Stewart Wright**
**Judge of the Upper Tribunal**

**John Hutchinson**
**Member of the Upper Tribunal**

**Suzanna Jacoby**

**Member of the Upper Tribunal**

On 30 January 2025