Independent Review of the Barring Operations of the Disclosure and Barring Service

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Chair's Foreword

The Board of DBS commissioned an independent review of our Barring Function in May 2014 to ensure that the process appropriately reflected the legislative intent and to assess the effectiveness of our process.

We were delighted to be able to appoint Eleanor Grey QC to lead the review along with a small team of subject matter experts.

The Board have discussed the contents of this report and had the opportunity to speak to Eleanor Grey about her findings. We are pleased to confirm that the Board has accepted the report and its recommendations in their entirety.

We are now in the process of implementing the necessary changes across DBS and we expect to complete this work by mid 2016.

I would like to take this opportunity to thank Eleanor and her team for their commitment to this review. We are assured that our processes are fundamentally sound and the proposed changes will enhance our work in the future.

Bill Griffiths

Chair

Introduction

1. This Report records the main themes and recommendations of the Independent Review of Barring Operations commissioned by the Disclosure and Barring Service (DBS) in summer 2014. The Review was carried out by Eleanor Grey QC, an independent barrister, supported and assisted by Dr Joe Sullivan (clinical psychologist and expert in child protection) and Bridget Penhale (expert on elder abuse and adult safeguarding, with a background in social work). Short details of their backgrounds are to be found in Appendix 1.

2. The DBS was created in December 2012, when it took on the functions of the Criminal Records Bureau (the CRB) and the Independent Safeguarding Authority (the ISA). The ISA was, and the DBS now is, responsible for the 'barred lists': that is, registers of people who are judged to be unsuitable to work with children and vulnerable adults. DBS must consider whether or not to put the names of individuals referred to it on its lists. It has a further power to remove names which are already on a list, if, following review, it is considered that there is no longer sufficient justification for their inclusion.

3. The review was commissioned by the DBS Board to allow it to assure DBS practices and procedures, in respect of its barring functions. It reflected DBS's aim of ensuring continuous improvement and development, and came two years on from the joining of the ISA and CRB. The review born was commissioned on a proactive basis, to assist in the development of a relatively new organisation.

4. The review's Terms of Reference required it to:

- Undertake a review of the DBS's Barring Decision Making Process (the BDMP) to ensure that it fully reflects and incorporates the statutory responsibilities of the DBS as set out in the Safeguarding Vulnerable Groups Act 2006 (as amended) and the Safeguarding Vulnerable Groups Act (Northern Ireland) Order 2007 (as amended);
- To assess the application of the five stages of the BDMP by DBS caseworkers and the extent to which the five stage process facilitates quality decision- making;
- To identify any areas where guidance needs amendment or additional procedural guidance is required;
- To identify any process or procedural change that would create operational efficiencies in the context of case handling and enhance the service DBS that provides to the public; and

- To report to the DBS Board, making relevant recommendations for the Board's consideration.

5. Over a number of days spread across September 2014– February 2015, the team examined case files and appeal files held by the DBS in offices in Darlington. Ms Grey examined just over eighty files drawn from the range of cases referred to DBS (both children and adults, and involving physical, sexual or emotional harm, or neglect and financial abuse). The cases included files that had been closed without bars, as well as those that resulted in bars. A selection of files (some thirteen in total) had been subject to DBS's quality assurance checks and that process too was examined. Other files were drawn from those which had gone or were going through the appeals process. Further case files were examined by Ms Penhale and Dr Sullivan in the course of their discussions and investigations. These two experts each spent four or five days at DBS offices, speaking to staff and examining decision-making materials.

6. The authors of the report spoke to numerous DBS staff, from its Chair to the caseworkers, about their work and the issues revealed by files. In an attempt to capture wider feedback on DBS's role and functioning, Ms Grey also spoke to a number of external stakeholders. The twenty bodies or organisations consulted are listed in Appendix 2.

7. Following initial findings from the review presented in January 2015, there was a further request from the Board to assess the quality of the training offered to staff. The purpose of this work was again to seek assurance that the correct policies and procedures were in place to ensure the effective decision-making. This work was carried out by Dr Sullivan and Ms Penhale.

8. In September 2015, Ms Grey attended DBS to examine a further sample of 19 case files, to revalidate and refresh the original case sampling and to confirm the findings in this Report.

9. Although nearly 100 files were examined by Ms Grey in total, and further files were reviewed by the two independent experts, the files were not treated as a representative sample with statistical validity. Rather, the strength of this review lies in the links made between what was seen in files by all three members of the review team and the issues discussed with both DBS staff members and external stakeholders. We have sought to ensure that any observations in the report are founded not on isolated examples, but can be traced back to themes that recurred across those varied sources of information.

10. There was discussion and liaison between the three members of the Review Team. Authorship of this Report, and responsibility for any mistakes, rests with Ms Grey, but it is based on the work of all three contributors and its contents have been reviewed and agreed by all three.

The nature of the work carried out by DBS

11. A summary of DBS's powers, in relation to its barring decisions, is contained in Appendix 3 to this report, together with figures relating to the numbers of cases handled per annum and the barring outcomes. Against that background, we make a few introductory points.

12. First, DBS plays an important role in the safeguarding landscape. Consultees noted that abusers and offenders can be drawn to positions where they may secure not only access to, but the trust of, the young and the vulnerable. The barring service, coupled with disclosure checks on employment, not only assists in the protection of those groups if individuals were appropriately barred, but also has an important deterrent effect which is capable of having a wider impact. We found that staff were conscious of the importance of their work and keen to secure effective and appropriate decision-making which safeguarded the vulnerable.

13. That said, plainly DBS cannot secure the safety of children and vulnerable adults on its own. It is heavily reliant on the insight and actions of those organisations and individuals who either have immediate contact with those suspected of abuse, or have responsibility for investigating or prosecuting such conduct. The DBS's role is a secondary one: it can act only when a case is referred to it, either following the commission of a criminal offence, or because other concerns have led to information being referred by an employer, a regulator, the police[1] or other safeguarding authorities.

14. At least in cases where there has been no criminal conduct and the autobar procedures apply, the 'default' position is *not* to bar. By this we mean that in such cases the DBS can only act if 'relevant conduct' has been established on the balance of probabilities, or it can find that there is a 'risk of harm' on the basis of past conduct. Making a finding of fact that someone has 'on the balance of probabilities' engaged in abusive activity which has not been proven in a criminal court is a significant responsibility, and one that staff take seriously. If the

[1] Including information included by the police as 'soft intelligence' on a enhanced disclosure check for employment purposes, which will be scrutinised by the DBS's Disclosure Information Team (DIT).

evidence is not considered sufficient to support such a finding, a bar will not result. Thus, the scope for action by DBS will be heavily influenced by the nature, quality and completeness of the information received by it, even before it can consider the 'appropriateness' and proportionality of a bar.

15. Further, the framework established by the SVGA, including the amendments made in 2012, reflected a political judgment as to the balance to be struck between a national scheme, operated by government or a government agency, and the devolution of responsibility for employment decisions to employers and voluntary agencies. The changes made in the Protection of Freedoms Act 2012 were described by government as "scaling back the criminal records and barring systems to more proportionate levels whilst ensuring that they continue to provide effective protection for those who need it." In particular, the definition of 'regulated activity' was changed in 2012, with the intention of focussing on work which involved close and unsupervised work with vulnerable groups, including children.

16. The balance struck by these changes continues to be contentious. The opinions heard by stakeholders who were consulted reflected this. Opinions varied, both on the legislative framework and upon the weight to be given to public interests that were often in conflict, such as the need to allow for rehabilitation and change whilst still providing effective protection for children and vulnerable adults. There was repeated criticism of both the complexity, and completeness or scope of the legislation which DBS must apply; for example, in relation to the test for 'regulated activity', or in relation to disclosure of information about who is included upon a barred list. This Report focusses upon the issues within DBS's power and control.

17. DBS operates within this contested landscape. Attitudes to its decisions, and to whether a bar is "appropriate", may therefore legitimately vary. The authors have sought to acknowledge this, when examining individual decisions.

The DBS's Barring Decision Making Process (the "BDMP")

18. The DBS's statutory task and the processes which it, together with its predecessor the Independent Safeguarding Authority (the ISA) have developed to carry out its work, are explained in some detail in Appendix 3. Key to the work of caseworkers is a five-stage process known as the "BDMP" (barring decision-making process). For discretionary referrals, the DBS decision-making process involves:

1. Stage 1: an initial sift, looking to see if the essential elements of a referral are in place and the DBS has the power to consider the case; this is followed by a process of gathering any further necessary information;

2. Stage 2: evaluation of the evidence, and making provisional findings of fact. Findings are provisional only because the potential barree has not yet been given a chance to make representations;

3. Stage 3: an assessment of the risk posed in the future;

4. Stage 4: issuing a 'Minded to Bar' letter giving the barree the opportunity to make representations on the provisional decision and the information considered by the DBS, and assessment of any representations;

5. Stage 5: the final decision.

19. The assessment of a case can be brought to a close at any one of these stages if the evidence does not justify the imposition of a bar, and files may be passed back for further information-gathering if later stages reveal gaps in the information held. There are some modifications to the process in 'Autobar' cases: those cases where referral is triggered by the commission of a relevant criminal offence.

20. The BDMP requires staff, at each step of the decision-making, to assess the issues that are relevant, and in particular whether:

    a. There is evidence of participation in 'regulated activity', in the past, present or future;

    b. There has been 'relevant conduct' or there is a 'risk of harm' in the future; and

    c. It would be 'appropriate' to bar the person referred.

21. The BDMP template must be populated by the evidence gathered and evaluated in each case. It contains prompts to the reconsideration of issues as more evidence is accumulated. At the third stage, the BDMP incorporates risk assessments tools (the Structured Judgment Process or "SJP", and the Financial Abuse Tool) which encourage the systematic assessment of risk factors.

22. We note that the completed BDMP is habitually disclosed in appeals heard by the Upper Tribunal, where its basic structure has not attracted adverse comment and the use of the SJP has been accepted. This right of appeal to the Upper Tribunal against a barring decision ensures that the requirements of Article 6 of the European Convention on Human Rights (the ECHR) are respected.

23. We have concluded that the five stages of the barring decision-making process or BDMP represent a logical and structured method for assessing the issues that must be evaluated by DBS caseworkers in reaching decisions on barring referrals. Overall, the process to be followed accurately reflects the statutory framework regulating barring decisions. We have concluded that the BDMP should continue to be used in, essentially, its present form. The greater part of the observations and recommendations below therefore concern how staff may be further supported in using the BDMP to make appropriate decisions.

24. That said, decision-making at 'Stage 3' of the BDMP (risk assessment) is underpinned by the use of two risk assessment tools, the Structured Judgment Process ("SJP") and the Financial Abuse Tool. We have recommended that work is carried out to refresh both tools; see further below.

25. We also note that legal decisions have required DBS to consider the circumstances in which oral, instead of written, representations may be received from those at risk of being barred. We recommend that this policy be further developed and made accessible so that its existence is properly understood. We note that DBS may require to develop the capacity to enable such oral representations to be received and assessed.

The application of the BDMP by DBS Caseworkers: decision-making.

26. The practical application of the BDMP, and decision-making by staff, requires difficult judgments to be made, both in evaluating evidence in order to establish facts (on the balance of probabilities), and in assessing future risk. We have sought to assess both the quality of decision-making, and how staff are supported and assisted, by training, guidance and opportunities to seek assistance and advice when confronted with difficulties.

27. **Training**. Caseworkers receive initial 'starter' training when recruited, and are supervised and subject to checks as they are further trained and

accredited to use the BDMP. There is a programme of refresher training. In addition, in 2010 Teesside University accredited the continuing development programme to provide opportunities for staff to obtain a Post Graduate Certificate (PGCert) in Professional Development. That accreditation programme is currently being re-tendered.

28. The training of caseworkers was considered by Ms Penhale and Dr Sullivan. They concluded that much of the training material is of a high standard and should be retained; however, some of the material is outdated and needs refreshing, so as to include more information about issues such as the Care Act 2015 or patterns of offender behaviour. In due course, there will be a further need to align training with any redevelopment of the risk assessment tools used.

29. Ms Penhale and Dr Sullivan also recommend that consideration should be given to having the updated 'New Starter Training' accredited as a post graduate certificate. There is also potential to combine the 'refresher programme' and 'continuing professional development' qualification and for having the new programme accredited as a post graduate diploma.

30. **The development of staff expertise**. We have identified further opportunities for DBS to draw on the experience of its own staff and to also to widen ease of access to appropriate specialist expertise, by:

    a. Completing a register of the safeguarding knowledge and experience of its existing caseworkers and ensuring its existence is properly shared amongst staff members;

    b. Developing a network of 'subject experts' amongst caseworkers, whose task would be to keep up to date with sectors or subject areas, and take the lead in sharing knowledge, both by assisting with training and providing advice to colleagues; and

    c. Recruiting a small number of expert practitioners with current experience of adult and children's safeguarding practice, to attend regularly at DBS on a part-time basis. They should be available to lead training and to participate in case conferences, specialist 'surgeries' or other means of supporting staff decision-making in cases of complexity.

31. Steps along these lines should ensure that depth of knowledge in safeguarding practice is recognised and fostered amongst caseworkers

and further embedded in decision-making processes. They should also provide an opportunity to assess whether a report by an independent expert or other forms of expert advice should be commissioned.

32. In the longer term, the development of specialist cases conferences or surgeries along the lines set out at (c) above would imply that the role of the DBS's Quality and Standards Committee could be re-shaped, to remove the function of providing advice on individual cases and to enable it to concentrate instead on its more general function of assuring the quality of the decision-making processes.

Stage 1: Information-Gathering and Investigations.

33. The early stages of checking and reviewing the information referred to DBS raises a number of disparate issues. We have noted the need to ensure that all teams tasked with this information-gathering take similar approaches to their work and that best practice is shared.

34. At an early stage, staff must determine whether there is evidence that the "test for regulated activity" (TRA) is satisfied. Work – past, present or future - within these areas is generally required for a person to be subject to a barring decision. One important source of evidence is the existence of an employer's request for an Enhanced Disclosure and Barred Lists (EDBL) check to be carried out. We have noted the possibility that such a request may, on occasion, be made in error or unnecessarily. It is our view that, when assessing the application of the test for regulated activity, DBS should be alert to this possibility and (in particular) be prepared to check the position if representations about possible errors are made to it.

35. A wider issue is the extent to which DBS should seek to gather further information about any case referred to it.

36. The DBS's current view is that its statutory powers establish it as an 'information-gathering' rather than an 'investigatory' body, and that it should be mindful of this when making requests for further information.

37. Furthermore, the emphasis is upon gathering sufficient material to enable proper decision-making, rather than following all possible lines of enquiry unnecessarily or to the very end. The question of when sufficient material is available is, of course, a matter of judgment. We recognise that deciding when more information about a case is needed is not straightforward. This is particularly so in cases where the behaviour alleged is relatively 'low level' and seems unlikely to justify a

bar, or when the potential sources of further evidence appear scarce. Information-gathering also comes at a price to the person referred to DBS, who faces a more protracted period of uncertainty and stress whilst the referral is being considered. It risks a loss of privacy if additional agencies or employers are contacted by DBS to ask for information and knowledge of the referral ripples outwards.

38. That said, a number of appeals have succeeded in the Upper Tribunal when the Upper Tribunal has identified a need to secure further evidence, either to resolve factual issues raised by representations or to ascertain current risk. These are, of course, the most serious cases which have led to a bar. It is more difficult to assess both the need for, and the potential effects of, fuller information-gathering in the great majority of cases that do not proceed to a bar. We consider, however, that there is scope for further work to ensure consistency of approach.

39. We have recommended that tools should be developed to assist in the identification of cases suitable for early closure (see below). Part of that work could usefully consider standards for the quality and completeness of information contained in a file, before closure.

40. We also note the importance of evaluating the requests for further information that are sent to the information-gathering team (HUB) by other teams, with a view to learning from any patterns revealed by such requests.

41. Beyond the question of whether DBS is making the most appropriate and proportionate use of its powers to seek information, is the question of whether it may seek to gather 'new' information, if the material sent by referrers or other agencies approached appears incomplete and further enquiries might reveal more.

42. We recommend that DBS takes steps to clarify the extent of its powers to seek further information, if necessary by commissioning legal advice. It is our view that this issue requires further evaluation.

43. We further recommend that DBS considers, in the light of such an exercise, the creation of an Inquiry team of caseworkers. Their function would be to explore relevant questions in more depth at the information-gathering stage, or as the cases progresses, so as to obtain further information to help in the risk evaluation and decision-making process. We are not advocating that DBS undertake such work routinely, but rather that such a team might be usefully employed in particularly complicated cases.

44. With full training, such a team could take the lead in:

    a. Commissioning medical reports from those at risk of barring, in cases where risk is linked to (say) mental health issues;

    b. Commissioning specialist assessment of risk;

    c. Running any process of oral representations, if required under DBS's policies concerning such representations; and/or

    d. Conducting interviews with those at risk of barring, if they were willing to participate.

45. Bottlenecks. Despite its powers to require evidence from a number of public bodies, the provision of information to DBS can still be a slow process. We have recommended that DBS seek to negotiate a memorandum of understanding about information-sharing with the CPS, update its agreements with the National Offender Management Service (NOMS), and enter into discussions with groups representing relevant officers within local authorities (such as Local Authority Designated Officers) to speed up the transmission of information to the DBS. Finally, we have noted that information from family law court proceedings can be disclosed to the DBS without the need for an order from the family courts. There is a case for exploring whether court rules could be extended to make similar provision for papers from the Court of Protection, which protects vulnerable adults.

Strengthening Decision-Making in Stages 1 and 2

46. **The Disclosure Information Team (DIT).** From June 2013, the barring wing of DBS has received copies of enhanced disclosure certificates when their contents reveal information that needs to be assessed to see whether it should lead to a bar. The numbers of referrals are high (1153 case files were opened by DIT between April and September 2014), but the proportions ultimately barred are low (in the region of 7% or less). The information received by DBS in each case will be very limited. Compared to the information received from other sources, convictions or incidents disclosed can be relatively old, and may concern behaviour in (for example) the domestic setting rather than the workplace. Features such as this can make the work of the team challenging and leave scope for inconsistencies of approach, compared to the approach of other teams within DBS.

47. Given that this aspect of DBS's casework is relatively new, we recommend that it should be subject to further review. Any review

should assess the consistency of DIT's approach with other teams, including its approach to information-gathering and to decision-making.

48. It may be that any evaluation of consistency can be developed alongside the evaluation of the work of the 'Fast DMU' team; see below.

49. **Early Closures**. 'Stage 2' of the BDMP involves the evaluation of evidence and making findings of fact. However, not all cases demand a full evidence evaluation; it may be apparent that the allegations will never justify a bar. So there are various means of closing down cases summarily, without a full evaluation of all the evidence. A relatively recent development (in around November 2014) has been the creation of a "Fast DMU" team which is taking the early closure cases identified by each of the various teams: DIT, HUB, DMU and Autobar. This has the potential to ensure consistency of approach and could be very significant.

50. Review of this team's practice and success is likely to be the best means of rationalising processes. We have not, therefore, commented further on this topic, save to emphasise its importance and the need to review the work of this new team within the near – medium term.

51. Early closure of cases on limited information is a necessary part of DBS's work but it does carry risks. A sound appreciation of the higher-risk scenarios and clear policies to help identify them is important to minimise the risk of error. We consider that DBS should develop a tool which would guide initial sifts and early Stage 2 closures, for use by all those carrying out early closures. It could seek to develop standards for the completeness or quality of material held in files before closure, as well as seeking to distinguish between cases that should be closed and those that require full evidence evaluation.

52. **Strengthening Decision-Making: Policy Guidance**. Consistency of approach to the different scenarios which present in barring referrals would be strengthened by the development and approval, ultimately at Board level, of policies governing the areas of:

    a. The 'transferability' of risk from one sphere to another: for example, the question of whether abuse of vulnerable adults is evidence of a risk to children, or vice versa. This is an area where policy could usefully be informed by further expert input, providing evidence on matters such as whether offenders move

from one vulnerable group to another, or are consistent in their preferences;

b. The passage of time, and its place in assessing the diminution of risk – which may vary depending on the type of behaviour in issue. Such guidance would also potentially be highly relevant when DBS is asked to exercise its power to review bars that have already been imposed;

c. The legitimacy of reliance on other supervisory systems and/or enhanced disclosure checks, including mechanisms such as Sexual Offences Prevention Orders (SOPOs); and

d. When it is appropriate to obtain up-to-date medical information, for example in cases where mental health issues, alcohol or substance abuse have been raised. Guidelines in relation to the need for probation / offence-related evidence, and when this may be most relevant to ongoing risk, could also be further developed.

53. We have also recommended that the Master Casework Guidance could usefully be refreshed to give more detailed consideration to the nature of 'relevant conduct', particularly in the context of the exploitation of young people over the age of consent. It could also discuss the distinctions between 'professional' misconduct and behaviour that may lead to barring. In addition, 'not guilty' verdicts in the criminal courts are seen as stretching. There is also a case for reviewing guidance and training materials to ensure a thorough understanding both of the types of evidence that should be available in such cases, and the need for clear reasons explaining any departure from previous findings by a court.

The examination of evidence evaluation (stage 2) by the review

54. Overall, the standard of evidence evaluation seen in the main file review carried out by Ms Grey was either reasonable or good. Caseworkers clearly 'grappled' with the evidence in files and (generally) identified and sought the information that was needed to reach proper decisions. In those cases which received a full evidence evaluation, there was usually a very careful documenting of all potential allegations and the evidence in support.

55. Indeed at times, the sense was that the documenting was arguably too thorough, leading to the consideration of allegations that were unlikely

to support a bar. This was an issue in discretionary referrals from sectors such as the care sector, where cases could often involve a large number of allegations of varying importance, and there could be a potential lack of focus on the key allegations, and the evidence needed to support them.

56. The sheer volume and numerous potential allegations in some of the cases from (e.g.) the care sector were plainly challenging. If the evidence contained in numerous statements is to be properly marshalled and evaluated, the reality is that these sorts of cases demand a great deal of time and thought. Caseworkers need to be supported to carry out that exercise thoroughly.

57. The generally favourable impression of the standard of evidence evaluation has to be qualified by:

    a. A lack of inquisitorial rigour seen in a number of the files reviewed;

    b. The fact that the quality of the evaluation of evidence and reasoning was frequently more 'patchy' in cases subject to early closure. Whilst the outcome (closure) was generally reasonable, the quality of the supporting reasons could more readily be queried; and

    c. The fact that, as might perhaps be expected, the appeal files reviewed were much more likely to demonstrate flaws in the evidence evaluation, as well as the difficulties of relying on written accounts from witnesses who might not be available for tribunal hearings if their evidence was challenged.

58. Overall, it was difficult to make generalisations about the evaluation of evidence. It appears that the standard of evidence evaluation is generally reasonable, but there are still errors in individual cases.

59. The present system appears to be us to be well-structured, underpinned by training and guidance, and subject to appropriate quality checks (see further below). That does not mean that it is proof against all mistakes. Like any complex system that is highly dependent on individual judgement (albeit subject to supervision), standards have to be maintained continuously by training, quality assurance checks and learning from appeals and escalation advice.

60. It is also important that caseworkers have sufficient time to discuss cases and to share problems which they find difficult, and have ready access to expert advice in difficult cases. Professional experience can

assist in evidence evaluation as well as risk assessment. Earlier recommendations made by us have sought to strengthen access to such advice.

Risk Assessment Tools: Stage 3

61. 'Stage 3' of the BDMP involves an assessment of the risk posed by an individual. The DBS has two tools at its disposal: a Structured Judgment Process (the "SJP") and the Financial Abuse Tool.

62. The SJP is a tool devised by a forensic psychologist whose background was in the offender management, parole board and prison services. It was created to assist the ISA, now the DBS, to structure its evaluation of risk and inform the decision to bar individuals from work with children and vulnerable adults.

63. The Financial Abuse Tool was devised 'in-house' to assist in risk assessment for cases of financial abuse. Its development arose out of a perception that the SJP was not well suited to deal with this type of abuse. Consistently with the SJP, the tool is intended to guide thinking and decision-making but is not a substitute for the use of judgment. The use of both tools, as guides to structured decision-making, has been approved by the higher courts.

64. There are clearly great strengths derived from the use of tools to guide the assessment of risk by DBS staff. The tools are generally used in those cases in which a risk assessment is needed.

65. However, we take the view that the current SJP now requires re-development, to ensure that it still clearly encapsulates best practice in relation to child sexual abuse or exploitation, which is its 'core' application. In addition, further tools should be developed to accompany it, to address more directly the range of abusive conduct which may lead to consideration for a bar. For example, the exploitation of adults (physical, sexual, emotional) requires to be addressed more specifically by a revised tool.

66. The work may be done internally; DBS caseworkers have a good understanding of what tools will best assist them. However, it would be useful to appoint an external facilitator (or facilitators), to steer the process and to ensure that the assumptions built into the tool are sound and that account had been taken of such models that exist elsewhere. A facilitator would also be responsible for ensuring that comments from suitable experts or organizations with safeguarding knowledge or expertise are sought on any revised tools.

67. In relation to the Financial Abuse Tool, a small working group should discuss the relevance of the questions within the tool and to see whether any of the individual questions can be omitted from sections and the tool simplified.

Communications with those subject to the barring process

68. Publicity about the work of DBS is clearly very important in encouraging appropriate referrals. It also has a wider role in maintaining public confidence in its work, and fostering debate about how to strengthen systems which safeguard against abuse.

69. In addition to the need to foster knowledge about DBS with the public at large and with referring organisations, DBS also has to manage its interaction with those who come into contact with it only reluctantly: those at risk of barring. Communicating with those subject to the barring process is difficult, and making improvements will be challenging. However, we heard concerns that the letters and factsheets sent out at present are not as effective as they might be in: (a) encouraging those at risk of barring to participate in the process and to make representations; or (b) communicating the outcome in a fashion that is both easy to understand and accurate.

70. In our view, there is a strong case for a 'mini-review' to examine the language and presentation of DBS's correspondence and interactions. Organisations such as the RCN, UNISON, charities such as Unlock, the CAB, are potential participants. The aim would be to work closely with those who have real experience of representing would-be barrees, as well as referring bodies, to develop revised letter templates or fact-sheets. Whilst we are aware that DBS is already examining its Early Warning Letter, for example, a process of engagement with user groups should serve to capture wider perspectives on how further improvements can be made.

71. Issues include:

    a. The content of early warning letters in discretionary cases. These need to ensure that individuals know they may participate at any stage of the process;

    b. Ensuring that invitations to make representations present information in an accessible form and maximise the prospect of receiving useful and relevant input from those at risk of barring;

c. The need to ensure that any additional findings are clearly identified in autobar cases, to ensure representations can be made;

d. The wording of decisions not to bar. When there are real concerns about an individual's conduct but the allegations found proven stop short of justifying a bar, there is concern that a decision not to bar can be seen as a 'clean bill of health'. There is a case for re-working the passages on the retention of information to make it clearer what view DBS has taken of the facts referred, and how they may be taken into account if allegations are received in the future; and

e. Further review of barring decisions: ensuring that information on the right to request a review is clearly and accurately set out.

72. DBS has been challenged by court decisions to develop a policy on the receipt of oral representations. A full policy needs to be developed and made publicly accessible. There will need to be supporting protocols for issues such as:

a. The scope of hearings: whether this an opportunity to hear directly from the would-be barree only or there scope to hear from other witnesses;

b. Whether there will be questioning of any person speaking to the DBS, and, if so, the extent to which this will be a treated as an opportunity to elicit new information. If information is to be gathered in this fashion, witnesses will need to be warned appropriately; and

c. How information will be recorded, and the opportunity (if any) to be given to those at risk of barring to check any record and suggest amendments or additions.

73. **Links with referring bodies and the wider public**. In the course of consultations, we identified a perception on the part of some stakeholders, particularly in the voluntary sector, that opportunities for regular engagement with the DBS had diminished since the earlier days of the creation of the ISA. Our understanding is that the CRB had maintained several stakeholder sector groups (e.g. local government, health and social care, education, etc) which met on a quarterly basis and included the ISA too. Under the DBS, there have been some specific consultation activities on new services such as the disclosure Update Service to help inform the development of these services, but not the same regular meetings.

74. DBS is now emerging from the initial challenges created by the task of establishing itself. We understand that the Communications team is presently developing a corporate stakeholder engagement strategy and plans. As part of this it is also developing new stakeholder advisory groups.

75. We endorse the importance of this work, and recommend that it pays particular attention to engagement with: (i) those with the ability to reach smaller groups or organisations which may have relatively poor access to information about the duty to refer; and (ii) organisations in contact with, or representing, groups most likely to be subject to the barring process. We also note the importance of providing 'targeted' information about the barring process aimed at particular sectors.

76. A particular issue for those who make referrals was the absence of information about the outcome of those referrals. The statutory scheme enables the DBS to pass information about barring decisions only to those who have a 'legitimate interest' in that information.[2] The current view is that a 'legitimate interest' must be linked to safeguarding, for example:

    a. Any person or organisation if they employ the person or are considering employing the person in regulated activity.

    b. A professional regulator or supervisory authority for the purposes of carrying out their functions.

    c. The police for the prevention, investigation and detection of crime or the apprehension or prosecution of offenders.

77. The effect of these legal constraints was to raise concerns about accountability and transparency. It was also argued that the lack of any obvious means to challenge a decision *not* to bar removed a potential means of securing improvements in DBS's decision-making.

78. Against these arguments must be set the privacy rights of those who have been subject to the barring process. The scheme plainly does not contemplate the general release of information about who is on a list, and even limited disclosures increase the prospect of information 'leaking' out.

[2] Article 7 of the Safeguarding Vulnerable Groups (Miscellaneous Amendments) Order 2012/2157.

79. Discussion of this issue is complicated by the fact that the current legal provisions regarding access to information are due, in time, to be replaced by sections 30A and 30B SVGA (provisions contained in the Protection of Freedoms Act 2012 but not yet brought into force). These provisions would remove the reference to 'legitimate interest' and create a scheme whereby (in broad terms) those either permitting, or considering whether to permit, a person to engage in regulated activity, would be entitled to know whether that person was on a barred list. The DBS would not possess the power to decide upon the existence of a 'legitimate interest'.

80. Although such a scheme would change the current rules, the issue is unlikely to go away. We take the view that the DBS could give consideration to whether, and if so how, it can contribute to the information available to both sides of the debate, in order to inform thinking and policy-making in the future.

81. **Evaluating Representations**. The BDMP's 'Stage 4' offers the opportunity for a full assessment of representations received from the person at risk of barring. Again, staff generally 'grappled' conscientiously with the information received, noting areas where either facts were challenged or mitigating information provided.

82. However, it was apparent that caseworkers found it difficult to make allowances for the quality of representations, which varied greatly. Training could usefully be reviewed to strengthen the evaluation of representations and the place of mitigation, remorse and insight.

83. The barring decision template clearly allows for representations to be evaluated, and their impact on previous findings of fact, etc, to be assessed. Equally, there is a process for requests for additional information to be passed down to HUB, who will seek it. What is not so clear is whether 'protocols' exist, for highlighting cases in which representations reveal challenges to facts or the need for further evidence.

84. We recommend that this issue is reviewed, with particular reference to issues such as the circumstances in which updating evidence of ongoing risk is needed.

85. **Stage 5: the decision to bar**. Stage 5 involves cases where the representations did not lead to the conclusion that a bar was inappropriate, and final decisions to bar must be reached and justified. Generally, the decisions here are driven by the reasoning which has

already been developed in Stages 2 – 4, and little needs to be added to what has already been said. Quite full and careful reasons were generally given in the BDMP. Care needs to be taken to ensure that the decision letter accurately and fully reflects those reasons.

86. Proportionality. Practice on whether or not proportionality was expressly mentioned in the reasoning appears to vary. Cases in which a person is already engaged in regulated activity do raise issues under Article 8 ECHR, bringing the issue of proportionality into play. Recent refresher training for caseworkers has drawn out the factors that should be considered in a proportionality assessment. Since practice was not wholly consistent in decisions seen, the effectiveness of the training given and the adequacy of the treatment of this issue should be a specific focus for quality assurance reviews.

87. Although some caseworkers wanted to see more guidance on the meaning of the term 'appropriate', we take the view that further general guidance on the term is unlikely to assist. The term deliberately confers a wide measure of discretion upon the DBS. The best way to ensure that this discretion is used properly and consistently would be to develop fuller guidance in areas of difficulty, as previously suggested. In addition, staff should not only consider, but reference their consideration of the guidance handed down by the Secretary of State.

88. There is already work on the possible development of a 'decisions bank'. We agree that a library of 'approved' past cases that was accessible could potentially be a valuable aid. The organisation has the opportunity to develop more 'precedents' or worked cases examples as its electronic case management system is developed further. Provided they are not followed slavishly, this will be useful.

89. Public Confidence. We discussed with DBS whether the existing Board guidance on 'public confidence' could be further developed.

90. The guidance is important because it states that there may be situations in which, even though there is limited evidence of future risk of harm, public confidence may still justify a bar. The purpose of the barring scheme is to protect children and vulnerable adults; it is not punitive but protective. Nevertheless, the legislation envisages that the DBS may find that it is 'appropriate' to bar on the basis of 'relevant' (i.e. past) conduct, as opposed to finding a clear 'risk of harm'. Given also that past behaviour is (generally speaking) a predictor of future risk, it seems to us that:

a. Any review of risk assessment tools and/or their place in barring decision-making should be careful to emphasise that risk assessments alone are not determinative of barring decisions, however important they may be;

b. There should be a clear link back to the Board's guidance to emphasise that there may be cases where, despite limited evidence of ongoing risk, the seriousness of the offences/conduct means that it is appropriate to impose a bar.

91. This is not to say that bars will be appropriate when changes in circumstances, and/or offence-related work and the passage of time demonstrate that there is no real risk, or only a fanciful one. But because the issue of 'public confidence' is a difficult one (and opinions might vary on what the reasonably informed observer might think), there is sometimes a sense that this issue is referred to only as a makeweight (in cases where a barring decision would have been imposed in any event), or else is reserved for discussion in a small number of highly unusual cases which fall outside of normal parameters. We would suggest that this factor could play a larger part in deciding upon a proportionate outcome, provided always that relevant conduct was properly established.

92. **Autobar Cases**. The analysis above has largely followed the 5-stage process of the BDMP. It is followed in a modified form in 'autobar' cases. We have made few separate comments on the autobar process. The issues in such decisions usually mirror those we have discussed in the main body of this Report.

93. We have noted:

a. A case for considering existing guidance to see whether: (i) it takes account of the reasons why criminal charges can be allowed to remain on the file; and (ii) the need for a clear process to decide whether it is necessary and appropriate to add further allegations in cases where there are already convictions;

b. The importance of the Upper Tribunal decision in *SR v DBS* [2013] UKUT 0103 (AAC), which held that there was no 'presumption' in favour of barring in an autobar case which attracts a right of representations, once such representations have been made; and

c. The case for further assessing the Stage 2 template in autobar cases, to draw a clearer distinction between: (i) findings on the

nature of the offence which gave rise , to the potential case for barring, including aggravating features; and (ii) any mitigating circumstances relied upon by the individual concerned, and any findings upon the extent to which these were accepted or rejected by DBS, so as to distinguish more clearly between these issues.

94. **Appeals**. There is a right of appeal against most barring decisions[3] to the Upper Tribunal. An appeal may be brought on the basis that the DBS has erred in law, or has made a mistake of fact. These appeals are potentially challenging for the DBS, because its processes are essentially based on written documentation. In an appeal, if the appellant alleges that DBS got the facts wrong, he or she may seek to give or call evidence in support. That evidence is not restricted the evidence that the DBS received. In turn, if the underlying facts are in issue, the DBS may either be required to trace and call primary witnesses of fact (e.g., employers or co-workers of the appellant) or accept that, if it cannot, it may not be able to prove its allegations.

95. Appeals are generally handled in-house by the Appeals Team, with support from barristers as appropriate. However, the DBS Legal Team plays a major part in appeals, giving advice on strategy and managing the litigation from a legal perspective. They have also recently started to represent the DBS at hearings, starting with permission hearings.

96. We recommend that:

    a. Any review of stakeholder engagement should pay particular attention to contact with organisations (the CAB, FRU, etc) which may be in a position to offer representation before the Upper Tribunal, as well as support and assistance in the barring process more generally;

    b. The Appeals team should study good practice in witness support, including the support of young or vulnerable witnesses. It should ensure that DBS has written policies and practices which encompass these findings, and that any barristers or representatives instructed in appeals are made aware of them too and are in a position to help the Tribunal on these points.

97. We were not in a position evaluate the capacity and resources of the Appeal Team. However, we note that it, together with the Legal Team

[3] There is no right of appeal in those Autobar cases in which there is no right to make representations against the imposition of a bar.

that assists it, needs to be adequately resourced to handle the gathering of witness evidence as well as presenting 'existing' material.

98. We note that members of the Appeal Team could be in a position to play a key role in any new Inquiry or Investigations unit and/or the handling of any oral representations, if there is development along these lines.

99. **The Quality Assurance Process.** The DBS has a full programme of quality assurance checks. A sample of case files are checked by the immediate team leaders. Team leaders are expected to feed back the results of such checks to their caseworkers. A sample of Team Leaders' checks are in turn checked by the Casework Assurance and Improvement Team (CAIT), to assess the quality of those checks and to review consistency across teams.

100. In looking at files that had been quality-checked, it was usually apparent that there was careful consideration of files by team leaders and CAIT, with some detailed feedback made on, for example, the quality of the reasons given to support barring outcomes. On occasion, this included feedback on good practice, which was encouraging to see.

101. We consider that DBS should review the quality of the information and evidence it holds on the issue of learning from quality checks, to see whether there is genuine evidence of such learning from the quality checking process.

102. Although there was a reasonable measure of concordance between the initial judgments of the team leaders and the CAIT team, and the review for the purpose of this report, there were also occasions in which the review went further than the team leader's review in identifying questionable reasons for the decisions taken, or noting language that was poorly chosen.

103. In order to widen the nature of the scrutiny brought to bear, we recommend that some or other of the following:

    a. The Legal and/or the Appeals Team; and/or

    b. Team leaders from other teams;

c. The DBS 'subject experts' we have recommended be identified, trained and supported;

d. The specialist advisors we have recommended be engaged;

be involved in the process of quality checking, whether on a regular basis or for periodic 'specialist' audits. This would strengthen the quality of the checks and provide further assurance of consistency of decision-making across teams.

Data Handling and Retention. The information held by DBS is highly sensitive and requires to be treated accordingly. Its retention and any disclosure must comply with legal requirements, including those under the SVGA, the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights (the ECHR), which protects the right to a 'private life'.

104. We endorse the importance of the work that we understand is currently being undertaken by DBS, to identify how best to take steps to confirm the address given on a referral form, so that communications are sent to the right people. DWP and HMRC are to be consulted, to identify the possibilities for information-sharing (which may need legislation).

105. Both within DBS, and as part of any Working Party on communications with those at risk of barring, the most appropriate way of delivering Minded to Bar Bundles requires further attention.

106. Except in cases where bars are automatically imposed without a right to make representations, there is a statutory requirement to give those at risk of barring the opportunity to make representations on the material on which DBS intends to rely. We take the view that writing an initial letter asking the person at risk of referral to confirm his / her postal address and that s/he would wish to take delivery of a bundle at that address would not be inconsistent with that requirement. In other words, it would be sensible to require some form of confirmation of address, before 'Minded to Bar' bundles are sent out. This issue could be further considered as part of the Working Party on communications with persons at risk of barring. An 'initial' letter could play a part in explaining the nature and purpose of representations in a simple way, helping to de-mystify the process. It would be important to keep the means of reply simple and cheap to avoid the objection that DBS was narrowing access to the material on which DBS was intending to rely.

107. Including and withholding information from Minded to Bar Bundles. The precise scope of the obligation to send "all of the information on which [DBS] intends to rely" is capable of causing problems in cases where (for example) witnesses would wish not to be identified or there is sensitive personal information relating to children or vulnerable adults. There is a need to identify such situations to ensure they are handled appropriately.

108. There is then a potential conflict between a desire to anonymise or protect confidences, and enabling a person who may be subject to a barring order to have the fullest opportunity to respond to any material relied upon. DBS policies and training were strengthened and updated in October 2014 to introduce necessary safeguards into the process of producing a Minded to Bar bundle. The aim was to ensure that issues relating to the disclosure of sensitive or confidential personal information were identified, fully considered and any necessary legal advice sought, before information was disclosed. Standard processes for asking referrers who have sought to protect information or have redacted information to justify these requests have also been developed. There are 'failsafe' checks of redactions (or the need for them) before 'Minded to Bar' or other information bundles are sent out. Such guidance, if properly followed, should ensure that legal or information governance advice is sought before bundles are sent out.

109. In relation to the decisions to be taken by the legal team / information governance:

    a. Each case for removing or redacting information from a bundle must be considered on its individual merits;

    b. Explicit consideration should be given to whether, if DBS proposes to disclose confidential material affecting third parties, those affected are warned (so as to enable support to be obtained) and, if so, how or by whom;

    c. The decision-making process by which decisions are reached upon the need to disclose (or withhold) sensitive information should be fully documented at the time when they are made.

110. The revised policies on redaction, and training given, need to be reviewed to ensure that these principles are clear.

111. Data Retention. We have recommended that the existing policies on the retention of information after barring decisions (positive and negative) should be made more accessible, and also (for the sake of completeness rather than because there are signs of any particular issues) reviewed for consistency with the guidance adopted by the police on this issue.

Concluding Observations.

112. Of the cases examined in the file review, the vast majority led to decisions that appeared lawful, defensible and sound. A smaller number generated queries. However, these were generally because:

a. There were queries about the thoroughness with which evidence had been gathered or evaluated. The concern was not so much that the decision was potentially incorrect on the basis of the information held, but that further enquiries could usefully have been attempted;

b. Linked to this: there were cases, particularly DIT ones, in which the evidence available to support judgments was very limited;

c. There was room for debate on the issue of whether a bar was 'appropriate', and the application of such guidance as there is did not assist. This was an issue in relation to cases which fell in the difficult 'policy' areas highlighted in paragraph 52 above; finally

d. The appeal files in particular suggest that evidence evaluation, as well as reasoning decisions, are skills that require constant practice and reinforcement through training, discussion and feedback.

113. DBS has difficult balancing judgments to make. Although the review found case files which could have been decided differently, the decisions on 'appropriateness' seen in the case files fell within the wide area of discretion granted to it by statute.

114. In relation to DIT, in particular, the organisation can acknowledge openly that there will be cases where the passage of time, the presumption of innocence and the importance of allowing offender rehabilitation, makes it disproportionate to 'rake over' long-past convictions or events. This point does not, of course, prevent the investigation of more recent information that raises fresh concerns about possible ongoing risk.

115. The Review has made recommendations aimed at reinforcing DBS's willingness and capacity to investigate evidential gaps and to commission specialist input. It has also aimed to ensure that staff have a sufficiently deep knowledge of safeguarding practice, both by further developing in-house expertise and by securing quicker and informal access to expert advice, and by refreshing the risk assessment tools used.

116. We have recommended that the SJP and Financial Abuse Tool be refreshed. Apart from this, there has been no recommendations for major change to the five steps of the BDMP's stages of decision-making process or templates used. These five stages are logical, and well-tried and tested. Although there were frustrations voiced by some about the templates, and arguments in favour of a looser or narrative style of submission, it is not obvious that a major shift to such an approach would increase the quality and consistency of decision-making and reasoning. Staff are well capable of discussing minor 'tweaks' in the course of the planned development of DBS's document management systems.

117. Despite the breadth of this Review, it still managed to assess a relatively small number of cases, at least compared to the numbers of decisions made by DBS annually. It was therefore difficult to form a judgment on the *consistency* of decision-making. The tools for achieving consistency (escalation to team leaders, case conferences) are useful but relatively informal. The observations on the further development of policy, tools for sifting and re-development of the risk assessment tools, are intended to increase the consistency of decision-making. It is also hoped that they might enable staff to be more confident in decision-making at each stage of DBS's processes. Nonetheless, the facts of each case will always differ, and caseworkers must apply both guidance and their judgment to those individual facts.

118. The general reaction of external stakeholders was that the DBS as a whole presents as an organisation that is open to review and learning. Both from discussions with staff and also with external stakeholders, there is a sense of a desire to 'get it right'. However, having now established the new organisation and revised practices to deal with recent statutory changes, there is a need to improve links with stakeholders. This is both to encourage regular feedback and dialogue, and to strengthen input into barring decisions. There is scope both for increasing referrals from regulated activity providers, and input by way of representations from those at risk of barring.

119. Staff at DBS are very committed to their work. There is a high internal awareness of the issues raised; indeed, the single most useful source of information has been the discussions with caseworkers, who have been very helpful indeed. Many of the points raised in this Review are already the subject of action, and will come as no surprise to the organisation. The Review has sought to build on those existing strengths in its recommendations.

120. Finally, the Review would like to thank all officers and staff of DBS, from its Chair and Chief Executive to the caseworkers who volunteered their knowledge, thoughts and opinions, for their valuable contribution to this study.

121. The reviewers are equally grateful to all those from the external organisations consulted who made time available to assist us and who have strengthened and deepened the analysis presented in this report.

Eleanor Grey QC
September 2015

Appendix One:
The Authors of the Report

Eleanor Grey QC

Eleanor Grey took silk in 2011. As a long-standing member of the Attorney General's 'A' Panel prior to taking silk, she possesses great experience in the field of administrative and public law, including in areas such as mental health and immigration. She has a thorough understanding of disciplinary and regulatory proceedings, and of the health and social care sector in particular. Clients include the Department of Health, the General Medical Council, the General Dental Council and other public bodies. She has represented clients in a number of major healthcare public inquiries, recently acting for the former Healthcare Commission in the Mid-Staffordshire NHS Foundation Trust Public Inquiry. She has developed extensive expertise in the law relating to freedom of information and data protection and contributed to the latest edition of the leading text-book in the field. She represented the House of Commons Authorities throughout the litigation concerning MPs' expenses. Eleanor sits as a Tribunal Judge in the First-Tier Tribunal (Mental Health). In 2014, she was appointed as a Deputy Judge of the Upper Tribunal (Administrative Appeals Chamber).

Dr Joe Sullivan

Dr Sullivan is a Registered Forensic Psychologist. He holds a PhD in Forensic Psychology, a Masters Degree in Criminology, a Post-Graduate Diploma in Psychology, a Bachelor of Arts Degree in applied Social Sciences, and a Certificate of Qualification in Social Work. Dr Sullivan is an honorary lecturer in Forensic Psychology at the University of Birmingham, UK.

For the past 20 years, Dr Sullivan has worked with police officers, social workers, probation officers, faith groups and educationalists to provide insights into the motivations, thoughts and behaviours of child sex offenders. He is regularly commissioned to undertake assessments for the Social Service Departments, Probation Services, Churches and Education departments and has been called as an expert witness to give evidence to criminal, civil and

family courts. Since 2006, Dr Sullivan has also been the Forensic Psychologist in the Behaviour Analysis Unit in the Child Exploitation and Online Protection Centre (CEOP).

Dr Sullivan has been involved in providing training to frontline staff and management on the issues related to child sexual abuse since 1993. He currently trains clinicians, probation and law enforcement officers in interview and risk assessment techniques with alleged perpetrators of child sexual abuse. He is a consultant/trainer for various law enforcement organisations in the UK, USA, Canada and Australia. The Mentor Academy core curriculum training and professional development course which he has developed have been accredited as part of a post graduate certificate in behaviour analysis and forensic psychology.

Bridget Penhale

Bridget Penhale is currently a Reader in Mental Health of Order People at the University of East Anglia. After a successful career as a social worker and manager spanning some 15 years, she took up an academic post. She is former Vice-Chair of the charity Action on Elder Abuse and independent co-chair of the Hull Domestic Violence Forum. Bridget is a Board Member of the International Network for the Prevention of Elder Abuse. She is recognised nationally and internationally for her work on adult safeguarding and elder abuse. In 2010, she received the Rosalie Wolf Award for her research and work in this area.

Bridget has been involved in providing training to professionals (including managers) concerning elder abuse and adult safeguarding since 1989. Her work has included sessions at pre-registration, post-qualifying and in-service training levels and is an area of particular focus in her academic post. During the period 2008- 2013 she also acted as external examiner for the BA Abuse Studies, (Manchester Metropolitan University) and the PQ Advanced Award in Adult Care (Northumbria University) in which she had specific responsibility for modules on Adult Safeguarding and the Mental Capacity Act/Best Interests Assessor Award. She has also acted as consultant to the Department of Health (England) and Scottish Government on adult safeguarding, including discussions on education and training for professional and para-professionals involved in this area of work.

Appendix Two: Statutory Bodies and Organisations Consulted

Contact was made with officials or individuals who liaised with DBS or otherwise had knowledge of its work, in the following organisations:-

Department for Education

Department of Health

Home Office

The Northern Ireland Office

The Upper Tribunal (Administrative Appeals Chamber)

Disclosure Scotland

Children's Services, Durham Council

Adult Services, Durham Council

The Children's Commissioner

Child Exploitation and Online Protection Centre (CEOP)

The National Society for Child Protection (the NSPCC): Safe Network

The National Society for Child Protection (the NSPCC): Protection in Sport

National College for Teaching and Leadership

The Nursing and Midwifery Council (NMC)

The General Medical Council (GMC)

The Quality and Care Commission (CQC)

Bupa UK

Unlock

Action on Elder Abuse

The Royal College of Nursing (RCN)

Appendix Three: Barring Decision-making by the Disclosure and Barring Service

1. The Disclosure and Barring Service (DBS) was created in December 2012, when it took on the functions of the Criminal Records Bureau (the CRB) and the Independent Safeguarding Authority (the ISA). The ISA was, and the DBS now is, responsible for the 'barred lists': that is, registers of people who are judged to be unsuitable to work with children and vulnerable adults. DBS must consider whether or not to put the names of those referred to it on its lists. It has a further power to remove names which are already on a list, if following review it is considered that there is no longer sufficient justification for their inclusion.

2. The DBS also has responsibility for administering the system of criminal records checks formerly run by the CRB. These checks are now known as 'DBS checks'. Depending on the nature of the position which an applicant is seeking to obtain, a check may be a 'standard' one, or a fuller 'enhanced' check, or it may be an enhanced check which includes a check of the barred lists.

The Statutory Framework

3. The ISA was created by the Safeguarding Vulnerable Groups Act 2006 (the SVGA). The SVGA replaced older barring lists which had existed: 'List 99', the Protection of Children Act (PoCA) List and the Protection of Vulnerable Adult (PoVA) List. The SVGA remains the core statute governing DBS's work with regards to its barring functions, but it was amended in 2012 by the Protection of Freedoms Act. It was this Act which established the DBS.

4. For Northern Ireland cases, the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 ('SVGO') applies. Requests for information are made under Article 39 of the SVGO and the Safeguarding Vulnerable Groups (Prescribed Information) Regulations (Northern Ireland) 2009.

5. The DBS shares information and co-operates with its sister organisation in Scotland, Disclosure Scotland, but it is not responsible for barring decisions in Scotland. Any reference to the 'national' picture which may have crept into this report should be understood with that caveat in mind.

The Barring Scheme

6. The key characteristics of the barring scheme, as it now exists in England, Wales and Northern Ireland, are set out below. What follows is not a comprehensive account of a complex scheme, but a summary only.

7. There are four barred lists: two covering England and Wales, the other two established in respect of Northern Ireland. They cover work with children and with vulnerable adults. Inclusion on the children's lists means that an individual is prohibited from working with children, i.e., those under the age of 18, in any form of "regulated activity". The second two lists covers work with 'vulnerable adults': those whose names are included on the adults' barred list are prohibited from working with adults, within "regulated activity". For ease of reference, this report has referred to 'the children's list' and the 'adult's list' only.

8. There are a number of different routes into a barring decision:

    a. 'Automatic Bars' which follow certain criminal convictions or cautions, without the right to make representations;

    b. Automatic Bars with the right to make representations: certain other defined criminal convictions or cautions attract the right to make representations before a bar can be imposed. If representations are received, the DBS must make a judgment upon whether or not a bar is 'appropriate'. If no representations are received, DBS must impose a bar;

    c. 'Discretionary' bars: these are the bars which do not arise out of the commission of specified criminal offences. Instead, DBS must consider information referred to it, and decide whether or not the facts established justify placing an individual on either or both lists.

9. Automatic Bars. In the case of 'automatic bars without representations', there is no need to consider whether or not the person concerned is, has, or may in the future work in 'regulated activity' with children or adults, or both, as the case may be. The statutory scheme deems that proof of commission of the offence is enough to justify inclusion on a list. There is no right to make representations aimed at persuading DBS to take another course of action.

10. Some offences, such as the rape of a child, attract automatic inclusion on one list but representations are permitted in respect of the other list.

11. Since September 2012, the offences which attract a right to make representations before inclusion also require consideration of whether the test for regulated activity has been met. That is, it is not enough for DBS to be informed by the police that a person has been convicted of (say) an offence of wilful neglect of a child, however serious: before steps can be taken to include him or her on a barred list, DBS must check for evidence to see whether or not the offender is working, has worked, or may in the future work, in regulated activity. The result can be that a person with such a conviction will not be included on the barred list, if his records show no evidence of working with children. Of course, if in the future that position changes – if the DBS receives an application for an employment check which shows that he is contemplating work with children – the DBS will be alerted and the automatic barring decision-making process will begin again at that point.

12. In the case of offences in which a decision to bar is subject to the right to make representations, if no representations are received, DBS must place the individual on the appropriate list or lists. But if representations are received, DBS must decide whether or not inclusion would be 'appropriate'.

13. Regulated Activity. It can be seen that '*regulated activity*' is a key concept under the Act. It is a complex concept. For the purposes of this report and from September 2012 onwards, 'regulated activities' concerning children can be summarised as:

    (i) Unsupervised activities: teaching, training, instructing, caring for or supervising children, or providing advice or guidance on well-being, or driving a vehicle only for children;

    (ii) Working for a limited range of establishments ('specified places') with opportunity for contact with children: eg, children's homes, schools, childcare premises (but not, in general, hospitals[4]). This does not include work by supervised volunteers.

    Work under (i) and (ii) is regulated activity only if done regularly: once a week or more often, or four times or more in a month.

    (iii) Relevant personal care, for example washing or dressing; or

    (iv) Healthcare by or supervised by a professional;

[4] Work within children's hospitals in Northern Ireland is included within the definition.

(v) Registered childminding and foster carers.

14. Turning to adults, the SVGA does not label certain adults as 'vulnerable'. Rather, it identifies certain activities which, if the adult requires them, lead to that person being considered vulnerable at that particular time. So the focus is upon the services required by an individual, not the setting in which they are performed or the personal characteristics of the adult in question.

15. There are six relevant categories of activity, comprising (broadly): (i) the provision of healthcare; (ii) the provision of personal care; (iii) providing social work; (iv) assistance with cash, bills or shopping; (v) assistance in the conduct of a person's own affairs; (vi) 'conveying': this covers transport to and from places where an adult receives health, personal or social care, but does not include transport provided by friends, family or taxi drivers. The services need only be provided once to amount to 'regulated activity'.

Discretionary Bars.

16. The criteria for inclusion are that:

    a. The person concerned has engaged in 'relevant conduct' or there is a 'risk of harm';
    b. There is reason to believe that person is or has been, or might in future be, engaged in 'regulated activity' relating to either children or adults; and
    c. The DBS is satisfied that it is 'appropriate' to do so.

17. Regulated activity has been explained above.

18. Relevant Conduct and Risk of Harm. To consider a bar, the DBS must be satisfied that there has been 'relevant conduct' or there is a 'risk of harm' in the future. Both of these phrases have a statutory definition. They look to see whether a child or vulnerable adult may be endangered by abusive or harmful conduct or neglect. The 'conduct' may include sexual activity or the possession of sexual images or material.

19. The DBS must have regard to guidance issued by the Home Office when it decides whether (i) sexually explicit images involving violence against people or (ii) 'conduct of a sexual nature', involving a child or a vulnerable adult, are 'inappropriate' and amount to relevant conduct. In relation to the latter, the guidance makes it plain that 'sexual conduct' is not confined to intentional touching of a sexual nature but may include wider conduct,

such as solicitation or grooming for a sexual purpose. A failure to have regard to this guidance when it applies can amount to an error of law.[5]

20. Further guidance has been approved by the DBS Board[6] on child pornography cases. Its approach on barring even if there is no or little demonstrable risk of direct contact being made with a child is supported by the Upper Tribunal case of *CB* [2013] UKUT 605 AAC. There is harm to children caused by the perpetuation of the market or distribution networks for indecent images.

21. 'Appropriateness': even if there is 'relevant conduct' or a risk of harm, DBS must decide whether or not a bar is 'appropriate'. For example, if a care worker lashed out at a service-user, this would constitute 'relevant conduct', as it endangers and may harm that person. But the surrounding circumstances, or the employment record of the care worker, or the work done since to show that the incident would not be repeated, could well justify a decision that it would be inappropriate to impose a bar.

22. The DBS Board has approved[7] guidance on the role of 'public confidence' in decision-making. This is defined as the question of whether a reasonable member of the public, if they had knowledge of all of the facts of the case, would have their confidence in the effective operation of the statutory safeguarding arrangements undermined by DBS's decision to bar or not to bar a person from working with a vulnerable group. The courts have held that the DBS "can and should"[8] consider public confidence as part of the appropriateness test, in both discretionary cases (where there is relevant conduct or risk of harm, and the test for regulated activity is met) and in autobar cases where representations are received.

23. The effects of a bar. It is a criminal offence to engage, or to seek or offer to engage in 'regulated activity' whilst included on a barred list. A criminal offence may also be committed by the employer or personnel supplier, if the employer or personnel supplier enables a barred person to engage in regulated activities, and they either knew or had reason to believe that the individual was barred from that activity.

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[5] *MR v ISA* [2012] UKUT 234 (AAC).
[6] It was first issued by the ISA Board but has been endorsed by the DBS Board.
[7] It was first issued by the ISA Board.
[8] *ISA v SB* [2012] EWCA Civ 977. See also *AP v ISA* [2012] UKUT 412, where the Upper Tribunal noted that in *Secretary of State for Children, Family and Schools v BP* [2009] EWHC 866 (Admin) Munby J re-affirmed that public interest is a relevant factor in barring decisions. The Tribunal continued: "The seriousness of these offences, in terms of the sentencing guidelines alone, was clearly a matter to be taken into account as affecting the public interest, irrespective of the psychological drivers for the appellant's offending behaviour."

24. Review. Once imposed, a bar lasts indefinitely unless ended following a review by DBS. A review may be requested at the end of the following minimum periods:

    a. After 1 year, if the barred person was under 18 when the bar was imposed;
    b. After 5 years, if the barred person was under 25 when the bar was imposed
    c. After 10 years, if the barred person was over 25 when the bar was imposed.

25. DBS must give permission for a review to be carried out; if it is not, or the decision to bar is upheld once more, the bar will continue in place.

26. In addition to reviews at the end of the minimum period, the DBS possesses a further power to review cases at any time. This power is not dependant on an application by the person concerned.[9] Inclusion in a barred list can be reviewed at any time if there is evidence of:

    a. Information which is now available which was not, at the time of inclusion in the list;
    b. Any (material) change in circumstances since barring ; or
    c. An error by the DBS.

27. Appeal. Save in the cases of automatic bars imposed without a right to make representations, there is a right to appeal against a bar to the Upper Tribunal (Administrative Appeals Chamber). The Upper Tribunal must grant permission to appeal. It may not assess whether or not the bar is 'appropriate', but it may consider whether or not:

    a. There was a mistake in any of the findings of fact DBS made; or
    b. The DBS erred in applying the law.

28. The limited grounds of appeal mean that the Tribunal cannot:

> "... impose its own different decision where the decision taken by ISA [or DBS] is one based on properly found facts and properly understood law within the proper area of discretion accorded to ISA as an expert decision maker. It is, in other words, for ISA to have

[9] SVGA, Schedule 3, paragraph 18A. In addition, decisions made before September 2010 can be reviewed if the person concerned has not or will not in the future be working within 'regulated activity' and so a bar is not necessary or proportionate.

the final say in those cases where there is a proper balance to be struck between the interests of the individual and the interests of children and vulnerable adults generally." *(K v ISA* [2012] UKUT 424 (AAC)).

29. However, the Tribunal may consider whether decisions comply with Article 8 of the European Convention of Human Rights, by assessing whether the outcome is 'proportionate'. In practice, a large number of appeals focus primarily on the facts found by the DBS, and whether or not they were correct. The Upper Tribunal may receive evidence on paper or hear witnesses orally to resolve such issues.

DBS Decision-Making

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30. For discretionary referrals the DBS decision-making process involves a five-stage decision-making process:

    6. Stage 1: an initial sift, looking to see if the essential elements of a referral are in place and the DBS has the power to consider the case; this is followed by a process of gathering any further necessary information;

    7. Stage 2: evaluation of the evidence, and making provisional findings of fact. Findings are provisional only because the potential barree has not yet been given a chance to make representations;

    8. Stage 3: an assessment of the risk posed in the future;

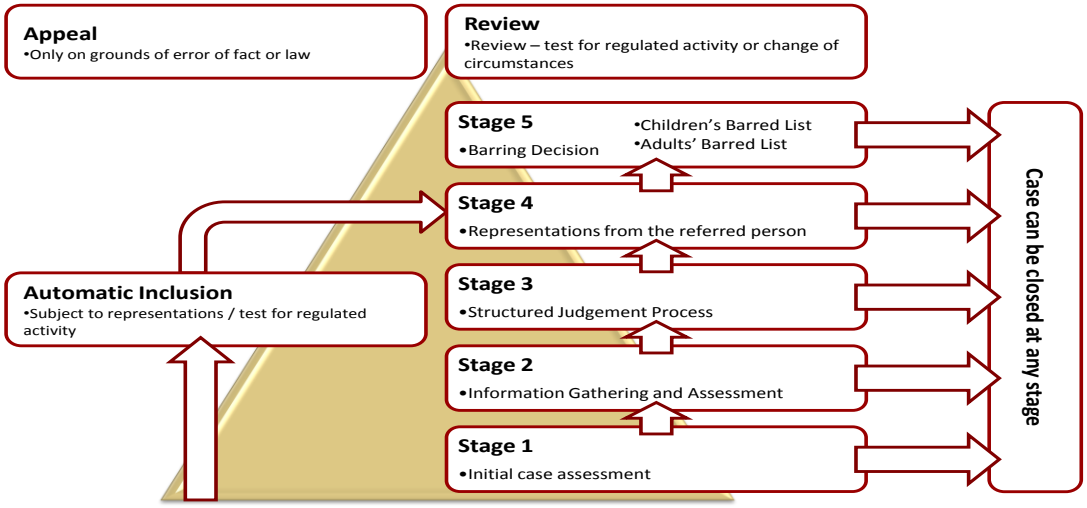
    9. Stage 4: issuing a 'Minded to Bar' letter giving the barree the opportunity to make representations on the provisional decision and the information considered by the DBS, and assessment of any representations;

    10. Stage 5: the final decision.

31. Cases can be closed at any stage if the evidence or risk assessment does not justify proceeding any further.

32. See the diagram, overleaf.

Typical Barring Decision Making Process



33. The process for 'automatic' bars ("Autobars") is slightly different:

a. In the case of automatic bars, DBS's role is limited to checking that the information in its possession meets the statutory criteria for the bar, and sending out notice of it to the individual concerned (frequently serving it on him or her in prison);

b. In the case of autobars with representations, there will be an initial check of the information from the Police National Computer and the records of employment checks to see if the offence is an autobar offence, and whether or not the person concerned meets the test for regulated activity. This may show that inclusion on one or both lists has to be considered. If so, a letter inviting representations will be sent. At this stage, DBS will have only basic information in its possession. If no response is received to the invitation and a reminder, the person will automatically be included in the list. If late representations are subsequently received, the decision may be re-opened.

c. If a substantive response is received, fuller information-gathering starts. New information is sent back to the barree to enable comment; it is important that all the material relied upon is disclosed. When complete, a 'Stage 2' evidence evaluation takes place, incorporating the representations as well as DBS's information. The Stage 3 risk assessment also takes place, if needed. If a bar is deemed appropriate, it is imposed without a further round of representations or comments.

Patterns of Decision-making

34. In 2013/2014, the barring rates for the four DBS referral types were as follow:[10]

Type of Case	Numbers received	Numbers barred	Percentage Barred
Autobar (representations not permitted)	1,092	1,092	100%
Autobars (representations permitted)	2,098	1,348	64.3%
Discretionary referrals (of which 5793 were closed)	5,854	475	8.3%
Disclosure information referrals (June 2013 – March 2014)	1,528	43	4.8%
Totals	10,572	2,958	-

35. From April 2014 – February 2015 (i.e., not a full year), the figures were as follows:

Type of Case	Numbers received	Numbers Barred	Percentage Barred
Autobar (representations not permitted)	511	511	100%
Autobars (representations	922	612	66.4

[10] Paper from DBS Staff, 10 June 2014.

permitted)			
Discretionary referrals: cases closed	2528	191	7.6%
Disclosure information referrals (of which 995 were closed)	1153	67	6.7

36. In 2013/2014, 85% of discretionary referrals did not pass beyond Stage 2. 6% of cases are closed at Stage 3. Of the cases that proceed to Stage 3, DBS bars just over 50%. Of the cases that progress past Stage 3 (so that a 'minded to bar' decision has been made), DBS will go on to bar 89%.

37. Representations, where provided, result in a 'no bar' in approximately 20% of discretionary referrals cases, i.e. representations are successful in changing the 'minded to bar' position in 20% of these discretionary cases. However, less than half the persons invited to do so, actually provide representations.

Appendix Four

Review of Training Materials

Introduction

1. It was decided that producing a joint document in respect of the review of both training packages would be most useful as many of the general observations will be duplicated. Following the observations in respect of each part of the programme we offer some joint recommendations.

Safeguarding Adults (**Author** - Bridget Penhale)

Sources

2. For the purposes of this review I have had access to training materials provided by DBS and additional supplementary information sent to accompany the material. Unfortunately due to illness I was not able to attend the meeting with DBS in March 2015 to discuss the current training packages so was not able to meet with members of the CAIT team. As a paper-based exercise it is of course difficult to know how material is presented and what happens in terms of discussion and so forth in training sessions.

Observations

3. Following my paper-based review of the material provided I provide these observations.

4. It would appear that the internal, in-house training that is now provided contains many of the key messages about safeguarding (and so forth) but some of the material requires updating. It also seems that the material has been updated in a rather ad-hoc fashion as new information has become available and when gaps have been identified. Whilst the use of an internal training team has advantages in terms of training and instruction about the use of the decision tools and frameworks that are used with DBS, there are some disadvantages in relation to the expertise that can be offered on 'external issues' (those of more general safeguarding relevance) by external experts, particularly in relation to clinical expertise.

5. This review has recommended that the SJP tool is replaced with a newly developed process, or at least revised and refreshed. If the recommendation is accepted by the DBS Board, the content of the training programme (at both Starter and Refresher levels) will need to be revised to reflect the change(s) made to the process, once these have been developed and are due to be implemented.

6. Whilst much of the training material seen appears to be of a good quality and standard and should be retained (depending on previous point above), some of the material on adult safeguarding requires updating. This includes more information about changes required by the Care Act, 2014 and could also usefully include some focus on perceptions and attitudes towards abuse and legislation (or the lack of) in relation to this area. Such provision on adult safeguarding could also perhaps be more generic (not as single-authority focused).

7. The training programme, which was accredited by Teesside University some 4 years ago, provides staff with opportunities to obtain a Post Graduate Certificate (PGCert) in Professional Development. The programme is credit-rated and consists of two modules, with differential credit-rating for the modules (as normal). This is a unique programme, offering a work-based qualification, but it is not clear from the documentation how often updating and revision of the programme takes place or how comprehensive this is.

Safeguarding Children (**Author** - Dr Joe Sullivan)

Sources

8. I have visited Stephenson House in Darlington on 7th March 2015 to discuss the current training packages. I had previously been provided with the printout of the slides used in the various training. I met with Nick Gibson and John Nodding and established that there were several elements to the training delivered to DBS staff

   - New starter training
   - Refresher training
   - Continuing professional development (post graduate certificate in professional development).

9. I also had the opportunity to visit the resources room and examine some of the material available to DBS staff.

Observations

10. It would appear that the training for staff was originally provided by an external organisation but that this became an internal function some years ago. Hence the new and existing staff are now trained by an in-house training team. There are advances in this in that in-house staff are most familiar with the tools regularly used by the DBS and are best placed to teach them. There are also limitations in that DBS staff lack the necessary clinical expertise to teach new staff about perpetrator perspectives to the required standard.

11. The current training material appears to include some of the original material with new material added as gaps have been identified.

12. Much of the training material is of a high standard and should be retained; however, some of the material is outdated and should be refreshed.

13. There are some useful books, articles and videos provided in the resource rooms which trainees are encouraged to visit to expand upon their knowledge.

14. There is a significant gap in the training in relation to understanding the offender behaviour and patterns of manipulation they typically use.

15. In the event that the decision is made to create an inquiry team who might meet with suspected offenders then additional staff training will be required to teach specialist techniques and an additional level of supervision will be required.

16. A review has recommended that the SJP is refreshed. If this recommendation is accepted then it will have significant implications for the content of future New Starter and Refresher training.

17. In 2010 Teesside University accredited the continuing development programme to provide opportunities for staff to obtain a Post Graduate Certificate (PGCert) in Professional Development. This is divided into two sections the first providing 20 points and the second the remaining 40 points required for a PGCert. The update for the second part has been limited which is a shame as this is a very innovative programme which offers staff the opportunity to obtain work related qualifications. Ultimately it will only benefit the DBS as a business to have well qualified staff.

Recommendations (joint authorship)

18. The following section contains recommendations about the adult and child safeguarding training as well as some comments referring to the programme in general.

    1. The 'New Starter Training' should be updated in both the adult and child safeguarding sections. In relation to adult safeguarding this will need to include more about changes occurring from April 2015 with the implementation of the Care Act and other areas. Ideally, external consultants should be involved in this process, but care will need to be taken in putting together the programme as a whole (especially if experts are also involved in revision/updating of material in other sections of the programme).

    2. In respect of the child safeguarding training a substantial additional section on understanding the perpetrator perspective should be included. Consideration should be given to this new section being provided by an external body which has the ability to show trainees a wide selection of offender interviews which illustrate the most common traits and characteristics which caseworkers will encounter in their child safeguarding work. (The chosen expert consultant/adviser should be able to assist with this).

    3. Consideration should be given to having the updated 'New Starter Training' accredited as a post graduate certificate. This will require additional work to achieve the accreditation but we believe there is significant merit in having all staff qualified to a minimal level.

    4. Consideration should be given to combining the 'refresher programme' and 'continuing professional development' qualification and having the new programme accredited as a post graduate diploma (if agreed this will have implications for resourcing and the timing of bids).

    5. Any new protocols arising out of the reconsideration of the SJP will need to be taught to all staff. The timing of this training will be critical to the success of the project. Expert consultants/advisors should be involved in the planning and delivery of this training. Time will need to be factored in for the development (and if possible piloting) of the training as part of this process. Implementation of the training will also need careful and thorough planning. Regular review and updating of the (revised) materials will also be necessary and planning should take account of this. Resource implications will need to be considered from

the outset as there are significant implications for resourcing into the future.

6. If the decision is made to create an inquiry team who might meet with suspected offenders then an additional layer of training will be required to teach interview skills and risk assessment techniques.

7. Discussions should be held between DBS and Teesside University (or whichever institution is awarded the tender) relating to regular updating of the accredited programme (if this is not already in place) and also whether the qualification portfolio can be broadened for staff, for example through other programmes that might be available or as in points 2 and 3 above.

Appendix Five: Summary of Recommendations Made

Training and access to Expertise	
R1	The 'New Starter Training' should be updated. Updating should cover the changes under the Care Act 2015 and understanding the perpetrator perspective.
R2	DBS should evaluate the case for: a) accrediting the updated 'New Starter Training' as a postgraduate certificate; b) combining the 'refresher programme' and 'continuing professional development' qualification and accrediting the new programme as a post graduate diploma.
R3	a) A register of staff members who possess knowledge or experience of fields relevant to DBS's safeguarding decisions should be developed, maintained and publicised to staff. b) Staff with such expertise should be supported to keep up to date with developments in their fields.
R4	DBS should develop a group of 'subject experts' amongst its caseworkers, and use them to strengthen the analysis of difficult cases and to disseminate learning and training.
R5	DBS should secure the services of a small number of experts (2 – 3) who are available to support decision-makers in Darlington on issues of complexity.
R6	The processes for assessing the need to obtain specialist risk assessments and medical evidence should be reviewed, with a view

	to: a) strengthening guidance on the circumstances in which they may be required; and b) developing standard letters of instructions and templates for medical reports.
R7	The role of the Quality and Standards Committee should be reviewed, after the recommendations at R4 and R5 have been implemented.
R8	DBS should review its instructions upon the use of EDBL checks to demonstrate compliance with the test for regulated activity, to ensure consistency of approach in the event that it is asserted that checks were made in error.
R9	DBS should review its analysis and use of the requests for further information sent back to HUB, to ensure that adequate learning is taking place
R10	DBS should review its understanding of the scope of its information-gathering powers, and seek legal advice to clarify this issue.
R11	DBS should assess the feasibility of establishing a small team of caseworkers trained to explore significant issues of uncertainty more fully, in complex cases. The remit of such a team should be developed in the light of the advice received under R10.
R12	a) The two 'instructions' negotiated with NOMS should refreshed by negotiation with NOMS. In the interim, standard letters seeking information form police and prison services should be reviewed to see if they make best use of these instructions. b) Attempts should be made to agree a similar MOU with the CPS. c) Stakeholder initiatives with local authority groups should include discussion of how DBS's powers under s40 SVGA may be used most effectively.

R13	The President of the Court of Protection (COP) should be approached to discuss possible changes to the Court of Protection Rules, to enable the DBS to obtain material from COP proceedings without need of a court order.
R14	a) The work of the Disclosure Information Team (DIT) should be reviewed, to ensure that its processes or approach are consistent with the remainder of DBS; and b) to assess the potential for development of a tool to help guide initial sifts and early Stage 2 closures (see also R22(b), below).
R15	In the longer term, the appropriateness of the classifications of offences in the Business Engine Rules should be reviewed.
R16	DBS should develop specialist guidance upon evaluation of: a) The 'transferability' of risk from one sphere to another; b) The relevance of the passage of time, and its place in assessing the diminution of risk; c) The legitimacy of reliance on other supervisory systems and/or enhanced disclosure checks; d) The circumstances in which it is appropriate to obtain up to date information to support decision-making.
R17	The guidance on 'relevant conduct' in the Master Casework Guidance should be refreshed.
R18	Guidance and training materials should be reviewed to give further guidance on :

	a) handling cases where there has been a previous 'not guilty' verdict and/or material from criminal or civil proceedings is available; b) the evaluation of representations and the place of mitigation, remorse and insight; c) the reasons why criminal charges can be allowed to remain on the file and the process for deciding whether it is necessary and appropriate to add further allegations in cases where there has been a criminal conviction triggering the autobar provisions.
R19	DBS should evaluate the need for protocols or guidance on the circumstances in which further information should be sought in response to representations.
R20	Any development of further guidance should be followed by a process of training /re-training to ensure that any new guidance is known and applied.
R21	Training and guidance should remind caseworkers of the need both to identify and consider relevant guidance, and to document such consideration in the decisions made.
R22	A review of the work of Fast DMU should be carried out, to: a) assess the extent to which practice in closing cases at Stage 2 has been rationalized and consistency of approach achieved; b) explore the creation of tools to assist in sifts and early Stage 2 closures.
R23	The SJP tool should be refreshed to ensure that it encapsulates current best research and practice, and to ensure that it, or further tools developed to accompany it, directly address the range of abusive conduct which may lead to consideration for a bar tool.
R24	A small working group should review the working of the Financial Abuse Tool.

R25	Any review of risk assessment tools and/or their place in barring decision-making should recognise that risk assessments alone are not determinative of barring decisions, and address the relevance of the Board's guidance on Public Confidence.
R26	DBS should ensure that risk assessment tools are subject to periodic review and updating, as necessary.
R27	A 'mini-review' or working party should be established to examine the language and presentation of DBS's communications with those at risk of barring, working with those with experience of representing such groups.
R28	DBS policy on the circumstances in which oral representations will be received should be fully developed and made publicly available and accessible.
R29	The Communications Team's developing Corporate Stakeholder Strategy should pay particular importance to engagement with: (i) organisations in contact with or representing groups most likely to be subject to the barring process; (ii) organisations (the CAB, FRU, etc) which may be in a position to offer representation before the Upper Tribunal, as well as support and assistance in the barring process more generally; (iii) those with the ability to reach smaller groups or organisations which may have relatively poor access to information about the duty to refer.
R30	DBS should address whether, and by what means, it could contribute to the debate upon whether referring bodies should be granted access to further information about barring decisions.
R31	The effectiveness of the training given on the topic of 'proportionality' and the treatment of proportionality in decision-making should be a specific focus for quality assurance reviews.

R32	The need for files to record the point at which decisions are made, as well as the ultimate rationale for them, should be reinforced.
R33	There should be further discussion with the Autobar team, to assess the merits of alterations to the BDMP template used in Autobar cases, to draw a clearer distinction between findings on the nature of the offence and/or any further allegations, and any mitigating circumstances.
R34	The Appeals team should document good practice in witness support and ensure that relevant guidance or practice is drawn to the attention of any barristers or representatives instructed in appeals.
R35	DBS should review the information it holds on learning from quality checks, to see whether there is genuine evidence of learning from this process.
R36	DBS should involve in its quality checks, whether on a regular basis or as 'one-off' evaluative exercises, some or other of the following: a. The Legal and/or the Appeals Team; and/or b. Team leaders from other teams; c. The DBS 'subject experts'; d. The specialist advisors recommended at R5.
R37	DBS should ensure that its review of the most appropriate way of validating the addresses given on any referral is completed in a timely fashion.

R38	Delivery of Minded to Bar bundles should be preceded by a letter asking the person at risk of referral to confirm his / her postal address; This recommendation should be the subject of consideration in the Working Party referred to at R27 above.
R39	Policies and training on redaction of MTB bundles need to be reviewed to ensure that the guidance is full and clearly understood.
R40	The 'warning' on the referral form should be reviewed, to make it explicit that the referral form, as well as the supporting material sent with it, may be disclosed by DBS to those at risk of barring.
R41	There should be reference to DBS policy on information retention in letters communicating barring decisions; the policy should also be clearly accessible via DBS's website.
R42	The current DBS policy on data retention in respect of barring files is reviewed for consistency with the guidance in "*Authorised Professional Practice: Information Management – Retention, review and disposal*", published by the College of Policing in 2013.