THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

UPPER TRIBUNAL CASE NO: UA-2022-001170-V
[2024] UKUT 30 (AAC)
WR V DISCLOSURE AND BARRING SERVICE

THE UPPER TRIBUNAL ORDERS that:

No one shall, without the consent of the Upper Tribunal, publish or reveal the name or address of any of the following:

(a) WR, who is the Appellant in these proceedings;

(b) any other person mentioned in this decision, in the documents or during a hearing;

or any information that would be likely to lead to the identification of any of them or any member of their families in connection with these proceedings.

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

Decided following an oral hearing on 18 December 2023

Representatives

WR	Unison
Disclosure and Barring Service	Ashley Serr of counsel, instructed by DLA Piper LLP

DECISION OF THE UPPER TRIBUNAL

On appeal from the Disclosure and Barring Service (DBS from now on)

DBS Reference: 00946631490
Decision letter: 14 March 2022

This decision is given under section 4 of the Safeguarding Vulnerable Groups Act 2006 (SVGA from now on):

As DBS made mistakes in the findings of fact on which its decision was based, the Upper Tribunal, pursuant to section 4(6)(b) and (7)(a) and (b) of SVGA:

> makes findings of fact and remits the matter to DBS for a new decision; and
>
> directs that the appellant remain in the lists until DBS makes its new decision.

REASONS FOR DECISION

A. DBS's decision

1. On 14 March 2022, DBS added WR to the children's barred list and the adults' barred list on these findings of fact:

- you failed to notify the Safeguarding Team of the full details of a safeguarding incident involving service user BB reported on 30 September 2020, including staff use of the hot tub for de-escalation, allegations of staff pushing BB into a hot tub, BB being held in the hot tub as a form of restraint and the harness being used to redirect BB with the potential for further physical and emotional harm;
- you failed to follow service user, BB's Positive Behaviour Support Plan written by the Behaviour Advisor prior to BB's arrival … and failed to arrange best interest decision to support this with the potential for physical and emotional harm; and
- you made additions to the Positive Behaviour Support Plan in October 2020 without following the correct procedures resulting in paperwork not supporting the actions that were carried out by staff regarding the use of harness/jacket for redirection of BB and use of hot tub for de-escalation of BB with the potential for physical and emotional harm.

We refer to Positive Behaviour Support Plans as PBSPs from now on.

2. Unusually, the second and third of these findings do not disclose the underlying issues. They can only be understood in the light of DBS's Barring Decision Summary. We refer to this later.

B. The appeal to the Upper Tribunal

3. Judge Jacobs gave WR permission to appeal against DBS's decision. This is why:

> I have given WR permission to appeal on his grounds submitted with his application for permission to appeal, which was dated as lodged on 6 April 2022. DBS set out three findings of fact in its letter of 14 March 2022. Having read the grounds of appeal, there are realistic grounds on which the Upper Tribunal could make findings that are sufficiently different to change at least the circumstances in which the events occurred to an extent that could affect the ultimate decision that it was appropriate to include WR in either or both lists.

4. The panel of the Upper Tribunal that heard this appeal consisted of a judge and two specialist members. The Upper Tribunal explained the qualifications of its members and their appointment in *CM v Disclosure and Barring Service* [2015] UKUT 707 (AAC) at [59] to [64]. We have relied on the practical knowledge and experience

that the specialist members bring to this jurisdiction in: (a) questioning WR at the hearing; (b) understanding how PBSPs operate: (c) assessing the evidence; and (d) making our findings. We had the benefit of hearing WR give evidence in response to questions from his representative, the panel and Mr Serr. We have read the employer's investigation report. It contains summaries of what WR said, but in assessing its significance we accept (as his representative argued) that for the most part we do not have the questions he was asked or his precise answers.

5. All page references in this decision are to the page numbers in the judge's printed copy of the Upper Tribunal's bundle. Other versions of the papers have different numbers.

C. The legislation

6. Section 4 SVGA contains the Upper Tribunal's jurisdiction and powers.

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

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

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

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

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

…

D. The case law

7. We limited ourselves to the ground on which permission was given, as required by *Disclosure and Barring Service v JHB* [2023] EWCA Civ 982 at [97]. That is why we have dealt with the appeal as one involving potential mistakes of fact. Some of the mistakes in this case could, though, equally have been analysed as ones of law.

8. We have directed ourselves on mistake of fact in accordance with the Upper Tribunal's decision in *PF v Disclosure and Barring Service* [2020] UKUT 256 (AAC), [2021] AACR 3; the panel's reasoning was approved by the Court of Appeal in *JHB* and subsequently in *Kihembo v Disclosure and Barring Service* [2023] EWCA Civ 1547 at [26]. We do not need to repeat what the Upper Tribunal said in *PF*, but we emphasise part of [39]:

> There is no limit to the form a mistake of fact may take. It may consist of an incorrect finding, an incomplete finding, *or an omission*. [Our emphasis]

That paragraph was quoted in *Kihembo* at [24].

9. We have not limited ourselves to identifying mistakes of fact in DBS's findings. Having done so, we have gone on to make our own findings. In doing so, we have followed the Court of Appeal in *Disclosure and Barring Service v AB* [2021] EWCA Civ 1575, [2022] 1 WLR 1002 at [55]. We are satisfied that we have the evidence on which to make the findings and consider that it is appropriate to do so.

E. BB

10. We are concerned with the period from July 2019 to October 2020. At that time, WR was the registered manager of the bungalow occupied by BB as his home. BB has autism, learning disabilities and asthma. He was born in 2001, is 6 feet 4 inches tall and weighs 20 stones. He has challenging needs and behaviour. His size and strength add to the difficulties in managing him when he is in an elevated state. He is water sensory, meaning that being in water helps to calm him and keep him calm. WR told us that, in his experience, BB was unique as a service user.

11. BB was the only resident of the bungalow, although his carers were on the premises by day and night whenever he was present. He moved into the property on 23 July 2019, initially on an emergency placement. That placement was due to last for 13½ weeks, but he was still there in October 2020. Before moving in, he had been in a residential education placement. There was no bath on the premises when BB arrived, only a shower. A hot tub was installed on decking in the garden, which he used

several times a day for his personal pleasure. It was also used as a tool to keep him calm.

12. BB has a vehicle that is used to take him out for drives and for visits in the community. When in this vehicle, he has to wear a Houdini harness so that he can be secured for his own safety and that of others with him. The harness cannot be put on without his cooperation and cannot be put on or taken off when he is in the vehicle. It is held in place by magnetic fastenings that are too strong even for BB to unfasten. A special tool is required.

13. Those facts are not in dispute.

F. The incident on 30 September 2020

14. DBS's findings, especially the second and third, only make sense against the background of an incident that happened on 30 September 2020.

15. WR was not on duty at the time of the incident. He was on sick leave and had not yet notified his employer of when he would be fit to return to work. The incident happened at the transfer of shift from day to night staff. The documents before DBS and us contain evidence from some of the carers present at the time. They naturally give accounts from their individual perspectives and vary in content and detail. Although the descriptions vary, the overall picture is of BB being out of control, with staff being taken by surprise at his extreme aggression and struggling to find a way to protect him and themselves.

16. We began to discuss this evidence with Mr Serr, but he told us that we did not have to make findings on what actually happened. Given our findings, we have decided that it is possible to deal with this case without resolving exactly what happened. We reach that conclusion, because the issue for us is the extent to which WR has any responsibility for what happened.

17. It is, though, possible to give a flavour of what happened. BB had been taken out for a drive and was in a highly elevated state when he returned home. He was aggressive and volatile, difficult to control, and did not respond to the carers' attempts to calm or control him. Eventually, he found himself in the hot tub. How he got there varies in the statements. Some accounts say that he was directed or guided into the tub (pages 72 and 75-76). Other accounts are more dramatic. This is how one of the carers described what happened (page 59):

> AP grabbed BB by his harness and forcely threw BB into the hot tub. …

Later:

> JM then grabbed BB by the harness and forcefully threw BB across into the hot tub causing a big slash and BB to inhale the faeced filled water.

We have not corrected the spelling in those quotations.

G. DBS's reasoning on the second and third findings

18. We begin with these findings, because they relate to the incident itself. The first finding relates to the investigation of the incident, which is later in time. The second and third findings represent DBS's conclusion that although WR was on leave, his actions contributed to how the staff tried to manage BB's behaviour.

19. For convenience, we repeat the findings together with DBS's analysis in the Barring Decision Summary.

20. The second finding was:

> you failed to follow service user, BB's Positive Behaviour Support Plan written by the Behaviour Advisor prior to BB's arrival … and failed to arrange best interest decision to support this with the potential for physical and emotional harm.

21. DBS's analysis of this finding was:

> Staff member JM reported Studio 3 walk around with the harness was used to redirect BB during the incident on 30 September 2020 and stated the harness was used to keep BB in the hot tub as advised by WR but acknowledged that this was not in BB's care or support plans. AP also provided a statement in which he claimed WR had advised BB keep the harness on until he returns into the house due to increasing incidents as it was easier to direct BB with the harness.
>
> [The employer] highlight the approved PBS Plan details the harness was to be used when travelling in the vehicle to keep BB safe and only to be used in the house when BB was going to the vehicle. The Plan also did not state the hot tub was to be used as a form of de-escalation, despite this being used in the incident on 30 September 2020.
>
> During a fact finding meeting WR confirmed staff used the harness for redirection when BB leaves the vehicle to the house and there were difficulties if BB ran to the house. He stated the harness would be taken off at a reasonable time in BB's and staff members' best interest, if BB's behaviour elevated it would stay on but that it was not used in the house.
>
> In an informal meeting with SR WR initially stated the harness was not to be used in the house, but then said that the harness was to be used in the house or garden if BB was a danger to himself or others. He also acknowledged that what he said was conflicting.
>
> WR also stated the harness was in the care plan for redirection and transportation purposes. During an Investigation Meeting WR acknowledged the support provided to BB was outside of the PBSP Plan.
>
> WR agreed he had given advice to staff that was not prescribed as per BB's PBS plan or discussed in a best interest meeting.
>
> The evidence provided by the employer is considered to be credible and given that WR admitted to the alleged behaviour there is no reason to reach a different conclusion.
>
> The evidence provided by the employer is considered to be credible and given that WR admitted to the alleged behaviour there is no reason to reach a different conclusion.
>
> Therefore given the information available to the DBS and the admission of WR it is proven on the balance of probabilities that on various dates WR failed to follow service user, BB's Positive Behaviour Support Plan written by the Behaviour Advisor prior to BB's arrival and failed to arrange best interest decision to support this with the potential for physical and emotional harm.

22. The third finding was:

> you made additions to the Positive Behaviour Support Plan in October 2020 without following the correct procedures resulting in paperwork not supporting the actions that were carried out by staff regarding the use of harness/jacket for redirection of BB and use of hot tub for de-escalation of BB with the potential for physical and emotional harm.

23. DBS's analysis of this finding was:

> Information provided by [the employer] which is deemed credible details that a secondary, unapproved plan had been developed which mirrored the support already being given to BB.
>
> The August PBS plan did not state the harness/jacket was to be used for redirection outside of the vehicle and its use was only for safety in transport. The October 2020 plan stated BB would be required to be redirected at times as he would walk away from staff and staff were to use the strap of the harness/jacket to redirect when/if required. It further stated when BB was displaying anxious/heightened behaviour staff were to try and redirect BB to use the sensory pool (hot tub) as this was known to help to de-escalate.
>
> WR confirmed he had spoken with SP regarding the need for a best interest meeting to make amendments to the PBS Plan which he claimed was not in use despite staff supporting BB in line with the revised plan.
>
> WR admitted he had made additions in October 2020 regarding the use of the harness/jacket for redirection and the use of the hot tub for de-escalation to the PBS plan. He claimed he was tidying it up for the best interest meeting and was trying to save time.
>
> WR stated if BB's behaviour was heightened he would not let staff take the jacket off and took responsibility that the paperwork did not support the actions that were carried out.
>
> WR acknowledged it was his responsibility to ensure the correct paperwork was in place to support the care being given to BB.
>
> The evidence provided by the employer is considered to be credible and given that WR admitted to the alleged behaviour there is no reason to reach a different conclusion.
>
> Therefore given the information available to the DBS and WR's admission it is proven on the balance of probabilities WR had made additions to the Positive Behaviour Support Plan in October 2020 without following the correct procedures resulting in paperwork not supporting the actions that were carried out by staff regarding the use of harness/jacket for redirection of BB and use of hot tub for de-escalation of BB with the potential for physical and emotional harm.

24. The essence of the findings and the analysis is this. On 30 September 2020 (and at other times as well) the carers had acted outside the permitted scope of the original PBSP and had been led into doing so by an unauthorised version of the plan that had been devised and put into circulation by WR without following the correct procedures. It is on that basis that WR has been treated as responsible for what happened.

H. The second and third findings - PBSPs

25. After hearing the evidence and discussion, WR's representative said that these two findings had 'morphed' together. We agree with that description. We have done our best to deal with them separately, but this has not been entirely possible.

26. A PBSP is divided into three parts: primary prevention, secondary prevention and reactive strategies. Primary prevention includes sections on how to interact when the service user is at baseline, target behaviours that he may display, early indicators that he is moving away from baseline, and slow and fast triggers for challenging behaviour. Secondary prevention includes sections on distraction techniques, how to interact when the service user is off baseline, and self-protection for carers. Reactive strategies include sections on self-protection and breakaways, medication, physical intervention, and community access.

27. The PBSP beginning on page 78 is the original plan. We accept WR's evidence on the circumstances in which the plan was written. He was present when BB arrived and was the manager of the premises. What he says accords with the documentary evidence, as we explain. The plan was written up on 2 August 2019 and marked for review in September 2019. It was revised on 2 September 2019. It was then reviewed and revised in October 2019. There were subsequent reviews in November and December 2019 and June 2020. All those dates are recorded on page 92. That page is part of the other version of the plan, which we come to later. It follows that the plan in the papers was not the plan in force on 30 September 2020. This must have been the plan provided by the Behaviour Advisor who wrote (page 68): '… I will send you an old PBSP to see changes made recently …' For some reason, he did not provide the October 2019 version, which was operative on 30 September.

28. We do not know how the October 2019 revision differed from the original. WR did not argue that the relevant provisions of the plans differed in any way relevant to his appeal. He would surely have done so if they had. We have therefore treated the original PBSP as showing the relevant provisions in force at the time of the incident.

29. The plan was 'written up on August 2nd 2019' by the Behaviour Advisor for WR's employer (page 83). That is the language of the plan itself. We accept WR's evidence that there was no plan in place before BB arrived. That is consistent with the emergency nature of his placement and with what the plan itself says. We accept WR's evidence that the Behaviour Advisor wrote up the plan, incorporating information from BB's previous carers and including the limited experience that BB's carers had acquired since his arrival. It was not solely devised by the Advisor. That is consistent with the nature of PBSPs and with the language used. It may be sensible for a single person to 'write up' a plan, but that is not the same as devising it.

30. The finding refers to the plan as being 'written by the Behaviour Advisor prior to BB's arrival'. If that is intended to be descriptive only, it is wrong for the reasons we have just given. If it is intended to suggest that it derives some particular status or significance from having been written by the Advisor, it is also wrong. Plans like this are collaborative efforts and benefit from that. The most that can be said is that the plan benefitted from the involvement of the Advisor.

31. The finding ends: 'failed to arrange best interest decision to support this with the potential for physical and emotional harm'. This is an example of the second and third

findings morphing into each other. It only makes sense as referring to the other version of the plan, which is the subject of the third finding.

32. The mistakes we have identified so far are not sufficient to satisfy the test in section 4(2)(b). There is, though, a fundamental mistake of fact in the second finding that does satisfy that test. The finding is based on the mistaken assumption that PBSPs provide an exhaustive set of rules that have to be followed and must not be departed from. That is a misunderstanding of their nature and purpose. They contain a lot of useful information, as BB's did. But they are not, and are never intended to be, exhaustive. We accept WR's evidence that the staff had to adapt to cope with BB's moods and behaviours. The plan was then reviewed and, if appropriate, revised to take account of the experience of caring for BB. PBSPs are the result of a continuing process of experience, leading to review of the plan, followed by a revision.

33. The use of the Houdini harness is a good example of the need to supplement BB's plan. The purpose of the harness was to hold BB securely in his vehicle. That is what the original PBSP said (page 79): 'When going out in the vehicle BB uses a harness to ensure he remains safe in the seat of the vehicle.' The plan does not mention wearing the harness outside the vehicle. That does not mean that it would only be worn when in the vehicle. If that were so, it would be rendered ineffective. It had to be attached and removed, and those actions could only be performed when he was outside the vehicle. And they had to be performed safely – for BB, for his carers, and for any member of the public in the vicinity. BB's home was on a development of private family homes. His vehicle could not be taken onto the property and had to be parked on the road. This meant that BB had to be guided to and from his vehicle and across the public pavement while still wearing the harness. In practice, it had to be fastened and removed when indoors. That was not mentioned in the PBSP, but that did not prevent it being done. The Behaviour Advisor recognised this when he wrote (page 68) that from his arrival BB would be 'using a harness when travelling in the vehicle keeping him safe and that he only puts the harness on in the house when he is about to go out into the vehicle.' That supports what WR told us and is consistent with our understanding of the nature of PBSPs.

34. We accept WR's evidence and find as follows. BB's harness was put on and taken off when BB was indoors. It was for practical purposes, if nothing else, impossible to perform those tasks in the vehicle, whatever the plan said. And safety made it sensible for them to be carried out indoors. Acting in this way is consistent with the plan, although it was not mentioned in it. And removal of the harness might be further delayed, in the interests of safety for BB and his carers, if BB's mood were elevated. That was also consistent with the PBSP. Given BB's elevated state when he returned to his home on 30 September 2020, his carers were entitled to leave him in his harness. By doing so, they did not fail to act in accordance with the PBSP. Nor did WR fail to act in accordance with the plan when he allowed the carers to delay removing the harness in the interests of safety.

35. We deal later with precisely what WR had agreed the carers could do.

36. We referred earlier to another version of the plan, which begins on page 85. This is the plan referred to in DBS's third finding. The closing words of the second finding also relate to this plan. DBS has treated this as a plan altered and put into circulation by WR without following correct procedures or holding a best interests meeting.

37. There is a fundamental mistake of fact in this finding that satisfies the test in section 4(2)(b). The document beginning on page 85 was not an unauthorised plan put into circulation without following the correct procedures. It was merely a draft plan. We accept WR's evidence on this. What he described is what should have happened. It is consistent with the conversation described by the Behaviour Advisor (page 68), which describes an ongoing process of development consistent with the process of review and revision. It would be, to say the least, surprising if a manager were going through that process while presenting the draft as a final plan that would authorise carers to use BB's harness to propel him into his hot tub or hold him there.

38. WR told us that the draft plan was held password-protected in his personal folder on his work computer; he expressed surprise and puzzlement that it had ever seen the light of day. However that happened, we accept WR's evidence that it was a draft. It may have been written in a form that, once approved, could be issued as a revised PBSP. But it was not circulated or presented to BB's carers. The carers would, though, be familiar with some of what it contained, because it reflected their growing, collective experience of managing BB in his varying moods. Incorporating such experience is in the nature of a PBSP, as we have already explained. The review and revision of a plan is not hermetically sealed from the experience of the carers. BB's carers and WR as their manager would hold conversations about difficulties that had occurred and solutions that had worked or not worked. The results of these conversations would inform revisions to the plan. The carers would know of techniques that would later appear in the plan without the draft plan being disclosed.

39. WR told us that he had allowed the carers to use BB's harness, but only for safety, not for control. We accept that and so find. At page 67, he is recorded as using 'redirection' and 'guide'. We have already noted the use of those words on pages 72 and 75-76. This language, in its context, is consistent with the use of the harness for safety.

40. If the carers were directing and guiding during the incident on 30 September, that was within the guidelines that WR had given. They were properly given to supplement the PBSP and were consistent with the original PBSP. The carers had not seen the draft plan and could not have been misled to believe that it was authorised. If the carers went beyond directing and guiding, as the most dramatic account describes, they did not do so because of anything in the draft plan. We do not have to decide whether they acted as described or why they did so. It is sufficient for us to find that WR had not authorised the use of the harness as described.

41. Picking up the final part of the second finding, WR was in the process of arranging a best interests meeting. He had already consulted BB's parents, who were supportive of the use of the harness. There was no failure on is part.

42. Just for completeness, there are references in the evidence to a care plan (pages 44 and 67) and a risk assessment (page 67) for BB. They were not provided to DBS and were not before Upper Tribunal. The references to the care plan are confusing. Some of the references on page 44 could be read as references to the PBSP, although that acronym is also used on that page.

I. The first finding – the investigation of the incident of 30 September 2020

43. DBS's first finding refers to the incident and concerns WR's involvement in the investigation. That does not depend on what actually happened. He accepted that he had made mistakes in the way this was handled.

44. We consider that there were omissions in DBS's fact-finding that could have affected its assessment of appropriateness. This is why we have remitted the case to DBS with the following findings.

45. WR was not on duty on the day of the incident, which was a Wednesday. He was on sick leave and had not notified his employer of when he would be fit to return to his duties. In the event, he returned to work on the following Monday 5 October 2020. That is not in dispute. We accept his evidence that he was contacted at home on Saturday by his manager, who asked if he would be returning to work on the Monday and he said he would be.

46. We find that it was not WR's responsibility to investigate the incident. He was on sick leave and his deputy manager was covering for him. That manager was one of those involved in the incident. It would not have been appropriate for him to investigate it. The appropriate person to carry out the investigation was WR's line manager. It should have been carried out immediately, or the next day at the latest. Instead, it was left until WR returned. There was then confusion over responsibility for conducting the investigation. We note that the original allegation of misconduct during the incident was made by a whistle-blower in an email, which was only made available to WR after he had completed the investigation he was required to carry out on his return to work.

47. We also find that, although WR had long experience in caring, he was a relatively new manager. Mr Serr referred us to the list of courses that WR had attended (pages 33-34). It is, though, significant that we cannot identify any training in management or leadership. We do not know what was covered in the final course on the list, so it may be the exception.

J. Article 8

48. This was not part of the appeal and we make no findings on it. WR was, though, naturally concerned. He and his wife have been fostering two children, both with special needs. The details of his family are set out on page 14. Given the children's ages, they can have no recollection of a family other than that of WR. They are thriving in his family's care and his wife has been allowed to continue as their foster carer while this appeal was pending. If WR remains in the lists, the children will have to be placed with another family.

49. We mention this to record WR's concern. In legal terms, this raises the relevance of his Convention right under Article 8 to a family life. It will be considered by DBS when it reassesses whether it is appropriate for WR to remain in either or both lists. Its significance is a factor for DBS to consider.

K. A reminder

50. The papers contain an allegation by a female (SJ) of a sexual offence. It did not lead to a prosecution and did not figure in this case. Nevertheless, the papers contain some details of the allegation and the ensuring investigation. The provisions of the

Sexual Offences (Amendment) Act 1992 apply to SJ. No matter relating to her shall during her lifetime be included in any publication if it is likely to lead members of the public to identify her as the person who alleged that an offence had been committed. This prohibition applies unless waived or lifted in accordance with section 3 of the Act. It is irrelevant that no prosecution followed.

Authorised for issue
on 26 January 2024

Edward Jacobs
Upper Tribunal Judge
Brian Cairns
John Hutchinson
Members