IN THE UPPER TRIBUNAL **Case No. UA-2022-001773-V**
ADMINISTRATIVE APPEALS CHAMBER **[2024] UKUT 258 (AAC)**

The Upper Tribunal has ordered that there is to be no disclosure or publication of any matter likely to lead members of the public to identify AW or six other named individuals.

Between:

AW

Appellant

- v –

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Citron, Ms Smith and Mr Turner

Decided following an oral hearing at Field House, Breams Buildings, London EC4 on 24 June 2024

Representation:

Appellant:	by Ms Laura Bayley of counsel, instructed by Ms Rebecca Austin, legal officer, Royal College of Nursing
Respondent:	by Mr Tim Wilkinson of counsel, instructed by DLA Piper

DECISION

The decision of the Upper Tribunal is to ALLOW the appeal. The Respondent made mistakes in findings of fact it made and on which its decision of 22 August 2022 (reference DBS6191 00960513296) to include AW in the children's and adults' barred lists was based. The Upper Tribunal directs the Respondent to remove AW from both barred lists.

REASONS FOR DECISION

This appeal

1. This is an appeal against the decision ("**DBS's decision**") of the Respondent ("**DBS**") dated 22 August 2022 to include AW in the children's and adults' barred lists.

DBS's decision

2. DBS's decision was made under paragraphs 3 and 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 (the "**Act**"). These provide (in very similar terms as regards both children and vulnerable adults) that DBS must include a person in the relevant barred list if
    a. it is satisfied that the person has engaged in relevant conduct,
    b. it has reason to believe that the person is, or has been, or might in the future be, engaged in regulated activity relating to children/vulnerable adults, and
    c. it is satisfied that it is appropriate to include the person in the list.
3. Under paragraphs 4 and 10, "relevant conduct" includes, amongst other things, conduct which endangers a vulnerable adult (or child) or is likely to endanger a vulnerable adult (or child), or which, if repeated against or in relation to a child (or vulnerable adult), would endanger them or would be likely to endanger them; and a person's conduct "endangers" a vulnerable adult (or child) if she (amongst other things)
    a. harms them or
    b. causes them to be harmed or
    c. puts them at risk of harm.
4. The letter conveying DBS's decision (the "**decision letter**"):
    i. found that
        a. on 11 March 2021 AW failed to provide care to JB when he was up and ready to be supported
        b. on 17 March 2021 AW
            i. failed to provide personal care to JB despite knowing that he was soiled
            ii. did not attend to TH and therefore failed to notice and respond to dried vomit on TH's bed and did not carry out personal care
            iii. falsified bowel monitoring checks for a vulnerable adult

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

ii. stated that DBS was satisfied that AW engaged in relevant conduct in relation to vulnerable adults, on the basis that she had engaged in conduct which endangered a vulnerable adult or was likely to endanger a vulnerable adult;

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

iv. stated that DBS was satisfied that on three occasions AW failed to provide care to vulnerable adults; that DBS recognised that on one of these occasions it was reasonable for AW to have refused to provide care as it was nearing the end of her shift; however, the other two occasions showed that AW had failed to carry out her role and provide care. DBS recognised that for one of them AW was aware that the vulnerable adult required care as his pad was wet;

v. stated that DBS was satisfied that AW's behaviour showed her to be irresponsible in her attitude towards care to vulnerable adults and as such has exposed them to physical and emotional harm; AW intentionally ignored a wet pad, then failed to check on a vulnerable adult that resulted in a vulnerable man being left in bed with vomit on him and the bed; and he had soiled himself. AW showed herself to be irresponsible in that she falsified checks that she had carried out regarding bowel movements of a vulnerable adult. DBS was satisfied that these acts were intentional and had exposed the vulnerable to harm;

vi. stated that DBS was satisfied that AW's behaviour was not a one-off occurrence and that AW repeatedly failed in her role to provide care whilst working in a position of trust; that AW's behaviour caused emotional harm and had the potential to cause physical harm; DBS was satisfied that instead of attempting to provide care (to a person who had in the past refused it) AW did not even attempt to do so, thinking it would be refused.

Jurisdiction of the Upper Tribunal

5. Section 4(2) of the Act confers a right of appeal to the Upper Tribunal against a decision by DBS under paragraphs 3 and 9 of Schedule 3 to the Act (amongst other provisions) only on grounds that DBS has made a mistake

   a. on any point of law; or

   b. in any finding of fact on which the decision was based.

6. The Act says that "the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact" (section 4(3)).

The grant of permission to appeal

7. In giving permission to appeal, Judge Citron gave the following by way of "reasons":

> "The grounds of appeal include factual assertions by the Applicant, to the effect that the findings of fact on which DBS's decision was based (essentially, the second, third and fourth allegations, as the first allegation was acknowledged by DBS (for

example, at page 303 of the bundle, under "Post Reps") to be less significant) failed to take into account relevant and important contextual facts such as:

- as regards the second allegation, the fact or belief held by the Applicant, that JB was not to be woken, even though his pad was wet
- as regards the third allegation, the fact that TH was difficult to deal with and refused personal care from the Applicant
- as regards the fourth allegation, the fact (as alleged by the Applicant) that she did [not] make the 5.30 am entry on TH's bowel monitoring chart on 17 March 2021.

It seems to me arguable that factual assertions of this kind could be proved by the Applicant on the balance of probabilities, and that, if they were so proved, that DBS made a mistake in the findings of fact on which the decision was based, and/or on a point of law, by omitting important and relevant context.

It also seems to me arguable that the decision to include AW in the barred lists was disproportionate.

Permission to appeal is not formally limited. However, the matters which have led me to give permission are as set out above, which I regard as arguable with a realistic (as opposed to fanciful) prospect of success. In particular, I am not persuaded of the arguability of the mistakes on points of law alleged at paragraph 32 b i to v inclusive of the Applicant's "submissions on barring decision process" document.

Documentary evidence in the bundle

8. The documentary evidence in the bundle of 406 pages included:

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

b. an internal investigation report re: AW dated 15 April 2021, by GLP (the "regional support manager" at the care home)

c. investigation meeting notes re: AW dated 6 April 2021

d. investigation meeting notes re: PK (support worker who, like AW, worked on the 16-17 March 2021 night shift) dated 16 March 2021

e. investigation meeting notes re: IG (senior support worker) dated 18 March 2021

f. investigation meeting notes re: ER (support worker) dated 18 March 2021

g. statements of GB (the "service manager" at the care home) of 18 March 2021

h. email sent by GB on 11 March 2021 at 07:46

i. email sent by AB, another support worker at the care home, on 17 March 2021 at 12:37

j. care home's "standard operational procedures" document; amongst many other things, this said that "handovers will take place every shift

change …"; "handovers will be full and detailed with a walk round between shift leaders afterwards"

k. JB daily records for 10-11 March 2021

l. AW's supervision records, dated 5 March 2021 and 29 October 2020

m. JB bowel monitoring chart 16-17 March 2021

n. photographs of wet bed and clothing

o. TH bowel monitoring chart 16 March 2021

p. TH and JB daily records 16-17 March 2021 (we note that JB's daily records for this night were not in the papers originally disclosed by DBS (on 23 March 2023) to AW; DBS disclosed them some seven months later, on 6 November 2023, when it said that it had come to its attention that it was in possession of those documents)

q. photograph of wet bedding

r. "significant discussion" re AW, meeting of 8 December 2020

s. emails between GB and GLP on 6-7 March 2021

t. transcript of disciplinary hearing on 7 May 2021

u. disciplinary hearing outcome letter dated 9 June 2021

v. disciplinary appeal outcome letter dated 23 July 2021

w. AW's initial submissions to DBS, August 2022

x. seven character references for AW, from four different persons

y. DBS's "barring decision summary" document. Amongst many other things, this stated:

    (i) "all four allegations remain proven after representations. However the first one is not seen to be as serious as first thought as it was nearing the end of AW's shift and understandable as to why she did not complete personal care."

    (ii) a night check was carried out on 16 March 2021 which identified concerns regarding the completion of documentation – completing recording books and bowel monitoring charts in advance and prior to doing checks

    (iii) AW had had a discussion in December 2020 regarding the completion of paperwork following an injury to a vulnerable adult

    (iv) that a decision had been made "to proceed straight [to] minded to bar" as "there appears to be evidence that AW has

intentionally neglected vulnerable adults and this caused emotional harm"

z. undated statement of AW reflecting on 16-17 March 2021 night shift

aa. five further character references for AW (three from the same people as the character references at x. above)

bb. witness statement of AW dated 15 December 2023, with exhibits

cc. supplementary witness statement of AW dated 23 May 2024.

The hearing

9. AW attended the hearing, gave evidence, and was cross examined

10. We are grateful to counsel for both parties for their written and oral submissions.

Background facts

11. The following background facts did not appear to be in dispute:

a. AW was a support worker at the care home in question; she started working there in December 2014; she was in her early 50s at the time of the incidents in 2021.

b. The home provided support to people with mental health, learning disabilities, autism, brain injuries and other complex needs. It was a 6 bed unit and operated two shifts: a day shift from 7:15 am to 9:30 pm, and a night shift 9:15 pm to 7:30 am. AW worked mainly night shifts. There were usually 5 support workers during the day and 2 support workers at night.

Review of the key evidence

The evidence of AW – the only witness to give "live" evidence

Routines of support workers on night shift

12. AW's evidence was that, when the night shift took over from the day shift, or vice versa, there was a "handover", both by way of the outgoing team speaking to the incoming team about information relevant to the service users in their care, and by means of the two teams going round to see the service users individually in their rooms.

13. The night staff's duties included giving personal care to service users, including changing their incontinence pads, and putting them to bed. Once service users had gone to bed, the night staff would do things like clean the service users' clothes and clean the communal areas. Whilst doing this work, night staff were expected to check on service users - and if the service user was wet due to incontinence, the night shift would change their pads and reposition them.

14. In the morning, night staff would provide personal care to the service users that were awake; night staff would check at around 6 am to see who was awake, and if they were wet, night staff would change the service users before "handover" to day staff.

TH

15. TH was in his late 50s; AW first worked with him in 2015; he had mental illness, learning disability and physical disabilities. TH was supported with personal care and preparing of food. AW's evidence was that TH was difficult as a patient. AW's evidence was that TH had a history of physical assault on staff. AW's evidence

was that TH had physically attacked her in her first few months of working in the home and was regularly racially abusive to her (and other support workers who were black). AW's evidence was that TH regularly told her "get lost", "I hate you" "I don't want you" and verbally threatened to harm her.

16. AW's evidence was that TH would allow some staff to perform personal care, but not others; that the care home arranged for TH's preferred members of staff to come in early in the morning to attend to his personal hygiene; that AW's previous manager had arranged matters such that, for AW's safety, AW did not have to attend on TH; and that the manager at the time of the relevant incidents (GB) was aware of this.

JB

17. JB was in his late 30s; AW first worked with him in 2015; JB had mental illness, learning disability and physical disabilities; JB had complex needs and required personal care including feeding and bathing; he did not have "capacity". JB struggled to sleep both day and night and would often scream. JB had communication difficulties; he could not verbally express his needs.

Night of 16-17 March 2021: general

18. There was a "spot check" (i.e. an unannounced visit by the home care management (TT and GLP)) in the middle of the night. PK and AW (the night shift) were at first slightly frightened/discombobulated by people coming into the home in the middle of the night (the care home was in a relatively quiet, remote setting). The "spot check" lasted about half an hour.

19. There was a "handover" by AW and PK to the incoming day staff on the morning of 17 March, as per the usual routine as described by AW above.

Night of 16-17 March 2021: JB

20. At the start of the night shift, PK and AW were told that JB had had a covid vaccine injection during the day and been drowsy since then. They were told that JB needed to be supported intermittently (15 to 30 minutes), to monitor any side effect of the injection. JB was in bed asleep at the start of the night shift; he was intermittently awake; he seemed very lethargic; at the 10 pm check JB was not fully asleep but appeared very tired in bed; when AW checked his pad, it was dry; she repositioned him back to bed. At about midnight during intermittent checks, JB was observed to be half awake; AW noticed that he was wet; his pad was changed; she repositioned him back to bed and he slept. JB was wet again at 4:25 am and AW changed him then. At about 6:45 am AW checked JB's pad; JB was fully asleep at the time. AW's evidence was that JB's pad was "damp" but not wet; she decided that it was not necessary to change the pad, particularly as this would (or might) wake JB up. AW's evidence was that JB's care plan sanctioned not changing JB's pad in these circumstances.

21. AW denied making the entry on JB's "bowel monitoring chart" showing a check at 5:30 am; she said it was not her handwriting. AW also said she might have made a mistake by writing 5:30 am rather than 2:35 am, which was when (according to the "daily records") she checked on JB (as it was around this time that the "spot check" occurred, which caused some discombobulation on AW's part).

Night of 16-17 March 2021: TH

22. TH appeared to be awake most of the night, looking at family photos. He slept intermittently. The last check AW and PK did was at 7 am: TH was awake, his side light was on, he was sitting on his bed, AW entered the room whilst PK was standing by the door. TH appeared physically well. AW spoke with him; he asked who was coming to attend to his personal care that morning; AW replied that she was about to go for handover and after handover one of the day staff would come to support him. There was no vomit on TH. TH declined personal care from AW (or PK), as he usually did.

Aspects of AW's evidence emphasised in cross examination

23. In cross examination, some emphasis was put on the following evidence of AW's:

    a. in the transcript of the disciplinary hearing on 7 May 2021, AW at one point said that she did *not* offer TH personal care in their interaction at 7 am on 17 March, as it was "ongoing" that TH would decline personal care from AW (the point ends with the management representatives saying they would "investigate" whether it was documented that TH routinely refused personal care from AW)

    b. PK (according to investigation meeting notes dated 16 March 2021) said "around 6:45" in answer to the question: ""What time was the last time you checked [TH] prior to leaving your shift?" (this came after two questions referring specifically to "the handover" on the morning of 17 March); it was suggested in cross examination that this contradicted AW's saying that there was a handover at around 7:15 am

    c. it was said to be very odd that AW did not emphasise to the home care management (in the various investigatory meetings) the fact that (according to her account) AW had seen JB at "handover" at 7:15 am (as well as at 6:45 am (or thereabouts), when she had decided that his pad, though damp, did not need changing).

Other evidence

Care home records completed during the night of 16-17 March 2021

24. "Daily records" for JB recorded as follows (all entries were made by AW except the last one, at 7:30 am):

    a. 16 March; 10 pm: "checked fall asleep, repositioned well in bed and checked dry no concern";

    b. 11:58 pm: ""checked asleep, wet pad changed and repositioned well no concerns in bed";

    c. 17 March 2:35 am: "checked appears asleep breathing OK";

    d. 4:35 am: "appeared asleep pad checked wet changed and back to bed settled asleep no issue";

    e. 5:32 am: "checked appears asleep pad dry and OK";

    f. 6:45 am (unclear): "remains in bed asleep, pad wet in deep sleep breathing and body movement observed";

    g. 7:30 am to 9 am: "woke up around 7:30 am and crawled to the lounge. He was incontinent of urine. He was drenching in urine. …".

25. JB's "bowel monitoring chart" recorded as follows:

    a. 16/3 11:58 pm;

    b. 17/3 5:30 am

26. "Daily records" for TH recorded as follows (all entries were made by AW except the last one, at 8 am):

    a. 16 March 9 pm: "checked appears asleep breathing and body movement observed";

    b. 11-11.05 pm: "checked asleep breathing observed";

    c. 17 March 12:45 am: "checked asleep breathing noted";

    d. 2 am: "checked awake seated on the edge of the bed no issue";

    e. 3:30 am: "checked remains awake talking to himself calling different names of his family members";

    f. 4:45 am: "check still awake talking to himself";

    g. 7-7:30 am: "remain awake approach for personal hygiene declined wanting for day staff and screaming at staff";

    h. 8-10 am: "This morning after night shift handover I come to – room knocked at his door. TH was upset and crying. TH was cover sick in his bed during the night? Also soaking wet. I asking – can I help him with his morning personal care and TH say yes please".

Documents recording PK's views shortly after the night of 16-17 March 2021

27. The near-contemporaneous documentary evidence from PK largely corroborated what AW said about TH being highly uncooperative with AW, and sometimes violent. It indicated that PK was standing behind AW, at the door, when AW interacted with TH. Like AW, PK denied that there was vomit on TH at the end of the night shift on that morning.

Documents recording IG's and ER's views shortly after the night of 16-17 March 2021

28. The near-contemporaneous documentary evidence from IG and ER indicated that there was a "handover" from the night shift staff on the morning of 17 March.

29. IG's account was that, at the handover, AW and PK said that TH always declined personal care, was aggressive, used bad language and was moaning at them. ER's account was that AW and PK had said that TH had racially abused them.

30. IG's and ER's accounts was that they attended to TH at 8 am on the morning of 17 March. When asked what she found in TH's room, IG's response was

> "ER found him, she went to administer meds and ran to me saying he was soaking wet soaking, been sick during night and there was poo. I went to the room and the sick was dry, when you are just sick you can smell it but it was not smelling, room smelt of poo. Wee was leaking from sheet/bed onto the floor".

31. When then asked how TH was, IG responded: "He was sitting on his bed and crying."

32. When asked what was said about JB "in handover", IG's first response included that AW had said that JB was "not changed as he was asleep". When then asked if she had been told by the night staff in the handover (or around that time) that JB was wet, IG is recorded as saying:

> "Actually she didn't say he was soaking wet but just before they left JB came out of his room and he was soaking wet. AB came in to the office to tell GB, and after AW heard and came in to the office, AB me and GB, she said I gave you handover to say JB was wet in his bed, I said you didn't say that and that should not be handed over you should change him and she got angry".

33. ER's account was consistent with the above.

Documents recording GB's views shortly after the night of 16-17 March 2021

34. GB's account speaks of a meeting with AW, PK and IG on the morning of 17 March "discussing the events of the previous night" (she says this meeting followed the staff having a handover). The meeting finished just after 7:30 am. AB then went to attend on JB; soon after, AB came to GB and made her aware that JB was sodden in urine; AW was just leaving and "called out" that she had handed over (to IG) that JB was wet; GB took photos of JB's top, and the stain on his bed, at around 7:50 am. Shortly after this, IG asked GB to come see TH. GB reported that, when she visited TH at around 8 am, TH said he was "not happy", and was sitting in wet pyjama bottoms and a wet bed; his top had dried vomit on it and there were deposits around his mouth. With TH's permission, GB took photos of TH and his bed. In response to being asked whether anyone came to see him in the night, TH shook his head.

35. GB's email to GLP of 7 April 2021 stated: "there is nothing in the guidance to say [JB] should not be woken up. JB hardly wakes when he's changed, he is semi-conscious, and goes straight back to sleep afterwards. Since I've been doing the nights I regularly change him around 0100-0200 and he goes straight back to sleep".

Documents recording AB's views shortly after the night of 16-17 March 2021

36. AB's account, concerning both JB and TH, was consistent GB's, IG's and ER's, as summarised above.

The "significant discussion" with AW and employer on 8 December 2020 - the record keeping issue

37. The record keeping issue in this "discussion" was that AW had not completed required documentation regarding an injury; specifically, it had not been recorded that there had been a deterioration with an "old" injury and that additional support was needed from the district nurses.

Points emphasised by DBS's counsel on the evidence

38. DBS's counsel emphasised the following evidential points:

TH

a. AW was not to be believed when she said there was a "handover" in respect of TH, at which he was fine: AW was not recorded as mentioning this "handover" in the notes of the care home's internal investigations

b. it is open to tribunal to conclude that checks did not occur as documented in the "daily records" for TH – the 7 am check for TH did not occur, DBS counsel suggested

c. there was inconsistency or lack of clarity in AW's account e.g. did she offer TH personal care or not? Where exactly was PK at the time?

JB

d. AW did not emphasise in investigation notes, that she checked JB's pad at the morning "handover" (around 7:15 am)

e. AB's evidence of JB's urine-drenched state *just after 7.30 am* i.e. only 15 minutes after the "handover" to day staff, as described by AW

f. the tribunal should not believe AW's point about a care home policy not changing JB if he was sleeping: see GB's 7 April 2021 email on this point; also, note that the "daily records" entries show that JB was changed through the night (when he was sleeping …)

g. the tribunal should not accept that the 5:30 am bowel check entry was a mistake.

Our factual findings

JB

39. We find that the "daily records" for the night of 16-17 March 2021 are a reliable record of what AW did for JB that night: she checked on him six times, at roughly two hour intervals; she changed him when she found him wet at around midnight and again at around 4:30 am.

40. Based on a combination of the 6:45 am (or thereabouts) entry in the "daily records" and AW's oral evidence (which, in large part, we found reliable and credible), we find that at around 6:45 am, AW again checked JB, and, finding his pad to be damp but not entirely wet, made a "judgement call" to the effect that it was in JB's best interests not to change his pad because so-doing risked waking him up, and it was not strictly necessary to change his pad at that stage. AW's judgement in that matter was very much coloured by her understanding that the care home sanctioned not changing JB's pad in such circumstances, given that JB had a history of difficulty sleeping. We find that it was wrong for AW to say that this point was formally written in to AW's care plan; however, we on balance believe her when she says that she believed this was an approach sanctioned by the care home. To be clear: the approach which AW believed was sanctioned by the care home was one that applied only where it was not strictly necessary to change JB's pad; in other words, if JB had soiled his pad (with faeces), or if his pad was entirely wet (as opposed to just damp), AW's understanding, we find, was that the pad had to be changed – even if JB was woken up in the process. It was only because the pad was damp, rather than wet, that AW thought it was proper, and sanctioned by the care home, to delay changing it and avoid any risk of waking JB up as a result of changing the pad.

41. It follows that we have found, on the balance of probabilities, that the urine-sodden state that JB was unfortunately found in, sometime after 7:30 am that morning, is something that had occurred after AW's check at around 6:45 am.

42. We find that there *was* a "handover" to day staff at around 7:15 am on 17 March 2021 but this was done via day staff and night staff speaking to one another, but without a physical examination of the service users. In this respect, we have not found AW's evidence wholly credible, on the balance of probabilities: whilst we believe her that there *was* a "handover" (and this is also very much corroborated by the notes of the various investigation minutes), we find that this was not done in as thorough a way as is suggested by the care home's standard operational procedures document i.e. there was no "walk round" to each of the service users. We note that this failure to do a "walk round" at "handover" was not AW's fault:

we find that, in all likelihood, it reflects a pattern into which the support workers at the care home had fallen, and we think it equally probable that the care home was fully aware that "short cuts" were being taken by staff at "handovers" in this way.

43. We find it probable that, in the "handover" meeting with the day staff on that morning, AW conveyed, in essence, everything that she had written in the "daily records" over the night – including the fact that she last changed JB's pad at around 4:30 am, and that she had not changed his pad at around 6:45 am, as it had not been sufficiently wet. In making this finding, we rely on AW's oral evidence, which in general we found to be credible, as well as intuitive common sense: if AW had written something in the records, it is likely that she would convey the essence of that information to those taking over, at the oral "handover". We put less weight on the recorded views of IG, ER and AB to the contrary (that AW did not tell them that JB's pad was damp but not wet at around 6:45 am) in documentary evidence, given that it would have been in their interests to deny being given full information by AW, and that we had no opportunity to test their evidence, as they were not called as witnesses.

44. We find it probable that the 5:30 am entry in JB's "bowel monitoring" was a simple error on AW's part: the other entry for the same night, at 11.58 pm, exactly mirrors the time at which she checked on JB and changed his pad per the "daily records" (which, as we say above, we find to be an accurate record of the care given to JB over that night); we find AW to be, generally, credible, and we see no benefit (or other rationale) to her inserting "5:30 am" on a false basis.

TH

45. In parallel with our findings in relation to JB above, we find that the "daily records" for the night of 16-17 March 2021 are a reliable record of what AW did for TH that night: in essence, she looked in on him periodically (six times overnight) to ensure he was still breathing (when sleeping) and (when awake) that he was generally "okay". We find that, in the morning (and exactly as recorded in the "daily records"), AW "approached" TH for personal hygiene (i.e. making it quite clear, by body language, that she was offering to do this for him), but that TH reacted (as he was very well known to do, by all who worked at the care home, including its management) by making it clear that he did not want AW to help him (and in doing so, abused her verbally, in all likelihood by reference to her (non-white) race). We find that AW could not "force" TH to accept help from her; and we also find, for the avoidance of doubt, that the care home management was aware of the problem with TH not wanting to receive personal care from AW (and others on night shift who were not "white") and relied on the fact that there were support workers on the day shift who TH would accept personal care from.

46. In parallel, again, with our findings in relation to JB above, we find that at the "oral" handover to the day shift, AW probably conveyed, in essence, everything that she had written in the "daily records" over the night – including that TH had been approached for personal care at 7 am and had refused to be helped by AW or by PK.

Our conclusions as to mistakes of fact in DBS's decision

47. DBS accepted in its skeleton argument for the hearing that its core factual finding about 11 March 2021 was not one on which its decision was based; it follows that this factual finding is irrelevant for the purposes of the Upper Tribunal's jurisdiction in this appeal.

48. Turning to DBS's other core factual findings, on which its decision was based, we find that DBS made mistakes in all of these:

    a. DBS's finding about AW on 17 March 2021 "failing to provide personal care to JB despite knowing that he was soiled" is mistaken because, as per our findings above, AW provided personal care to JB throughout the night, and made the decision not to change JB's pad at around 6.45 am for the (entirely rational) reasons set out in our findings; JB was not "soiled" at this point; and AW's decision-making cannot accurately be described as a "failure to provide personal care";

    b. DBS's finding about AW on 17 March 2021 in relation to TH is mistaken because, as per our findings above, AW properly kept an eye on TH overnight and approached TH in the morning with a view to giving personal care; TH made it quite clear that he would not accept it from AW; it is not therefore accurate to say that AW did not "attend" to TH; and (in the circumstances as we have found them) it is obviously misleading (if technically accurate) to say that AW failed to notice and respond to vomit on his bed and did not carry out personal care;

    c. DBS's finding about AW on 17 March 2021 "falsifying" bowel monitoring checks is mistaken because, as per our findings above, it was a simple mistake on AW's part to make the "5:30 am" entry on JB's record.

Disposal

49. In the light of our factual findings, it seems to us the only decision that DBS could lawfully reach would be to remove AW from both barred lists.

50. It follows that we have directed DBS to remove AW from the barred lists.

Zachary Citron
Judge of the Upper Tribunal

Rachael Smith
Matthew Turner
Members of the Upper Tribunal

Approved for release on 27 August 2024