IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Appeal No. UA-2022-001771-V
[2024] UKUT 318 (AAC)

Between:

RR

Appellant

- v –

Disclosure and Barring Service

Respondent

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

Decided following an oral hearing on the CVP video hearing platform on 30 July 2024

Representation:

Appellant: by himself
Respondent: by Ashley Serr of counsel, instructed by DLA Piper

DECISION

The decision of the Upper Tribunal is to dismiss the appeal. The decision of the Respondent made on 5 October 2022 (DBS reference DBS6191 00974116299) to include RR in the adults' barred list is confirmed.

REASONS FOR DECISION

This appeal

1. This is an appeal against the decision ("**DBS's decision**") of the Respondent ("**DBS**") dated 5 October 2022 to include RR in the adults' barred list.

DBS's decision

2. The decision was made under paragraph 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 (the "**Act**"). This provides that DBS must include a person in the adults' 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 vulnerable adults, and

    c. it is satisfied that it is appropriate to include the person in the list.

3. Under paragraph 10, "relevant conduct" for the purposes of paragraph 3 includes conduct which endangers a vulnerable adult or is likely to endanger a vulnerable adult; and a person's conduct "endangers" a vulnerable adult if he (amongst other things)
    a. harms a vulnerable adult or
    b. causes a vulnerable adult to be harmed
    c. puts a vulnerable adult at risk of harm or
    d. attempts to harm a vulnerable adult.
4. The letter ("**DBS's decision letter**") conveying DBS's decision:
    i. stated that DBS was satisfied that
        a. Finding 1: on Christmas Day 2021 RR did not adhere to company policy when he drank alcohol while in the workplace - at the end of his shift, RR drank "Lambrini" belonging to service users (and did not have their permission to do so);
        b. Finding 2: on 10 January 2022, RR said he planned to drink alcohol while on a sleep-in shift if he could not sleep;
        c. Finding 3: on unspecified dates prior to 17 January 2022, RR did not adhere to PPE guidelines: he did not wear PPE properly – he had his mask under his nose on occasions;
        d. Finding 4: on unspecified dates prior to 17 January 2022, RR did not follow people's support plans or usual routines and had not read all the available information. RR also had not listened to staff or paid attention when told or shown things;
        e. Finding 5: on unspecified dates prior to 17 January 2022, RR behaved in a way that affected service user JP's behaviour, causing him to not eat or drink more frequently when RR was supporting him;
        f. RR had engaged in relevant conduct in relation to vulnerable adults because he had engaged in conduct which endangered a vulnerable adult or was likely to endanger a vulnerable adult;
    ii. found it established that RR had not followed service user JP's usual routine when his stoma was to be changed, as RR did not notify anyone that the stoma was ready to be changed and proceeded to get JP dressed; DBS stated that this caused JP to be upset when he had to be undressed slightly for the stoma to be changed;
    iii. stated that DBS considered that in future RR could repeat his behaviour by not following policies and procedures or residents' support plans or usual routines.

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 paragraph 3 of Schedule 3 (amongst other provisions) only on grounds that DBS has made a mistake

    a. on any point of law;

    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)).

7. Permission to appeal was given by the Upper Tribunal (Judge Citron) in a decision issued on 11 April 2024. The permission decision indicated the kind of evidence RR would present at a substantive hearing, to support an argument that there was a material mistake in DBS's factual finding, as follows:

    a. Finding 1: RR's evidence would be that he did drink some "Lambrini", but that it was *a very small volume* (and so DBS's finding made the mistake of omitting material context); and that he *did* have the permission of the service users who owned it (and so DBS's finding was mistaken to have found otherwise). The permission decision also noted that, according to the internet, "Lambrini" was a light and fruity pear cider;

    b. Finding 2: RR's evidence would be that he would not have drunk the alcohol (cider) without first consulting his manager (and so DBS's finding made the mistake of omitting material context);

    c. Finding 3: RR's evidence would be that this happened infrequently and well away from service users, in particular when he was approaching the toilet (and so DBS's finding made the mistake of omitting material context);

    d. Finding 4: RR's evidence would be to deny that he did not follow service users' support plans. The permission decision noted that, in addition, the documentary evidence suggested that a "language barrier" may have been a factor here (see for example page 93 of the Upper Tribunal bundle (DBS's "barring decision summary" document)) – yet DBS's finding did not resolve whether this was the reason for the problems identified. This was arguably a mistake of failing to make a necessary and material finding of fact;

    e. Finding 5: RR's evidence would be that there was nothing in his (RR's) behaviour (such as the allegation that RR "got too close" to JP) that, considered objectively, *caused* JP to not eat or drink; in any case, RR's evidence would be that his (RR's) conduct did not *cause* JP not to eat or drink (as JP often did this, regardless of which member of staff was assisting him); hence, the finding by DBS was mistaken.

8. The permission decision concluded that it was realistically arguable that RR's oral evidence, which was not available to DBS, could, if deemed credible, provide information sufficient to show that DBS made material mistakes in all or some of its findings of fact.

Documentary evidence in the Upper Tribunal bundle

9. In addition to DBS's decision letter, evidence in the bundle of 145 pages included:

    a. two one-page notes of meetings held on 10 January 2022 with two support workers at the home where RR worked, about concerns raised by them about RR's performance

    b. 2-page note of employer's meeting with RR on 10 January 2022

    c. 4-page document of RR's employer dated 12 January 2022, authorising RR's suspension

    d. 7-page note of a probation review meeting on 17 January 2022 attended by RR and two representatives of his employer

    e. RR's email to his employer dated 17 January 2022

    f. dismissal letter from RR's employer, dated 18 January 2022

    g. a DBS referral form from RR's employer dated 4 February 2022 which, amongst other things, described RR's work as 'support worker' and his employer as 'learning disability support provider'; and showed that RR worked there from 21 November 2021 to 17 January 2022 (when he was dismissed) – just under two months; it said that service user JP had complex learning disabilities, physical support needs and health support

    h. 1-page statement by RR, dated 7 July 2022, and an undated 3 page letter from RR to the "Madam Helen"

    i. 2-page letter from RR to DBS dated 5 October 2022

    j. DBS's "barring decision summary" document: amongst other things, this recorded "definite concerns" under the heading "irresponsible and reckless"; and "some concerns" under "callousness/lack of empathy" and under "poor problem solving/coping skills".

The Upper Tribunal hearing

10. RR attended the hearing, as did Mr Serr representing DBS. We are grateful to them both, for presenting their respective arguments clearly.

11. RR, representing himself, also gave evidence at the hearing, including via cross examination and answering questions from the panel.

12. The hearing was held on the CVP video platform, rather than "face to face", largely because RR had informed the Upper Tribunal that this was his preference (he had had experience of an Upper Tribunal hearing on the CVP video platform in the oral "permission" hearing, on 12 February 2024, that preceded the giving of permission for his appeal). RR explained his preference for a "remote" hearing by reference to his health difficulties, as follows:

a. he had had an aneurysm, and consequent brain surgery, in 2010

b. the side effects of this, he said, were that he was easily scared and confused (due to pressure on his brain)

c. he said that thinking of going to London (from his home in the west of England), made him feel like his brain was "going to explode"

d. he was nearly 64; his memory was deteriorating to his medical history.

13. RR also said that his mother had unfortunately recently passed away (in the Philippines, it would seem); he was booked to travel to the Philippines, to see the family, and was returning (only) 10 days or so before the hearing.

14. There were regular breaks during the hearing to cater for RR's difficulties and ensure that he participated in the proceedings as fully as possible.

Review of the evidence, our findings of fact, and conclusions on whether DBS made mistakes in its factual findings

Finding 1

15. It was not in dispute that RR had drunk the Lambrini, that "company policy" was that alcohol was not to be drunk by support workers at the home, and that the Lambrini did not belong to RR.

16. RR emphasised that Lambrini was a light, sparkling drink (as opposed to an alcoholic spirit), and that he had drunk a relatively small amount (at the hearing he said it was 10 ml, although his earlier documentary evidence said it was 10-20 ml, or 20-30 ml). RR also argued that he had the service users' implied permission to have the drink, as it was Christmas, and they did not object.

17. We find that Lambrini was an alcoholic drink and that RR did breach "company policy" by drinking alcohol at the home. We find that he drank a relatively small amount (a "shot" might be the best way to refer to the amount he drank). We find that he did not have the service users' express permission prior to his drinking the Lambrini although he was entitled to infer from their body language that they did not object to him doing so.

18. We do not consider that DBS erred materially in failing to make findings about the relatively small amount of Lambrini RR drank, or that RR reasonably inferred from the service users' body language that they did not object to his having a drink of their Lambrini. This is because the *material* finding by DBS was that RR drank some amount of alcohol in the home, and this was against "company policy".

Finding 2

19. It was not in dispute that RR did say that he planned to drink alcohol while on a sleep-in shift if he could not sleep; but RR's evidence was that he would only actually have drunk the alcohol if a manager had permitted it, via text.

20. We find that RR planned to use the alcohol as a sleeping aid, as he had difficulties getting to sleep and had forgotten to bring his sleep medication. We think it

unlikely that, had he been about to drink the alcohol to help him sleep, RR would first have texted his manager for permission. We do not therefore think that DBS erred in making the factual finding it did.

Finding 3

21. RR accepted that occasionally he did not wear PPE properly (for example, he would remove his face mask when on his way to use the toilet); but he said it was always done in a low-risk way, for example, when no one else was within 2m of him. On the other hand, the contemporaneous documentary evidence recorded him as "often" not wearing PPE correctly; being seen walking through the home with his mask down; and these occurrences happening three times on the same day.

22. It seems to us that, by finding that, at times, RR did not adhere to PPE guidelines, and had his mask under his nose on occasions, DBS well-reflected the evidence, and did not make any mistake.

Finding 4

23. RR accepted that he did not read service users' support plans properly; his evidence was that he relied on oral instructions from colleagues as to how to care for service users (like JP). RR accepted that he departed from service users' usual routines in minor ways – he overlooked to give JP his coffee on one occasion; RR said that the reason he did not ask colleagues to change JP's stoma before getting him dressed, was that there was no body waste in the collection bag at the time. RR's evidence was that his English was adequate and there was no language barrier; but he denied not paying attention when instructed by colleagues as to how to do his job as a support worker.

24. The key evidence on which DBS relied for Finding 4 was:

    a. one of RR's co-workers at the home was recorded (on 10 January 2022) as saying that:

        (i) RR did not pay attention when he was being spoken to; she had seen RR looking around and when asked shortly after what to do he had not known

        (ii) the colleague had told RR how to do something which, the next day, RR had not completed; when asked why, RR said he didn't know how

        (iii) the colleague felt that RR was not following JP's support plan; for example, RR tried to get JP to transfer from his bed to his wheelchair in the morning; JP refused; JP's routine was to have a coffee whilst sitting on his bed and his medication prior to moving to his wheelchair

        (iv) RR had not been summonsing support when JP was ready to have his stoma changed; instead RR was dressing him fully, meaning that JP needed to be partially undressed again when changing his stoma; this upset JP;

    b. another co-worker was recorded (also on 10 January 2022) as saying the following:

(i) RR did not listen when things were explained to him; for example, RR was told how to administer medication for a particular service user but during the explanation he was looking around and not paying attention; the next day, when asked if he knew how to administer medication (for a different service user), RR said he did not, and had not been told

(ii) the support worker in question was very concerned that there was a language barrier as RR was not seeming to understand what was being said

(iii) (RR responded that he was not authorised to administer medication);

c. the employer's note of a meeting with RR on 10 January 2022 recorded the employer's view that RR was not following JP's support plan and routine e.g.

(i) RR was trying to get JP to sit in his wheelchair before having had coffee and medication (the note said that JP liked to have his coffee and medication prior to leaving his bed);

(ii) RR was dressing JP but not asking a trained colleague to change his stoma; this meant they needed to undress JJP again to do this; this unsettled JP.

25. It seems to us there were communication difficulties between RR and his co-workers, on whom he relied for information for how to care for service users in accordance with their support plans and usual routines. On the evidence, we find that these communication difficulties were not because of any language barrier – we find that RR was adequately fluent in English (as he was at the hearing before us) – but rather on account of a certain independence of mind on RR's part that made it difficult to persuade him to do things other than "his way". We thus find, on the balance of probabilities, that the documentary evidence is accurate in recording that RR did not always pay attention to what he was told by co-workers as regards caring for the service users and, partly as a consequence, did not fully follow support users' support plans or usual routines. The example of RR not changing JP's stoma before dressing him is a case in point: this was a routine to which JP had grown accustomed; and yet RR did things "his way", because he saw no reason to change the stoma when there was no refuse in the collection bag.

26. It follows that, in our view, DBS did not make a mistake in this factual finding.

Finding 5

27. The evidence on which DBS relied for this finding was:

a. one co-worker recorded as saying (on 10 January 2022) that:

(i) JP had begun to not eat or drink when RR had supported him; this appeared to be more frequently of late although JP at times declined to eat; it wasn't normally for more than 24 hours and JP would often still drink; the colleague noted that JP did not appear happy around RR

(ii) RR seemed to "be in JP's face" all the time, not giving JP any space to just meander around the home as JP liked to do

(iii) when asking JP to do something RR repeatedly asked and this unsettled JP

b. another co-worker was recorded, on the same date, as saying that RR "followed JP around" and this was off-putting for JP; the support worker was concerned about a change in JP's behaviour especially in relation to eating; JP appeared not to want to eat drink or engage when supported by RR, and looked unhappy

c. the locality manager is recorded as saying at the probation review meeting on 17 January 2022 that JP's "not eating" happened "more frequently" when RR supported him; that perhaps RR came across as overpowering by trying too hard; that RR sat at the table looking at JP when JP was eating.

28. RR argued that it was not his care that caused JP not to eat; JP had "not eaten" on many occasions/periods prior to RR caring for him.

29. We find it unlikely, given the undisputed fact of JP going into periods or phases when he would "not eat", that that there was a causal link between RR's care and JP's not eating at around that time; the opinions of RR's co-workers on causality are unconvincing, given that they were not qualified to opine on such medical/psychological matters.

30. It follows that, in our view, Finding 5 was mistaken: it was not RR's behaviour, or style of care, that caused JP to "not eat or drink" more frequently.

31. However, this does not seem to us a material mistake, in that DBS's decision was based on "definite concerns" in one area, "irresponsible and reckless" – and the factual findings cited with reference to this concern, on pages 104-105 of the bundle, do not include Finding 5. Moreover, even where Finding 5 is cited in respect of one of two areas where DBS had "some concerns" – that of "callousness/lack of empathy" (pages 103-104) – it is one of three factual findings cited, implying it was not in itself determinative of that area of concern.

32. It follows that, in our view, DBS's mistake in making Finding 5 was not a material one.

Submissions on mistake on point of law

33. RR argued that barring should be for "abuse"; and DBS's factual findings did not come anywhere near showing RR had "abused" service users. This seemed to us, in legal terms (and bearing in mind that the Upper Tribunal has no jurisdiction to question whether a barred list decision by DBS is "appropriate"), to be an argument that DBS's decision was irrational, or disproportionate.

34. DBS submitted that the matters that caused RR to be included in the list must be viewed cumulatively; they demonstrated a pattern of conduct by RR of not adhering to rules and guidance for the safety of the service users. DBS argued that RR's conduct had the capacity to cause harm to a vulnerable adult if repeated and suggested that RR was temperamentally unsuited to work with vulnerable service users.

35. In our view, and based on DBS's factual findings (which we have found contain no material mistake), DBS's decision was not irrational, as there is a pattern of non-compliance with rules and procedures on RR's part. As far as proportionality of DBS's decision is concerned, this is at heart a balancing exercise, with, on the one side, the risk RR posed to the safeguarding of vulnerable adults, and, on the other side, the detriment to RR of his being barred (being that he would be unable to work in his chosen field of care). It is well established that in striking this balance, appropriate weight must be given to DBS's views on safeguarding risk, as this is its specialist field; as well as to public confidence in the safeguarding of vulnerable persons. In our view, and given that DBS's decision was a rational one, the balance is struck in favour of avoiding the safeguarding risk posed by RR. DBS's decision was not, therefore, disproportionate.

36. Finally, we acknowledge that RR felt that he was not afforded "due process". We have no jurisdiction as regards the process followed by his employer; but as regards the process followed by DBS, we can see no procedural irregularity that would amount to an error of law, and so see no mistake on a point of law in DBS's decision in this respect.

Conclusion

37. DBS's decision involved no mistake either in a factual finding on which it was based (i.e. a material finding), or on a point of law. DBS's decision is accordingly confirmed.

Zachary Citron
Judge of the Upper Tribunal

Rachael Smith
Roger Graham
Members of the Upper Tribunal

Approved for release on 7 October 2024