IN THE UPPER TRIBUNAL **Appeal No. UA-2023-000256-V**
ADMINISTRATIVE APPEALS CHAMBER **[2024] UKUT 389 (AAC)**

On appeal from Disclosure and Barring Service

Between:

SK

Appellant

- v –

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Meleri Tudur, Specialist Members Suzanna Jacoby and Dr Elizabeth Stuart-Cole

Hearing date: 27 September 2024
Decision date: 28 November 2024

Representation:
Appellant: Represented herself
Respondent: Mr T Wilkinson, counsel represented the Disclosure and Barring Service ("the DBS").

DECISION

The decision of the Upper Tribunal is to allow the appeal. The decision of the Disclosure and Barring Service made on the 22 January 2023 (wrongly stated as 2022) was based upon material errors in findings of fact. The decision of the DBS is therefore remitted for a new decision under section 4(6)(b) of the Safeguarding Vulnerable Groups Acct 2006 based upon the findings we have made for the purposes of section 4(7)(a). The Appellant is to remain on the list pending the fresh decision being made pursuant to section 4(7)(b) of the Act.

The Upper Tribunal makes anonymity orders directing that there is to be no publication of any matter or disclosure of any documents likely to lead members of the public directly or indirectly to identify the Appellant, witnesses, or any person who has been involved in the circumstances giving rise to the appeal. The anonymity order and directions are made pursuant to rule 14 of the Tribunal Procedure (Upper Tribunal) Rules 2008.

Introduction

1. On the 7 March 2023, the Tribunal received an application for permission to appeal from the Appellant, seeking permission to challenge the decision of the DBS dated 22 January 2023 (wrongly dated on the final decision letter as 22 January 2022) to place her name on the Adults' Barred List pursuant to paragraph 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 ("the Act").

2. The application was made on two grounds relating to two separate incidents relating to the same service user. The first incident occurred on the 26 July 2021. The second on the 15 November 2021.

3. Permission was granted to appeal on the second ground, against the decision that the Appellant had behaved inappropriately on the 15 November 2021 by failing to follow a Service User's risk assessment and risk management support plan by allowing the Service User to remain in his flat listening to a CD, when it was known that the Service User had a tendency to self-harm using any tools available to him. In the event, the Service User broke the CD and used it to self-harm.

4. The basis for the decision in relation to the second incident, as set out in the DBS decision letter was as follows: "We are satisfied a barring decision is appropriate. This is because it has been established that on two occasions you behaved inappropriately and not the way you would be expected to behave in your role when you have not followed [the service user's] support plan, risk assessment and protocols in relation to his self-harming. It has been determined that you think you know best as despite being aware of this you allowed him to be alone in his flat with a CD after he asked you to leave, he then broke the CD and used it to injure is arm. You justified this by saying he seemed calm and settled before and had been left alone since previous incidents, however this would not justify your behaviour."

5. At the hearing, the Tribunal heard oral evidence from both the Appellant and Ms B, a former colleague of the Appellant's, who worked with her at the time of the incident. Both were team leaders in the care home where the incidents happened. The only formal evidence before the DBS from Ms B were short notes of an investigation interview by her employer regarding the incident which took place on the 15 November 2022.

6. At the start of the hearing, Ms B agreed that the notes of interview could be used as her evidence in chief and Mr Wilkinson could cross examine her on the contents and her recollection of the incident. Ms B had been under the impression that she had been called as a character witness but agreed to answering questions about the incident to the best of her recollection at the hearing. She did not have a copy of the tribunal bundle or the notes of the investigation meeting held on the 17 November 2021 setting out her evidence as relied upon by the DBS. Time was allowed for Ms B to read the documentary evidence relating to the investigation before she gave evidence.

The statutory framework

7. The Safeguarding Vulnerable Groups Act 2006 ('the Act') section 2 requires the DBS to maintain the adults' barred list. By virtue of section 2, Schedule 3 applies for the purpose of determining whether an individual is included in the list.

8. Section 3 provides that a person is barred from regulated activity relating to vulnerable adults, if the person is included in the adults' barred list. Regulated Activity is determined in accordance with section 5 of and Schedule 4 to the 2006 Act.

9. Section 4 of the Act provides that:

> (1) An individual who is included in a barred list may appeal to the Upper Tribunal against—
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> (a) . . . . . .
>
> (b) a decision under paragraph 3, 5, 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.
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> (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—
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> (a) direct DBS to remove the person from the list, or
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> (b) remit the matter to DBS for a new decision.
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> (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
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> (b) the person must be removed from the list until DBS makes its new decision, unless the Upper Tribunal directs otherwise.

10. 'Relevant conduct' is defined under paragraph 10 of Schedule 3 to the Act which states:

> 10(1) For the purposes of paragraph 9 relevant conduct is—
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> (a) conduct which endangers a vulnerable adult or is likely to endanger a vulnerable adult;
>
> (b) conduct which, if repeated against or in relation to a vulnerable adult, would endanger that adult or would be likely to endanger him;
>
> (c) conduct involving sexual material relating to children (including possession of such material);
>
> (d) conduct involving sexually explicit images depicting violence against human beings (including possession of such images), if it appears to DBS that the conduct is inappropriate;
>
> (e) conduct of a sexual nature involving a vulnerable adult, if it appears to DBS that the conduct is inappropriate.

Upper Tribunal Powers on Appeal

11. Section 4(2) of the Act sets out the limited bases for an appeal to the Upper Tribunal against a barring decision:

"(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."

12. A person included in either barred list may appeal to the Upper Tribunal on the grounds that the DBS has made a mistake of law or a mistake of fact on which the decision was based. Any mistake of fact or law, must be material to the ultimate decision i.e. it may have changed the outcome of the decision.

13. The appropriateness of a person's inclusion on either barred list is not within the Upper Tribunal's jurisdiction on an appeal. The Upper Tribunal does, however, have jurisdiction to determine whether DBS's decision to bar is irrational or disproportionate, because that would be an error of law.

14. Recent caselaw in the higher courts has considered the mistake of fact jurisdiction of the Upper Tribunal. In PF v DBS [2020] UK UT 256 (AAC), a Presidential Panel of the UT (Administrative Appeals Chamber) chaired by Farbey J said:
"37. Section 4(2)(b) refers to a 'mistake' in the findings of fact made by the DBS and on which the decision was based. There is no avoiding that condition. The issue at the mistake phase is defined by reference to the existence or otherwise of a mistake. If the Upper Tribunal cannot identify a mistake, section 4(5) provides that it must confirm the DBS's decision. That decision stands unless and until the tribunal has decided that there has been a mistake."

15. We have reminded ourselves that it is not enough that the Upper Tribunal would have made different findings (para 38 of PF). We have reminded ourselves of what was said by the Court of Appeal in DBS v AB [2021] EWCA Civ 1575, with respect for the need to distinguish findings of fact from value judgments at para 55L "First, the Upper Tribunal may set out findings of fact. It will need to distinguish carefully a finding of fact from value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness. The Upper Tribunal may do the former but not the latter."

16. The scope of the mistake of fact jurisdiction was further considered by the Court of Appeal in the cases of Kihembo v DBS [2023] EWCA Civ 1547 and in DBS v RI [2024] EWCA Civ 95. In both cases, the Court of Appeal confirmed that PF v DBS is good law. In RI v DBS, at paragraph 34. Bean LJ rejected the DBS's argument that the Upper Tribunal was in effect bound to ignore an Appellant's oral evidence unless

it contains something entirely new. He said at [37] that: "where Parliament has created a tribunal with the power to hear oral evidence it entrusts the tribunal with the task of deciding, by reference to all the oral and written evidence in the case, whether a witness is telling the truth."

Evidence

17. Ms B had not submitted a formal witness statement in the appeal, but had sent an email to the Tribunal which stated that she had been requested to attend as a witness and continued: "In relation to this, I would like to state that I would ask the Respondent to reconsider their action of the 12 January 2022, placing [the Appellant] on the barred list as this has had a detrimental impact on their character and future life choices and that I agree to answer any questions asked."

18. The judge read out at the hearing the statement of Ms B to the employer (p49 – 51) and she confirmed in oral evidence that she was working at the residential care home with the Appellant, as a work colleague, for about two years.

19. Ms B gave evidence that her recollection was that the Appellant had not said specifically that the service user had a CD in his flat. Ms B was under the impression that the service user should not have a CD or a CD player in the flat because of his history of smashing, breaking or using objects to self-harm. That was a risk that existed at all times, as far as she was concerned. The risk was managed by conducting a rolling risk assessment on a minute-by-minute basis: he would use anything to self harm and had even cut bits of his flat wall to use them to harm himself. The difficulty was that if he asked the support worker to leave and was calm, then it could be regarded as restrictive practice to refuse to do so or to take objects from his possession. It was a fine line to tread.

20. Ms B confirmed that she had been surprised that the service user had been permitted to buy a CD player at all. He had a tough furniture cabinet in his flat and she would have expected the CD player to be in the cabinet so that he could listen to music safely. The arrangements for care of the service user presented a number of anomalies. For instance, he was not permitted china or cutlery in his flat, but if he asked for his food on a plate, then it would be regarded as restrictive practice to refuse his request. If he was calm and settled, his request would have to be granted. She regarded the situation as very difficult for the service user's support workers, whatever they did.

21. She stated that "You couldn't do right for doing wrong." and explained that when providing support, if the service user asked the support worker to go away, then the support worker was not allowed to stay and would have to stay outside the flat until he was calm and settled again.

22. The Risk Assessment (p102) stated that that an early indicator of his becoming heightened is that the service user asks support workers to leave, yet Ms B's evidence was that he could ask the support worker to leave if he was calm and settled. She confirmed that he could ask staff to leave and could decline staff support. If he asked staff to leave then it could be an indicator of his challenging behaviour but it was dependent on his mood. She explained that every incident had to be considered in isolation because he had a diagnosis of Pathological Demand Avoidance, staff would have to leave and wait next door leaving him unsupported but checking in on him at intervals. His interactions with staff had to be service user led and he would not allow staff to sit with him for very long. Managing the behaviour

was treading a very fine line. The practice was that if he asked staff to leave, they would leave and check in on him every ten or fifteen minutes. When he was very distressed, staff could not enter his flat. His baseline presentation is when he is happy and singing but he could escalate and switch very quickly and he would then withdraw and demand to be left alone. This was a major concern for Ms B and ultimately a reason why she left her employment there. The service user's impulsive nature meant that he could self harm with anything at any time. The fact that items could not be removed from him proved very frustrating and ultimately led to her moving on. The only time he could be asked to give back an item was if he had expressed an intention to cut or pick. Items could not be removed from him if he was calm and settled. He would tell staff if he was going to pick/cut or punch them. If he shouted at staff to leave his flat, he would say he wanted to punch them but then he could have days of calm when his presentation was very different.

23. When the service user was calm and not off his baseline, staff would go in to check on him every quarter of an hour, depending on the staff working. On the day of the incident, Ms B was supporting another service user who was trying to swallow a chain. The nature of the service users made it a very complex setting. At the time, there were five service users at the home. Ms B clarified that because the service user had a positive behaviour support model, he could be left with things, if he was calm and settled. However, he was a prolific self-harmer and in her view, the CD player should not have been bought for him unless it was to be stored in the tough furniture cabinet. The decision to allow him the CD player was that of a manager or clinical team member.

24. To withhold the CD from him would have been restrictive practice once he had been given the CD player. She gave evidence that it was a very difficult way of working because positive behaviour support can work well in the context of a secure unit but not in the community. The risk assessment did not mention the level of observation required for the service user and there were no observation charts because they were not used at the setting. The service user was deemed to have capacity and was not therefore subject to the Mental Health Act, although he had been previously sectioned in hospital. The role of the provider was to bring him back into the community. Nothing prevented the service user from coming and going as he pleased. The service user was very attached to the Appellant who took him out into the community.

25. The Team Leader's office on the premises was so small that it was not possible to carry out a handover there. On the day of the incident, there had been five members of staff on duty when there should have been ten. Ms B recalled calling the company and asking what happens if a particular service user absconds. She had been told that in those circumstances, she should call the police. She also recalled the comment from the Appellant about the service user having a Joseph party, but did not link this to an understanding that he had a CD. She believed he was listening to the radio and could hear him singing in his flat.

26. Ms B confirmed that she was the team leader on duty in the afternoon and there was a new manager on duty. She was dealing with medication and supporting another prolific self harmer. The other support workers who were on duty were Nurse Line staff who were not trained to deal with challenging behaviour. She gave evidence that she would not have given the service user the CD player because it simply created a greater risk for the team leader. Her interview notes confirmed that

her primary concern was the remote control which operated the stereo because she knew that on a previous occasion the service user had swallowed batteries and she was concerned that if he had a remote control he might do so again. She had to support two or three service users because they were the only ones on duty.

27. The evidence of the other person on duty, Mr T, was provided in an interview by the employer on the 17 November 2023. He confirmed that he had set up the CD player for the service user that morning and the service user said that he didn't have a CD because he wouldn't be safe with it. Mr T had inserted batteries into the remote control for the system and left the service user with it. In his investigation interview, he confirmed that he had been aware that the service user had a CD and was listening to it. He believed that the appellant had stated that the service user would be "alright with a CD". He believed that had been said to Ms B in the office rather than directly to him.

28. The Appellant's evidence was set out in the interview notes taken by her employer during the investigation on the 16 November 2021 (p32-35). In the course of the interview, the Appellant mentioned that it had been a long time since the previous incident of self harming, that the service user had asked her to leave the flat, appeared calm and settled and wanted to listen to his music alone. She decided to demonstrate trust in him by allowing him to listen alone and told him to call someone when he had finished. The Appellant stated that she had done a handover to Ms B as she was leaving her extended shift at 2.45 and told her that if she heard a Joseph disco it was the service user in his flat. She told the employer that Ms B was aware that he had a CD in his flat as was Mr T, the other carer on duty at the time. In the course of the interview, the Appellant stated that she had been struggling with family issues relating to a bereavement and ill health and that the home was very short staffed.

29. The report to the Adult Safeguarding Board recorded the care and support needs of the service user as 15 hours of 1:1 support, shared waking night staff and shared sleep in staff. The service user had a mild/moderate learning disability, ASD poor mental health, highly anxious, pathological demand avoidance disorder and a borderline personality disorder. He also had a diagnosis of Attention Deficit Hyperactivity Disorder. It was recorded that the service user was supported to purchase a new stereo which had arrived at the end of the previous week and had remained unopened until the 15 November. A member of staff had then unpacked and set up the stereo system for him. Following the incident, a protocol for use of the stereo had been prepared.

30. The notes of her disciplinary hearing held on the 29 November 2021 (pages 57 – 67). She confirmed that in his support plans, the service user was to be assessed on his mood and had "..appeared in a calm state with no anxiety. Happy CD player set up." In his risk assessment, the service user is to be allowed to spend his time as he chooses and to make decisions about day to day life – (p59). At the meeting, the Appellant drew attention to the fact that from the documentation, there did not appear to be any agreed ways of working with the service user. Nowhere did it state that he was not to be left with a CD. She acknowledged that previous incidents had taken place with CD cases, and that she had replaced the CD case in a locked cupboard. She maintained that the service user had been left in a good place and she had gauged his mood and in accordance with the risk assessment was using a flexible and adaptable approach to his support and left him listening happily to the Joseph

CD. She confirmed her view that the service user had asked to listen to the CD himself and that given his good mood, to require him to give up the CD would have been a trigger for him to escalate. She denied that she had told Mr T that the service user would be alright with the CD, but confirmed that she had mentioned the CD to the other members of staff. She confirmed her belief that she had said to the other two members of staff that the service user was listening to his Joseph CD.

31. On the day in question, the Appellant had been rostered to work the shift until 12.30 pm. Because the home was short staffed, she had stayed on to work until 3.15. She was not by then the team leader and considered that she was being person centred – the service user had not shown any signs of anxiety, he had just wanted to listen to his CD on his own. At that point, she had worked at CTS for six years. Following the disciplinary hearing, the Appellant was dismissed for gross misconduct because she had left a CD with a vulnerable adult in his flat which led to his self-injurious behaviour and as a result of her failure to follow the Positive Behaviour Support plan, the risk assessment and the health passport.

32. In oral evidence, the Appellant confirmed that the service user did not verbalise to her that he would self harm with the CD after she left. She recalled that she had locked the CD case away as required by the Property Damage list in the risk assessment documentation and realised that this was to prevent him from self-harming. The appeal meeting document was not available to the DBS when they made their decision.

33. The Appellant confirmed that she did not think 1:1 support for the particular service user was enough but having two supporting him would mean that if he sent one away, then he would still have another left to support him.

34. The appellant had a lift home at 3pm, so left at about 2.45. She had already handed over to another team leader and was no longer on shift or the team leader following the end of her own shift at 12.30. because they were so short staffed on that day, there was no formal handover. Only Ms B and Mr T were at the informal handover and the Appellant told them as she was leaving that the service user was having a Joseph party. She confirmed that she had not been involved in preparing the risk assessment document (p82) but agreed with the risk matrix set out. The Appellant was aware that the service user could use anything to self harm and that if every item he might use was listed, it would be a very long list. At the time that she left him, however, he was calm and in a happy place, so she applied the person centered approach. There were no indicators that he was anything other than calm and happy. Although his mood could change quickly, he was also very good at letting people know if he was going to self harm and asking people to remove an item from him. The Appellant had a very good relationship with the service user and could take him out into the community. She was aware that he could choose not to have staff support. She used distraction techniques if he indicated an intention to self harm and used that to remove items from him. He would self harm when he was on his own or in the presence of members of staff.

35. The employer's investigation included minutes of a meeting with Mr T, the other carer on duty on the 15 November 2021 held on the 22 November 2021. (p52 – 54).

36. The daily notes on the date of the incident (p119) recorded that the service user "Appeared settled at the start of the shift" and recorded that "Staff set up his new

stereo system and he listened to "Joseph and his Amazing Technicolour Dreamcoat CD – [SU] said that he would tell staff when he had finished listening."

37. The service user's risk assessment and risk management support plan were part of the evidence submitted by the employer to the DBS.(p77- 119) The areas of risk were identified as suicide/self harm – with the service user gouging his arms, inserting items into or picking at old wounds/scars; ingesting hazardous fluids and/or objects i.e. batteries. His risk of harm to others was by verbally threatening staff or physical harm by punching and kicking and property damage by throwing objects or smashing glass or CD cases or other objects to use for self harming behaviours.

38. The present self harming behaviours were identified as low level picking of wounds, high level of inserting or gouging at his arms, using foreign objects to insert or cause damage as well as making unwise decisions related to diet and medication and ingesting hazardous fluids. The assessment recorded that the behaviours may occur at any time and the service user will gouge/insert when alone, or when support staff are present. Under the heading "Damage to property" it was recorded that he will smash, break or use objects to self harm and this could include CD cases, light bulbs, plates, plastic forks etc.

39. Under the heading "What existing support is in place" it was identified that the service user's own flat is his own space and that he has an option to decline staff support dependent on well-being; opportunity and support to spend his time as he chooses and to make decisions about his day to day life and a Positive Behaviour Support Plan identifying primary prevention support plans and secondary prevention, known triggers, indicators and management support strategies. The non-physical restrictive practices include: "Items/objects are removed at [service user's] request and/or staff will advise [service user] they are removing items if he is verbalising he will self harm and has not asked for the items to be removed." The plan included a need for staff briefing meetings 3 times daily and monthly key worker meetings.

40. Under the heading "Secondary prevention, a list of strategies were provided which are "…those things that can be done when the person seems to have become more anxious or unsettled (ie. behavioural escalation) to help reduce the likelihood of challenging behaviour occurring. There will normally be clear signs (early indicators) when this is happening." The early indicators included the service user withdrawing from staff support and/or asking staff to leave. The intervention strategies included "Flexible and adaptable approach which responds to [service user's] mood on a day-to-day basis." "Listen to and respond to [service user's] requests". The list of "Non-physical restrictive strategies " included "there is no china in [service user's] flat – [service user] has the use of plastic crockery and cutlery at his request." And "Items/objects are removed at [service user's] request and/or staff will advise [service user] they are removing items if he is verbalising, he will self harm and has not asked for the items to be removed." and "Staff withdrawal support when requested."

41. Mr Wilkinson on behalf of the DBS submitted that the Tribunal should find that the Appellant had made a judgement call regarding the CD which ran contrary to the risk assessment and made a conscious decision to allow the service user to retain the CD. He submitted that the fact that the service user asks staff to leave does not mean that he should be left with an item in his possession with which he could self harm. Whilst his right to decide what he does with his day was protected, that does not extend to leaving him with items with which he could self harm. He disagreed with the two witnesses' evidence that to remove items would amount to restrictive

practice but did not provide any evidence to support that challenge. His submission was that staff are required to use whatever tactic they can to remove items from his possession.

Reasons for the decision

42. It was not in dispute that the service user had been left with a CD which he destroyed and used to self harm.

43. The issue was that the Appellant considered that she had applied the Risk Assessment and complied with the Positive Behaviour Plan, in a situation where the service user has a propensity to self harm much of the time.

44. We considered the Risk Assessment document, which we noted was very poor and woolly in its presentation, especially in respect of the action to be taken by members of staff in relation to the service user. It was not specific about the action that a support worker was to take and left the decisions to be made by the support worker with very limited guidance. The Positive Behaviour Management plan confirms that the service user was not to be subject to constant observation and could leave the premises if he so wished. The guidance specified that if he was calm then his wishes were to be respected and he was to be permitted to make decisions about how he spent his time day to day.

45. There were anomalies within the risk assessment document. For instance, whilst plastic cutlery was identified as a possible area of property damage and use of such broken cutlery for self harming, the service user was given plastic cutlery instead of standard cutlery because this was perceived as reducing the risk. Whilst under the risk assessment, a request by the service user to be left on his own was to be regarded as an early indicator of escalation of his behaviour, the document also stated that staff should not remain with the service user if they had been requested to leave and his requests were to be respected.

46. The position in which support workers are left by the lack of clarity in the risk assessment and positive behaviour plan, is that they must gauge the presentation of the service user and make dynamic assessments of what they can do there and then. It is a very difficult balance for the support workers to know what they can allow the service user to do. It is especially so when the setting is under staffed and the on duty staff are managing very challenging behaviour.

47. We concluded that the risk assessment was very poorly written and doesn't make sense when read objectively. The documentation provided contradicts itself and best practice would dictate that the support workers would have to use their common sense in any given situation. It is impossible, in those circumstances, to impose a blanket ban on the service user having any items left in his possession and the Appellant was required to make a judgement call on a minute by minute basis.

48. The situation was further complicated by the fact that the two other witness interviews were with a team leader and support worker, who were both potentially at risk of criticism in the decisions they had made in relation to the service user. It was not the Appellant who permitted the service user to have the CD player installed in his flat on the morning of the 15 November. When she was then asked by the service user, who was very well known to her, to listen to a CD and to do so on his own, she assessed him as being in a settled and happy place and we have concluded that contrary to the finding of the DBS, complied with the Positive

Behaviour Plan recommendation that his requests should be respected where he was settled and happy.

49. Based on her service history and her knowledge of the service user, that was a conclusion that she was entitled to reach on the basis of the situation as she saw it and which was in compliance with the guidance provided in the risk assessment and positive behaviour plan documentation. The failure to consider the wording of the risk assessment document was an error of fact on the part of the DBS.

50. The Appellant's description of the events has been consistent throughout and whilst she conceded at the hearing that she may not have specifically referred to the service user having a CD, the contemporaneous evidence at the time from Mr T, the support worker who had set up the stereo system for the service user, was that he knew that the service user had a CD.

51. The evidence from Ms B's interview on the 15 November was that she could recall the reference by the Appellant to the "Joseph party", could hear the service user singing in his flat and believed that Mr T had been made aware of the CD. In oral evidence, she stated that the CD had not been specifically referred to, but she was the Team Leader at the time the incident occurred and it was she who should have been checking in on the service user, once the Appellant had completed her shift. The reference to the CD in the daily notes, again suggests that there was awareness of it being left with the service user.

52. We have concluded that on a balance of probability, the Appellant had made sufficient reference to the CD to her work colleagues, to make them aware that the service user was listening to the CD. They did not observe him for approximately 45 minutes after the Appellant left the home. The home was seriously understaffed on that day and we realise that the pressures on the staff who were on duty must have been extraordinarily high: these were complex service users with very complex needs and we understand that the difficulties for the staff were significant.

53. We found the conclusion that the Appellant had failed to comply with the risk assessment and positive behaviour plan to be based on an error of fact. The DBS in reaching their conclusions did not identify the way in which the assessment documentation had been breached and focussed on the outcome of the incident rather than the question of how the wording of the risk assessment and positive behaviour plan had been breached. The assumption that the Appellant sought to justify her action by stating that the service user appeared calm and settled before he had been left alone is not borne out by the evidence of the daily notes which were contemporaneous and confirmed that he "appeared settled at the start of the shift" and was heard by both Mr T and Ms B to be singing along to the CD when the Appellant left the home are indicative of her assessment of the service user being accurate at the time that she left.

54. We conclude that the Appellant, having worked successfully over an extended period with the service user, was in a situation where she was required to dynamically risk assess the situation from one minute to the next. Her job was to undertake that assessment on the day and make a judgement call based on her observation of the service user, her understanding of his presentation and her experience of his behaviour. The judgement call she made may have been the wrong one, but errors of judgement can be made, but they are not indicative of a failure to adhere to the paperwork, risk assessment, plan or health passport. We note that the

protocol for safe use of the stereo was not produced until after the incident and consequently, the Appellant could not be criticised for a failure to comply with that.

55. The structured decision making by the DBS relied on the assertion that the Appellant has left the service user alone with items that he could use to harm himself but does not at any point address the contradictions within the risk assessment, between the risks identified of self-harming and the service user's verbalisation of those intentions and the secondary strategies recommended of respecting the service user's requests when he is calm. The evidence from the risk assessment documentation is that the service user had capacity to make decisions about his day to day life, but there is limited information about how the very sensitive issue of respecting his rights as an individual and imposing restrictive practices on him to prevent him from self-haring are to be addressed. There is a significant difference between a carer who believes that they 'know best' as concluded by the DBS and a carer who must make judgement calls in the best interests of the service user because the guidance from the risk assessment is so poor as to be undeliverable.

56. In her response to the Minded to Bar letter (p182), the Appellant made reference to her difficult family circumstances at the time of the incident and two bereavements in close succession. We noted the DBS assessment of the Appellant especially that she was callous and had no regard for the welfare of the service user. Noting that the Appellant was due to conclude her shift at 12.30 on a day when the setting was seriously understaffed and had carried on working until 2.45, we conclude that the finding that there were some concerns that she was callous and lacked empathy, is an error of fact which does not reflect the evidence presented that she continued working well beyond her allocated hours to assist service users at the setting and was empathetic to the service user in allowing him to have the Joseph CD.

57. Finally, we concluded that there were errors of fact in the decision and that there were other elements to be taken into consideration in reaching a conclusion in relation to placing the Appellant's name on the Barred List: she had been subject to significant bereavements and encountered two errors in work within a relatively short space of time, following several years of unblemished working. The issue of the serious understaffing of the setting was also a factor to be taken into consideration in making the decision and the potential self-interest of the two witnesses whose evidence was relied upon by the employer and the DBS in reaching their respective conclusions.

58. For these reasons, we have concluded that the decision of the DBS was subject to errors of fact and should be remitted for reconsideration.

59. Because the appeal related only to the second incident in November 2021, the first incident on the 26 July 2021 remains unchallenged. In those circumstances, we have decided that we do not direct the removal of the Appellant's name from the list but remit the decision back to the DBS for reconsideration.

Appeal allowed

Meleri Tudur
Judge of the Upper Tribunal
Authorised for issue on 28 November 2024