Neutral Citation Number: [2025] UKUT 008 (AAC) **Appeal No. UA-2023-001146-V**

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

OS

Appellant

- v -

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Wikeley, Mr Akinleye and Dr Stuart-Cole

Hearing date: 2 December 2024

Representation:
Appellant: Mr T Atanda of Tonda Chambers
Respondent: Mr A Serr of Counsel, instructed by DLA Piper UK LLP

On appeal from:
DBS ID number: P0005YYUFKB
Customer reference: 00986026873
Decision Date: 4 May 2023

RULE 14 Order

The Upper Tribunal has made an order prohibiting the disclosure or publication of the names of certain individuals or any matter likely to lead members of the public to identify those individuals or the care agency concerned; see pages 226-227 of the Upper Tribunal bundle for details of these orders.

SUMMARY OF DECISION

KEYWORD NAME (Keyword Number)

65.1 Safeguarding Vulnerable Groups – children's barred list
65.2 Safeguarding Vulnerable Groups – adults' barred list

Judicial summary

The Disclosure and Barring Service included the Appellant on both barred lists following an incident in which a service user fell from his bed to the floor while the Appellant and a co-worker were providing personal care. The DBS made the barring decisions not because of the fall itself but rather for the attempted cover-up through repeated failures to report and record the incident. The Upper Tribunal dismissed the Appellant's appeal, holding that there was no error of law or material mistake of fact in the DBS's decision.

Please note the Summary of Decision is included for the convenience of readers. It does not form part of the decision. The Decision and Reasons of the judge follow.

DECISION

The decision of the Upper Tribunal is to dismiss the appeal. The decision of the Disclosure and Barring Service dated 4 May 2023 did not involve an error of law or material mistake of fact.

REASONS FOR DECISION

Introduction

1. This is an appeal by OS, a care assistant, against the decision ('**DBS's decision**') of the Respondent ('**DBS**') dated 4 May 2023 to include him on both the adults' barred list and the children's barred list.

2. DBS's decision arose out of an incident in which OS was involved when a service user fell out of bed whilst OS, together with a co-worker (who we call Kim), was providing personal care. However, the barring decision was not made because of the accident itself, but rather because of the attempted cover-up that followed.

3. We dismiss the Appellant's appeal for the following reasons. All references to page numbers are to the printed pagination in the Upper Tribunal bundle rather than the electronic pdf page numbering.

The Upper Tribunal oral hearing

4. We held an oral hearing of the appeal on 2 December 2024. We heard oral evidence for nearly two hours from the Appellant, OS, who was represented by Mr T Atanda. The DBS was represented by Mr A Serr of Counsel.

The legal framework

5. The DBS decision to include OS on the adults' barred list was made under paragraph 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 ('**the 2006 Act**'). This provides that the 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.

6. Under paragraph 10, “relevant conduct” for the purposes of paragraph 9 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 or

   c. puts a vulnerable adult at risk of harm or

   d. attempts to harm a vulnerable adult.

7. The 2006 Act includes parallel provisions relating to children for the purposes of barring decisions in relation to the children’s barred list (see Schedule 3 paragraphs 3 and 4).

8. Section 4(2) of the 2006 Act confers a right of appeal to the Upper Tribunal against a decision by DBS under paragraph 9 of Schedule 3 (amongst other provisions) only on grounds that DBS has made a mistake on any point of law (section 4(2)(a)) or in any finding of fact on which the decision was based (section 4(2)(b)). However, the 2006 Act states 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)). In effect, therefore, issues of appropriateness are non-appealable.

The people involved in this case

9. As already noted, in this decision we refer to the Appellant as OS. We refer to the other people involved by the following names (which are not their true names) or (with respect to one individual) an abbreviation:

Clive:	The Deputy Manager
Edward:	The service user
Kim:	The co-worker
Linda:	The care agency line manager
NOK:	Edward’s wife, the next-of-kin

10. To ensure anonymity remains in place, where we have quoted from original source documents, we have replaced the various individuals’ real names with the

appropriate pseudonyms as detailed above. We show how that is done in the next part of this decision by the use of square brackets in the extract from the DBS's decision. After that, we just insert the relevant names where appropriate. For the same reasons of ensuring anonymity, we refer to OS and Kim's employer as simply 'the care agency'.

The DBS decision

11. In its decision letter, the DBS found the following allegations to be made out on the balance of probabilities (for convenience we have numbered the various allegations):

> On 5 June 2022 in your role as a senior carer … and having provided personal care with a colleague [Kim] to [Edward], an 80 year old adult service user suffering with cancer of the prostate, multiple bone metastasis of the spine and sacrum; and having an internal pacemaker and defibrillator due to heart disease, you

- (*allegation 1*) assisted in lifting [Edward] from the floor following a fall contrary to moving and handling guidelines;
- (*allegation 2*) did not seek medical attention for [Edward] following the fall in which [Edward] sustained bruises on his left arm and right foot;
- (*allegation 3*) did not report the fall in line with the company's incident reporting processes;
- (*allegation 4*) did not disclose that service user [Edward] had fallen when asked by [Edward]'s next of kin why the fall had not been reported;
- (*allegation 5*) did not disclose in a timely manner to the manager on call about the circumstances leading to [Edward]'s injury;
- (*allegation 6*) did not accurately record information in [Edward]'s file;
- (*allegation 7*) asked colleague [Kim] who was working with him at the time of the fall to deny the fall had occurred in order to protect your work visa.

12. Next, we summarise the grounds of appeal.

The grounds of appeal

13. The Appellant's grounds of appeal, as set out in the original application for permission to appeal and in Mr Atanda's skeleton argument, allege that the DBS's decision involves both errors of law and mistakes of fact. The grounds may be conveniently summarised as follows.

14. So far as error of law is alleged, Mr Atanda submitted that OS had been denied a fair hearing contrary to Article 6 of the ECHR. He argued that the DBS's approach was unfair in two respects in particular. The first was that the DBS had failed to call for or receive direct evidence from Kim, being solely reliant on her hearsay evidence. The second was that the DBS had changed the nature of allegation 1 without giving OS the opportunity of making representations on the point. Thus, the minded to bar letter alleged that OS had lifted Edward from the floor whereas the final decision found that OS had assisted in lifting Edward.

15. So far as mistake of fact is alleged, Mr Atanda's main argument was that OS was shadowing Kim and acting under her supervision, and as the senior member of the care team it was her responsibility, and not OS's, to take the various steps which he was being criticised for not taking.

Our findings of fact

16. First, we have some observations to make in relation to some associated employment tribunal (ET) proceedings (case 2602311/22). The Upper Tribunal hearing bundle included a copy of the grounds of complaint brought by OS in the ET against the care agency (pp.145-151) together with the employer's response to that claim (pp.152-159). The bundle disclosed no further information as to the outcome of those proceedings. However, it emerged at the hearing before us that the ET case had gone to trial. Mr Atanda told us that he had a copy of the ET judgment but not with him. Mr Serr not unreasonably raised the question as to whether we should have sight of the ET decision.

17. However, we took the view that an adjournment, even a short adjournment to source an electronic copy of the ET decision, was not necessary and announced as much in the course of our hearing. The ET proceedings were concerned with a range of different issues, several of which (e.g. various contractual matters) had no direct or indirect bearing on the matters before us. We had to decide on the lawfulness of the DBS decision on the basis of the evidence before us, applying different legal tests under different legislation. We simply note our concern that this matter arose at such a late stage in the proceedings. It is true that there was no Upper Tribunal direction to file a copy of the final ET judgment. However, parties are under a duty to co-operate generally with the Upper Tribunal (see rule 2(4)). We consider that this includes a duty of candour, to ensure that all relevant documents are disclosed in good time so that the Upper Tribunal has a complete picture.

18. We now turn to the incident in question and the subsequent developments. It is not in dispute that OS had only recently been recruited by the care agency from his home country. OS's letter of appointment is dated 1 February 2022 and provided for a start date of 28 February 2022 (p.96). In fact OS did not start working in the role of 'senior care assistant' until 16 April 2022 (p.80 and p.155 para 23). He had undertaken a range of training before taking up his appointment, but this had been done remotely, i.e. on-line.

19. The incident in question took place on 5 June 2022. For a while previously OS had been working solo on night shifts. At fairly short notice he was rostered to be part of a two-person team (with Kim) on the day shift assisting Edward with his personal care at home. Kim had been working with Edward for some time but this was OS's first occasion with him. On their first visit of the day Kim and OS were washing Edward while he was lying in bed. They were standing on either side of the bed (to start with at least). OS then moved away to pick up a sheet or bedcover while the bed-guard was down. At the same time Kim, who was wetting a flannel, asked Edward to turn over – Edward did so but fell to the floor on OS's side of the bed. The fact that this accident happened was not relied upon by the care agency as a reason for the subsequent dismissal of OS. It was accepted that accidents happen. Equally, the accident itself is not the reason or one of the reasons why the DBS has made its barring decision.

20. It is not in dispute that immediately after his fall OS and Kim then lifted Edward back into bed. It is also not in dispute that manual handling protocols stipulate that a person who has had such a fall should not be lifted – not least so as to avoid the risk of injury both to the service user and/or the carer(s) in attendance. This was made clear in the relevant training module undertaken by OS, as he himself recognised in his disciplinary hearing. We also accept as inherently credible Kim's detailed account of the immediate aftermath of the fall (p.104):

> OS said "lets help him up onto the bed" I completely forgot the training we underwent that tells us 'in such a situation they should not pick someone up but wait for emergency services'. I unwisely agreed and we proceeded to support Edward up off the floor and put him on the bed. He used his weight to leverage on the bed while we used our shoulders as support (again not allowed in moving and handling).

21. It follows there is no mistake of fact in allegation 1, that OS assisted in lifting Edward from the floor following a fall contrary to moving and handling guidelines.

22. Kim's account then continued as follows (p.104):

> When I looked closely I discovered that as a result of the accident Edward had sustained bruises on his left arm and right foot. OS then appealed to me not to tell anyone. I asked OS to let the manager know what had happened and tried to convince him that Linda is very supportive and easy to talk to. But OS said he was scared that he would lose his job as he has only just been in the country on a carers visa for 2 months. He was scared that he would lose his visa. After the incident I could see he was visibly shaken. I again asked him to call Linda which he asked me for a bit off time to collect himself before he can go there and talk about it. He was in tears and was begging me not to ruin his livelihood that he has a wife and child depending on him. … I felt sorry for him and gave time for him to talk to Linda.

23. In sworn testimony before us OS, on at least two occasions, denied having appealed to Kim not to tell anyone about Edward's fall. We were unable to accept that evidence. This account by Kim was in effect corroborated by OS himself in his disciplinary hearing, when he said "I did not record it because I was really scared that I would be sent back to my country because I'm on a sponsorship visa and that's my livelihood of feeding my family. So I didn't report it in the continuation sheets of the notebook I didn't report it, what happened, at all" (audio file 08:00-08.18). He also agreed that he had noticed the cut on Edward's elbow (but not the injury to his toe) (audio file 13:55). In addition, he accepted that his record in the notes that there were no concerns was not true (audio file 15:03). Those admissions provide support for allegations 2, 3 and 6.

24. At the hearing before us an objection was raised as to the record of OS's statement in the disciplinary investigation. OS denied having ever made the statements in the last four sentences of his version of events (at the foot of p.105), namely: "I begged Kim not to say anything and that if asked I would speak. We maintained this even on our second visit. When NOK asked why we did not report. In hindsight I know it was a very silly lie and we should have followed proper procedure." The suggestion was that this passage had been fabricated by the employer. OS showed Mr Serr a WhatsApp entry containing his statement which purportedly did not include this passage. We do not believe the passage in question has been fabricated. In part at least, the contents are demonstrably true, in that the pretence that nothing untoward had happened was maintained on the second visit (see below). We note that the text is described as being part of OS's 'version of events', rather than his 'statement' as such, and we consider it most likely that the disputed passage is simply the investigator's summary of an admission made orally by OS.

25. We also interpose here that it was alleged on behalf of OS in the ET proceedings that Kim "had told the claimant not to report the incident or log it, otherwise there would be trouble. The claimant was the junior colleague who had just been sponsored into the UK and regrettably went ahead with the plan devised by [Kim]" (p.148 para 26). However, that account is completely inconsistent with the version of events that OS gave in the disciplinary investigation. Although part of that statement as recorded was disputed (see above), this specific passage was not (p.105):

> The management at the care agency is very keen on safeguarding clients avoiding incidents. Because of this I panicked with the fear of losing my job as this is my only source of income to feed my family. I'm on a skilled work visa of which I do not want anything to happen to my visa I didn't record the incident in our continuation sheet and I didn't tell Edward's wife what had happened.

26. As we will see, we would add it was not simply a case of not telling NOK what had happened but rather actively seeking to deceive her as to what had happened, e.g. by denying that a fall had happened in their presence. That finding supports allegation 4. For all the reasons identified above, we entirely reject the false account as alleged in the ET proceedings that Kim was the instigator of the attempted cover-up.

27. The next developments were recorded by Linda, the line manager, as follows in her statement to the subsequent investigation (p.106):

> 10:46: OS called to report that on the morning visit they noticed a tear on Edward's skin but were not sure how it happened. I advised him to do an incident report on returning to office and also notify the team to be careful. He made it sound like his skin integrity was compromised by his condition which is not uncommon in our client type.
>
> 10:54 OS put a message on the team handover group saying 'Please note Edward's skin is very tender so we need to be gentle with him during wash time'.

28. The disclosure by OS at 10:46 was incomplete and positively misleading. OS knew how the tear had happened but was denying he had any such knowledge. This finding of fact supports allegations 2, 3 and 5.

29. At about 2 pm NOK telephoned the care agency to report that Edward had told her he had fallen out of bed during his morning wash. NOK was obviously concerned for her husband but was also concerned because the fall had not been

documented in the client folder. Moreover, "she asked the carers about the fall and OS denied that they witnessed a fall" (p.101). Kim's account of what happened at lunch-time was as follows (pp.104-105):

> At lunch time when we both went back for the afternoon call with Edward his NOK asked us why we hadn't reported the incident of her husband falling off the bed? OS immediately jumped in and said Edward had not fallen and denied the accident. As we were leaving the afternoon call I reminded OS that he needed to call and inform management of the incident especially after getting Linda's call. I explained to him that the lie was getting out of control. I finally called Linda to tell her what had happened and sent her a text that I wanted to open up about what had happened.

30. The failure to be frank with NOK was admitted by OS at his disciplinary hearing: "The second time I was still not composed… I was still scared of telling her what had happened. .. On my mind I was still thinking about my family, how will I feed them? How will I feed them?" (audio file 09:20-09:45).

31. The further developments in the early afternoon were reported by Linda as follows (p.106):

> 13:52 – Call from OS stating that Edward's wife was accusing them of dropping Edward but not documenting. OS maintained when queried that Edward had not had a fall in their presence. I asked if they had left bed rails up on leaving and he confirmed they had. At that point I said to him the story does not add up. Why would NOK say he fell if he didn't? and I asked him if I could speak to Kim. Call was put on loud speaker as she was driving and she said she would call me back.
>
> 13:58 – I called NOK to get more information about the incident. She explained she had been told by Edward that he had a fall and that on checking the notes the incident had not been recorded. I apologized and asked to attend their home to talk to her and Edward about the incident.

32. The exchange noted on the telephone call at 13:52 was likewise misleading on the part of OS, in that he was again denying to his manager that Edward had had a fall in their presence. This finding provides further support for allegations 3 and 5.

33. At 14:23 pm, according to the care agency's response in the ET proceedings, "as Linda was heading to the client's home to discuss the incident, Kim sent a message to Linda stating, 'please pick up my call I will tell you the truth,' which

was followed by several missed calls and finally a call to the Director, where she [i.e. Kim] explained that OS had asked her to lie about the incident that took place" (p.157, para 38). This corroborates Kim's own evidence as above.

34. At 15:00 pm Linda asked OS and Kim to attend a brief meeting later that day at the end of their shift, when they were each asked to prepare a statement detailing what had happened (p.157, paras 38 and 39).

35. OS (and indeed Kim) was suspended on the same day pending a disciplinary investigation (p.97). The disciplinary hearing for OS took place on 14 June 2022, conducted by Linda and Clive, a Deputy Manager – there is both a (non-verbatim) transcript of the hearing (pp.111-114) and an audio file recording, which we have had the opportunity to listen to. The report of the care agency's investigation into the NOK's complaint is at pp.101-110.

36. On 15 June 2022, i.e. the day after the disciplinary hearing, and according to the employer's ET response, an 'in-house reflective practise meeting' took place, attended by Linda, Kim and OS "at which Linda gave both OS and Kim an opportunity to be truthful and give accurate information. However, OS continued to give an inconsistent narrative according to what the client's next of kin had explained. This caused a lot of shouting and aggressive behaviour between OS and Kim" (p.157, para 42).

37. The complaint investigation report concluded as follows:

> When we employ our carers we trust that they will work in a manner that will safeguard and put our clients wellbeing first. It is clear that both individuals acted unprofessionally and put our client health and our company's reputation at risk. Their behaviour and actions as a result of this accident went against all company protocol and guidelines that they were taught during their induction and training with us. Accidents happen but the individuals in this case chose to lie and hide the fact from both the NOK and the company. Had they been upfront and honest from the beginning, the matter would have been dealt with differently and the client NOK would not have been put through the distress of this whole situation. OS one of the carers was found to still be lying on investigation and making stories up to implicate his colleague. He had made claims that his colleague knew he had moved as he was looking for bed sheets but was not able to give rationale why he would be looking for bed covers while still giving a client a wash. He then stated that actually they had finished with the wash and they in fact looking for bedcovers and even NOK was looking for it too. He then said when asked why Kim would need to ask Edward to turn if they had finished with the wash and were just left with coving him. He then said he did not know. He did not show proper

> remorse for his actions even though he claimed to understand where he had gone wrong. We only managed to get a true statement from him after we informed him client has a camera in the room and we will need to go and check what happened. We concluded that OS was more concerned about his families' livelihood than his duty of care.

38. Following the meeting on 15 June 2022 and the disciplinary investigation, OS was dismissed for gross misconduct. The letter of dismissal (p.99) gave the following reasons:

> You have been dismissed for the following reasons:
>
> - Failure to comply with company incident reporting processes.
> - Entering a false record in the client's file
> - Deceiving the Manager on call about the circumstances leading to client injury.
> - Making a member of your team to lie on your behalf so as to further deceive the company about the incident that happened on the 5/6/2022.
>
> Further investigation shows that after the client had a fall on the morning call on Sunday the 5th of June you and your colleague did not record in the notes what had happened. You met the NOK before leaving and still did not inform her that her husband had a fall. This put the clients health and safety at risk as you did not follow protocol to ring emergency services and NOK immediately before moving the client.
>
> You further coerced a member of the team to not report the incident citing that you were worried that you would lose your sponsorship as an international candidate.
>
> You further lied on returning to the client for lunch call and declined any knowledge of the incident in the presence of the client and NOK.
>
> The investigation has found that the fall was a result of an accident and due mainly to lack of proper communication between you and your colleague during the procedure. This on its own is considered an accident that could have happened to any other carer regardless of their experience. However, the main failing was of falsifying records, attempting to deceive the client and failing to contact your manager on call proper incident management and to safeguard the client's wellbeing.

39. The care agency referred OS to the DBS with the following summary of the circumstances (p.81):

> It was determined that the incident itself and the fall is an accident; that this on its own would not have been considered a safeguarding concern had the right protocol been followed in

> reporting it. The fact that OS continued to lie, and even faced the patient and confirmed that he had not had a fall regardless of the evidence of injuries makes his actions neglectful. He did not consider the detriment to the client's health and was more concerned about safeguarding his job that he was about his duty of care. The fact that even after being reassured by management that accidents happen and while attending another session of induction, OS maintained a lie that would have resulted in his colleague losing her job. He knew he had instigated the whole process and emotionally blackmailed her to not speak a word of the incident and yet at the meeting he had fabricated another fake story to make her the one in the wrong. This made it that we as an employer could not trust his integrity and ability to serve the best interest of the team and clients. This resulted in the ultimate dismissal from the service.

40. Finally, so far as the facts are concerned, our attention was drawn to the differing outcomes of the two disciplinary cases. In the course of the ET proceedings the care agency gave four reasons to justify its differential treatment of the two carers involved in the incident with Edward and its aftermath (p.158, para 49):

> 1. Kim was not on probation, OS was.
>
> 2. Kim whistle-blowed, OS did not.
>
> 3. Kim had an 18-month excellent record with the agency, OS does not.
>
> 4. Kim was remorseful and able to reflect on what she did wrong; OS was and is still not able to reflect on what he did wrong, which is the lying and dishonesty which led to putting a client and the agency at a detriment.

41. Although she was not dismissed, Kim was in fact subject to a raft of disciplinary sanctions – she was suspended for 2 weeks without pay, demoted in her staff grade and required to re-do certain induction and training courses, as well as shadowing a senior carer for 3 months and being subject to spot checks for 6 months (p.109).

Discussion of the 'error of law' grounds of appeal

42. Mr Atanda sought to persuade us that OS's ECHR Article 6 rights had been breached by the DBS's reliance on Kim's hearsay evidence. This submission is misconceived. It is a well-established principle that in general terms the DBS system is compliant with human rights legislation. Indeed, Wyn Williams J has held that "the absence of a right to an oral hearing before the [DBS] and the absence of a full merits based appeal to the Upper Tribunal does not infringe

Article 6 EHCR" (*R (on the application of) Royal College of Nursing and Others v Secretary of State for the Home Department* [2010] EWHC 2761 at [103]). More particularly, we were not persuaded that there was any unfairness to OS in the two respects alleged.

43. So far as Kim not giving direct evidence – either to the DBS or before ourselves – was concerned, the answer is that her evidence has to be assessed in the round. Just because it is hearsay evidence does not mean it has to be excluded. Rather, her evidence has to be assessed for what it is worth and in the context of other evidence to determine its reliability, bearing in mind that the Appellant has not had the opportunity of having it tested by cross-examination and by questions from the panel. Even allowing for that, we found Kim's evidence to be credible and reliable, not least as it was consistent in several respects with the evidence from Linda.

44. So far as the shift in the terminology of allegation 1 was concerned (from <u>lifting</u> to <u>assisting in lifting</u>), this argument is simply hopeless. The change in terminology simply reflected, no more and no less, the DBS's further consideration of the evidence, including OS's own representations. In any event it is not in dispute that OS and Kim lifted Edward up together – both Kim and OS said as much. The allegation did not expressly state or even suggest that OS had been the instigator of this manoeuvre. There is accordingly no conceivable unfairness in the DBS's decision to redraft the terms of allegation 1.

45. At the hearing Mr Atanda submitted in addition that there had been further unfairness in that Mr Serr had framed the Respondent's case in terms of the overriding importance of honesty, whereas allegations of dishonesty had played no part, Mr Atanda argued, in the original DBS allegations on which the barring decision had been made. This submission lacks any merit. For example, it completely overlooks Mr Serr's detailed response to the appeal on behalf of the DBS, dated 16 April 2024, which made it perfectly clear that "the issue however is that OS was <u>repeatedly</u> dishonest about the incident to both the NOK and the employer" (at para 46, original emphasis). OS accordingly has had ample time to prepare his case and has not been taken by surprise.

46. It follows that we conclude that the error of law grounds of appeal are not made out.

Discussion of the 'mistake of fact' grounds of appeal

47. Most of the allegations on which the barring decision was based, namely allegations 2 to 6, were of the 'did not' variety, i.e. omissions to act – did not seek medical attention, did not report the fall in accordance with procedure, did not disclose the fall to the NOK, did not disclose the circumstances to the manager and did not accurately record information on the service user's file. On the facts, OS effectively conceded that he had not taken the necessary steps in each case. But Mr Atanda's submission was that any such admissions by OS were irrelevant. Rather, he argued that in each instance the duty fell on Kim to take the required steps. This was, he said, because Kim was the supervisor, and OS was under her supervision, and so it fell to her to take the lead, while OS was merely shadowing her. In short, he was not responsible for these omissions because he was being supervised at the time.

48. We do not accept that submission. We accept that OS was still on probation with the care agency. However, Kim was not his senior, she just had more experience than OS had. However, they were both employed at the same grade (senior care assistant). Nor do we accept that OS was working under her supervision – he had been through all the necessary induction and training stages and was approved for solo working. Even if he was operating under Kim's supervision – which we do not accept – it remains the case that they each had a personal responsibility to act in a professional manner.

49. Mr Atanda also emphasised what might be described as several mitigating factors – OS had only recently arrived in the UK, his training had all been on-line, he was still on probationary employment, he had just finished a night shift and was tired, this was the first time on which he had cared for Edward and – so he said, and we are prepared to accept in the circumstances as credible – he had not seen Edward's care plan. OS had also worked for another agency for 9 months after the incident and before he was barred in the course of which there were no concerns expressed about his conduct. However, none of these factors points to any mistake of fact in the 'did not' allegations 2 to 6 inclusive. In addition, they are for the most part matters which were taken into account by the DBS in its Barring Decision Process document and/or final decision letter. Further, and in any event, they are all issues which go to the question of appropriateness, in respect of which the DBS has an exclusive and appeal-free jurisdiction.

50. We have already dealt with allegations 1 and 7 and repeat that they disclose no mistake of fact.

51. It follows that our conclusion is the mistake of fact grounds of appeal are not made out.

Conclusion

52. We therefore conclude that the decision of the Disclosure and Barring Service does not involve any error of law or material mistake of fact. We accordingly dismiss the appeal.

Nicholas Wikeley
Judge of the Upper Tribunal

Mr Christopher Akinleye
Specialist Member of the Upper Tribunal

Dr Elizabeth Stuart-Cole
Specialist Member of the Upper Tribunal

Authorised by the Judge for issue on 8 January 2025