Appeal No. UA-2024-001001-V
NCN No. [2025] UKUT 079 (AAC)

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

RM

Appellant

- v -

THE DISCLOSURE AND BARRING SERVICE

Respondent

THE UPPER TRIBUNAL ORDERS that, without the permission of this Tribunal:

No one shall publish or reveal the name or address of any of the following:

(a) RM, who is the Appellant in these proceedings,

(b) Any of the patients or staff mentioned in the documents or during the hearing,

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

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

Decided following an oral hearing on 24 February 2025

Before: Upper Tribunal Judge Church and Tribunal Members Stuart-Cole and Turner
Hearing date(s): 24 February 2025
Mode of hearing: Oral Hearing at Field House, London

Representation:

Appellant:	S Aziz, instructed by Patrick Apraku of Adam Bernard Solicitors
Respondent:	B Fullbrook, instructed by Isabelle Turnnidge of DAC Beachcroft

On appeal from:	*The Disclosure and Barring Service*
Case No:	01014965869
Decision Date:	23 April 2024

DECISION

The decision of the Upper Tribunal is to dismiss the appeal. The decision of the Disclosure and Barring Service was not based on any mistake in any finding of fact and involved no mistake on any point of law.

REASONS FOR DECISION

Introduction

1. This appeal is about whether the Disclosure and Barring Service (the **"DBS"**) based its decision made on 23 April 2024 to place the Appellant's name on the Adults' Barred List (the **"Barring Decision"**) on one or more mistakes of fact.

Factual background

2. It is agreed that in the summer of 2023 the Appellant was working as a care assistant at the nursing and dementia care home at which MW, a vulnerable adult with dementia, resided. The Appellant accepts that this amounts to "regulated activity" for the purposes of the Safeguarding Vulnerable Groups Act 2006 (the **"SVGA")**.

3. On 15 June 2023 the Appellant started her shift at about 8 pm. On that shift the Appellant and her colleague JN were assigned to attend to the personal care of resident MW, who required two care assistants. While the Appellant was in MW's room with JN, at around 9:30 pm, MW fell to the floor and was returned to her bed.

4. A "night duty report" meeting took place at about 11:45 pm between staff nurse OB and the three care assistants on duty (the Appellant, JN and PK). At this meeting JN told Nurse OB that MW had bumped her head on the cot bumper of her bed and that everyone was to monitor her, though she exhibited no bruising. Neither the Appellant nor JN said at this meeting that MW had experienced a fall. At the end of the shift, shortly before 8 am on 16 June 2023, Nurse OB told the Appellant that MW had a swollen bruised right knee and hip and asked the Appellant whether MW had had a fall, and the Appellant confirmed that she had had a fall.

5. On 16 June 2023 the Appellant's employer initiated an investigation into the events of the shift of 15 June 2023 (the **"Incident"**). On 16 June 2023 the Appellant was suspended pending the outcome of the investigation. JN, who was still serving his probationary period, was dismissed.

6. The investigation involved the investigating manager interviewing the Appellant and her colleagues JN and OB, as well as examining the resident safety check charts and the daily notes entry in relation to 16 June 2023.

7. The investigation resulted in findings made on 23 June 2023 that the Appellant had:

    a. failed to inform Nurse OB that MW had fallen to the floor,

    b. knowingly withheld information from Nurse OB in the "night duty report" meeting at 23:45 (which was detrimental to MW's welfare),

    c. picked MW up with JN, without using manual handling equipment,

    d. inaccurately recorded in her safety check charts that MW was checked from 8 pm until midnight, that she was safe and that there were no concerns, and

    e. inaccurately recorded in her daily notes on 16th June 2023 that there were no concerns (failing to record that MW had fallen onto the floor).

8. The investigating manager recommended that the allegations should proceed to a formal disciplinary hearing. A disciplinary hearing was held on 20 July 2023, at which the Appellant was accompanied by her union representative. The outcome of the disciplinary hearing was a finding that the Appellant had:

    a. failed to report the MW's fall in a prompt and timely manner contrary to the 'Falls Care Management Policy', resulting in a delay in MW receiving the treatment appropriate to a head injury in a prompt manner, amounting to neglect,

    b. failed to report MW's fall during the handover, made a false statement, and made no efforts to correct that false statement, and

    c. failed accurately and legibly to document the incident, making a false report.

9. The Appellant was dismissed for gross misconduct on the basis of those findings. A referral was made to the DBS, which commenced its own investigation. That investigation involved a paper review of the documentation supplied by the Appellant's employer. No witnesses were interviewed.

10. The DBS wrote to the Appellant to inform her that it was minded to place her name on the Adults' Barred List and to invite her to make written representations should she disagree with her proposed barring.

11. In response, the Appellant made written representations to the DBS (see the undated letter at pages [77]-[83] of the appeal bundle) (the **"Appellant Representations"**). In the Appellant Representations the Appellant gave an account of the Incident. She said that

MW had fallen while her back was turned as she was attending to MW's bedding. As such, she didn't see the fall, but she did hear it. She said JN immediately picked MW up singlehandedly, and she had immediately run to tell the nurse in charge (OB) that MW had fallen and JN had put her back into bed. She said that the nurse nodded in response to her report, which the Appellant took to mean that she had taken note of her report and would take the necessary immediate actions. The Appellant said she didn't "recheck" with the nurse because she had already reported the incident to her, and she heard nothing from the nurse until around midnight, when Nurse OB called the three care assistants on duty to discuss the service users for the night duty report as usual.

12. The Appellant said that during this meeting Nurse OB confirmed that she had checked on MW and found some bruises on her hand. Nurse OB asked JN specifically what had happened in MW's room, to which JN responded that MW's head had hit the bed rail, and this was the first time that the Appellant had become aware that MW had hit her head.

13. The Appellant said in her representations that at about 8 am on the morning of 16 June 2023 Nurse OB called her into MW's room and showed her MW's swollen leg and at this point the Appellant told her that the "bang" sound she heard was the main reason why she had rushed to report the falling incident to her the previous night, and reminded Nurse OB that she (i.e. Nurse OB) had herself reported having inspected MW. The Appellant said that on her way home she received a call on her mobile from Nurse OB, suggesting that "we" should say that MW had had her fall in the morning instead of the previous evening, but she refused to lie about the incident.

14. The Appellant denied acting in a manner that could have endangered MW or any other service user. She said that she reported both the fall and the inappropriate returning of MW to her bed immediately to the nurse in charge, and she expected the nurse and her colleague JN, who was responsible for room 41 (MW's room), to do their jobs. She said that her reporting of these matters meant that she hadn't falsified her account, and indeed she had resisted the nurse's attempt to get her to lie.

15. Notwithstanding the Appellant's representations, on 23 April 2023 in its Final Decision Letter the DBS informed the Appellant that it had decided to place her name on the Adults' Barred List.

The permission stage

16. The Appellant was unhappy with the Barring Decision and made an application to the Upper Tribunal for permission to appeal. She argued that the Barring Decision was wrong because she had denied the allegations against her.

17. On 11 September 2024 Judge Church granted permission to appeal, explaining that what the Appellant had said amounted, in legal terms, to an argument that the Barring Decision was based on material mistakes of fact, namely that it was mistaken in its findings that she:

    a. witnessed the fall of resident MW;

    b. failed to report MW's fall on a timely basis;

    c. improperly transferred MW back into bed; and

    d. misled the nurse in charge about the incident, causing the resident to suffer neglect.

18. Judge Church gave permission on the basis that he was satisfied that it was arguable with a realistic prospect of success that the DBS had based the Barring Decision on material mistakes of fact. He directed an oral hearing and ordered that the Appellant attend and make herself available to be cross-examined by counsel for DBS and to answer questions from the panel.

Legal framework

The statutory scheme

19. There are multiple gateways under Schedule 3 to the SVGA to a person's name being included on a barred list.

The 'relevant conduct' gateway

20. In this case the DBS relied upon the 'relevant conduct' gateway. That required the DBS to be 'satisfied' of three things:

    a. that the Appellant was at the relevant time, had in the past been, or might in future be 'engaged' in, 'regulated activity' in relation to vulnerable adults (see paragraph 9(3)(aa) of Schedule 3 to the SVGA);

    b. that the Appellant had 'engaged' in (see paragraph 9(3)(a) of Schedule 3 to the SVGA) 'relevant conduct' (defined in paragraph 4); and

    c. that it was 'appropriate' to include the Appellant on the Adults' Barred List (see paragraph 9(3)(b) of Schedule 3 to the SVGA).

21. If the DBS was satisfied of all three matters above, it was required to place RM's name on the Adults' Barred List.

22. The Appellant accepts that the 'regulated activity' requirement is met in this case by reason of her having worked as a care assistant, so there is no issue with regards to 20 a. above.

23. With regard to the issue at 20 b., the Appellant's case was that she had not engaged in the conduct alleged. In her grounds of appeal she did not argue that the alleged conduct would not amount to 'relevant conduct' for the purposes of paragraph 4 of Schedule 3 to the SVGA.

24. In terms of issue c. in paragraph 20 above, 'appropriateness' is not a matter for the Upper Tribunal unless the decision-making around appropriateness is irrational (see below).

The Upper Tribunal's jurisdiction under the SVGA

25. Section 4 of the SVGA sets out the circumstances in which an individual may appeal against the inclusion of their name in the barred lists or either of them. An appeal may be made only on grounds that the DBS has made a mistake on any point of law or in any finding of fact which it has made and on which the barring decision was made (see section 4(1) and (2) of the SVGA).

26. An appeal under section 4 SVGA may only be made with the permission of the Upper Tribunal (see section 4(4) SVGA).

27. Unless the Upper Tribunal finds that the DBS has made a mistake of law or fact, it must confirm the decision of the DBS (see section 4(5) of the SVGA). If the Upper Tribunal finds that the DBS has made such a mistake it must either direct the DBS to remove the person from the list or remit the matter to DBS for a new decision.

28. Following *DBS v AB* [2021] EWCA Civ 1575 (***"DBS v AB"***), the usual order will be remission back to DBS unless no decision other than removal is possible on the facts.

29. If the Upper Tribunal remits a matter to DBS under section 4(6)(b) the Upper Tribunal may set out any findings of fact which it has made (and on which the DBS must base its new decision) and the person must be removed from the list until the DBS makes its new decision, unless the Upper Tribunal directs otherwise.

30. Section 4(3) SVGA provides that, for the purposes of section 4(2) SVGA, whether or not it is 'appropriate' for an individual to be included in a barred list is "not a question of law or fact".

The relevant authorities

31. The relevant principles regarding factual mistakes have been set out in several recent decisions of the Court of Appeal (see *PF v DBS* [2020] UKUT 256 (AAC); *DBS v JHB*

[2023] EWCA Civ 982; *Kihembo v DBS* [2023] EWCA Civ 1547; and *DBS v RI* [2024] EWCA Civ 95). These decisions are binding on the Upper Tribunal.

32. As to whether it is 'appropriate' to include a person in a barred list, the Upper Tribunal has only limited powers to intervene. This is clear from the section 4(3) SVGA and relevant case law. The scope for challenge by way of an appeal is effectively limited to a challenge on proportionality or rationality grounds. The DBS is well-equipped to make safeguarding decisions of this kind (*DBS v AB* (paras 43-44, 55, 66-75)).

33. At paragraph [55] of *DBS v AB*, the Court cautioned:

> "[The Upper Tribunal] 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…".

and at paragraph [43], the Court stated:

> "…unless the decision of the DBS is legally or factually flawed, the assessment of the risk presented by the person concerned, and the appropriateness of including him in a list barring him from regulated activity…, is a matter for the DBS".

34. In the subsequent Upper Tribunal case, *AB v DBS* [2022] UKUT 134 (AAC), the Upper Tribunal decided (albeit in the context of a case that was based on the 'risk of harm' rather than the 'relevant conduct' gateway) that *DBS v AB* meant that the Upper Tribunal could consider, on appeal under the SVGA, a finding of fact by DBS that an individual poses "a risk" of harm but not a DBS assessment of the "level of the risk posed" (see [49]-[52] and [64]).

35. When considering appeals of this nature, the Upper Tribunal:

> "must focus on the substance, not the form, and the appeal is against the decision as a whole and not the decision letter, let alone one paragraph…taken in isolation": *XY v ISA* [2011] UKUT 289 (AAC), [2012] AACR 13 (at [40]).

36. When considering the Barring Decision, the Upper Tribunal may need to consider both the Final Decision Letter and the document headed 'Barring Decision Summary' that is generated by DBS in the course of its decision-making process. The two together, in effect, set out the overall substantive decision and reasons (see *AB v DBS* [2016] UKUT 386 (AAC) at [35] and *Khakh v ISA* [2013] EWCA Civ 1341 at [6], [20] and [22]).

37. The statement of law in *R (Iran) v Secretary of State for the Home Department* [2005] EWCA Civ 982 indicates that materiality and procedural fairness are essential features of an error of law and there is nothing in the SVGA which provides a basis for departing from that general principle (*CD v DBS* [2020] UKUT 219 (AAC)).

38. DBS is not a court of law. Reasons need only be sufficient/adequate. DBS does not need to engage with every potential issue raised. There are limits, too, as to how far DBS needs to go in terms of any duty to "investigate" matters or to gather further information for itself, but it must carry out its role in a way that is procedurally fair.

The Appellant's evidence at the hearing before the Upper Tribunal

39. The Appellant attended to give evidence, and Mrs Ali, a Twi interpreter, assisted. The Appellant adopted what she had said in her witness statement dated 19 February 2025 as her evidence in chief and was cross-examined by Mr Fullbrook, for the DBS.

40. In her evidence the Appellant said she had worked at the care home for 1 year and 10 months by the time of the Incident, and prior to that had worked for another employer in a care home for 2 years, and not been subject to any disciplinary proceedings or complaints during that time.

41. She confirmed she had received training in relation to her role as a care assistant. She said she performed her role "exactly how I was trained". She said her training included training on what to do if a patient has a fall, and the proper action was to "push the emergency alarm and remain with the patient".

42. The Appellant gave her account of the events of 15/16 June 2023. She explained that she was paired with JN to provide personal care to MW. JN was junior to her, was not a responsible employee. He "didn't listen". He was still on probation at the time of the Incident and was sacked immediately afterwards.

43. The Appellant went into MW's room with JN to discover that MW's bed was soiled. She and JN got her out of bed and sat her on a chair, which was right next to the bed. The bed was against two walls in the corner of the room. JN stood next to MW's chair. Because MW's bed was soiled, the Appellant started to change the sheets, which required her to reach over the bed to the far side against the wall. She therefore had her back to MW and JN. When she was changing the bed, she heard a loud noise and turned around straight away, albeit that because she was leaning over to the far side of the bed it took her more time to turn around. By the time she had turned around, JN had already picked MW up from the floor. She said "put her down", and he put her down.

44. When asked by Mr Fullbrook whether, as the more senior worker, she should have intervened to stop JN lifting MW inappropriately, she said she didn't see MW on the ground and she didn't see JN pick her up.

45. At this point, the Appellant said, she raised the bed rail and informed Nurse OB what had happened. She didn't press the emergency alarm, despite having been trained to do so, because she "panicked". The Appellant left MW alone when she went to speak to Nurse

OB, despite her training being to stay with the patient, because Nurse OB was just outside MW's room.

46. The Appellant said she didn't know what Nurse OB did after she informed her of MW's fall. At about 11:45 pm Nurse OB called the care workers in to discuss the personal care they had given to the patients, and she asked what had happened to MW. According to the Appellant, JN said MW bumped her head on the bed rail, but didn't mention her falling from her chair to the ground, and the Appellant accepts that she herself said nothing.

47. The Appellant said the reason she said nothing was that she had already told Nurse OB that MW had fallen earlier in the shift, immediately after it happened. Mr Fullbrook put to the Appellant that it made no sense for Nurse OB to be asking what had happened to MW if the Appellant had already told her what had happened. When asked by Mr Fullbrook why she didn't correct JN's untruthful account of what had happened to MW, the Appellant said that Nurse OB didn't address any questions to her, and had only asked JN.

48. The Appellant said that when, the next morning, Nurse OB showed her bruises on MW's legs and said that it looked like she had fallen, she had responded "yes, I told you".

49. The Appellant said that Nurse OB was lying when she said that the Appellant didn't tell her about the fall, and JN was also lying in his account when he said that it was Nurse OB who heard a noise when passing MW's room and asked the Appellant what had happened. Her explanation for Nurse OB and JN lying and creating a false narrative together was that they were from the same country.

50. Mr Fullbrook asked the Appellant why she had only mentioned the call she says she received from Nurse OB on the morning of 16 June 2023 asking her to lie and to say that MW had fallen on the morning of 16 June 2023, rather than the night before, for the first time in April 2024 in her written representations to DBS. The Appellant said she had told the manager who conducted the employer's investigation about this, but she didn't want to hear anything about it. She said that she had raised it, but it hadn't been written down.

51. When asked why she hadn't written anything in MW's patient records for 15/16 June 2023, she said that it wasn't her role to do that, because MW was JN's patient. She said she didn't know whether he wrote anything or not.

52. When the handwritten incident report form completed by Nurse OB at page [51] of the appeal bundle was shown to the Appellant, which was timed at 7:55am on 16 June 2023, and it was suggested that this report was inconsistent with her account that Nurse OB had telephoned her at about 8:30am to ask her to give a different account, the Appellant said that Nurse OB was lying and this report was a fabrication. She had the same explanation for the entry in MW's patient records at page [65] of the appeal bundle.

53. Under questioning from Dr Stuart-Cole the Appellant explained that each floor of the care home had 32 beds, and each room was small, with a hospital bed against wall on two sides, and a chair with arms right next to bed. She said that they had put MW in the chair and JN was supposed to stand there, as MW could get up. The Appellant said she didn't know how MW fell out of the chair because she didn't see her, being bent over the bed dealing with the sheets.

54. When asked about handover between shifts, the Appellant said it was the nurses who did handover, not carers, but she had mentioned to a colleague on the ground floor that "the lady had fallen".

55. When asked why she had "panicked", the Appellant said it was "because of the noise I heard, and I saw JN picking her up, and I knew we shouldn't do that. I was panicking." The sound was, she said, like "a bouncing ball".

56. The Appellant said it was for JN to check his patients (and MW was his patient, and not the Appellant's), but she checked on MW when JN went on break. She said she saw the bruise on MW's forehead, but didn't see bruise on leg. She said she didn't report or record the bruise she saw on MW's head because she had already told Nurse OB about the fall, and because it was not for her to write in JN's patient's records.

The parties' positions in summary

57. Mrs Aziz invited the Upper Tribunal to give considerable weight to the Appellant's oral evidence at the hearing, at which her evidence was tested under cross-examination and, she said, stood up. By contrast, the evidence of witnesses OB and JN, upon which the DBS relied in reaching its findings of fact has not been tested, and should be given less weight.

58. The Appellant's case is that each of the findings summarised in paragraph 17 above was mistaken and, because the DBS based the Barring Decision on those mistaken findings, the Barring Decision was wrong, the appeal should be allowed, and the interests of justice require the Upper Tribunal to direct that the Appellant's name be removed from the Adults' Barred List. The Appellant's case was that it was her colleague JN who had caused harm, while she had done no wrong and had done her best to assist MW.

59. Mrs Aziz also argued that irregularities in the way that the Appellant's employer had dealt with matters, failing to give the Appellant verbal or written warnings before referring her to the DBS, resulted to procedural unfairness. She argued that the Barring Decision was also disproportionate.

60. The DBS resists the appeal, arguing that it was entitled to make the findings that it did on the balance of probabilities based on the evidence before it. The DBS says it was entitled

to give weight to the evidence of the Appellant's colleague JN, who had admitted wrongdoing himself and so had no apparent motive to give a false account of the events of 15 June 2023, and was entitled to give less weight to the Appellant's evidence, given that she had given inconsistent accounts in her initial interview with the investigating manager, in her subsequent written representations to the DBS, and before the Upper Tribunal.

61. Mr Fullbrook, for the DBS, argued that nothing the Appellant said in her evidence at the hearing before the Upper Tribunal indicates that any of its findings was mistaken. In the alternative, he argued that even if the Upper Tribunal is persuaded that the DBS was mistaken to find that the Appellant had herself transferred MW back to her bed following her fall, such a mistake would not have been material to the Barring Decision because the Appellant's failure to report MW's fall promptly and having misled the nurse in charge about the events of that night would by themselves have caused the DBS to place her name on the Adults' Barred List.

Analysis Mistake of fact?

62. The DBS made the Barring Decision based only on paper evidence. It evaluated the written statements made in the context of the employer's investigation, as well as the accident report completed by Nurse OB and MW's daily patient records. It preferred the evidence of Nurse OB, JN and the written records to the evidence of the Appellant, and it explained with adequate clarity why it assessed the evidence as it did. It made clear findings of fact based on the evidence, and the most important of these (and the ones on which it based the Barring Decision) were those set out in paragraph 17 above. The DBS was entitled to make the findings that it given the evidence before it.

63. However, the Upper Tribunal may consider not only the evidence that was before the DBS when it made the decision under challenge, but may also consider new evidence (see *DBS v RI* [2024] EWCA Civ 95). As well as the evidence that the DBS considered, we had fresh evidence in the form of the witness statement of the Appellant's colleague PK, and we had the Appellant's oral evidence, tested by questioning at the hearing. We considered whether any of the new evidence (considered with the rest of the evidence) indicated that the DBS made any material mistake of fact.

64. We acknowledge that the Appellant was the only witness whose evidence has been tested. Because the statements of Nurse OB, JN and PK are hearsay evidence, so there has been no opportunity to test their veracity, we treated them with caution.

65. Alongside the Appellant's witness statement, the Appellant sought to adduce a witness statement from her colleague PK. The Upper Tribunal was invited to consider compelling the witness to attend the hearing so that his evidence could be tested.

66. As the judge explained at the hearing, he was not satisfied that it would be proportionate to compel a witness whose statement made clear that he had no direct knowledge of the key matters in issue in this appeal: he says that he worked the night shift of 15/16 June 2023 but worked alone and doesn't know what happened to someone we infer to be MW (albeit that the name has been redacted), because he didn't work with her. The only evidence of relevance in his statement is his account of the 11:45 pm meeting with Nurse OB and the other carers (the Appellant and JN). His evidence is broadly consistent with the accounts of each of the Appellant, JN and Nurse OB in that he says that Nurse OB asked JN and the Appellant what had happened to MW. PK says that JN responded that MW "knocked her head against the bedrail" and this was the first time he had learned of this. The statement was admitted into evidence in the absence of any objection from Mr Fullbrook, who himself relied substantially on hearsay evidence.

67. If anything, PK's statement tends to undermine the Appellant's case because PK indicates that the question about what happened to MW was directed not only to JN (as the Appellant says), but rather to both JN and the Appellant. In any event it doesn't shed any light on the issue whether the Appellant had informed Nurse OB about the incident when it had happened earlier in the shift. As such it is of limited utility.

68. PK's evidence wasn't the only new evidence we had: we also had the Appellant's oral evidence. The Appellant was consistent in some elements of her evidence, most notably in saying that she had not seen MW fall, and that she had alerted Nurse OB of something having happened to MW (whether that was her falling to the floor, or being on the floor, or having been put back on her bed). She was also adamant that she had done nothing wrong, and that her duties in respect of MW were very limited. However, just because evidence is consistent doesn't mean that it is truthful or reliable. Its truthfulness and reliability must be assessed by looking at the evidence in the context of all the other evidence. While much of the evidence was hearsay, many of the difficulties for the Appellant's case on the facts arise from her own account of what happened, as we explain below.

69. We took into account that English is not the Appellant's first language (and appears not to have been the first language of the other witnesses who gave statements either), and we kept in mind the possibility that there could have been misunderstandings between the staff working on the Appellant's floor on 15/16 June 2023 as a result.

70. We also gathered during the course of the hearing that the Appellant struggles significantly with reading, and she confirmed in response to questioning from the judge that she had difficulty with both reading and writing. We took care not to draw adverse inferences from the absence of any written entries by the Appellant in the patient records or from the fact that the Appellant didn't check what JN had (or hadn't) written in MW's

patient records. These omissions might well be explained by her difficulties with reading and writing.

71. Overall, we did not find the Appellant to be a compelling witness. Even on her own account at the hearing, the Appellant was present in MW's room when, having moved MW to a chair with JN, she heard a loud noise "like a bouncing ball" which made her turn around to see JN holding MW and putting her into bed.

72. The only reasonable inference from what the Appellant heard and saw (in its context) was that MW had fallen. This is consistent with the Appellant's oral evidence that what she had heard and seen caused her to "panic". We infer from her reaction of "panic" that the Appellant herself concluded from what she had heard and seen that MW had had a fall, and we also infer that she was alive to the possibility that MW may have sustained a serious injury as a result of that fall.

73. The Appellant was clear in her evidence that she had been trained that in the event of a fall she must push the emergency alarm and remain with the patient until assistance arrived. She did neither.

74. We do not accept her explanation that she didn't press the emergency alarm because she "panicked". It is not credible that she would fail to press the emergency alarm because she was panicked by the possibility that MW might have sustained a serious injury. To the extent that that knowledge caused her to panic, the much more likely response would be the most obvious one of pressing the emergency alarm and staying with the patient until assistance arrived, just as she had been trained to do. The more likely inference from the Appellant's failure to push the emergency alarm button is that her "panic" was about being blamed for the incident. We find that rather than informing Nurse OB about the accident, the Appellant sought to conceal it.

75. The Appellant claims that, instead of pressing the alarm, she went to speak to Nurse OB because she was only a few metres away outside MW's room. The Appellant has given differing accounts of the precise words she said to Nurse OB, but the upshot of them is that she told the nurse either that MW had fallen, or that MW was "on the floor". We assessed this evidence in the light of all the other evidence, but we were not persuaded that the Appellant had informed Nurse OB either that MW had fallen or that she had been on the floor. That is because this account is inconsistent with the Appellant's own account of the interactions that she had with Nurse OB later that evening at 11:45 pm, when Nurse OB called the care assistants for the usual meeting to discuss the personal care that they had given their allocated patients. The Appellant said that Nurse OB asked JN what had happened to MW. She had no credible explanation as to why Nurse OB would ask that question if she had already made Nurse OB aware that MW had had a fall.

76. The Appellant was clear in her evidence that she hadn't corrected JN's account (which made no reference to MW experiencing a fall). When asked why she hadn't said anything about the fall, the Appellant's explanation was that she had already done so at the time that the incident had occurred. We didn't find this explanation to be believable. Even had the Appellant informed Nurse OB of MW having experienced a fall, the nurse asking what had happened and receiving an inaccurate response that omitted mention of the fall would surely have raised the possibility that Nurse OB had misheard or misunderstood her earlier report of he fall. Given that the noise the Appellant had heard and the sight of JN mishandling MW had been so concerning to her that it had caused her to "panic", the Appellant would surely have sought to correct JN's account to make sure that MW's potential injuries were properly assessed and so she could get any treatment she might need.

77. Similarly, the Appellant said that Nurse OB called her into MW's room on the morning of 16 June to show her MW's swollen legs and asked whether MW had had a fall. That sits uncomfortably with the Appellant's claim that she had already informed Nurse OB that MW had had a fall (and that Nurse OB had acknowledged that information and had reported that she had checked MW). Nurse OB's response (making an entry in MW's patient record, completing an incident report form, and calling an ambulance) is exactly what one would expect of a nurse in charge who has just become aware of a serious accident.

78. There was a striking inconsistency between what the Appellant claimed to have said to Nurse OB, and what Nurse OB said and did. The Appellant's explanation for this was that:

    a. Nurse OB and JN had conspired together against her to get her into trouble,

    b. Nurse OB and JN had lied in their respective accounts of the events of 15/16 June 2023,

    c. Nurse OB had fabricated her incident report and her entry in MW's patient record.

    She maintained that this was because Nurse OB didn't like her, and because Nurse OB and JN were both from the same country.

79. We did not find this explanation to be credible. Like the DBS, we thought it unlikely that JN would have been motivated to give an inaccurate account of the events of the shift, given that he had admitted responsibility and said that he covered up the accident because he was scared. Placing blame on the Appellant wouldn't have lessened JN's own culpability, and we don't find it credible that JN would be motivated to cause serious trouble for the Appellant just because he was from the same country as Nurse OB.

80. We were similarly unpersuaded by the Appellant's account of having been called on her mobile by Nurse OB on the morning of 16 June 2023 after having left work. She alleges

that Nurse OB asked her to say that MW's fall had occurred on the morning of 16 June 2023 rather than when it in fact occurred on the night of 15 June 2023. The first time that this account appears in the papers is in the Appellant's written representations to the DBS. There is no mention of it in her interview in the context of her employer's disciplinary investigation. The Appellant told us that she had mentioned it in the context of the disciplinary process but that no-one had wanted to hear about it. We found that this account was inconsistent with the incident report recorded as having been made at 7:55 am by Nurse OB, which we accepted to be a genuine and accurate report. We decided that the Appellant's account of being telephoned by Nurse OB and asked to lie was fabricated by the Appellant.

81. We did not find the evidence to support the DBS's finding that the Appellant had herself put MW back into bed after her fall to be strong, but neither did we find that that finding was material to the DBS's decision making. That is because the real mischief in this case in terms of "relevant conduct" was not the fall itself, or the inappropriate handling of MW to return her to her bed, but rather the failure to report the incident accurately by either JN or the Appellant. In the circumstances each of them was clearly under a duty to do so, whoever was named as principally responsible for the patient. This had the result that MW, a vulnerable adult, was not properly assessed on a timely basis and no appropriate treatment plan was arrived at. The Appellant's dishonest attempts to conceal what had happened exacerbated the situation as they prolonged the period for which MW was left without appropriate assessment or treatment. This conduct caused MW harm, or at the very least put her at risk of harm. Even if the DBS's finding about putting MW into bed was mistaken it would still have placed the Appellant's name on the Adults' Barred List, and it would clearly have been entitled to do so.

82. Given our assessment of the evidence, we were not persuaded that the DBS had based the Barring Decision on any material mistake of fact.

Mistake of law?

83. Although the grounds for which permission was sought and granted related only to arguments about mistake of fact, Mrs Aziz sought to argue that the Barring Decision was marred by mistakes of law. We deal with those arguments briefly for the sake of completeness.

84. The first argument was that the Appellant's employer had acted unfairly by failing to give the Appellant verbal or written warnings before referring her to the DBS. This argument is misconceived, because it doesn't allege any unfairness in the decision making of the DBS, and in any event the Appellant's employer was under an obligation to make a prompt referral to the DBS so that the DBS could assess the evidence for itself. The DBS gave the Appellant an opportunity to make representations, which the Appellant duly did

(see pages [77]-[83] of the appeal bundle). It is clear from the DBS's 'Barring Decision Summary' document (see pages [90]-[110]) that the DBS considered what the Appellant said in her representations and it explained how it factored that into its decision making.

85. It was argued further that the DBS failed to consider the Appellant's previously unblemished career working with vulnerable adults, or made a decision that was disproportionate, given the profound impact that a decision to place her name on the Adults' Barred List would have on the Appellant in terms of preventing her from pursuing her vocation as a carer and depriving her of her livelihood. However, the Appellant did not make any assertions about having a "previously unblemished career" when she sent her written representations to the DBS, let alone provide any evidence of it. As such the DBS can't be criticised for failing to take her record into account. In any event, given the seriousness of the findings made against her, barring would still have been open to the DBS even in the context of a pristine prior work record. As to proportionality, we performed our own assessment of proportionality (in line with the recent decision of a Presidential Panel of the Upper Tribunal in *KS v DBS* [2025] UKUT 45 (AAC)).

86. While we acknowledge that the impact of barring on the Appellant was likely to be considerable, the potential for harm should there be a repetition of the 'relevant conduct' for which she was responsible in this case was great. MW was a very vulnerable patient and, due to her dementia, she was unable to communicate the pain that she must have suffered (given the bruising to her face and legs that gradually became apparent) or to alert staff to the fact that she had fallen. There was a very real risk that she could have sustained serious injuries in the fall. It is apparent from her patient notes in the appeal bundle that she was still in hospital 13 days after the incident (see page [66] of the appeal bundle). In her evidence before the Upper Tribunal the Appellant sought to evade responsibility for patient MW, notwithstanding that she was jointly charged with providing her with personal care when she witnessed an incident that "panicked" her because it indicated that she could have suffered a serious injury. Rather than act in accordance with her training to alert others to the situation and to allow MW to be properly assessed and to receive appropriate treatment, the Appellant sought to conceal the incident. In her oral evidence the Appellant insisted she had done nothing wrong. This indicates a striking lack of insight and a risk that she might act similarly should she be permitted to work with vulnerable adults and should similar circumstances arise in the future. As such, we are not satisfied that the Barring Decision was disproportionate.

87. The other criticisms that Mrs Aziz makes of the Barring Decision in her skeleton argument, while couched in the language of error of law, amount in substance to a simple disagreement with the DBS's assessment of the evidence, with the ultimate outcome of the barring process, and with the adequacy of the DBS's reasons for the Barring Decision. We are not persuaded that the Barring Decision involves any material mistake of law and

we are satisfied that it is explained with adequate clarity in the Final Decision Letter and the 'Barring Decision Summary'.

Conclusion

88. The Upper Tribunal therefore concludes that the decision of the DBS was not based on any mistake in any finding of fact and involved not mistake on any point of law. The Barring Decision is confirmed.

89. The appeal is dismissed.

Thomas Church
Judge of the Upper Tribunal

Elizabeth Butler-Cole
Tribunal Member

Matthew Turner
Tribunal Member

Authorised by the Judge for issue on 27 February 2025