THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

UPPER TRIBUNAL CASE NO: UA-2023-000546-V
[2025] UKUT 081 (AAC)
LJ V DISCLOSURE AND BARRING SERVICE

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) LJ, who is the Appellant in these proceedings;

(b) any of the service users or members of staff mentioned in the documents or during the hearing;

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, 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 29 April 2024 and 11 October 2024

Representatives

Appellant	James Halliday of counsel, instructed by Thompson Law
Disclosure and Barring Service	Andrew Deakin of counsel, instructed by DLA Piper UK LLP

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DECISION OF THE UPPER TRIBUNAL

On appeal from the Disclosure and Barring Service (DBS from now on)

DBS Reference: 00972767763
Decision letter: 9 February 2023

This decision is given under section 4 of the Safeguarding Vulnerable Groups Act 2006 (SVGA from now on):

As DBS made mistakes in the findings of fact on which its decision was based, the Upper Tribunal, pursuant to section 4(6)(b) and (7)(b) of SVGA:

remits the matter to DBS for a new decision; and

directs that the appellant remain in the lists until DBS makes its new decision.

REASONS FOR DECISION

A. History and background

1. On 9 February 2023, DBS included LJ in the children's barred list and the adults' barred list on these findings of relevant conduct:

- Allegation 01:

  Whilst employed as the Home Manager/General Manager at TP you breached safeguarding requirements when you failed to appropriately escalate and manage a safeguarding incident where child ECH had a pillow held over his face by a staff member.

  You removed the Debrief Report in relation to this incident from the records. This meant that the appropriate safeguarding authorities were not informed of the incident and the child's Social Worker was unaware of the incident and could not therefore escalate the safeguarding concerns themselves.

- Allegation 02:

  Whilst employed as the Home Manager/General Manager at TP you failed to act appropriately and professionally in relation to concerns surrounding drug use by staff, both on the premises and outside work, thereby placing children in their care at risk of harm.

  Concerns included:

  Failure to properly investigate when a bag suspected of containing cocaine residue was found at TP.

  Failure to fully investigate reports of staff members using drugs whilst on duty – most notably RD (agency worker).

  Failure to fully investigate reports of staff members using drugs outside of work and therefore potentially attending work under the influence and,

  Failure to undertake random drug tests to address these concerns.

- Allegation 03:

  Whilst employed as the Home Manager/General Manager at TP you failed to appropriately and professionally safeguard the welfare of child CC following a significant injury he sustained following a physical contact incident with staff member IR. As a result of the incident CC suffered physical injuries including a leg injury, multiple bruises to his arms and a large laceration and bruise to his back. He was also very emotionally distressed.

- Allegation 04:

  Whilst employed as the Home Manager/General Manager at TP you failed to appropriately and professionally act to best protect the safety and welfare of children in your care, leading to your dismissal:

  Concerns included continued contact with staff member HR following an alleged strangulation incident; failing to manage ECH's sexualised behaviour to best protect himself and other child residents; failing to protect staff and residents by allowing a Christmas Fete to take place during COVID restrictions whilst children were in receipt of a positive diagnosis; failing to protect CC and fully investigate when he made allegations that he was having a sexualised relationship with staff member CL.

The decision was made under paragraphs 3 and 9 of Schedule 3 to SVGA.

2. Upper Tribunal Judge Jacobs gave LJ permission to appeal and directed an oral hearing of the appeal. The hearing began on 29 April 2024 before the judge and two specialist members. It was not finished on that day and was resumed on 11 October 2024.

3. We are grateful to LJ for her evidence and to counsel for their questioning of LJ and their written closing submissions.

B. The legislation

Grounds for barring

4. Paragraphs 3 and 4 of Schedule 3 apply to children:

Paragraph 3

(1) This paragraph applies to a person if–

(a) it appears to DBS that the person —

(i) has (at any time) engaged in relevant conduct, and

(ii) is or has been, or might in future be, engaged in regulated activity relating to children, and

(b) DBS proposes to include him in the children's barred list.

(2) DBS must give the person the opportunity to make representations as to why he should not be included in the children's barred list.

(3) DBS must include the person in the children's barred list if–

(a) it is satisfied that the person has engaged in relevant conduct,

(aa) it has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to children, and

(b) it is satisfied that it is appropriate to include the person in the list.

(4) This paragraph does not apply to a person if the relevant conduct consists only of an offence committed against a child before the commencement of section 2 and the court, having considered whether to make a disqualification order, decided not to.

(5) In sub-paragraph (4)–

(a) the reference to an offence committed against a child must be construed in accordance with Part 2 of the Criminal Justice and Court Services Act 2000;

(b) a disqualification order is an order under section 28, 29 or 29A of that Act.

Paragraph 4

(1) For the purposes of paragraph 3 relevant conduct is–

(a) conduct which endangers a child or is likely to endanger a child;

(b) conduct which, if repeated against or in relation to a child, would endanger that child 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 child, if it appears to DBS that the conduct is inappropriate.

(2) A person's conduct endangers a child if he–

(a) harms a child,

(b) causes a child to be harmed,

(c) puts a child at risk of harm,

(d) attempts to harm a child, or

(e) incites another to harm a child.

…

(5) A person does not engage in relevant conduct merely by committing an offence prescribed for the purposes of this sub-paragraph.

(6) For the purposes of sub-paragraph (1)(d) and (e), DBS must have regard to guidance issued by the Secretary of State as to conduct which is inappropriate.

Paragraphs 9 and 10 of Schedule 3 apply to vulnerable adults. They are in equivalent terms to paragraphs 3 and 4.

Appeals

5. Section 4 SVGA contains the Upper Tribunal's jurisdiction and powers.

> **4 Appeals**
>
> (1) An individual who is included in a barred list may appeal to the Upper Tribunal against–
>
> …
>
> (b) a decision under paragraph 2, 3, 5, 8, 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.
>
> (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–
>
> (a) direct DBS to remove the person from the list, or
>
> (b) remit the matter to DBS for a new decision.
>
> (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

(b) the person must be removed from the list until DBS makes its new decision, unless the Upper Tribunal directs otherwise.

…

C. Our approach to DBS's findings on relevant conduct

6. We heard LJ give oral evidence, as we were entitled to do, in accordance with *Disclosure and Barring Service v JHB* [2023] EWCA Civ 982 at [95]. Having done so, we assessed that evidence and the evidence that was before DBS as a whole, in accordance with *RI v Disclosure and Barring Service* [2024] 1 WLR 4033 at [28]-[29], [31] and [50].

D. Some background

7. We accept LJ's evidence that she was appointed to TP on the basis that she would assist the general manager and learn the role, effectively as her deputy. In the event, the general manager left soon after her appointment and LJ became the general manager in her place. It was clear from LJ's evidence that she cared deeply for the children in TP and that she was trying her best to help them. She worked excessive hours and struggled with anxiety. Despite trying her best, her evidence to us showed that she was out of her depth. She repeatedly told us of occasions when she had consulted senior managers for advice on how to proceed. She was confused about her responsibilities in terms of managing some of the safeguarding risks. She was sometimes slow to act and her ability to properly safeguard children in her care was sometimes clouded by her anxiety and her focus on trying to gather evidence to establish what had happened.

8. We accept that LJ learned from her experience and that she would do things differently now, but we have to consider her appeal at the date of DBS's decision to include her in the lists, which was 9 February 2023. See *SD v Disclosure v Barring Service* [2024] UKUT 249 (AAC).

E. Allegation 1

9. There are two parts to this finding.

Breaching safeguarding requirements

10. This involves an allegation that a member of staff held a pillow over the face of ECH. LJ told us that this did not happen. ECH was spitting at the member of staff, who used the pillow as a shield.

11. The difficulty we have with this part of the finding is that it refers to a failure and a breach of requirements. That language presupposes a duty. We do not have the evidence of rules, policies or protocols that would lay down which matters should be referred and who was responsible for investigating. This is a Welsh case and we are

concerned that the background knowledge of this Tribunal is essentially related to the position in England and may not be applicable elsewhere.

12. We find that, without the necessary evidence of the terms of the duty to support it, DBS made a mistake in this part of the finding.

Removal of the Debrief Report

13. LJ told us that she had not removed the report and did not have the permission on the internal computer system to do so. We accept her evidence. There is nothing to contradict it and it is plausible that there would be safeguards on the system to control deletions, whether accidental or deliberate.

14. Mr Deakin argued that this was 'a semantic point' and that it did not undermine 'the core finding that, as a result of LJ's decision, material was not placed before relevant safeguarding authorities'. We do not accept that this is semantic. DBS found, and recorded as a finding in its decision letter, that LJ removed the report. That was the precise wording of the allegation that the caseworker found proven on the balance of probabilities. The worker said that this was 'Of central importance to concerns in this case'.

15. We find that DBS made a mistake in this part of the finding. On the evidence before us, she could not have removed the report on her own.

16. Mr Halliday also referred to DBS's conclusion that LJ had colluded with senior colleagues to remove the report. We accept Mr Deakin's argument that DBS made no such finding.

F. Allegation 2

17. Like allegation 4, this allegation contains an overarching finding that LJ 'failed to act appropriately and professionally', in this case in relation to concerns about drug use by staff. This finding is followed by a non-exhaustive list of instances.

18. The most convenient way to deal with this allegation is to focus on the overarching finding and bring in the specific instances as appropriate. We accept that LJ did take some action in relation to concerns about drug use, but there were clear themes that support the overarching finding.

19. LJ was slow to react. She told us – and this was a theme throughout her evidence on all the allegations – that she consulted senior management for advice. The judge put it to her near the end of the second day that she was out her depth. She accepted that that was so. Her regular need to consult and take advice was a manifestation of that. She did not know what to do. As she admitted about RD, she did not know what to report or who to report it to. And her uncertainty and need to seek advice inevitably led to delays in taking the necessary steps. To add to this, she did not understand that urgently safeguarding the children in her care was paramount over the need to substantiate allegations with conclusive evidence. Her evidence was that she could not act without first finding out what had happened. She spoke almost in legal terms, saying she could not rely on *hearsay* that RD had smoked cannabis on duty and that whistleblower evidence of drug use by staff was *gossip and hearsay*. Even when a

package that probably had contained drugs was discovered, it took five days before she sent an email to staff. Finally, we come to the drug tests. LJ told us that she had no power to require members of staff to take blood tests. There was no evidence about any provision in the contracts of employment relating to drug tests. Nor was there any evidence, aside from what LJ told us, about the company's policy. We therefore cannot make findings one way or the other. But, even assuming that LJ is correct about company policy, there is no reason why she could not have obtained drug tests and invited staff to use them. She accepted in her evidence to us that she could and should have done this.

20. LJ surely understood the potential danger of drug use by staff either on duty or before coming on duty. She was, though, surprisingly dismissive of the evidence of whistleblowers, 18 of whom were staff and 7 of whom were anonymous, each of whom was interviewed by senior managers. Her description of their evidence as gossip and hearsay was dismissive. Mr Halliday has conveniently collected 21 statements in the evidence from members of staff who said they had no evidence of, or concerns about, drug use. The important point, however, is that safeguarding is protective. These were serious allegations with a substantial body of support that should have been taken seriously by LJ. They were not.

21. There is no mistake of fact in this allegation.

G. Allegation 3

22. We must focus on the finding made by DBS. We have already quoted the finding as set out in the decision letter. It is identical to the allegation set out in the Barring Decision Summary, which the caseworker found proven on the balance of probabilities. The caseworker's analysis referred to evidence of an alleged practice of play fighting with CC, which LJ at least tolerated and perhaps encouraged. However, that was not part of the allegation found proven.

23. DBS's finding is in two parts. First, DBS found that LJ failed to safeguard CC 'following a significant injury he sustained following a physical contact incident with staff member IR.' Playfighting might have been relevant to explain how the incident came about, but this part of the finding relates to what LJ did after the incident, not what happened before it or led to it. Second, DBS found that, as a result of the incident, CC sustained physical injuries and emotional distress. LJ did not challenge that part of the finding. We need, therefore, only consider whether DBS made a mistake of fact in the first part of the finding.

24. We begin with the incident on 11 May 2021, as witnessed by TL. CC was throwing sweets at IR and abusing him. IR threw things back. CC was becoming elevated and more abusive. At that point, IR came 'from one corner of the lounge to another side dropped his shoulder and barged [CC] with great force knocking him off his feet over the arm of the chair of the sofa, [he] landed on the plastic bin which then smashed to pieces he then hit the radiator, [and] was instantly in pain as he struggled to speak, and made a yelping pain when landed, stood up slowly then sat on the sofa and began to cry'. That account was given the day after the incident. IR was interviewed about a number of matters on 25 August 2021. He gave a less dramatic account, saying that

he wanted to take the sweets off CC, but he toppled over the sofa and sat on the bin, breaking it. When his actions were described as a rugby tackle, IR said that 'It probably did look like that mind.' When TL's account was put to him, he said he was 'Gutted it looked like that. No malice, it was a misjudgement, I am a big guy' and 'Just a lack of judgement, lack of thought.' We accept TL's account. It was given soon after the incident. IR seemed more concerned to clarify his intentions rather than challenge the account of his actions. Even if we were to accept IR's account that he was just trying to take the sweets off CC, his actions were out of proportion in a caring environment to a child throwing sweets.

25. The question for us is whether LJ 'failed to appropriately and professionally safeguard the welfare of child CC' after the incident. What did she do?

26. LJ suspended IR. She says this was with immediate effect, meaning that it took effect as soon as she informed IR of the suspension. That action was protective of CC from the moment it took effect. She did not, though, act immediately. LM said that LJ rang her and 'I said he's got to be suspended immediately which she did'. We accept what LM said, as it is consistent with LJ's regular practice of seeking advice before acting. Given the nature of the incident, the decision to suspend IR should have been instinctive and not require discussion.

27. LJ gave evidence that the staff were asked, probably by email, to make a body map of CC's injuries, but she did not know what it showed. When IR was interviewed in August 2021, the investigating officer said that 'What concerns me is that there wasn't a body map.' We find that even if LJ told the staff to make a body map, that was not done and LJ took no steps to check that it had been.

28. LJ's evidence was that she referred the matter to the Single Point of Contact and that a full investigation into the incident was done as part of the strategy meeting. She said that she was not allowed to do the investigation herself. We accept that this is more likely than not the correct procedure. However, LJ did not provide the Single Point of Contact with the full extent of the incident and injuries. The result was that the incident was never fully investigated.

29. When IR returned from suspension, his probationary period was extended. He was not allowed to work with CC. That provided some protection for him. It did not, though, prevent them having any contact or being in the same building. Further, IR returning to work could have posed a risk of harm to other children. Allowing IR to return to work was in contrast to another person of whom LJ told us she made sure they never worked at TP again.

30. In his closing submission for LJ, Mr Halliday argued that she 'did everything she could do to safeguard CC'. We find that she took some steps to safeguard him, but they were partial. Taken together, they could not properly be described as appropriate and professional safeguarding.

31. There is no mistake of fact in this allegation.

H. Allegation 4

32. Like allegation 2, this allegation contains an overarching finding that LJ 'failed to appropriately and professionally act to best protect the safety and welfare of children in your care'. This is followed by a non-exhaustive list of instances. Mr Deakin accepted in his closing submission that there was a mistake of fact in respect of the Christmas Eve fete. We note his argument that this mistake was not material. Otherwise, we say no more about this finding. We come now to the remaining instances.

Contact with HR

33. We have read this finding in the context of the overarching finding of protecting the safety and welfare of children at TP.

34. LJ told us that she and HR were personal friends. We accept that; there is nothing to contradict it or cast doubt on it. Having contact on a personal basis does not of itself amount to a failure to protect the safety and welfare of children.

35. When she was interviewed on 10 September 2021, LJ was asked 'So did we not undertake not to employ HR again?' LJ replied 'Yes, I'm not sure well I am but think [HR] took it upon herself not to come back.' She then accepted that TP had continued to use a staffing agency run by HR's husband. She said she did not know if HR was involved. In her evidence to us, she said that 'She [HR] was employed as an external service to do audits for us. HR did not set foot in TP after that. She reported herself to Social Care Wales.' Mr Deakin referred us to this evidence. We do not understand how it supports DBS's finding. Whether LJ undertook not to employ HR or HR withdrew, the effect was the same. Using HR to undertake an audit does not have any effect on the safety or welfare of children, as it does not involve any presence in TP. Nor does using a family business, in which HR may have been involved, to employ staff.

36. Mr Deakin told us that DBS accepted that the allegation had been reported to the Single Point of Contact, but said that the issue was whether it was sufficient. The evidence does not allow a finding on that. As Mr Halliday said: 'no SPOC record or reports have ever been collected during the course of the investigation, nor were available during the DBS' decision.' That is correct. It has been a concern to us that there is evidence missing that should exist.

37. On the evidence before us, we find that DBS made a mistake in this finding relating to HR.

ECH's sexualised behaviour

38. This behaviour manifested itself in three ways. First, ECH inserted objects into his anus, including a toothbrush and a Harry Potter wand. Second, he viewed child abuse videos. Third, he bullied another child, KS, including threats to rape him.

39. LJ set out in her perfected grounds of appeal, under twelve bullet points, the steps she had taken to deal with ECH's behaviour. Mr Halliday gave a fair summary: weekly meetings with ECH's social worker; counselling sessions; two key workers in close proximity to him; communications strategies to support him; moving him to another

bedroom; installing locks on doors to protect other children; and reporting all incidents to his social worker.

40. Mr Deakin accepted that some steps had been taken, but not appropriate steps.

41. We consider that LJ did act appropriately and professionally to safeguard ECH's safety and welfare. She was very engaging with ECH, she was intuitive in her approach and response, she got to the bottom of why he displayed sexualised behaviour, and she worked closely with his social worker. The staff behaved shockingly. Just to take a couple of examples, they watched footage of ECH putting a toothbrush up his bottom and watched him ejaculate. LJ denied any knowledge of that. We accept her evidence, as it is consistent with the rest of her approach to ECH.

42. We find that DBS made a mistake of fact in this finding.

Sexualised relationship between CC and CL

43. CC was the male service user involved in Allegation 3. CL was a female support worker. The allegation is that there was a flirtatious relationship between them that became fully sexual. We accept Mr Halliday's argument that investigations by the police and the Single Point of Contact were discontinued when the allegations were withdrawn and said to be false. We also accept Mr Deakin's argument that this does not prevent DBS from making findings on the evidence available.

44. The issue for us is not what took place between CC and CL. The issue is how LJ reacted to the allegations and, in particular, whether she failed to protect CC and fully investigate when he made his allegations.

45. Mr Deakin argued that: (a) there was a clear and consistent pattern of evidence that there was flirtatious conduct, which escalated; and (b) LJ did not properly engage with the staff who reported their concerns, and did not manage their reports appropriately.

46. This was the evidence.

- HM reported raising the issue, as had TD. CC used to talk a lot about staff and had described CL as 'touchy feely'. He was known to make false allegations. This was reported to the shift manager who escalated it, presumably to LJ.
- TD was concerned about CC and how CL was with him. CL had said to CC that if he was good, he 'would get some tonight.' Lots of staff had concerns and put these into writing, but LJ 'scrunched these up and threw them in the bin on occasions.' LJ did raise the issue, but only when TD had told her in front of SA that he would report her to Social Care Wales if she did not.
- Another member of staff reported that CC spoke to CL as if she was his girlfriend. When he was seen with his legs over her and was told to get off, CL said 'oh no he's fine.' The member of staff told her to pull her t-shirt down as it 'wasn't covering her privates or her bum.'
- SA said that she had reported to LJ about the relationship. CC was saying he and CL had fingered each other and had sex. SA had asked the staff to write everything down and it had been put into LJ's drawer. CL was suspended briefly,

but then came back. Other children knew about it. LJ had reprimanded SA for demoralising one of them. CC was not offered counselling.

- SA also said that CL was flirtatious with CC. SA did not report this 'as nothing being done. Was like management had blinkers on. … LJ felt forced to do it cos of mount of paperwork where staff were reporting concerns. Staff were asking for follow up to it and that nothing was being done.'
- IR said that CL had told CC that if he misbehaved, 'you won't get any'. CC also said that CL had given him a handjob. IR had documented this on one occasion, and had told LJ on other occasions. However, CC's story differed over time.

47. It is right to add that in her evidence to us LJ challenged all or part of some of those statements. On her behalf, Mr Halliday said that the incident was reported to the Single Point of Contact as soon as it was reported to LJ. Reflective accounts were provided to LJ for her to assess the evidence. The police were informed and CL was interviewed.

48. We accept Mr Deakin's submission that different staff reported incidents and concerns to LJ. Their accounts covered different incidents. They convey a consistent story of sexualised behaviour between CC and CL, and of reports to LJ without result. There is no mention of reflective accounts. We notice that Mr Halliday, as recorded in [47], referred to 'The incident' (singular) rather than to a pattern of behaviour over a period that was noticed and reported by different members of staff. We accept the point that LJ made in evidence – the staff would not know what was being done in confidence. We also accept that CL was suspended for two months, but she then returned to duty.

49. Taking the evidence as a whole, we find that there was no mistake in DBS's finding.

I. Other grounds of appeal

50. Mr Halliday has argued that there were also mistakes of law in DBS's decision.

Failure to wait for the decision by Social Care Wales

51. The Upper Tribunal has dealt with this argument numerous times. DBS has to apply the legislation. Once the conditions for including a person in a barred list are satisfied, DBS is under a duty to include the person. See, for example, paragraph 3(3) of Schedule 3 SVGA, which we have set out. DBS might, of course, have decided not to act immediately but to wait for the outcome of proceedings before the regulatory body. But it could only do so on the basis that it would not be appropriate to include LJ at that stage. However, that is outside our jurisdiction, as section 4(3) precludes an appeal on that ground.

52. There could also be a mistake of law if the decision was irrational. That means, irrational at the time it was made. On the findings made by DBS, we can see no basis on which we could find that the decision was irrational, even allowing for the mistakes that we have identified.

Proportionality

53. Proportionality was recently considered by a Presidential Panel in *KS v Disclosure and Barring Service* [2025] UKUT 45 (AAC). The Panel decided that, on an appeal against a decision of DBS, the Upper Tribunal had to decide the issue of proportionality for itself. We follow the Panel by adopting the formulation of the test given by Lord Reed in *Bank Mellat v Her Majesty's Treasury (No 2)* [2014] AC 700 at [74].

(1) whether the objective of the measure is sufficiently important to justify the limitation of a protected right

54. The measure in this case is the decision by DBS to include LJ in both barred lists. The purpose of doing so was to protect children and vulnerable adults from harm by those entrusted with their care in regulated activity. That objective is sufficiently important to justify interfering with the exercise by LJ of her Article 8 Convention right.

(2) whether the measure is rationally connected to the objective

55. Self-evidently, barring is rationally connected to the objective of the measure.

(3) whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective

56. Mr Halliday did not propose a less intrusive measure that was available to DBS. This was realistic, given that DBS was under a duty to include LJ in the barred lists once the conditions were satisfied.

(4) whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter

57. This is where Mr Halliday's argument fits most naturally. He argued that TP was in a state of 'some chaos' and LJ was unexpectedly left to 'fill the void' when the original manager left soon after her appointment. There was a lack of leadership structure and procedures were not enforced. LJ sought support at every opportunity, but it was not forthcoming. It was unfair for her to take responsibility for all the failings. Finally, Mr Halliday mentioned that there are still outstanding questions to be answered by the Social Care Wales investigation.

58. We accept that LJ was not solely responsible for all that was wrong at TP. But she has not been held responsible for all that went wrong. She has been held responsible for the matters for which she was responsible as general manager. She did not have to accept the appointment when the previous manager left. Having done so, she cannot avoid the responsibilities that went with the role. Even if we were to accept that others shared the blame for what occurred, that would not help LJ. She would still be responsible for her share. That others are also partly responsible cannot relieve her of responsibilities that she took on with her post and retained for so long as she chose to remain in post.

59. As for what will emerge in the Social Care Wales investigation, that is speculation at the moment. DBS has power when the result of the investigation is known to review its decision under paragraph 18A of Schedule 3 SVGA.

60. We have considered whether there are other arguments that could be put in LJ's favour in addition or substitution for those advanced by Mr Halliday, but have been unable to do so.

61. We have not so far mentioned DBS's reasoning. We have to give that appropriate weight. Having done so, we have come to the same conclusion as DBS, and find that at the date of decision and on DBS's findings, the decision was proportionate.

62. We have not attempted to assess proportionality on the basis that DBS's mistaken findings were excluded. DBS will now make a new decision, perhaps with more evidence, and will assess proportionality afresh.

J. Remitting the case to DBS

63. We have found some mistakes in DBS's decision, one of which was conceded. Given the nature of the mistakes, we consider that the appropriate disposal is to remit the case to DBS for a new decision. We have not made findings of fact, as it is possible that DBS may have further evidence when it makes its new decision.

Authorised for issue
on 03 March 2025

Edward Jacobs
Upper Tribunal Judge
John Hutchinson
Suzanna Jacoby
Members