The Upper Tribunal
(Administrative Appeals Chamber)

UT NCN: [2025] UKUT 116 (AAC)
UT Case Number: UA-2024-000482-V

Summary: Safeguarding Vulnerable Groups (65.9)

Safeguarding Vulnerable Groups Act 2006 - section 4(2)(b) – appeal on mistake of fact – distinction between fact in issue and fact that makes fact in issue more or less probable - Upper Tribunal heard oral evidence and made its own assessment of evidence – no mistake of fact – decision of DBS confirmed.

Before

UPPER TRIBUNAL JUDGE JACOBS
TRIBUNAL MEMBERS JOSEPHINE HEGGIE AND JOHN HUTCHINSON

Between

MD **Appellant**

v

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) MD, 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 on 01 April 2025 following an oral hearing on 14 March 2025

Representatives

Appellant	Thomas Buxton of counsel, instructed by Star Legal
Disclosure and Barring Service	Richard Ryan of counsel, instructed by DBS Legal

DECISION OF THE UPPER TRIBUNAL

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

DBS reference: 00995498078
Decision letter: 10 January 2024

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

DBS did not make mistakes in law or in the findings of fact on which its decision was based. DBS's decision is confirmed.

REASONS FOR DECISION

A. Introduction

1. On 10 January 2024, DBS included MD in the children's barred list and the adults' barred list on the following findings of relevant conduct:

> On unspecified dates between February and March 2020, while employed as a Healthcare Assistant you demonstrated inappropriate and sexualised behaviour towards a 16-year-old patient of BA Unit (Patient B), including:
>
> - Hugging and kissing patient B on the head and stroking her hands.
> - Encouraging Patient B to masturbate in front of you and when she declined you asked her to discuss intimate details with you afterwards.
> - Discussing sexually explicit themes with Patient B.
> - Using sexual innuendo and engaging in suggestive behaviour such as sharing Patient B's lollipop while discussing future relations.
> - Offering to buy Patient B items and complimenting her.
> - Encouraging Patient B to keep your relationship secret.
>
> On unspecified dates between February and March 2020 while employed as a Healthcare Assistant, you demonstrated an inappropriate use of touch without consent, involving a vulnerable 15-year-old resident (Patient A) of BA Unit which led to Patient A's significant emotional discomfort, behaviour which included:
>
> - Stroking Patient A's self-harm scars which were located on her forearm. [We have corrected some obvious typos in this finding.]
> - Frequently attending her room at night and rubbing her back, bra and lower back area despite Patient A informing you that she did not like this.

2. Upper Tribunal Judge Jacobs gave MD limited permission to appeal. For convenience, the grounds on which he gave permission are set out in the Appendix. Permission was given without an oral hearing. MD did not apply for an oral reconsideration of the limited grant of permission under rule 33(3)(b) and (4)(b) of the Tribunal Procedure (Upper Tribunal) Rules 2008 (SI No 2698). Nor did he apply for permission to amend his grounds (as explained in Section III of *KS v Disclosure and Barring Service* [2025] UKUT 45 (AAC). Accordingly, we limited our consideration to the grounds on which permission was given, as required by *Disclosure and Barring Service v JHB* [2023] EWCA Civ 982 at [97].

3. This is the Upper Tribunal's decision on the appeal. It is made with the benefit of the practical knowledge and experience that the specialist members bring to this jurisdiction. We refer to what the Upper Tribunal said about their qualifications for appointment in *CM v Disclosure and Barring Service* [2015] UKUT 707 (AAC) at [59] to [64].

B. Some background

4. We know little of MD's background before 2017. From October 2017, his CV contains five different roles overlapping in time. This appeal concerns his appointment as a Healthcare Assistant at BA Unit, which is a residential Tier 4 young persons' mental health unit. This was his first appointment in the NHS. His interviewers were impressed by his performance and he took up his post in 3 June 2019. When his case was referred to DBS, he was described as being:

> responsible for caring for a defined group of patients with complex needs, including a wide range of physical disabilities as well as cognitive, perceptual and mental health problems. They may have acute or chronic conditions and will be treated individually at home or in a ward setting using evidence based practice.

5. There was no criticism of MD's conduct until March 2020. Following a complaint by Patient B, he was sent home from his shift on 5 March 2020 and suspended on 9 March 2020. The allegations were reported to the police and to LADO. Following a disciplinary hearing, he was summarily dismissed on 23 November 2021. This decision was confirmed on appeal on 3 May 2022.

6. MD was not immediately informed of the nature of the allegations, as the police did not want this to impede their investigation. He only knew that they had been made by Patient B and was asked to provide a statement of what he could recall of interactions with her. In the end, the police took no action as doing so would be detrimental to the mental health of the patients.

C. The legislation

The barring provisions

7. We set out the provisions of Schedule 3 SVGA relating to children; those relating to vulnerable adults are essentially the same. Paragraph 9 and 10 are the equivalents for vulnerable adults.

Behaviour

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.

(3) 'Sexual material relating to children' means–

(a) indecent images of children, or

(b) material (in whatever form) which portrays children involved in sexual activity and which is produced for the purposes of giving sexual gratification.

(4) 'Image' means an image produced by any means, whether of a real or imaginary subject.

(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.

The appeal provisions

8. 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.

…

D. Our approach to the case

9. We heard evidence from MD, as we are entitled to do: *Disclosure and Barring Service v JHB* [2023] EWCA Civ 982 at [95]. That evidence was contained in a witness statement dated 6 March 2025. He supplemented this in response to questions from Mr Buxton, on cross-examination by Mr Ryan, and in answer to questions from the panel. Having heard that evidence, we approached the case in accordance with the decision of the Court of Appeal in *RI v Disclosure and Barring Service* [2024] 1 WLR 4033. Bean LJ there approved at [29] the submission by counsel for RI at [28] that 'the Upper Tribunal is entitled to hear oral evidence from an appellant and to assess it against the documentary evidence on which the DBS based its decision.' Later at [31], Bean LJ said that 'where relevant oral evidence is adduced before the UT … the Tribunal may view the oral and written evidence as a whole and make its own findings of primary fact.' And Males LJ said at [50] that the Upper Tribunal is 'entitled to evaluate that evidence, together with all the other evidence in the case …'

10. In deciding whether DBS made a mistake of fact or law, we had to consider the circumstances as they were at the date of DBS's decision, which was 10 January 2024. See *SD v Disclosure v Barring Service* [2024] UKUT 249 (AAC). We are entitled to take account of evidence that was not before DBS, provided that it can be related back to that date.

E. Mistake of fact

11. In terms of our jurisdiction under section 4(2)(b) SVGA, the issue is whether DBS 'made a mistake … in any finding of fact which it has made and on which the decision mentioned in that subsection [section 4(1)] was based.'

12. The grounds of appeal argue that DBS was not entitled 'to come to a finding of fact that MD carried out the alleged acts against Patient A and/or Patient B.' These are facts in issue. What constitutes facts in issue depends on 'the particular requirements of the statute in question': *R (Pearce) v Parole Board* [2023] AC 807 at [34]. Adapting from *Shagang Shipping Co Ltd v HNA Group Co Ltd* [2020] 1 WLR 3549 at [98], that

means that they have to be proved, on the balance of probabilities, as relevant conduct in order to justify DBS including MD in the barred lists under paragraphs 3(3)(a) and 9(3)(a) of Schedule 3 SVGA.

13. The grounds of appeal refer to other matters that are not facts in issue. These are 'facts which make a fact in issue more or less probable': *Shagang* at [99]. One example is the possibility of collusion between the patients; this makes the facts in issue less probable. Another example is that neither patient has complained about a member of staff before; this makes the facts in issue more probable. Neither of those facts involves conduct by MD. Neither is conduct that endangers a child. And neither amounts to relevant conduct, which (to repeat) is one of the conditions that had to be satisfied before DBS could add MD to the barred lists. These facts do not have to be proved on the balance of probabilities. Rather: 'Judges need to take account, as best they can, of uncertainties and degrees of probability and improbability in estimating what weight to give to evidence in reaching their conclusions on whether facts in issue have been proved': *Shagang* at [99].

F. The patients' evidence

14. After MD had been suspended, a meeting of all the patients on BA Unit was held on the morning of 6 March 2020. Its purpose was to reassure them. Following that meeting, interviews took place. We have the records for those of Patients A, B and E. We do not know whether statements were taken from other patients and, if they were, why they were not sent to DBS.

Patient A

15. Patient A was interviewed by Matron CC on 6 March 2020. This is the record of her interview.

> Patient A: I wasn't going to say anything, because I don't care about what happens to me. But as Patient B has got the ball rolling and informed staff, I'm worried others might have experienced things and that's not ok.
>
> *Are you able to tell me what you have witnessed or experienced with MD?*
>
> Patient A: He rubs my back a lot which felt inappropriate. I thought initially he didn't have good social skills, but it happened 4-5 times at night. It felt a bit predatory. He was rubbing up and down my back, he fiddled with my bra on my back, he didn't undo it but he rubbed my back quite low I felt uneasy about it at the time.
>
> I'm worried he had no bad intentions and what I'm saying is going to cause trouble.
>
> I told him 'I didn't like it'. He stopped rubbing my back then but two nights later he did it again. But he was aware I didn't like it.
>
> He's never said anything unkind to me. But this could have happened to someone else who's quieter and it wouldn't have been addressed. So that's why I'm talking about it.
>
> *Reassurance offered. Although this is a difficult conversation Patient A you are doing the right thing voicing your concerns so they can be investigated.*

> Patient A: He would stroke my scars (self-harm) on my arms (forearms). This happened at night in my room. This happened over the last two weeks or so. It made me feel very uncomfortable and a tiny bit threatened. I'm not sure why I felt like that but it gave me the same feeling as when he touched the back of my bra when stroking my back.
>
> There was a meeting with [members of staff] this morning to reassure us all. This is when I realised something had happened to other people and why I decided to speak up.
>
> I feel a bit used now. I'm fifteen, I've never done anything romantic before. I've never been in a relationship. It makes me feel sick. I'm trying not to be emotional about it but it's difficult.

Patient B

16. Patient B was also interviewed by CC on 6 March 2020. This is the record of her interview.

> Patient B: It got worse when MD returned from annual leave. Before that we just got on well nothing else happened.
>
> *Could you explain what you mean by got worse?*
>
> Patient B: I encouraged it, I said to him 'I want to kiss you'. MD asked me to explain how I wanted to kiss him.
>
> *Were there times when you did kiss on or off the ward with MD?*
>
> Patient B: No we didn't kiss on the lips. But he kissed me on the head. I'm not sure of when but it definitely happened twice. Actually one time was this Wednesday (04/03/2020) he came up to me and said 'Oh did you say you wanted to see me'. I hadn't asked to me[et] him but I went along with it. We walked to my room and he said 'I just wanted to hug you before I left'. This is when he hugged me and kissed me on the head.
>
> *Has MD touched you in other ways whilst on or off the ward?*
>
> Patient B: No not really, only my hands. He'd say they were cold and hold them, touch them and stroke them until they were warm. We'd often have PPT in my bedroom sometimes at night or in the day. We'd talk about things that had upset me that day or other stuff.
>
> *Could you explain what you mean by 'other stuff'?*
>
> Patient B: MD said to me he would make every inch of my body feel good. He has also asked me what I find attractive about other men and him in particular. He said things like 'You're really mature for your age' and that he hasn't had a connection in years with anyone else like he has with me. He also said 'I'd bought him back to when he was my age and that I'd boosted him up'. You know when I was on 1-1 for like two weeks, well when I came off 1-1 he said I can't have touched myself for all that time. He told me to do it that day because I wasn't on obs any more. He asked me if I would do it in front of him. I told him 'I dunno'. He told me I should have asked him when he was on my 1-1 as it could have happened then. He said he could have helped me. He told me he would ask me how it went. When I next saw him I told him it was really good. He asked me what

I was thinking about. I said something about porn. MD said ‘If you would have asked me yesterday I could have given you something to think about. I got embarrassed.

If I said things like f**k you to MD. He'd often say ‘You wish’. I think C (young person) overheard once and said to me ‘did you hear what he said’. He's also say things like ‘Try not to think of me’. When touching myself.

On another day he was chewing gum and I asked for some. He said no but that one day we would be smoking together and that I can put smoke in his mouth and he can put gum in mine. I was eating a lollipop - he licked it and then asked whether I'd still have it. So I eat it after - we were in the laundry room at the time.

On Wednesday (4/3/2020) MD said ‘I really want to buy you something’. He was asking me what types of things I like but I got embarrassed. He was supposed to take me on my walk to Tesco that day but he had to do obs or something so we didn't go.

When I started talking about him to the other young people, they knew something wasn't right. I asked them not to tell anyone because it would ruin everything. I think I made them feel awkward which I regret now. I didn't think what I was talking about at first was bad until how other young people reacted to it.

MD asked me had I told anyone about what was going on. He told me it would get him into a lot of trouble and it would ruin our relationship, it would have to stop. He said this to me in my room. He told me if we kept it a secret it would be more special and it would last longer.

Did you and MD ever exchange telephone numbers or emails or other communications.

Patient B: No, we only spoke on the ward face to face. He did ask me though, what we would do if I was discharged and he wasn't on shift. I told him we could email but he didn't like that idea. He asked me where I would be discharged to. I told him home. He asked me who I lived with, and I explained I live with my mum.

Also, he asked me what staff I thought were pretty. I said [members of staff] but he said I was prettier than them. He also asked me about the other male staff but I didn't answer that question.

He'd often say things to me like ‘I like the way you hug me, you're a sweet girl’. I didn't have a problem with our relationship but I started to worry if he said similar things to other young people that might be more vulnerable than me.

He did creep me out a bit actually. He told me he has a thing for ‘armpits’. He also asked if I shaved down there (genitals) as he likes ‘a bit of stubble’. It made me feel quite awkward.

I said to MD once, ‘I don't think you'd be into the things I'm into. MD said ‘what like choking you, tying you up and blindfolding you? I'm down for these things but only once a month. I'd need time to get the equipment’. We were talking about this in my room. He told me ‘sex is beautiful and it is like art’. MD told me ‘you shouldn't give your body to anyone, you should save it for someone special’.

Is there anything else you think is important you'd like to share with me. I thank you for being so open and honest, it takes a lot of courage to speak of these types of things.

Patient B: At first I felt like I had betrayed him. He trusted me you know. I will miss the attention. But I don't want it to happen to anyone else; I know it's not right. He would often check down the corridor if he was in my room to make sure no one would come in or hear what we were talking about. He also told me not to tell anyone and to keep it a secret, he obviously knew he was doing wrong otherwise you wouldn't do those things.

I remember a time he was with EP (young person), I don't know if she was on 1-1 or if he was just looking out for her. He was sitting near her room on a chair. He would pop in and out of my room to talk. He was security on that day because I remember his radio going off and he'd be like 'I'll be back soon'. I remember talking to some other young people and they'd say 'He's ugly' and it would make me think what does a 34 year old man want with someone my age, somethings not right. Even when I was banging my head all the time he would say I was beautiful, I thought that was a bit weird.

Patient E

17. Patient E is not mentioned in DBS's findings. She was, though, interviewed by LY a Consultant on 6 March 2020 and is mentioned in the grounds of appeal. This is the record of the interview.

LY opened the meeting explaining it had been a difficult day for the young people. He was aware there was a meeting this morning regarding concerns raised about a member of staff. Although Patient E hadn't asked to speak to anyone, LY was aware a few days ago when he asked Patient E regarding who she wanted to be part of her primary team, she specifically mentioned she did not want MD. LY therefore wanted to explore this further with Patient E to ensure she was ok and to offer a space to discuss further if she wanted to.

Patient E: Everyone is uncomfortable around MD. There's too much physical contact, he's overbearing. I'm not sure if he's got bad social skills or something.

I'm interested to know specifically why you pointed out MD when I asked who you didn't want on your team. You didn't mention anyone else. Is there anything we need to be aware of?

Patient E: Nothing like that. He had PPT with me once and I cried my eyes out that's all.

What were you upset about Patient E?

Patient E: You know when I was bottling things up and not telling anyone how I was feeling. Well he said to me that I wasn't doing enough. This was only a couple of weeks into my admission. It made me feel really pathetic.

I'm sorry that was your experience of PPT. Have any of the other young people, before today, mentioned anything about MD to you?

Patient E: Yes, Patient B told me MD called her attractive from a male perspective, that she was really attractive. But that's it really.

18. Patient E's evidence is mentioned in ground 7(a)(xxxii) of appeal. It is incorrect to say that it 'only referred to a conversation she had had with Patient B.' It is correct that B is the only patient that E had had a conversation with. But she had had a conversation with LY. The opening paragraph records that she had told him a few days earlier that she did not want MD as part of her primary team. Her opening remarks explain why she made that request.

The assessment of the reliability of the patients' evidence

19. The report of the Disciplinary Hearing Outcome for MD stated that 'neither Patient A nor Patient B had made allegations of this nature against any other staff.'

20. Matron CC 'informed the panel that the level of detail in the disclosures led her to believe that they were real. She further informed the panel that the disclosure did not feel scripted. In [her] professional opinion the disclosure was consistent, and the young people talked about the events as is [meaning 'if' presumably] they had lived it.'

21. Patient A's named nurse was ER. She said that 'in her experience of Patient A, she had not known the Patient to have made disclosures of this nature before. When asked whether in [her] knowledge Patient A had any warning about sexualised behaviour, to believe things and make accusations, she stated "She's not somebody like that, her risk is not about making allegations or being sexualised in any way".'

22. The report of the Disciplinary Appeal Hearing Outcome also contains evidence from both CC and ER.

23. CC said that 'in Mental Health nursing you tend to get a gut feeling and that she felt that when interviewed, the young person was credible, honest and that the young person came across as finding the whole process traumatic. That on each occasion CC spoke with them their recollection was consistent.' She also said that 'the young person did not have psychosis and that their diagnosis was due to a trauma and not experiencing altered reality, that their story remained consistent, and that the level of detail was considered, times and dates remained the same. That other young people were able to corroborate different parts of the young person's reflection.' Finally, she said that 'she appreciated that "gut feelings" did not make the statements fact, however she calls upon her 10 years' experience when making an assessment.' At that point, RB the Associate Director of Quality and Governance 'referenced "Bonner" which is a recognised writing and supports knowledge of experts.'

24. ER told the panel that 'young person [A] appeared credible and had not fabricated anything before, and that the young person's presentation of the allegation and levels of distress felt genuine.' Later, she said that 'the young person came across as truthful, that the young person had not discussed the incident with anyone else, that they were not bragging and that it was bothering them, and it wasn't something they wanted to talk about.'

G. MD's evidence

25. MD had been on leave and returned on 21 February 2020. He then worked three night shifts on 21, 22 and 23 February and three long day shifts on 2, 4 and finally 5 March until he was sent home from his shift. Both day and night shifts lasted for 12 hours from 8 to 8.

26. He has consistently denied the allegations. He denied them to the investigators during the initial disciplinary process with his employer and the subsequent appeal. He denied them again in his representations to DBS. And he denied them in his witness statement and in his oral evidence on this appeal.

27. He admitted giving High-5s to patients and shaking their hands; and he admitted touching patients in order to give treatment or medication, but only with consent. Otherwise, he had no physical contact.

28. MD could think of nothing he had done that would have caused either Patient A or Patient B to want to make false allegations against him. He denied doing anything that Patient A or Patient B might have misunderstood or misinterpreted. He did accept, though, that 'the relationship between the staff member and patient is quite involved', involving sensitive and personal information. He denied ever 'acting beyond my role' and said that all interactions were properly recorded.

29. MD told us that he did not enter a patient's bedroom uninvited. It was possible to hold a Patient Protected Time session in their bedroom if this is what they wanted. These are ad hoc sessions initiated by a patient with a member of staff chosen by them to talk about a specific topic that they wish to discuss. He denied having a session with either Patient A or Patient B in February of March 2020. ER told the disciplinary appeal hearing that these sessions 'can take place in a young person's bedroom but that this is not advised or encouraged.'

H. Our analysis of the evidence

30. DBS's findings on relevant conduct are based on allegations by Patient A and Patient B. MD has always and consistently denied the allegations. There were no other complaints about him while he was working at BA Unit. There is no evidence of any other kind of criticism or blemish on his character in any other context. He has provided 25 pages of references in his support.

31. A and B were both patients and resident on BA Unit. MD did not know when Patient A had come to the Unit, but told us that Patient B had been there from January 2020. They would have known each other for a couple of months by the time of the allegations. MD said that they were friends. Apart from that unparticularised statement, we know nothing of their relationship other than as fellow patients.

32. The evidence of Patients A, B and E are verbatim records of both the questions they were asked and the answers they gave. There is no reported speech and the context of their answers is set out.

33. The evidence of the allegations came only from the patients themselves. There were no witnesses and there was no CCTV. There were no records of MD visiting or having conversations with either patient, but MD was responsible for the record keeping. Patient B had, though, told Patient E that MD had told her she was attractive. And Patient E's evidence that 'Everyone is uncomfortable around MD' is generally supportive of the allegations.

34. Only Patient B made a complaint before the meeting on 6 March. It was only after that meeting that Patient A came forward. Patient E had not made a complaint, but she had already asked that MD not be part of her primary team. And even after the meeting, she did not come forward but had to be approached by LY about her request. Both A

and B conceded points in MD's credit and expressed concern about the effect their allegations would have for him.

35. The timing of the allegations and their content fits with MD's shift patterns on his return from leave. The allegations by Patient A and Patient B differ in their details. There is nothing in them to suggest possible collusion. We do not, though, accept Mr Buxton's argument that there is no pattern. Both patients reported being touched by MD in ways that were not appropriate for a member of staff. Both reported visits to their rooms. Both reported that they took place at night. And both reported conversations that were more personal and intimate than was appropriate for a member of staff.

36. CC and ER said that neither Patient A nor Patient B had made allegations against any other member of staff. ER said of Patient A that this was consistent with her diagnosis and presentation. Patient A had made another allegation against MD on 19/20 October 2020. The record is set out as Appendix A to the grounds of appeal. She said; 'I know that in the past I have thought things had happened when they hadn't, which makes me question whether this did actually happen, however I am 99% sure that it did as I know someone else [she proceeded to name the other young person] also made an allegation against MD'. We note that she volunteered this information, and that thinking something has happened when it had not is not the same as acting on that thought. Out of fairness to MD, we have not taken A's October allegation into account against him.

37. It is possible that a patient might misunderstand or misinterpret why a Healthcare Assistant was talking about personal or intimate matters. But the explicit nature of some of the conversations is beyond any misunderstanding of misinterpretation. And kissing, stroking and the other touching reported cannot arise from misunderstanding or misinterpretation.

38. It is possible that a person might develop a feeling of grievance against a member of staff, which could lead to false or exaggerated reports. This is a general possibility, but nothing more. There is no evidence that this had happened. MD denied knowing of any reason why the patients would have a feeling of grievance against him.

39. Mr Buxton criticised the assessment of credibility given by CC and ER. The former referred to 'gut feelings'. This was the context in which RB referred to *Bonner*. That is a typo in the report of the Disciplinary Appeal Hearing Outcome. The correct reference is to Patricia Benner PhD, who has been publishing on developing nursing excellence since at least 1984. She has built on the work of Hubert and Stuart Dreyfus. Their model of skill acquisition recognises that as practitioners becomes more skilled, their awareness of the context increases, they begin to recognise relevance, consider issues holistically rather than analytically, and operate intuitively. This is, though, by the way. Neither CC nor ER simply stated their gut feelings. They unpacked their assessment by referring to:

- there was consistency of details, times and dates;
- the accounts did not feel scripted;
- there was some corroboration;
- presentation and distress both felt genuine and truthful;
- there was an absence of discussion with anyone else;
- there was no bragging; and
- the patients were bothered about what they were reporting.

That allows us to assess for ourselves the cogency of the assessments made by the two experienced nurses. The factors they mentioned were not decisive, either individually or collectively. They were, though, all rationally relevant and help us to understand not just what the patients said, but how they behaved and reacted at the time through the eyes of experienced observers.

40. Finally and importantly, there were other allegations made against MD that DBS did not include in its findings of relevant conduct. One related to Patient A's complaint of October 2020. Another related to Patient B's complaint that MD suggested that he meet her after discharge. A third related to Patient B's complaint that MD had abandoned one patient in order to attend to another who was in distress. DBS found that these were not proven on the balance of probabilities and referred to the limited 'contextual information' available. DBS did not exonerate MD on those complaints. What it did was to accept that it could not make a finding against him as it lacked sufficient information to make a proper assessment of the allegations. To put it differently, its conclusions reflected the state of the evidence and not the patients' credibility. Out of fairness to MD, we have not taken these allegations into account against him.

I. Our conclusion on the facts

41. We have assessed the evidence afresh and as a whole, and made our own findings of fact. Having done so, we have come to the same conclusion as DBS. There was, therefore, no mistake in DBS's findings and we have confirmed its decision.

42. We have not found any evidence decisive of itself, one way or the other. There are points for and against each piece of evidence, as we have tried to draw out in our analysis of the evidence. Some of those points are more significant than others. Without attempting to be comprehensive, these are among the most significant factors that have influenced our findings. We have had the actual questions and answers in the patients' interviews, and the assessment by professional observers of the patients' feelings and emotions at the time. The accounts given by the patients were measured and balanced. The accounts showed a pattern of behaviour by MD. There was some corroboration. There are matters, such as the possibility of collusion or misunderstanding, that have to be considered. Having done so, we found no indication, let alone evidence, that any of these was present. That, as we say, is but a summary.

Authorised for issue
on 01 April 2025

Edward Jacobs
Upper Tribunal Judge
Josephine Heggie
John Hutchinson
Members

APPENDIX

Grounds of Appeal on which Permission was Given

Error in Fact: Insufficient evidence on the balance of probability to come to a finding of fact that the Applicant carried out the alleged acts against Patient A and/or Patient B:

1. The main submission of this appeal is that there is insufficient evidence to come to a finding on the balance of probability that the relevant conduct as alleged in the Minded to Bar letter (UTAAC 38-45) has occurred.

2. It has always been accepted by MD that the conduct as alleged would have fully justified a decision to bar. However, he has always maintained that it simply did not occur.

3. MD is a man of good character with experience in the regulated sector and no concerns had been raised prior to these events.

4. 'MD's former employer noted that he was outstanding at interview and demonstrated a keenness to learn and there had been no concerns regarding MD's conduct prior to concerns raised' (Barring Decision Summary document - UTAAC-277).

5. MD has maintained a blanket denial of the allegations throughout the internal investigations by his employers and any associated investigations by other agencies, including the DBS.

6. MD has provided a detailed explanation for his denial to both his previous employer in the internal investigation and the DBS in his representations in response to the Minded to Bar letter.

7. The decision to bar relies on two main findings:

a. The Patients were truthful in their account.

i. The main issue of this appeal is to challenge this finding that the Patients were truthful in their accounts. If the UTAAC are of the opinion that such a finding should not have been made on the evidence available to the DBS, or that there are material errors or omissions within the DBS decision making process, then it must grant permission to appeal.

ii. There are three Patient witnesses: A, B and E, Their respective testimonies are set out at UTAAC 70-71 (Patient A), UTAAC 73-75 (Patient B) and UTAAC 72 (Patient E).

iii. Patient B is the main witness and key to allegation 1.

iv. Patient B expressly admits that she had feelings for MD (This is something which MD has always denied being aware of until the allegation was made; he denies encouraging or reciprocating any attempts at friendship in any event).

v. The DBS have failed to take this into account when assessing the credibility of Patient B's account.

vi. The DBS have also failed to take into account MD's representations that the relationship between staff members and patients was quite involving and could include discussions in relation to gender preference and sexual health (See Minded to Bar representations, paragraphs 17.12-17.13 (UTAAC 138-139)).

vii. Furthermore, the DBS have failed to recognise the importance of this together with the fact that it was acknowledged by MD's employer during the internal investigation that it was known that patients can misinterpret situations and believe things that did not happen (See Minded to Bar representations, paragraphs 17.29 (UTAAC 141)).

viii. Likewise, the DBS have failed to consider that there is acknowledgement by SM, the Trust's Investigating Officer, during the meetings with MD that patients are known to misunderstand staff behaviours and interpret them wrongly to be personal interest. (See Minded to Bar representations, paragraphs 17.32 (UTAAC 142)).

ix. The DBS have taken a view that the Patients were honest and truthful. The Barring Decision Summary document states that one reason for preferring their account is that there is no reason for them (predominantly Patient B) to fabricate events.

x. It is respectfully submitted that such a rationale fails to consider that Patient B has admitted that she had an interest in MD.

xi. The DBS has gone on to justify its finding that Patient B's account was credible on the grounds that her account was detailed and was able to recall specific locations, conversations and the timeline of events which appeared to correlate with MD's shift patterns.

xii. It is submitted that by no means does a detailed account mean that it is an accurate account. The DBS is plainly wrong to confirm credibility of an account simply because it provides detailed descriptions of events.

xiii. The fact that events correlated with MD's shift patterns is not extraordinary given that he worked on the unit. In any event, Patient B did not provide specific dates and times of events which accorded with MD's shift patterns save for one date, namely 4 March 2020. No other dates are provided.

xiv. No locations are provided save for Patient B saying that Personal Protective Time (PPT) sessions often occurred in the bedroom (which is denied by MD).

xv. There is reference within Patient B's statement to another young person (C) overhearing a comment allegedly made by MD to Patient B and yet there is no evidence that C was ever spoken to to confirm this.

xvi. There is reference to Patient B asking other young people not to tell anyone but this is not corroborated by either Patient A or Patient E.

xvii. The DBS state that the fact that Patient B's account was detailed added significant weight to her account of events (See Barring Decision Summary document -UTAAC 273). Such a finding is unreasonable and illogical as there needs to be more than just a detailed account; there needs to be credibility that any detailed account is true and accurate. It is submitted that this is not the case with regard to the patient statements and there is no supporting or

corroborative evidence in any event. Such a finding is also unfounded as it is not accepted that Patient B's account was detailed in any event. It lacked dates, locations, full context and, where there was an opportunity for the employer to seek testimony from other young people to corroborate some of Patient B's account, this was not done. The DBS have failed in its assessment of the credibility of Patient B's account.

xviii. The DBS prefers to accept Patient B's account that interaction often occurred between herself and MD in her bedroom during PPT sessions despite the fact that there is no evidence that any such PPT sessions ever took place.

xix. The internal investigation sets out the dates of the shifts when MD worked during the months of February and March 2020. MD only worked 6 shifts during which time he did not carry out any PPT sessions with any of Patient A, B or E.

xx. The DBS suggest that the absence of records of any PPT session is down to MD failing to (or choosing not to) record them. This suggestion is totally unfounded and lacks any evidence. Indeed, closer scrutiny of the recording system (RIO) would have illustrated that MD always properly recorded any PPT sessions with all patients.

xxi. It is submitted that the lack of records of any PPT at the relevant time for these patients supports MD's account that no such sessions or meetings ever occurred.

xxii. The DBS have further failed to consider the credibility of Patient B's account (and her overall credibility) in light of the fact that several of the allegations which she made which were initially included as separate allegations within the Barring Decision Summary document- did not proceed to Minded to bar as there was limited contextual information available to establish the allegation on the balance of probability.

xxiii. The DBS come to an unrealistic finding that there is a pattern of behaviour by MD based on the fact that Patient A also describes MD as stroking part of her body.

xxiv. Patient As account should be treated with caution as there is clear evidence of the possibility of collusion between the patients. Patient B fully admits that she spoke about MD to others as it was apparently the reaction of others which led to her raising the allegations to staff.

xxv. Patient B was a friend of Patient A.

xxvi. The DBS have failed to consider the potential and credible effect of such discussions on the evidential value of any account which was subsequently provided.

xxvii. In addition to the private discussions between Patient B and other patients, the issue was also raised in a community meeting before Patient A and Patient E gave their accounts.

xxviii. The DBS have simply ignored the dangers of collusion and relied on these statements to wrongly come to a finding that there is a pattern of behaviour.

xxix. Several months after the allegations were made and Patient A had been asked about MD's conduct, she made a further allegation about him. The DBS have not considered why she did not raise such an allegation at the relevant time when assessing her overall credibility. (The allegation did not proceed to Minded to Bar due to lack of evidence).

xxx. With regard to the new allegation. Patient A was spoken to by MD's employers. A note of the meeting was made. Although the allegation did not proceed to Minded to Bar, the note is relevant to the overall credibility of Patient A as Patient A herself seems to have raised the fact that she had in the past thought things had happened when they had not: ' I met with Patient A where she began to say 'I know that in the past I have thought things had happened when they hadn't, which makes me question whether this did actually happen,..' (See Appendix A).

xxxi. Patient A's overall account of MD's alleged conduct lacked any specific dates and times. With regard to her statement which supported allegation 2, this consisted of a note of interview with CC on 6 March 2020 (Flag 3 - UTAAC 70-71). The facts are set out in a general nature with no specific details. No dates, no times, and no information providing any proper context to the events alleged. No reference to any conversations between MD and Patient A, or any of the alleged incidents came about. The only conversation referred to was when Patient A allegedly told MD 'I didn't like it' but even this statement has not been placed into any context in terms of how and when it was made and what MD said in response. As a result, as with other allegations which were initially considered by the DBS but did not proceed to Minded to Bar (see evidential analysis of allegations 3, 4 and 5 within the Barring Decision Summary document- UTAAC 287-288), it is submitted that in absence of the availability of limited contextual information, it is not possible to establish the allegation on balance of probabilities.

xxxii. Patient E's account also lacked any specific details and only referred to a conversation which she had had with Patient B. No date or context was given to this conversation (which was also not corroborated by Patient B's statement in any event). As a result, as with other allegations which were initially considered by the DBS but did not proceed to Minded to Bar (see evidential analysis of allegations 3,4 and 5 within the Barring Decision Summary document- UTAAC 287-288), it is submitted that in absence of the availability of limited contextual information, it is not possible to establish the allegation on balance of probabilities.

xxxiii. It is therefore submitted that, despite the fact that the patients made allegations which, in particular with regard to Patient B, included detailed accusations of MD's conduct, all the patient statements lacked sufficient detail with regards to specific times and dates; the fact that MD was on shift during some of the relevant time is not enough to add weight to their accounts.

xxxiv. When properly taking into account the credibility of the accounts of Patient A, B and E. the possibility of collusion (or contamination of issues), the known fact that patients are known to have misinterpreted actions by staff to be signals of friendship or personal interest when in fact the staff were carrying out professional tasks, the lack of corroboration and lack of any supporting

independent evidence, it is submitted that the DBS were wrong in finding that the Patients were truthful and honest. As a result, any finding of relevant conduct should not have been made.

b. *Professional Opinion ('gut instinct').*

i. No colleague of MD witnessed any of his alleged misconduct.

ii. No concerns were ever raised about his conduct and professionalism at work.

iii. The finding against him by his employers which led to his dismissal was based on professional opinion, based on 'gut feeling'.

iv. We submit that this is not sufficient to come to a finding of relevant conduct. (Note: there is a reference to reliance on the 'Bonner' principle - there is no evidence of such a principle).

8. The DBS has completely failed to properly assess the credibility of the accounts given by the Patients and has been too quick to discredit the appellant's account without any express justification and come to its findings with respect to allegations 1 and 2 based on pure opinion following brief meetings with the patients concerned.

APPENDIX A
(Ground 7(a)(xxx) of Appeal)

On Monday 19th October 2020, Patient A was seen in ward round and requested to speak to me afterwards on a 1:1 basis, and I said that this would be facilitated. Before I met with Patient A, Modern Matron RB informed me that she had spoken to Patient A regarding an allegation that she had made against a member of staff in March 2020, and that Patient A wanted to speak to me further about this. I met with Patient A where she began to say 'I know that in the past I have thought things had happened when they hadn't, which makes me question whether this did actually happen, however I am 99% sure that it did as I know someone else [she proceeded to name the other young person] also made an allegation against MD'. I reassured Patient A that she could take her time and there was no rush for her to tell me anything, which she was grateful for. Patient A then said 'I want to ask before I tell you anything, because I am 16 now will my parents have to know?', and then continued 'I was 15 when it happened though'. I explained to Patient A that I wasn't sure however I would clarify it, I told her that it was very likely that her parents would have to know, but that I would clarify it afterwards, which she accepted. At this point, Patient A's dad had turned up at the ward to visit her, so the conversation was cut short but I explained to Patient A that her dad would understand, but she didn't want to continue the conversation. I then reassured her that we would speak the next day which she accepted. On 20th October, I met with Patient A where she asked again if her parents would have to know, and I explained that I would still need to get clarification on that. Patient A then said 'what I said before [in previous statement] did happen, but there was more stuff that happened as well'. Patient A appeared to be struggling so I reminded her that she could take her time, and I asked her would she prefer to write it down, to which she replied 'no because then there would be evidence of it'. Patient A went on to say 'I think I am going to regret saying anything because I don't want to fuck up his career', and then said 'well his career is probably already fucked up to be honest'. It was silent for a while and Patient A then continued, saying 'he touched my back and then went down further', I waited

for Patient A to continue. She then said ‘he stuck his fingers inside me and went like that inside me’ and at this point she was showing me two fingers and was making a wiggling motion. Patient A repeatedly said that she didn't want to get him into trouble, and I gave Patient A reassurance explaining that although it may be difficult for her, she should try not to worry about the consequences for him and seek support for herself where she needs it, which she accepted. The conversation began to draw to a close and I asked Patient A if there was anything else that she wanted to speak about, she then said ‘A lot of me knows that it was wrong, but part of me felt wanted’. Patient A was offered support by myself and I reassured her that I would speak to her again later that day if she was struggling. The conversation ended at that point.