Neutral citation number: [2025] UKUT 221 (AAC)

Appeal No. **UA-2022-000770-V**

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

RO

Appellant

-v-

Disclosure & Barring Service

Respondent

DECISION OF THE UPPER TRIBUNAL

Upper Tribunal Judge Mitchell
Upper Tribunal Member Jacoby
Upper Tribunal Member Smith

Hearing: 12 July 2024, Rolls Building, central London

Representation:
Appellant: Laura Bayley, of counsel, instructed by Star Legal Solicitors
Respondent: Ashley Serr, of counsel, instructed by solicitor to DBS

On appeal from:
Decision-maker: Disclosure & Barring Service (DBS)
DBS reference: 00944631125
Decision date: 31 December 2022

SUMMARY OF DECISION

65. Safeguarding Vulnerable Groups
65.1. Children's Barred List
65.2. Adults' Barred List.

Judicial summary

DBS' barring decisions involved errors of law in that DBS' analysis of the evidence failed to take into account a number of relevant considerations. The Upper Tribunal remits the matter to DBS to reconsider the Appellant's barring, and its new decision must be based on the findings of fact set out in the Upper Tribunal's reasons for its decision.

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

DECISION

The decision of the Upper Tribunal is to allow the appeal. Under section 4(6)(b) of the Safeguarding Vulnerable Groups Act 2006, the Upper Tribunal remits this matter to DBS for a new decision. By virtue of section 4(7)(a) of the 2006 Act, the new decision must be based on the findings of fact set out in paragraph 147 of the Upper Tribunal's reasons for its decision.

REASONS FOR DECISION

Introduction

1. In these reasons:

- "2006 Act" means the Safeguarding Vulnerable Groups Act 2006;

- "DBS" means Disclosure and Barring Service;
- "Home 1" is the establishment referred to in paragraph 2 of these reasons;
- "Home 2" is the establishment referred to in paragraph 10 of these reasons;
- references to pages are to pages of the Upper Tribunal bundle.

Factual background

Evidence before DBS

Allegation 1 – sleeping on duty, 13/14 December 2019

2. Allegation 1 concerned events at a care home capable of accommodating six residents aged 16 to 25 (Home 1), operated by the Priory Group. The Appellant began working at Home 1 as a waking night support worker, as a permanent employee, in December 2017.

3. On 17 December 2019, KJ, a manager or supervisor at Home 1, interviewed support worker TE who was the sleeping night worker on 13/14 December 2019. The Appellant was the waking night worker. The note of the interview (p.58) reads as follows:

> "KJ. I am speaking to you following receipt of your email dated 14.12.19 where you have informed me that [Appellant] was asleep during his shift. This has been reported as a safeguarding incident and I have been asked to conduct the investigation by MM the home manager.
>
> Can you tell me in your own words what happened on the night of the 13.12.19?
>
> TE. At 22.00 I had finished shift and handed over to [Appellant] there was not any significant issues to handover.
>
> KJ. Was [redacted] in the house at handover?
>
> TE. He had left the house at around 20.00 and had gone to his friends on London Road.
>
> KJ. Was that handed over to [Appellant] during Handover?

TE. Yes it was [Appellant] had been told that only [redacted] was in the house and that [redacted] would be back around 04.30.

After handover I sat in the lounge and watched some TV before going to the sleep room at around 22.30.

KJ. Where was [Appellant] when you went to the sleep room?

TE. He was sat in the office with the door open, he was looking through some paperwork.

KJ. What happened next?

TE. I settled in the sleep room and around 23.00 settled to sleep. I was woken around 02.00 as I believed that I could hear [redacted] outside on her phone. Believing that [Appellant] was aware I did not get up to investigate. Although I am a very light sleeper, I could not recall hearing [Appellant] challenge [redacted] as to why she was outside at that time.

I settled back to sleep and was then woken by the doorbell at 04.23. I heard the bell ring again and a third time, and got up to let [redacted] back in the house. [redacted] was on the Phone to his parents at the time I opened the door and was heard to tell his parents, that all was ok as TE has just let me into the house.

[redacted] asked where was the Waking Night Staff and why had TE come to open the door. The office door was locked, and so we went to the lounge and found [Appellant] asleep on the sofa.

[redacted] went up to bed and informed me that this had happened before with [Appellant].

I returned to the sleep room, but was unable to settle. I heard [Appellant] moving around at 05.00.

…KJ…may I ask why you did not wake [Appellant] when you found him asleep on the sofa?

> TE: I have asked myself that question and I am not able to answer that myself. I wanted to get [redacted] to bed and settled.
>
> …KJ. May I ask why did you only report this via email to me, and not by phone to our on call MM the home manager on the Saturday 14.12.19.
>
> TE. I was unsure of how to report this, either officially or unofficially.
>
> …I did speak with CC my Team Leader, who advised me that it would have been better dealt with him speaking to [Appellant] when he came in to work on the night of 14.12.19. I said that doing that would only warn [Appellant] that he had been caught.

4. On 23 December 2019, KJ conducted a supplementary interview with TE, the note of which reads as follows (p.54):

> "KJ…Can you please tell me the environmental setting when you went to the lounge with [redacted] what lights were on? Was the television on? Did you see anything in the hands of [Appellant]?
>
> TE. The Christmas lights were on in the lounge. The dining area lights were off. The rest of the house was also in darkness. The television was on, on what I would describe as a normal level. I did not observe anything in [Appellant]'s hands at the time.
>
> KJ. Was [Appellant] talking in any way, even under his breath.
>
> TE. No. He was still and quiet.
>
> KJ. That is the end of my questions…".

5. CC was the day support worker to whom the Appellant 'handed over' on the morning of 14 December 2019. On 17 December 2019, KJ interviewed CC. The note of the interview reads as follows (p.55):

> "KJ. It has been alleged that [Appellant] was asleep on shift on the night of 13/12/19…you were on shift on 14.12.19 and would have received a handover from [Appellant] when you came on shift. Is this correct?

CC. Yes I was on shift and received a handover from [Appellant].

KJ. Can you tell me what was handed over to you?

CC. I was informed that only [redacted] was in the house [redacted] was on home leave, [redacted] was out and had not returned to the home over night.

…After [Appellant] had left I spoke with TE who had been on Sleep shift during the night, and she informed me that [redacted] was in fact in the house and had returned around 04.30 and when she had opened the door both she and [redacted] had found [Appellant] asleep on the sofa in the lounge.

Whilst doing [redacted]'s medication, he also informed me that [Appellant] was asleep when he returned from his night out, and that TE had opened the door for him.

…KJ. May I ask why you chose not to contact On Call and inform her of the situation a team member had brought to you?

CC. I was led to believe that this had been done via email and that it would have been followed up by the home management in due course…".

6. On 19 December 2019, Home 1's registered manager, MMG, interviewed the Appellant, the note of which reads as follows (p.56):

"MMG: I explained to [Appellant] that it has been alleged that on the shift he worked 13/14 December 2019 he was seen lying on the sofa, assumed asleep and this was observed by TE and a resident [redacted].

…Were you asleep on duty on the night of 13/14 December 2019?

Appellant: I was not asleep and I contest that allegation.

MMG: A member of staff says that they saw you at approximately 4.30am asleep on the sofa in the lounge.

Appellant: I think this member of staff was [TE] but I was not asleep I was praying and she is mistaken; she should have said something to me.

MMG: Was anyone with TE?

Appellant: I did not see anyone with her. When I finish my duties at approximately 02.30am I sometimes go into the back room with my bible and pray.

…I pray at intervals throughout the night and I am sometimes deep in prayer that I don't always notice things around me. I also fast.

MMG: Do you think it is acceptable to lie down on the sofa when you are on duty?

Appellant: Once I have done my duties I often lie down on the sofa to watch the television or pray.

MMG: Are you able to hear the doorbell from where you sit/lie?

Appellant: I will hear the bell if it is rung.

MMG: What information were you given at handover?

Appellant: I was told that [redacted] was out and he would be back late.

MMG: What time did [redacted] return to the house?

Appellant: He did not return to the house and this is what I told the day staff.

MMG: [redacted] did return to the house and TE had to get up from the staff room to let him in after hearing the bell ring three times and the door remained unanswered. Both of them then came into the lounge where they saw you lying on the sofa and described you as being asleep.

Why didn't you hear the bell?

> Appellant: I do not know. I didn't hear it. It is my responsibility to complete my duties and I did not hear the bell but I was not asleep…".

7. On 19 December 2019, MMG emailed the Appellant stating "attached is the transcript of today's conversation. If you agree with the content please return to me indicating that you agree" (p.66). On 20 December 2019, the Appellant replied stating, "I agree with the above interview content", and adding (p.66):

> "1. As the lounge TV is always left working at night, I may not have heard if the door bell was rang by anyone and the reason I was informed to always go about the flat with office phone, unfortunately this was not made use of by [redacted] when he returned to flat.
> 2. My staying at the lounge was an agreement between myself and Dave when I complained about the temperature of the staff office at night time…".

8. On 14 January 2020, the Appellant's employer held a disciplinary meeting, which the Appellant attended. The written note of the meeting includes (p.60):

> "Appellant: …I do not feel that the investigation was subjective [*observation*: *presumably, 'objective' was meant*] as I feel that historically there have been issues between myself and KJ…
>
> ..the office is near the front door. The lounge however is a long way from the front door and the doorbell can only be heard very faintly from the lounge location.
>
> The main reason that I have been asked to walk around the house with the mobile phone is because of this. The YP [*young people*] know to call the phone if they do not get a response from the doorbell. This night the YP did not call the phone. It was in my pocket and I would have heard it if they called.
>
> I always pray somewhere between 4:00am and 5:00 am. I get the cleaning done at about 02:30 am and not before because the YP [*young people*] like to come into the kitchen up until about 01:00 am. It takes about an hour and a half to complete the cleaning and then I do my prayers.

…The lights are out in the main part of the house to discourage the YP from being up and entering the kitchen etc. The Christmas tree lights were on and the TV was on so it wasn't very dark.

I was aware that [TE] came into the lounge whilst I was praying however no one else was with her, I looked at her briefly and then carried on praying. If she believed that I was asleep she should have tapped me on the shoulder or said my name – we have a collective responsibility to the young people in our care.

In her statement it says that TE took the YP to his bedroom. He is 18 years old and no one does this.

I didn't hear the bell and the telephone was in my pocket. I was not asleep.

No one has opened to door before to this YP. He always calls to let me know when he is on his way back. He hadn't called that night but he does know to call if no one answers the door.

[Manager of Home 1]: The lounge is down the other end of the house. Am I right in saying that there are no actual walls between the lounge area and the front door?

Appellant: That's right.

…Manager: You say that you were aware that TE came into the lounge. Can you clarify if there was any eye contact?

Appellant: I looked up at TE but there was no eye contact. I lifted my head and saw her. I don't break my prayer unless it's quite necessary. I didn't think there was any need to acknowledge her. I didn't see the YP. If I'd known the YP was present, I would have broken the prayer and acknowledged them.

Manager: TE said that you were lying down on the sofa with your eyes closed and you were very still. She clearly thought that you were asleep. Is this the normal way that you would pray?

Appellant: When I want to commune with god I do lie down quietly. When I pray in the office I sit and lean on the desk but in the lounge I lie on the sofa.

> In her statement she says she saw me at 04:25am asleep but then she says she heard me walking around at 05:00 am. This is confirmation that I was praying because this is my normal behaviour. I pray at a point between 4:00 and 5:00 am and then after praying I get on with my shift and walk around the house.
>
> Manager: Where TE was sleeping, i.e. in the sleep room. Is this closer to the front door?
>
> Appellant: Yes much closer than the lounge. It is parallel to the front door.
>
> …[Manager]: In hindsight would you have done anything differently?
>
> Appellant: I don't think I could have done anything differently. If I had heard the bell there is no way I would not have responded. If I could have been in the office rather than in the lounge I would definitely have heard the bell.
>
> [Manager]: Do you accept the allegations being put to you?
>
> Appellant: No, I strongly object to them. I was not asleep…".

9. On 16 January 2020, the Appellant's employer informed him by letter that the outcome of the disciplinary meeting was that he would be issued with a final written warning, to remain on his file for 12 months. The outcome letter, written by Home 1's manager, included the following (p.68):

> "…The evidence…shows that you were unaware of the doorbell ringing and unaware that another member of staff answered the door and subsequently let the young person in.
>
> The staff member and the young person both came into the lounge to find you. The staff member witnessed you lying very still on the sofa with your eyes closed and therefore believed that you were asleep…
>
> You have noted in your mitigation that the doorbell is difficult to hear from the lounge, I have therefore visited the home and tested this and I can confirm that in the middle of the day (when the house is arguably more noisy and active) the doorbell could be clearly heard from the lounge location.

> We can confirm that you were not adequately alert and aware of your surroundings during this timeframe as you failed to hear the doorbell ring three times and you failed to notice that the young person was present with the staff member…".

Allegations 2 and 3 – failing to support young people in line with care plans and failure to follow safeguarding procedures (night of 6/7 November 2020), and prior failure to report a safeguarding concern

10. Allegations 2 and 3 are linked and so we shall describe them in the same section of these reasons. They concern events at a registered children home (Home 2), also operated by the Priory Group, in late 2020. By this time, the Appellant was a member of Priory Group 'bank' night support staff, having resigned as an employee in April 2020, and it was in this capacity that he was working at Home 2.

11. An undated report prepared by Home 2's management about events on 6/7 November 2020 (p.70) stated as follows:

> "RDW [day staff member] arrived on shift at 7am and greeted CG and [Appellant], RDW asked for a Handover for the night from [Appellant]. [Appellant] reported that there were no disturbance during the night. RDW asked if anyone got up. [Appellant] said that [redacted] had been to the toilet once.
>
> CG had been standing in the hallway when RDW arrived, he told RDW that he had heard talking in [redacted]'s bedroom. RDW went over to [redacted]'s bedroom door and listened at the door. RDW could hear giggling. Upon opening the door RDW saw that both [redacted] and [redacted] were in the bedroom. Both [redacted] and [redacted] were naked, [redacted] was laying on [redacted]'s bed looking relaxed and [redacted] was stood at the end of the bed.
>
> …[redacted] said that [redacted] told him that if he took his clothes off that he would give him pocket money for three months. [redacted] said that [redacted] has been knocking on his door many times during the night and that after using the toilet he found [redacted] in his bedroom.

RDW walked out of the room to speak with CG. Whilst out [redacted] said to VS "He tried to fuck me"".

12. On 7 November 2020, Home 2's registered manager, LW, had an 'informal conversation' with the Appellant. The written note of the conversation (p.71) included:

"LW: Can you tell me about last night's shift?

Appellant: There was not anything that really happened. I was in the office I shut the door to read my book after my cleaning around 12:45. At 12:45 I turned off the toilet light and shut [redacted]'s bedroom door having observed him sleeping. At about half 2 I heard movement and when I opened the door to see who was walking I didn't see anyone and I assumed that [redacted] had used the toilet. I noticed [redacted]'s bedroom door was shut, and I saw that the light in the toilet was on that's why I believed he was the one who used the toilet. That was all that happened during my shift until this morning when he woke up around 7. He came to my office and asked what time was it, I said it's 6:55 and that today is Saturday and he can go back to bed.

LW: After you heard movement and checked did you close the door again?

Appellant: I closed the office door again.

LW: Why did you close the office door?

Appellant: When I came on shift the upstairs light is always off to discourage [redacted] from coming out of his room. Each time I see him open his door I always ask him to close it.

LW: Did you record the activities for the night?

Appellant: No, because I could not find any pens I was thinking that on tonight's shift I could document everything then.

LW: Did any other YP come out between [redacted] coming in the office and staff coming in on shift?

Appellant: No, I went downstairs to open the door for the day staff at 6:55-7:00am.

LW: Was you aware of any movement then?

Appellant: No not that I know of.

LW: Are you aware of the risks and behaviours the boys may display?

Appellant: Not really but there was a time I noticed something that could be a risk, 2 weeks ago around early in the morning. I wanted to open the front door for the day staff, [redacted] was in the toilet and [redacted] was also out he opened the bedroom door at the same time I needed to go downstairs to open the door for the day staff. I saw him going to [redacted]'s bedroom and I stopped and I didn't go downstairs and I asked him to go back to his room, he hid by the toilet I had to be firm with him to go back to his room. In between the time [redacted] came to meet me where he was trying to distract me to get [redacted] into his bedroom. I insisted [redacted] to go back to his bedroom. He then went to his room, and [redacted] went to his room. KIA [day staff member] was on shift I do not know how she got in but someone let her in, she came to where I was and she helped.

LW: Did you hand it over to anyone?

Appellant: Unfortunately no I didn't.

LW: Why?

Appellant: I do not know why because I know I'm supposed to document it to be discussed.

LW: Have you read the boys paperwork?

Appellant: No.

LW: Why?

> Appellant: Each time I come to work there is a handover and there was no mention of any risk among the young people in the past or within the time I have worked here so I just thought that the young people were settle with no risks that could potentially put them in danger. The only thing I am aware of is I need to support them at night if they need my support. I asked on my first shift here if there is a need for me to do observations throughout the night whilst they are asleep and they said no.
>
> LW: Do you know which staff that was?
>
> Appellant: I can't remember but I know I asked that question clearly if there is a need for me to check on anyone I am supporting throughout the night. If I am told no I believe the risks to be minimal and if I am cleaning in the night I tip toe and work quietly so I don't wake them up.
>
> LW: Are you aware that when working in all homes you are supposed to read their paperwork?
>
> Appellant: Yes, I know.
>
> LW: Is there anything else that you wish to add?
>
> Appellant: If I understand the context of the interview, I might be able to say something.
>
> LW: Currently I cannot disclose anything I will get back to you earlier next week with further information."

13. The note of the informal conversation was signed by LW and the Appellant, with both adding "7.11.10" after their signatures.

14. On 18 November 2020, LW conducted an interview with the Appellant. The assistant manager, HP, was also present. The note of the interview included the following (p.73):

> "LW: …there is an investigation that is ongoing relating to a safeguarding matter when you were last on shift on 6th November 2020, and into the morning of 7th November 2020 where two young people were found to be in each other's

bedroom. Both boys were naked and have made strong allegations against each other of a sexual nature.

Can you tell me about that night's shift?

Appellant: Exactly what I said the last time that's what it was I won't be able to remember very clearly…

LW: Why did you close the door?

Appellant: I closed the door because I don't want to distract [redacted] with the light and closed [redacted]'s door so no light is left on upstairs, so if I open the door the light will be on the landing.

LW: You stated you closed the door to read a book, is there any possibility you could have fallen asleep?

Appellant: I'm a waking night so I don't fall asleep.

LW: Are you aware of the safeguarding protocols and policies? You have signed the staff sheet to say you are.

Appellant: I signed one at [redacted] but not here, my understanding about the policy is to ensure the YP don't go out at night without notifications and that children are not allowed into the bedrooms after 10 pm

LW: I spoke to you before on 5th October when you came on shift at 09:30 and went into the lounge to watch match of the day. I informed you that you needed to be in the staff office on the middle floor with the door open to safeguard the children as they display sexualised behaviours, why did you then feel it was ok to close the door on the middle landing when on shift?

Appellant: Like I said I closed the door because of the light and maybe I had forgotten that you said to keep the door open. I have concerns about the policy- both were found in [redacted]'s bedroom naked what safeguarding did you put in place to ensure the yp are safe?

LW: the waking night is there to ensure the YP are safe.

Appellant: I'm not being rude just factual if we have noticed this and im part of this I need to let you understand things are lacking. The reason is as I'm a waking staff who is equally assigned to do the cleaning and the washing and ironing.

…LW: You told me before that there was no movement before 2am and that you had finished your cleaning duties at 12:45.

You previously stated there were no pens to complete the log-you arrived for shift at 930 and day staff were here until past 10pm. Why did you not ask for a pen at that point to sign in?

Appellant: When I came they were all in the office and gave me a key- I went on to start my cleaning, I didn't sign in that day.

LW: Are you aware that when working in all the homes it is your responsibility to make sure you have read and signed all the YP paperwork as this tells you the risks and how best to support them, why was this not completed?

Appellant: I was not given them to sign, I don't normally ask but been prepared by management for staff to sign.

LW: Is there anything else you wish to add?

Appellant: yes please, I was trying to pass across and be clearer, that the time the staff found the YP in the bedroom does not matter; it could have happened when I was cleaning up to roughly 1 am.

LW: you stated you heard movement at around 2am.

Appellant: before that moment I went downstairs to do the washing when I came back I shut the office door when I returned 10 mins after that I heard movement so when I went to see, the toilet light was left on and that was the reason I thought it was [redacted]. Because I was told they were settled in bed I wasn't told I needed to do a visual check and I assumed [redacted] was the one who used the toilet and then went back to his room. I didn't do the visual check because of the need to avoid him asking me to read a story as he normally does.

LW: Would it have been a problem to read him a story if needed?

Appellant: No but because I didn't want to keep him awake unnecessarily, I want to know like I said if there is a concern I would do visual checks but because [redacted] has history of using the toilet which is by his bedroom I assumed it was him then went back to his room. It doesn't matter if I closed the door."

15. The note of the informal conversation was signed by LW, HP and the Appellant, with each adding "18.11.10" after their signatures.

16. A management report about the events of 6/7 November 2020, dated 14 December 2020, included the following (p.80):

"…**Background to the service**

[Home 2] is a five bedroom Children's Home that meets the needs of young persons who have Behavioural, Emotional and Social Difficulties between the ages of 7-18 years.

…Due to the current risk of the young people within the home it is required there is 4 people on duty during the day and 2 people on duty throughout the night, unless risk assessed otherwise by management.

Background to the Employee

[Appellant] started working for the Priory Group on 18th December 2017 as a full time waking night, he resigned from this permanent role on 9th April 2020 and has since transferred over to a bank contract as of 10th April 2020.

There is a previous allegation of [appellant] allegedly being found asleep whilst on a waking shift…The outcome was that he was not fully alert throughout his shift in order to adequately safeguard the young people in our care and he was issued with a final written warning…

Evidence review

[*recounts what was written in the report referred to in paragraph X above*]

Young person 1 [in whose bedroom both young people were discovered] went on to make an allegation stating that young person 2 had tried to 'fuck him' and stated that 'if he got naked he would give him his pocket money for the next 3 months'…

Young person 2 then went on to make an allegation against young person 1 stating that he 'had throat slammed him on to the bed and laid on top of him and it hurt'…

[*recounts what was written in the notes of the informal conversation referred to at paragraph X above, and the interview referred to at paragraph X, save that the management report does not mention the Appellant's claim that he was told it was Home 2 policy to keep the office door shut to minimise light nor his claim that no paperwork about young people at Home 2 had been provided to him*]

Young person 2's core documents…highlight a previous safeguarding concern at the beginning of the year where an allegation was made against him of a sexual nature in receipt of toys and money.

In young person 1's core documents…it states he can display sexualised behaviours towards others and that due to his FASD [*foetal alcohol spectrum disorder*] it increases his vulnerability and impacts upon his level of understanding.

[Appellant]'s training matrix…shows he is up to date with his safeguarding children, his sexually harmful behaviour FFG modules and his face to face safeguarding level 3.

…[Appellant] stated that he had noticed YP2 try and go into YP1 room prior to this incident and did not hand this over to the team, admitting that he knows he should have…

[Appellant] stated he did not see which YP came out of their room and assumed this was YP1. He did not enter bedrooms to double check any of the YP. He stated he didn't check YP1 because he didn't want him to ask [Appellant] to read him a story.

…[Appellant] failed to report concerns the first time he noticed YP2 trying to get into YP1 bedroom.

…[Appellant] did not check to see who had come out of their room which resulted in sexual harmful behaviours (seeing each other naked and going on to make allegations against one another).

…[Appellant] did not read the YP BSP [*behaviour support plan*] therefore was unable to support the YP in line with their plans.

…[Appellant] did not read boys paperwork and admitted he knew he should have.

…[Appellant] did not record or report his concern the first time round, therefore we were unable to demonstrate effective, caring and responsive service to keep both YP safe.

…The child's wellbeing was not promoted or protected as [appellant] failed to keep them safe. It is sexually harmful for the boys to see each other naked. The impact this will have on them both when the ground work starts with both YP and the realisation of what has happened will mean both boys will experience shame.

…Neither boys dignity was protected due to not being safeguarded and that [appellant] assumed YP1 went to the toilet/left his room when in fact it was YP2 who left his room. Had [appellant] checked YP1 that night, he would have identified immediately that YP2 was in [redacted]'s room. All involved state there was movement at roughly 2am. Day staff heard giggling in YP1 room at 7am- this means there is a high probability that there was a 5 hour period where both boys were in YP1 room unsupervised.

Mitigation

[Appellant] has stated that he closed the office door and states this is so the light does not disrupt the young people during the night.

> [Appellant] states he did not check on YP1/2 after thinking it was him who used the toilet during the night due to YP1/2 may have wanted a story read to him and did not want to encourage YP1/2 to stay awake.
>
> **Conclusion**
>
> …[Appellant] was aware that an YP had left their bedroom at 2:00 am to go to the toilet; however, [appellant] did not check whom this was or where they then went, therefore this led to both young people being unsupervised in a young person's bedroom for a period of up to 5 hours.
>
> …within [Appellant]'s investigation meeting he confirmed that he was aware that the young people do display sexualised behaviours [and] that he was aware of a previous incident where YP2 tried to access YP1's bedroom however he failed to report this incident in line with policy, although he stated that he realised that he should have.
>
> …it is probable that the allegations are correct and I am therefore upholding all three of them.
>
> …my decision is that [appellant]'s bank agreement is terminated with immediate effect…".

17. The Appellant was informed of the Priory Group's decision by letter of 18 December 2020 (p.88).

18. In tandem with the Priory Group's disciplinary investigation, the events of 6/7 November 2020 were being considered by the relevant LADO (local authority designated officer, whose role under UK Government guidance is to manage allegations against adults who work with children). Priory Group referred the matter to the LADO on 9 November 2020.

19. An initial LADO meeting was held on 11 November 2020. Much of the minutes of the meeting (p.90, dated 16 November 2020) are concerned with the risk of sexual harm posed and faced by the two young people, which we need not set out, but the minutes also record that, following the incident, Home 2 changed its operating procedures "which primarily ensures that the children are supervised at all time throughout the day and night". Home 2 aimed to have two waking night staff situated

on the landing between the two young people's bedrooms, rather than one in the office, although implementing this measure had been hampered by staffing difficulties. Door alarms were also to be fitted to the doors of YP1 and YP2's bedrooms. The minutes also:

(a) record the manager's view that YP2 could not have entered YP1's bedroom at handover because this would have been witnessed by staff;

(b) state "on 09/11/20, [YP2] alleged that at about 6.50 am on 07/11/20, [YP1] knocked on his door and asked him for sex. [YP2] said that [YP2] 'poked me in the back, choke slammed and threw himself on top of me, he got on top of me and hurt me'" and "[YP1] has not wished to discuss the incident any further to date". The incident as reported by staff at Home 2 was that YP2 entered YP1's room, not the other way around as per YP2's reported account;

(c) under the heading "*SS [social worker from placing local authority] questioned the processes in place to ensure bank staff members were fully informed of young people's individual needs and care plans*", state:

> "When new bank staff come in, a verbal handover is given, and documents provided with details about all the children such as their risk assessments and support plans. Staff must read and sign to confirm they have read all of this paperwork.
>
> Day staff provide night staff with updates every day to let them know if anything has occurred which requires visual observations to take place throughout the night (this only happens when incidents or behaviours have occurred to warrant it to avoid institutionalising the children unnecessarily)…both [YP1] and [YP2] have presented with self-harming behaviours and used ligatures; LW confirms that all staff are aware of this, but again adds that nightly visual checks would usually only be completed if there were presenting as unsettled or dysregulated.";

(d) under the heading "[LADO / Chair] questioned the expectation placed on waking night staff members in terms of their duties during shift":

> "…cleaning duties were increased in response to COVID-19, but as they arrived at 9:30pm and Day Staff don't finish until 10pm, this should have taken place

> whilst other employees were still present. They were then expected to work in the staff office located on the same landing on the boys' bedrooms, with the door open at all times so they could see every bedroom and hear anything going on. They would have been expected to carry out any necessary paperwork, training or other office-based activities. Some would bring in their own coursework or research projects to complete. If a young person woke up distressed or was struggling to sleep, Waking Night staff would settle them.";

(e) state, "there is evidence that this staff member had not read and signed this paperwork even though he knows he should have. This is being investigated".

20. A subsequent LADO meeting was held on 25 November 2020. The minutes of this meeting (p.100) include the following:

> "…LW [manager of Home 2]…shared that she has two waking night staff where possible however this is not often. Instead waking night staff have been taken off cleaning duties once the day staff have left…".

DBS' decision making

Referral to DBS

21. The Appellant was referred to DBS by the Priory Group (p.40). The referral form listed all training courses completed by the Appellant, and gave a brief description of his role which said he was "responsible for duties such as waking nights, cleaning and working with other professionals". The reason for referral was that, on 7 November 2020, the Appellant failed to: support a service user in line with care plans; follow safeguarding and monitoring procedures; follow reporting procedures "after noticing a concern previously".

Representations against barring

22. The Appellant provided written representations in response to DBS' 'minded to bar letter', which argued:

(a) barring would prevent him from continuing to pursue a Masters in mental health nursing and end his dream of becoming a mental health nurse;

(b) as an "awake support worker", he was required to carry out hourly observations once the young people were asleep as well as a range of additional duties including washing and ironing clothes, and cleaning the kitchen, lounge, all toilets and all bathrooms. Cleaning tasks alone took up at least 8 hours of the Appellant's night shift;

(c) he was informed that, at Home 2, no light was to be left on in the corridor alongside the young people's bedrooms, and "office door also needs to be closed for the same purpose";

(d) on the night in question at Home 2, at about 2:15 a.m. he noticed that a young person was using the toilet, which was this young person's normal routine, and the appellant deliberately did not engage with him;

(e) on that same night, there was no pen available so he could not document nightly activities. At the end of his shift, the incoming staff member also had no pen, saying she would get one from the manager's office when it was opened at 8 a.m., so the Appellant did a verbal handover instead;

(f) at the end of the 'informal conversation' with the manager of Home 2 (see paragraph 12 above), he was asked to sign a note of the conversation, which he did, but the manager refused to provide him with a copy. The manager then pretended to call a HR manager for permission to provide a copy, but the non-existent HR manager did not, of course, answer the call;

(g) the Appellant was not told during the informal conversation what concerns had been raised. He learnt about these for the first time during the subsequent interview with Home 2's manager;

(h) the Appellant's previous experience of problems with the two young people was a short time before 7 November 2020 when, at about 7 am, one tried to get into the bedroom of the other. The Appellant and a staff member (KIA) helped to prevent this , so KIA was "clearly aware" of the incident;

(i) towards the end of the interview with Home 2's manager, the Appellant politely suggested a number of actions that could be taken to minimise night time risks at the home, which included having two waking night staff and lighting the corridor to "allow visibility of movement". The manager became angry at this. The Appellant accepted that he had not read the company safeguarding policy but added that he had not been

given a copy. The manager said it was his responsibility to ask for a copy. The Appellant said he could not have obtained a copy from the manager's office because it was locked at night. He also told the manager that she ought to share with staff her knowledge of these children's "sexual disinhibited behaviours";

(j) the employer's response could well have been influenced by Home 2's manager's anger that the Appellant had identified safeguarding weaknesses at the home;

(k) there were inaccuracies in the record of the 'informal conversation' with the manager of Home 2:

(i) it was held at 10:45 not 21:45;

(ii) it was more likely that one young person entered the bedroom of the other at around 7 a.m., rather than 2 a.m., after asking the Appellant for the time;

(iii) the previous incident at Home 2 was 'handed over' to staff member KIA. He did not document this but thought it was KIA's responsibility because it occurred after 7 a.m. that is after his shift had ended;

(iv) the record of the conversation did not include the Appellant's statement that he could not read the 'boy's paperwork' because it was kept locked in the manager's office.

23. The Appellant's solicitor also provided written representations on his behalf:

(a) at Home 1, the Appellant was allowed to use the lounge at night because the office was very cold;

(b) TE's evidence that, at Home 1, the Appellant was asleep was of doubtful reliability. If the Appellant was sleeping, why did TE not immediately wake him and report the matter as a safeguarding concern?;

(c) after the Home 1 incident, and the Appellant's resignation as a permanent Priory Group employee in April 2020, they asked him to become a bank support worker, which was indicative of their faith in him and belief that he was not a safeguarding risk;

(d) the Appellant worked infrequently at Home 2 because, by late 2020, he was only a bank worker and had a number of other commitments. He had never worked there while a manager was on duty. The absence of a manager meant that the Appellant never had the opportunity to see any care plans (locked in manager's office). At no point was the Appellant told about specific risk factors for these two young people, in writing or on a handover. All he was told was that they might try to move around and not stay in their bedrooms. The incident a few weeks earlier did not involve sexualised behaviour;

(e) at Home 2, the two young people could not have been together from 2 a.m. because the Appellant would have noticed this on his hourly checks;

(f) the LADO's recommendations for increased safety measures at Home 2 supported the Appellant's version of events;

(g) in the Appellant's case, and without prejudice to his argument that there was no 'relevant conduct', there were no long-term factors present, of the type used in DBS' structured decision-making process, such as to make barring him from working with vulnerable adults a proportionate response;

(h) a number of supporting character references were supplied, many from healthcare and social care professionals.

DBS' decision

24. On 31 December 2021, the DBS decided to include the Appellant on the list of persons barred from working with children and the list of persons barred from working with vulnerable adults.

Incident at Home 1 (Finding 1)

25. DBS' decision letter included a finding of fact that "on the 13th December 2019 whilst working as a Night Support Worker at [Home 1] on waking nightshift, you slept on duty" (allegation/finding 1). The finding was based on the following analysis of the evidence and the Appellant's representations against barring:

(a) "on the waking nightshift of the 13th December 2019, you laid on the couch in lounge area and fell asleep on duty. It is accepted that you had raised concerns about

the office condition and management were aware that the lounge could be used by staff. However, concerns remain that your actions led to a service user being unable to gain entry to the house in the early hours of the morning";

(b) "It is acknowledged from your representations that you suggest that it is one word against another, however the service user also confirmed they had witnessed you asleep. Therefore concerns are raised in your irresponsible and reckless behaviour, further supported by you confirming the service user had not returned home in your morning handover to CC, when in fact the service user had returned";

(c) "your suggestion that you were deep in prayer does not seem plausible, you were unable to hear the doorbell on multiple occasions, were unaware the service user was allowed into the house by your colleague and were unaware that your colleague and the service user witnessed you asleep on the couch";

(d) "you suggest the loudness of the television could also account for you not hearing the doorbell, however the information received from Priory that the doorbell is loud enough to be heard from the position even on this busiest of days is deemed credible."

Incidents at Home 2 (Findings 2 and 3)

26. DBS' decision letter included the following findings of fact:

(a) "on the 7th November 2020 whilst working as a Night Support Worker, you failed to support service users in line with their care plans and also failed to follow safeguarding and monitoring procedures. Which resulted in two Child service users being alone and naked in a bedroom together" (allegation/finding 2);

(b) "on an un-specified date, you failed to follow reporting procedures after noticing a previous concern" in that "you failed to report a previous safeguarding concern between the two Children, which if reported correctly may have prevented the incident on the 7th November 2020" (allegation/finding 3).

27. Findings 2 and 3 were based on the following analysis of the evidence and the Appellant's representations against barring:

(a) "DBS are … satisfied that on the waking nightshift of the 7th November 2020, you had shut the office door of [redacted] to read your book, even after you were aware

that a young service user had left their room to go to the toilet and through your own initial admission, did not check that the service user was safely back into their room over fears that you would have to read the service user a book";

(b) "This apparent negligence resulted in two young boys with documented sexualised behaviours and complex needs being left alone in a bedroom, resulting in them both being naked and both alleging sexual assault, which caused significant emotional and physical harm";

(c) "your version of events in your … representations are dramatically different to the version you gave in the internal investigation, which have been presented to the DBS as being signed by yourself and the witnesses present, however there is still no evidence or documentation that suggest you carried out hourly checks and in your representations you also state that it was impossible for you to oversee all the rooms and floors of the building due to your chores, such as cleaning and therefore concerns remain in your apparent irresponsible and reckless behaviour.";

(d) "It is acknowledged that your shift patterns meant that you could not carryout an induction to [Home 2] and this could account for you being unable to access the children's care plans which would have highlighted the sexualised behaviours on record. However, it would be considered appropriate to any experienced support worker that after previously witnessing concerning behaviour between YP1 and YP2, the care plans of both would be sought. There is no evidence to suggest that you attempted to obtain the children's care plans at any point.";

(e) "Consideration is also given to your representations in which you state that if you were unaware of the high risk behaviours and felt aggrieved that you were placed in that position and would not have worked there if you had been aware, however it is well documented that is a five bedroom children's home that meets the needs of young people who have behavioural, emotional and social difficulties between the ages of 7 – 18. Therefore it does not seem plausible that you were unaware that the service users could display challenging behaviours and why it was your duty to report the previous incident you witnessed when YP2 attempted to get into YP1's bedroom.";

(f) in relation to Finding 3, "it is acknowledged that you were on handover at the time and you assumed a colleague would report the incident, however it is your duty to report such incidents and there is no evidence that you reported the incident nor did you follow up to ensure it had been recorded correctly."

General findings and considerations

28. DBS' decision letter also stated:

(a) "you have engaged in conduct which harmed or could harm children and vulnerable adults";

(b) "It is acknowledged that you have worked in regulated activity for a number of years and the positive feedback from professional peers who all have significant experience in safeguarding has been fully considered, however concerns are raised in your lack of remorse or insight for your actions, which resulted in two vulnerable children being left naked in a room, further evidenced by your response after being told of the incident, 'I don't know how long this will take as I have other commitments that are equally as important after this meeting' and your previous statement that you would not do anything differently, even though a service user was left outside their home in the early hours of the morning";

(c) "due to the repeated nature of the incidents, significant concerns are raised that you would not change any of the behaviours that led to vulnerable Children being exposed to significant harm and the DBS are satisfied that if you were to continue in regulated activity with vulnerable groups you may continue to put your own needs ahead of people in your care, including vulnerable adults and this failure to safeguard would always expose both Children and Vulnerable Adults to significant risk of emotional and physical harm. Therefore, the DBS are satisfied that it is appropriate to include you in the Children's and Adult's Barred Lists";

(d) "In consideration of your Article 8 rights the following has been considered:

- It is acknowledged that your inclusion in the Children and Adult's Barred Lists would prevent you from pursuing your chosen career as a NHS Mental Health Nurse and impact future employment, volunteering and studying opportunities.

- It is also acknowledged that you could experience some personal stigma from your inclusion that may impact on your wellbeing and that inclusion may have some financial implications for you.

> However, any interference with your human rights must be balanced against the rights of vulnerable groups and, as it is believed you may pose a risk of exposing Children and Adult's to significant harm, the DBS are satisfied that your inclusion in the Children and Adult's Barred List is a necessary and proportionate safeguarding measure."

Legal framework

29. A person included in a barred list maintained under the 2006 Act may appeal to the Upper Tribunal against the DBS' barring decision (section 4(1) of the Act). An appeal may only be made on the grounds that the DBS made a mistake on any point of law, or in any finding of fact on which the barring decision was based (section 4(2)). Section 4(3) provides that "the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact". In other words, there is no right of appeal against DBS' decision that it is appropriate for a person to be included in a barred list.

30. While the 2006 Act provides no right of appeal against a DBS decision that it is appropriate to include a person in a barred list, that does not exclude a right of appeal on the ground that barring a particular person is disproportionate. However, in assessing proportionality the Upper Tribunal must accord appropriate weight to the decision of the barring authority "as the body particularly equipped to make safeguarding decisions" (*B v Independent Safeguarding Authority* [2013] 1 WLR 308).

31. In *AB* the Court of Appeal held, at [43], that, absent a legal or factual flaw in a barring decision, "the assessment of the risk presented by the person concerned, and the appropriateness of including him in a list…is a matter for the DBS". This was reflected in the Court of Appeal's decision in *Disclosure & Barring Service v JHB* [2023] EWCA Civ 982 where it said, "there is a distinction between the assessment of the evidential material on which a finding of fact is or might be based, and an assessment or value judgment, such as an assessment of risk, which is based on findings of fact which have already been made". A disagreement about the evaluation of the evidence is not an error of fact, and if the DBS makes a finding of fact that was open to it on the balance of probabilities it does not make a mistake of fact (*JHB* at [93]).

32. Regarding the credibility of evidence given in proceedings before the Upper Tribunal (typically oral evidence given by the barred person), in *Disclosure & Barring*

Service v RI [2024] EWCA Civ 95 the Court of Appeal, at [29], approved the following formulation:

> "The Upper Tribunal is entitled to make a finding that an appellant's denial of wrongdoing is credible, such that it is a mistake of fact to find that she did the impugned act. In so doing, 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. That is different from merely reviewing the evidence that was before the DBS and coming to different conclusions (which is not open to the Upper Tribunal)."

33. In *AB*, the Court of Appeal ruled, at [55], in relation to the Upper Tribunal's oversight of DBS fact-finding, that the Upper Tribunal "will need to distinguish carefully a finding of fact from value judgements or evaluations of the relevance or weight to be given to the fact in assessing appropriateness". A conclusion that a certain matter is likely to reduce the risk of inappropriate conduct is a value judgement rather than a finding of fact.

34. In *PF v DBS* [2020] UKUT 256 (AAC) a Presidential Panel of the Upper Tribunal said, at [43], that, on appeal, the Upper Tribunal could hear evidence that was not before the DBS. If the Upper Tribunal heard no new evidence, the DBS' decision "might well be the starting point" [49]. If the Upper Tribunal heard significant new evidence, the DBS' evaluation of the evidence would probably be 'overtaken', so that "the only appropriate approach for the UT would be to start afresh" [49]. *PF* was applied by the Court of Appeal in *JHB* in which it held, at [90] that, in a case where the Upper Tribunal heard "very limited evidence" so that the DBS' decision was the 'starting point', the Tribunal was not free to make its own assessment of the written evidence unless and until it found an error of fact or law.

35. In *JHB*, the Court of Appeal said:

> "95…the UT understood the DBS's reliance on paragraph 2 of *Volpi v Volpi [[2022] EWCA Civ 464]* as a submission that, in order to show that there has been 'a mistake of fact' it is necessary to show that there was no evidence to support that finding, or that it was irrational. I agree with the UT that if that were the position, section 4(2)(b) would be redundant. But, in my judgment, that is not the position on an appeal such as this, for two reasons. First, a finding may be 'wrong' for this purpose, even if there was some evidence to support it, or it was

> not irrational, as the reasoning in *Indrakumar* and *Subesh* shows. Second, a finding may also be 'wrong' for the purposes of section 4(2)(b) if it is a finding about which the UT has heard evidence which was not before the DBS, and that new evidence shows that a finding by the DBS was wrong, as the UT itself explained in *PF* (see paragraphs 63-65, above)…".

36. In *RI*, the Court of Appeal was of the view that the *ratio* of *JHB* was "difficult to discern'. Bean LJ said:

> "33…I venture to suggest that it [*JHB*] may be authority for the proposition that if the UT has exactly the same material before it as was before the DBS, then the tribunal should not overturn the findings of the DBS unless they were irrational or there was simply no evidence to justify the decision. The same rule may apply where, as in the *JHB* case itself, oral evidence is given but not on matters relevant to the decision to place the appellant on one or both of the Lists."

37. Within Part 1 of Schedule 3 to the 2006 Act, paragraph 3 requires DBS, once it has given an individual the opportunity to make representations against barring, to include the individual on the children's barred list if satisfied that the individual has engaged in "relevant conduct", has reason to believe that the individual might in the future be engaged in regulated activity relating to children and is satisfied that it is appropriate to include the individual in the list. The definition of "relevant conduct" in paragraph 4 of Schedule 3 includes conduct which endangers a child.

38. Part 2 of Schedule to the 2006 Act enacts, in relation to the vulnerable adults' barred list, similar provisions to those just described in relation to the children's list. Part 2's definition of "relevant conduct" includes "conduct which, if repeated against…a vulnerable adult, would endanger that adult or be likely to endanger him" (paragraph 10(b)).

Grounds of appeal and the parties' arguments

Grounds of appeal

39. Following a hearing at which both parties were represented by counsel, Upper Tribunal Judge Hemingway granted the Appellant permission to appeal against DBS' barring decisions. The Judge's permission determination read as follows:

> "5. I am persuaded, bearing in mind the relatively low threshold for the giving of permission, that the DBS's findings as set out above, are arguably mistaken. I am also persuaded that the outcome reached by the DBS, even if there was no mistake of fact, is disproportionate.
>
> 6. Permission is given, and the grant is not limited."

40. We are certain that, in the final sentence of paragraph 5 of the judge's permission determination, he intended to say that the outcome reached by the DBS was arguably disproportionate, and that is how we read the determination.

41. Following Upper Tribunal Judge Hemingway's retirement, case management responsibility for this case was transferred to Upper Tribunal Judge Mitchell.

Appellant

42. In relation to Finding 1, the Appellant argues:

(a) DBS placed disproportionate weight on his former employer's conclusions;

(b) DBS' barring decision making process document (BDMP) contained "no evidential analysis";

(c) TE's interview clearly shows that, following a brief look, she wrongly assumed that the Appellant was asleep in the lounge of Home 1. There is no evidence that the Appellant's eyes were shut or that TE made any attempt to interact with him. A finding that the Appellant was asleep can only be made by inference from the reported circumstances. Since the Appellant is of good character, a finding that he was asleep, whether or not based on an inference, would only be legitimate if supported by cogent evidence;

(d) the Barring Decision Making Process document (BDMP) shows that DBS misread the evidence in finding that the Appellant said 'he would not change any of his actions'. What he actually said was that he 'could not have done anything differently' which does not show a lack of insight and should have been excluded as a risk factor. Similarly, there is no evidence to support the BDMP findings that the Appellant "did not care about [service users] when he slept on shift at all" and "prioritised his own comfort by

lying on the couch" (there was no evidence that lying on the couch in Home 1 was not permitted);

(e) DBS found that the doorbell could be heard clearly from the lounge but, in that case, why was the Appellant issued with a mobile phone so that he could let young people in? There was no evidence that service users were woken by the doorbell which would be expected if it were as loud as DBS contend.

43. In relation to Finding 2, the Appellant argues:

(a) the evidence shows that one of the young people entered the Appellant's office at 6.55 a.m. and could not, therefore, have been in another young person's bedroom at that time. Other evidence shows that the young people were discovered together at 7.20 a.m. and the LADO minutes suggest that "[YP1] alleged that about 6.40am…Child [YP2] knocked on his door and asked him for sex". All this supports the Appellant's case that the incident occurred during the handover period and not five hours earlier, which strengthens his case that hourly checks were done as required. These errors of fact were clearly material to the barring decision;

(b) comments that the Appellant is said to have made to LW (manager of Home 2) during an informal conversation should not have been relied on as a risk factor. There is no evidence that the Appellant failed to ask to see YP1 and YP2's paperwork. This should not have been relied on as a risk factor. The same applies to the findings that the Appellant failed to carry out required visual checks, and failed to appreciate that the service users had emotional, behavioural and social difficulties;

(c) the Appellant's argument that, had he been made aware of the nature of the risks associated with these young people, he would have viewed hourly checks as inadequate, was supported by the LADO's recommendation for heightened safeguarding measures at Home 2. In any event, there was little or no evidence that the Appellant was actually required to undertake nightly visual checks. The LADO minutes stated that "day staff provide night staff with updates…to let them know if anything has occurred which requires visual observations to take place…LW…adds that nightly visual checks would usually only be completed if they were presenting as unsettled or dysregulated". The minutes also suggest that hourly checks were only implemented after the 7 November 2020 incident, and confirm the onerous cleaning duties of waking night staff which, of themselves, made it impossible for waking night staff to supervise bedrooms all night. DBS now argue that it is irrelevant whether hourly

checks were required but this overlooks that DBS made an adverse finding that the Appellant failed to adhere to Home 2's safeguarding and monitoring procedures;

(d) it was not open to DBS to find that hourly checks were not performed solely because a written record was not made;

(e) if, as DBS seem to suggest, night waking staff were required to monitor children throughout the night, they should not have been allocated cleaning, washing and ironing duties on a different floor to that on which young people slept. It was impossible for night staff to do both things;

(f) the young people's documentation has not been "considered" (which we assume means produced in evidence) and so DBS was not entitled to conclude that the Appellant failed to support young people in line with their care plans. The same applies to Home 2's safeguarding and monitoring procedures;

(g) there was no evidential basis for DBS' finding that, had the earlier incident been reported, the subsequent incident may have been prevented. And DBS had no evidence that the incident required reporting and to whom. Nevertheless, the Appellant acknowledged the need to 'handover' the incident, which he did, but reasonably assumed it was for day staff to write up the incident;

(h) it is not disputed that the young people's 'paperwork' was locked in Home 2 manager's office. The employer was ultimately responsible for the safety and wellbeing of young people in its care and, as such, it was their responsibility to ensure that all staff were aware of relevant information. Bank staff rely on a thorough handover of risk yet there is no evidence that the Appellant was made aware of any risk related to YP1 and YP2's sexualised behaviour. These considerations were not taken into account, or not given appropriate weight, when DBS made the adverse finding that the Appellant failed to read the young people's documentation;

(i) overall, DBS' failure to appreciate the context to the incident of 7 November 2020 led to it making findings of fact, and drawing inferences, which were not open to it on the evidence. This failure also suggests that DBS did not assess the facts fairly and impartially;

(j) DBS unfairly refused to ascribe any blame to the Appellant's former employer. Their characterisation of the Appellant's criticisms as 'baseless' went against the weight of the evidence, in particular the LADO meeting minutes.

44. The Appellant disputes DBS' reading of the case law authorities, in particular the Court of Appeal's decision in *JHB* (see below). The Appellant argues that a correct reading of *JHB* and other relevant authorities is as follows:

(a) the Upper Tribunal may examine the same material as was before DBS and come to a different conclusion 'in circumstances where mistake has been demonstrated';

(b) a finding may be wrong where the Upper Tribunal has evidence not before DBS, which demonstrates that a DBS finding was wrong;

(c) the Upper Tribunal's error of law jurisdiction allows it to hold that a barring decision was unreasonable, irrational or disproportionate;

(d) there is no limit to the form that a mistake of fact may take including an incomplete finding or omission or an inferential finding such as a person's state of mind (intentions, motives, beliefs): see *PF v DBS* [2020] UKUT 256 (AAC);

(e) findings of fact relating to risk factors are susceptible to appeal although assessing the degree of risk is solely a matter for DBS.

Appellant's witness statement

45. Before the hearing of this appeal, the Appellant supplied a written statement (verified by a statement of truth, as required by case management directions). In this statement, the Appellant repeated many of the factual assertions previously made and, in addition, stated:

(a) on 28 January 2019, he emailed management at Home 1 to request a better radiator for the office room (an email of that date was attached). It was in response to the Appellant's heating concerns that he was permitted to use the lounge at night when it was cold;

(b) when interviewed about the incident at Home 1, he asked for confirmation to be sought from the young person whom TE said also saw him asleep, but nothing was ever provided;

(c) he is aware of another case in which a worker at Home 1 was allegedly found asleep by another staff member. In that case, the allegation was not upheld because no effort had been made to wake the worker even though it was identical to the Appellant's case (the statement attached the disciplinary findings in that case as well as a written authority to use them in this case);

(d) at Home 2, no one ever told him that young people in his care displayed sexualised behaviour;

(e) he had only worked at Home 2 on four or five occasions and recalls that, each time, he asked to see the young people's care plans but was told they were locked away but "there were no specific areas of concern with regard to heightened risk factors";

(f) he was never told by LW, Home 2's manager, that he needed to be in the office on the middle floor with the door open. When LW put this to him in interview, he categorically denied it yet his denials were omitted from LW's record of the interview. He was not given any opportunity to agree the interview note and did not see it before his bank status was terminated;

(g) he did not close the office door at Home 2 to read a book. He did so because the home had a 'no light on the floor' policy to minimise sleep disruption, which was also why staff were also encouraged not to engage with young people at night;

(h) having reflected on events, the Appellant accepts that, although he requested care plans, he should not have passively accepted it when they were not provided. In future, he would insist on their provision.

Appellant's oral evidence: examination-in-chief

46. Before giving oral evidence, the Appellant (at his request) swore an oath on the Bible to tell the truth.

47. The Appellant confirmed, in response to a question from his counsel, Ms Bayley, that the contents of his witness statement remained accurate. The statement was incorporated in the Appellant's evidence-in-chief.

48. In response to Ms Bayley's questions, the Appellant said he would never sleep on duty. On the night in question at Home 1, he was aware that one young person, who was aged 18 and enjoyed free movement, had gone out. The Appellant explained why he was allowed to use the lounge at night (the allocated office was cold). He also said the doorbell was faint, possibly faulty, which is why he was issued with a mobile phone.

49. Ms Bayley asked the Appellant what he could remember about seeing TE on the night in question at Home 1. He said he was in the middle of a long prayer, TE came in, he looked up and then bowed his head back down to continue the prayer. The Appellant said he would have expected TE to 'tap' him if she really thought he was asleep.

50. Ms Bayley asked the Appellant general questions about his work at Home 2. He said he was unhappy with the way in which the sleeping allegation had been dealt with at Home 1 and resigned as a permanent Priory Group staff member. A manager then asked him to reconsider his resignation and, when he did not, asked him to join bank staff. The Appellant agreed on the condition that he would not work in Home 1. The Appellant thought he had only done four shifts at Home 2, and the duties of waking night staff were the same as at Home 1. However, Home 2 was larger, with a middle floor (three floors in total). The Appellant said his first duty at night at Home 2 was to go downstairs to clean common areas, including toilets, and wash and iron clothes. When ground floor tasks were completed, the Appellant would clean the middle floor.

51. The Appellant was asked by Ms Bayley whether it was normal for him not to be provided with the care plans for residents of the homes at which he worked as bank staff. He replied, 'it's not normal practice'. Ms Bayley asked the Appellant what he could recall about the handover session at the start of his night shift on 6 November 2020. He said that he was informed that all residents were settled in bed and there were no concerns or risks identified. The Appellant emphasised that he always asked at handover if there was anything 'to look into'. At the handover session, day staff told him that, if the children wanted anything, they would ask. The Appellant was also told to ensure that the lights were off on the middle floor. The Appellant asked why and was informed that the children would not settle if they saw lights, and Home 2 had a 'no lights' policy.

52. Ms Bayley asked the Appellant how the interview with Home 2's manager came about. He said he was on his way to college when the manager rang his telephone and asked him to come in, which he did. The manager did not explain why she had asked the Appellant to return to the home. Before the interview began, he was unaware of the allegation against him. In fact, he did not think what happened on 18 November 2020 was an interview because the manager told the Appellant that she was being investigated and, later in the interview, said that he could help her (the manager) to save her job. During the interview, the manager asked the Appellant why he had closed the door, and he said it was because of the 'no lights' policy.

53. The Appellant was asked to comment on the part of the interview record which stated that, on 5 October 2020, Home 2's manager told him that he needed to be in the middle floor office with the door open "to safeguard the children as they display sexualised behaviour". The Appellant categorically denied having been told this and said his interaction with the manager was only a brief greeting. Ms Bayley asked the Appellant if anyone in Home 2 had ever mentioned sexualised behaviour and he said that this had never happened.

54. Ms Bayley asked the Appellant why, after being told in interview that two young people had been found naked in the same bedroom, he had asked Home 2's manager what safeguarding measures had been put in place to keep the young people safe. He said he was concerned because, in his care experience, young people could be unpredictable. It was possible for young people at Home 2 to access the garden without being seen. The Appellant said he told the manager that, if children have this behaviour, someone needed to ensure that staff did not spend most of their time cleaning etc. The manager made it very clear that she was not interested in anything the Appellant had to say about safeguarding arrangements at Home 2.

55. Ms Bayley asked the Appellant to comment on that part of the interview note in which the manager reportedly informed him that it was his responsibility to "have read and signed all the YP paperwork" and asked why he had not. The Appellant said he told the manager that he had only ever seen her in the car park. He would have asked to see care plans but the room in which they were kept was always locked during the night shift; he relied heavily on day staff to let him know about any risks. Ms Bayley asked whose responsibility it was to ensure that bank staff understood what was required. He said it was the responsibility of staff at the home to tell bank staff about risks and then 'you sign', but at Home 2 no one there had time to give him any papers;

things were different at Home 1. The Appellant rejected the allegation that he had failed to support young people in line with their care plans, saying he supported them in line with the information he had.

56. In answer to Ms Bayley's questions, the Appellant said that, at Home 2, he was not expected to make an hourly record of things done. Staff at the home told him that. He was only expected to provide a summary of activities during the night shift. However, the Appellant's normal practice was to check hourly that the children were asleep.

57. Ms Bayley asked the Appellant to comment on the reported lack of a pen for recording events during the night shift. He said that, as bank staff, there was a limit to what he could access and he would not normally bring his own pen, only a laptop. On the night in question, the Appellant could not find a pen and his plan was to update records when day staff arrived. When asked to reflect on his actions by Ms Bayley, the Appellant accepted that the documentation should have been completed.

58. The Appellant was asked to comment on the allegation that he failed to report an earlier incident at Home 2 involving the young people concerned. He said that, after being told in the interview with Home 2's manager about the two young people being found in the same bedroom, he asked if that was why he had previously seen one of them trying to 'cross' to the other's bedroom. In that earlier incident, he tried to stop a young person who struggled with him but carried on trying to get into the other young person's bedroom. Another (permanent) member of staff came to assist and, by this time, both young people were out of their bedrooms and needed to be separated. The Appellant asked the other member of staff why these young people behaved like that and was told that they were always trying to get into each other's bedrooms. Since the incident had been witnessed by the other member of staff, to whom the Appellant was to hand over, he saw no need to record the incident. Having reflected, however, the Appellant now accepted that he should have documented the incident.

59. Ms Bayley asked the Appellant about his career history and plans. He had worked in the care sector for seven years, it was his 'passion', and being barred had prevented him from completing a nursing qualification. The Appellant was now working as a delivery driver and his household faced significant financial pressures.

Appellant's oral evidence: re-examination

60. The Appellant was re-examined by Mr Serr, counsel for DBS.

61. Mr Serr asked the Appellant about his professional experience before these incidents. He said that he started working for the NHS in 2012, and Priory Group in 2017. At the time of the incidents, the Appellant agreed that he was experienced in working with vulnerable young people. He also confirmed the accuracy of the training records provided by Priory Group to DBS, which included training on safeguarding, vulnerable young people and sexually harmful behaviour.

62. Mr Serr asked the Appellant about nighttime working arrangements. At both Home 1 and Home 2, two staff were on duty at night. One of these, the Appellant, was the waking member of staff; the other slept unless required to assist. The Appellant agreed that, as the waking staff member, he was responsible for residents' safeguarding and accepted that, if he was asleep, the consequences could be catastrophic.

63. Mr Serr questioned the Appellant about procedures at Home 1 if a young person returned to the home during a night shift. He said that young people were not given a front door key which meant the waking staff member was responsible for letting them in.

64. On the night in question at Home 1, the Appellant confirmed, in response to Mr Serr's questions, that he knew that one young person was out and expected to return later. Mr Serr took the Appellant to the record of TE's interview, which stated that, at about 2 a.m. she was woken by noise outside made by a female resident; she did not investigate because she thought the Appellant was aware but did not recall hearing him challenge the young person as to why she was outside. The Appellant said he recalled this incident. The young person was outside smoking a cigarette, but she was 18, had free access to the home and he had no right to challenge her.

65. Mr Serr took the Appellant to that part of TE's interview where she stated that, at 4.23 a.m. she was woken by the doorbell ringing three times, went to the entrance and let a young person in, the young person asked why TE had answered the door, rather than waking night staff, and the two of them went to the lounge where they "found [the Appellant] asleep on the sofa". Mr Serr asked the Appellant why TE heard the doorbell, but he did not. The Appellant said that this young person was often out at night and normally used a mobile phone to call waking night staff to be let in, but not on this occasion. He added that the office was closer to the front door than the lounge. Mr Serr suggested that it was odd that the sleeping staff member heard the doorbell ring three times, but the Appellant did not hear it even once to which he replied, 'that is what she

says'. Later, Mr Serr reminded the Appellant that, according to the record of his interview with Home 1's manager, he said that he would hear the doorbell from the lounge. The Appellant replied that he 'may not have heard the context of the question at the time'. Mr Serr asked the Appellant why he had said nothing about a faulty doorbell during his interview with Home 1's manager. The Appellant replied that the manager did not dispute that the bell was faulty. Ms Smith, Member of the Upper Tribunal, asked the Appellant to clarify whether there was any door or wall acting as a barrier between the lounge and front door, to which he replied, 'open plan I guess'.

66. Mr Serr questioned the Appellant about his use of the lounge at Home 1. The Appellant said that the only light sources were the TV and Christmas tree lights. On the night in question, the Appellant was lying on the lounge sofa while praying. Mr Serr asked if his employer was aware that, due to praying, he did not complete his duties. The Appellant said that they all knew that he prayed but he had not given formal notice of this. TE also knew that he prayed. Ms Smith asked the Appellant if he thought it was appropriate to lie on the sofa during working hours. The Appellant said that there was no chair in the lounge, but he was anyway more comfortable lying down, adding 'in Africa, we do that, rolling on floor thanking God, on the sofa it's the same thing'.

67. Mr Serr put it to the Appellant that TE, despite knowing that he prayed, did not think he was praying. The Appellant's response was 'maybe'. Mr Serr asked how he responded to TE entering the lounge. The Appellant said that he lifted his head before returning to prayer. Mr Serr asked the Appellant whether, since he was waking night staff and TE was sleeping night staff, he thought he should have asked TE why she had come into the lounge. The Appellant replied that TE smoked, it was not unusual for her to wake, she was an adult rather than a person with support needs and 'why should I ask?'. Mr Serr put it to the Appellant that the reason why he did not question TE about her presence in the lounge was because he was asleep. The Appellant denied it and said, 'why would I ask her why she's awake when I'm praying?'. Mr Serr asked the Appellant if he saw the young person enter the lounge with TE. He said he did not and accepted he was unaware that this young person had returned to the home. Later, Mr Serr put it to the Appellant that, when TE entered the lounge, she was neither smoking nor using the toilet. He responded that it was not for him to tell TE what to do.

68. In answer to a question asked by Ms Smith, the Appellant accepted that, once a young person had returned to the home, they were his responsibility. He was asked if he knew that this young person would be coming back late. The Appellant said he did but had not been told when to expect them. Ms Smith asked the Appellant if he was

concerned that, so far as he knew, the young person was not back by the early morning. He said he was, but this young person often stayed with his father. Ms Smith asked if the young person would call if not coming back to the home. He said he would, and Ms Smith asked if he was concerned because, on his evidence, he believed the young person had not returned to the home. The Appellant said yes, and, in such cases, they would report it to parents first and possibly the police as well.

69. Mr Serr asked the Appellant if his employer knew that he prayed at intervals during the night. He answered 'no' and agreed that he did not tell his employer in advance of his prayer practices. Mr Serr put it to the Appellant that he had accepted that he did not always notice things when in prayer, but 'that's what you were paid for'. The Appellant said he prayed when the young people were settled in their bedrooms and, if they came into the lounge, he would just stop praying. Mr Serr put it to the Appellant that it might be said that 'prayer' was a very convenient excuse. He replied that he was not asleep, and praying did not affect his ability to look after young people when they were in need. The Appellant also said that he did not pray at set times during his night shift, only when he was least likely to be interrupted.

70. Mr Serr asked the Appellant why he lay down to pray. The Appellant said that there was no chair in the lounge. Mr Serr asked if he accepted that lying on a sofa with eyes closed was consistent with sleep. He replied that he was not asleep and had his Bible beside him although would only turn the lights on for a very short time when he wanted to read from his Bible.

71. Mr Serr took the Appellant to his email of 20 December 2019 in which he wrote that he may not have heard the doorbell because the lounge TV was left on all night. The Appellant was asked why the TV needed to be on at all. The Appellant said he watched 'Christmas activities' on TV. Mr Serr asked if he would watch TV, pray or do both. The Appellant said he could be in prayer with the TV on. Mr Serr asked the Appellant if he maintained that he did not hear the doorbell because the TV was on to which the Appellant responded, 'could be but it's very faint'. Mr Serr put it to the Appellant that it was odd that the TV would be set to a volume loud enough to obscure the sound of the doorbell. The Appellant replied that 'it's not loud enough'.

72. Mr Serr asked the Appellant if he thought TE was at fault for 'not waking you'. He replied 'we support each other' but added that he did not think all that had happened was TE's fault.

73. Mr Serr concluded his cross-examination of the Appellant about events at Home 1 by asking him whether he could see how 'all this' looks improbable to an outsider. The Appellant said he did not understand. Mr Serr then read out Priory Group's disciplinary findings, in their letter of 16 January 2020. The Appellant pointed out that the letter did not say that he had been asleep, only that he was "not adequately alert and aware of your surroundings". Mr Serr drew the Appellant's attention to Home 1 manager's statement that the doorbell had been tested and could be clearly heard from the lounge even when the home was busy in the daytime. The Appellant said that his manager knew the doorbell was ineffective and he did not know what had happened in the interim.

74. After Mr Serr had completed his cross-examination about events at Home 1, Upper Tribunal Member Jacoby asked the Appellant how he could be sure that he did not temporarily drop off to sleep. He replied that he could not pray and sleep at the same time.

75. Mr Serr then cross-examined the Appellant on his evidence about events at Home 2. The Appellant said that four young people lived at Home 2 at the time. Mr Serr took the Appellant to the minutes of the LADO meeting on 11 November 2020 and drew his attention to its description of the backgrounds of the two young people concerned (pp. 93/4). The Appellant said that, at the time of the incident, he knew nothing about risks associated with these young people, no one told him anything about them. He added that this would be normal for a settled young person but not one with a background like that described in the LADO minutes. Mr Serr drew the Appellant's attention to the record of his interview with Home 2's manager where the manager stated that, on 5 October 2020, the Appellant was told that he needed to be in the office on the middle floor with the door open to safeguard children who displayed sexualised behaviour (p.76). Mr Serr asked the Appellant if he was on duty on 5 October 2020, but he replied that he was not really sure. He might have interacted with the manager on that day but, if he did, it was only in the car park. Mr Serr pointed out that the manager clearly stated that they spoke in Home 2's lounge and asked the Appellant if he was surprised to have read that. He replied that he had not been given full disclosure of documentation. Mr Serr pointed out that the Appellant signed the interview record (p.74) to which replied that he was unaware of any disciplinary investigation about him and thought that Home 2's manager was the one in trouble.

76. Mr Serr asked the Appellant what he had done, during his three previous shifts at Home 2, to appraise himself of the two young people's needs. He said that, each night,

he asked for their care plans but, on each occasion, was told they were in the manager's office which was locked. The Appellant did not pursue the matter but would have done if he knew then what he knows now about their risk profiles. He added that he now realised that he should have made a written record of the fact that he had not seen the care plans.

77. Mr Serr took the Appellant to the record of the informal conversation on 7 November 2020 which recounted the Appellant's description of an earlier incident involving the same two young people. The Appellant agreed that, on this occasion, he saw YP2 trying to get into YP1's bedroom, and he agreed with Mr Serr that 'with hindsight, it appears troubling'. Mr Serr asked the Appellant if children were allowed to enter, or attempt to enter, each other's bedrooms as described in the conversation record, and he replied 'no'.

78. Mr Serr asked the Appellant whether, when this earlier incident occurred, he was the principal carer on duty. He said, 'yes and no'; he had completed his night shift and was just waiting for day staff to do the handover. The Appellant said the other staff member did not see the entire incident and Mr Serr asked him if he should have documented it. He replied that he did not know the incident was a matter of concern and the other staff member knew the children better. Mr Serr pointed out that he had just said that only he saw the entire incident and put it him that this meant he should have recorded it. The Appellant replied that he verbally handed over to the other member of staff and 'I can't go back to write again as she's taking over'. Mr Serr drew to the Appellant's attention that, by signing the informal conversation record, he had accepted that he should have documented the incident. He replied that he signed the record without reading it (he was not allowed to), it was inaccurate, and he did not then know that the manager was trying to get him into trouble. Mr Serr asked the Appellant if he now regretted failing to record the earlier incident to which he replied that the other staff member should have recorded it and reported it to her manager.

79. Mr Serr asked the Appellant if, before signing, he read the written records of the conversation on 7 November 2020 and the interview on 18 November. The Appellant said he tried to force the manager to give him copies but was told it was 'not policy' and she even made a fake telephone call to HR about it. The judge asked the Appellant how he knew the conversation was fake and he said, 'it just was'.

80. The Appellant was asked by Mr Serr to describe what happened when he arrived at Home 2 on 6 November 2020. He mentioned care plans at handover and day staff

told him that the young people were settled and there were no concerns. The Appellant got on with his domestic tasks. He was not told to check on any bedrooms but did 'as I care'.

81. The Appellant confirmed, in response to Mr Serr's questions, that he made no record of activities on the night of 6/7 November 2020. He had no pen and there was no one around from whom he could have got a pen. The Appellant added that he had been booked to work again at Home 2 on the following night and thought he could make the record then. He only realised he had no pen at sign-in; most places use a computer to log-in. After Mr Serr had finished his examination, Upper Tribunal Member Smith asked the Appellant if he had asked the sleeping staff member for a pen. He replied that he asked the day staff, but they didn't have a pen. Ms Smith again asked the Appellant if he tried to obtain a pen from the sleeping staff member. He said 'no, they're all in the manager's office'. Ms Smith asked the question a third time and the Appellant said the sleeping staff member was in bed already. Ms Smith asked when he came on duty, and he said 9 to 9.30. He was then asked if the sleeping staff member was already asleep at that time, and he said she was. Upper Tribunal Member Jacoby asked the Appellant what he would normally do to obtain a pen. He replied that if he saw a pen, he would use it.

82. Ms Smith asked the Appellant why he brought his laptop to work. He said it was to keep awake and to do college tasks. Ms Smith then asked him why he did not make notes on his laptop, or a mobile phone and he said he had not thought of that. He was asked whether he made a written note of activities at Home 1 on the night in question and he said that he did, they were handwritten in a bound book. He never made notes of activities on the night of 6/7 November 2020 at Home 2.

83. Mr Serr asked the Appellant about his evidence that he heard a young person use the toilet around 2.30 a.m. on 7 November 2020. He said he knew it was YP1 because his routine was to visit the toilet at this time. He did not check on YP1 because all he had done was use the toilet. Mr Serr asked the Appellant if he did not check because he wanted to avoid being asked to read a story. He replied that was not the primary reason and Home 2's policy was to avoid unnecessary nighttime engagement. The Appellant also denied that he shut the office door so that he could read a book, it was to stop light getting out. Mr Serr asked why the office door needed to be shut if the bedroom doors were closed and the Appellant said that the moment the office door was opened the children would be attracted by rays of light. Staff told him to ensure that the young people's sleep was not disturbed. Mr Serr asked if the Appellant agreed

that, with the office door closed it was harder to monitor the young people. He did agree but said that he was given his instructions, and added that children would often come down to the ground floor at night when he was cleaning.

84. Mr Serr asked the Appellant whether he thought the young person he heard at 2.30 a.m. was one of those he had tried to separate in the earlier incident. The Appellant thought not because he didn't 'pad around'. He was asked if he knew that this child had gone back to his bedroom. He replied yes and Mr Serr asked if he was certain. To this, the Appellant replied he was not asked to be certain and, from his hourly checks, knew that everyone was where they were supposed to be. Mr Serr read out a passage from the LADO minutes which said that Home 2's manager confirmed that one young person could not have entered another's bedroom at night/day handover because the office door was open and it would have been seen, to which the Appellant responded 'correct'.

85. Mr Serr asked the Appellant if what was really going on was that he decided to clock off for some 'me time'. He replied that it was Home 2's policy to have the office door shut at night. Mr Serr said all this could be explained by the Appellant putting his own interests first. The Appellant said, 'not at all' and added that, on his first shift at Home 2, he read the young person a story and it was only later that staff informed him not to engage.

86. After Mr Serr had completed his cross-examination, Upper Tribunal Member Jacoby asked the Appellant if, looking back, he would have done anything differently. He said there was. He would have asked the young person at Home 1 if he saw him asleep, as TE alleged; would not have prayed at all. In relation to Home 2, he would have made records on his laptop; he would have taken the initiative and made a record of the previous incident rather than leaving it to the day staff member and, finally, if care plans were not made available, request them and, if not supplied, go home.

Closing submissions

87. Ms Bayley's closing submissions at the hearing argued that whenever the evidence in this case disclosed a conflict of fact, DBS consistently adopted the interpretation that was most damaging to the Appellant. The Appellant's testimonials counted for nothing. The evidence cannot reasonably support a finding that the Appellant ever intended to cause harm or neglect service users.

88. The Appellant has consistently denied having been asleep at Home 1, a denial that was maintained in his sworn oral evidence. Ms Bayley concedes that the Appellant cannot convincingly account for not having heard the doorbell at Home 1. However, the fact that young people at Home 1 were issued mobile phones demonstrates that they could not rely on the doorbell.

89. Ms Bayley argues that the factual burden is on DBS. In that light, it is notable that the only evidence that the Appellant was sleeping at Home 1 is a single email written by TE who has never been subject to any probing questioning. The Appellant does not however blame TE, only asking why, if she thought he was asleep, did she just go back to bed? It is quite possible that TE genuinely believed that the Appellant was asleep because the Appellant did not answer the doorbell, TE had to deal with it, and he was lying more or less immobile on a sofa. The Appellant gave sworn evidence that he was not asleep, which must carry significant weight in determining whose evidence to prefer especially in the light of TE's very surprising step, on her account, of leaving the Appellant to continue sleeping and, as a result, leaving the young people in Home 2 unsupervised.

90. In evaluating the evidence in relation to Home 2, the Upper Tribunal should bear in mind well-known difficulties in recruiting social care staff. Often, as in this case, staff are left ill-prepared and uninformed and it should also be noted that the employer did not provide, with its DBS referral, the Appellant's job description at Home 1 or as a bank worker. A night bank worker is not expected to be on constant watch. In practice, much if not most of the Appellant's night work at Home 2 was taken up with domestic tasks on the ground floor, making it impossible for him to keep constant watch over the middle floor even if that had been a role requirement. If the employer thought a constant watch was required, it should have funded a second night waking staff member or paid for a cleaner. The extent of the Appellant's domestic duties on the ground floor of Home 2 show that he was not in fact given an instruction to remain in the middle floor office or, if he was given such an instruction, it was given in the knowledge that it would be impossible to fulfil without ignoring another instruction (to do all the cleaning, washing and ironing). The residents of Home 2 were not properly safeguarded but that was not the Appellant's fault. If some young people displayed sexualised behaviour, the Appellant should have been informed and made aware of whatever arrangements were in place to manage risk. This was clearly the employer's responsibility. The Appellant relied on what he was told at handover and was not given access to the young people's care plans. Yes, perhaps he should have insisted but that does not mean he was responsible for obtaining information about the young

people let alone amount to 'relevant conduct' for the purposes of the 2006 Act. In the circumstances of this case, it was deeply unfair of DBS to make an adverse finding that the Appellant failed properly to support the young people in line with their care plans. DBS have never seen the two young people's care plans, and their decision letter further fails to identify the safeguarding policies, and reporting procedures, that the Appellant is said not to have followed. If the Appellant was in fact expected to be on permanent watch, he was set up to fail.

91. Ms Bayley concedes that not having a pen was a poor excuse for failing to make records at Home 2, but the Appellant's actions were mitigated by the fact that he gave a verbal handover to day staff.

92. The evidence does not support DBS' argument that, in Home 2, the two young people were together in one bedroom from around 2 a.m. The Appellant would have heard something given the hourly checks referred to in his sworn evidence and the LADO minutes report that one of the young people stated they were only together from 6.40 a.m.

93. That the Appellant was unaware of the allegations at the time of the informal conversation with Home 2's manager is shown by his final remark that he might be able to add something if he knew the context of the interview (p.72). To draw any inference from this reported conversation, when the Appellant was unaware of the incident and given no real opportunity to agree the report's accuracy, would be unfair. It goes to the Appellant's credit that, according to the interview with Home 2's manager, his primary concern was the adequacy of safeguarding arrangements. The Appellant's reasons for signing records that he now says are inaccurate are not fanciful since, at this time, he trusted Home 2's manager.

94. DBS were wrong to characterise the earlier incident at Home 2 as a 'previous concern' of which the Appellant should have been aware. If that matter should have been escalated, it was the other staff member's responsibility and the Appellant's failure to do so cannot reasonably be considered relevant conduct for the purposes of the 2006 Act.

95. Alternatively, Ms Bayley argues that, even on DBS' interpretation of the evidence, there is nothing to suggest that the Appellant poses an ongoing risk of harm.

DBS

96. DBS submit that the nature of the Upper Tribunal's factual jurisdiction, on an appeal against a barring decision, was clarified by several Court of Appeal authorities: *AB v DBS* (2021) EWCA Civ. 1575; *Kihembo v DBS* (2023) EWCA Civ. 1574; *DBS v JHB* (2023) EWCA Civ. 982; and *DBS v RI* [2024] EWCA Civ. 95. Those authorities establish the following propositions:

(a) the Upper Tribunal is entitled to find that an appellant's denial of wrongdoing is credible, such that it is a mistake of fact to find that he/she did the impugned act. In so doing, the Upper Tribunal is entitled to hear oral evidence from an appellant and to assess it against the documentary evidence on which DBS' decision relied. That is different from merely reviewing the evidence that was before the DBS and coming to different conclusions (which is not open to the Upper Tribunal). In most cases, in order to establish a material mistake of fact the Appellant will need to adduce new evidence not before the original decision maker that materially affects the outcome of the decision. New evidence is very unlikely to include the Appellant giving oral evidence that simply maintains existing denials;

(b) the Upper Tribunal must identify an error of fact in the findings on which the decision was based. The Upper Tribunal is not free to make its own assessment of the written evidence unless, and until, it finds such an error. It cannot simply examine the same materials as were before DBS and come to a different conclusion;

(c) any mistake of fact must be material to the barring decision;

(d) the Upper Tribunal must carefully distinguish findings of fact from value judgments based on DBS' findings of fact, such as an assessment of risk or evaluations of the relevance or weight given to findings of fact in assessing appropriateness;

(e) a disagreement about the evaluation of the evidence is not 'an error of fact' and, if the material before DBS permits a particular finding on the balance of probabilities, the DBS did not make a mistake in making that finding;

(f) if the Upper Tribunal allows an appeal against a barring decision, it should remit the matter back to DBS to reconsider whether barring is appropriate back unless no other decision but removal from the barred list/s is permissible following the Upper Tribunal's decision.

97. It follows from the above that the Upper Tribunal is entitled to hear oral evidence from the Appellant and, in the light of all the evidence, make a finding that he did or did not sleep on duty, did or did not follow safeguarding procedures, and did or did not fail to report an earlier concern at Home 2.

98. In relation to Finding 1, DBS argue:

(a) the allegation that the Appellant was asleep was the subject of a "thorough investigation" by the former employer and "found proven"; his claim to have been praying rather than sleeping was rejected and, in DBS's submission, "wholly improbable". The appeal against Finding 1 is hopeless;

(b) the appeal against Finding 1 is really an impermissible attempt to persuade the Upper Tribunal to evaluate differently the evidence that was before DBS. This is shown by the Appellant's arguments that "disproportionate weight" was given to a piece of evidence or that there was "no direct evidence of the Applicant being asleep, but only the inference to be drawn".

99. In relation to Findings 2 and 3, DBS argue:

(a) again, the Appellant really asks the Upper Tribunal to make different findings of fact on the same evidence that was before DBS;

(b) the Appellant completed no paperwork to record his supposed hourly checks, nor did he record hearing a child visit the toilet at 2 a.m. and, on his account, shut his office door to read a book, which prevented him from adequately monitoring the children, or not monitoring them at all. The Appellant's excuse for nor recording his actions – no pen available – is "somewhat feeble and improbable";

(c) the Appellant said that he did do hourly checks so the question whether such checks were required is of little importance;

(d) the Appellant was expressly told by LW on 5 October 2020 that he needed to be in the staff office on the middle floor with the door open to safeguard the children who displayed sexualised behaviours;

(e) the Appellant accepted during his interview with LW that he was supposed to read service users' paperwork. DBS were entitled to find on the evidence that the Appellant

should have sought out care plans, even if not provided by the employer, particularly given the behaviour witnessed shortly before the young people were discovered in a bedroom together. The Appellant was an experienced carer and fully trained. Had the care plans been consulted, the Appellant would have been aware that both young people posed sexual safeguarding risks;

(f) in the absence of any written records completed by the Appellant, DBS would have been entitled to rely on the former employer's finding that the two young people had been together in a bedroom since 2 a.m. In fact, DBS did not make any express findings about how long the children were together in a bedroom, but there was clear evidence before DBS that the incident did not happen during the very brief handover period but at some earlier time:

- one young person said that the other knocked on his door many times during the night;

- the Appellant himself stated that one young person could have entered another's bedroom from 1 a.m.

- the former employer stated to the LADO meeting that the bedroom could not have been entered during night/day handover because the office door was open and staff would have seen or heard a young person leaving their bedroom;

- it is true that the LADO minutes state that YP2 alleged that YP1 knocked on his door at 6:50am but that cannot be correct because the two were found in YP1's bedroom. It is also of note that YP2's allegation was made on 9 November 2020, two days after the incident "possibly in retaliation for [YP1]'s complaint";

(g) the Appellant's failure to report the earlier incident was "inexcusable". DBS' finding that he failed to report it was properly supported by the evidence (Home 2's managers comments when interviewing the Appellant) and the Appellant himself said that he may have forgotten what he had been told. He also accepted that he should have 'handed over' the incident to day staff;

(h) the Appellant's criticisms of the former's employer's practices are baseless and contradicted by the LADO minutes. DBS took into account the LADO's recommended changes to procedures, but these recommendations do not undermine the barring decisions. LADO minutes also record that the employer acted quickly and efficiently in response to the incident.

100. Overall, the Appellant's conduct demonstrated a "pattern of neglect/negligence in respect of vulnerable children". This gives rise to a serious safeguarding risk in relation to work with children, which is likely to be repeated if the Appellant were to undertake regulated activity with vulnerable adults.

101. DBS submit that it cannot seriously be argued that their barring decisions were disproportionate, given the following considerations:

(a) before the events of Findings 2 and 3, the Appellant was given a final written warning for sleeping on duty, and an express instruction, before the events of Finding 2, to keep the door to the office open "to safeguard children with highly sexualised behaviours";

(b) had the Appellant not failed to report the earlier incident, the incident on 7 November 2020 may not have occurred;

(c) on the night of Finding 2, the Appellant failed to follow a young person from the toilet back to his bedroom so that he could avoid meeting the young person's needs and, instead, closed his office door, read a book and failed to keep a note of his supposed hourly checks;

(d) by failing to seek out service user documentation in advance, the Appellant's actions / inactions led directly to children suffering harm and to them making allegations of physical and sexual abuse against each other, as evidenced by the finding that the LADO referral threshold was met.

Closing submissions

102. Mr Serr's closing submissions at the hearing of this appeal argued that the Appellant's evidence was contradictory and fanciful, and the Upper Tribunal should reject it. He takes no responsibility for sleeping on duty at Home 1, denies being told to keep the door open at Home 2, blames management for not having seen care plans, blames another staff member for not reporting the earlier incident at Home 2, blames his employer for not having a pen and the managers of Home 2 for weak safeguarding policies and practices. The Appellant denies everything and 'doubles down' on his excuses when flaws in his initial attempts to evade responsibility become apparent.

103. Mr Serr argues that no reasonable tribunal could accept the Appellant's version of events at Home 1, which is riddled with contradictions. Were the lights in the lounge on or off? Was the TV on or off? Was TE mistaken that the Appellant was asleep, or did she know he was praying and, for some unknown reason, decide to fabricate an allegation that he was asleep? Was the doorbell faulty or just inherently quiet? Why did the Appellant fail to hear a doorbell that woke the sleeping staff member? Why would the doorbell be clearly audible in the lounge in the daytime, according to the manager's test, yet inaudible to the Appellant in the quietness of night? Nothing really hangs together in the Appellant's account, and he consistently seeks to distance himself from written notes of an informal conversation and interview that he himself signed whenever something in those notes is inconvenient.

104. In reality, submits Mr Serr, the Appellant is an experienced and trained carer. He was in charge of a small number of vulnerable children / young people at night. At Home 1, he fell asleep leaving a vulnerable young person outside alone. The Appellant never pursued seeing the care plans of vulnerable young people in his care. Even if he did only interact with the manager of Home 2 in the car park (itself uncorroborated by any other evidence), that did not prevent him from raising the care plan issue. The Appellant knew about the sexual vulnerability of the young people in Home 2, which was why he was instructed to keep the office door open at night and it is obvious that children cannot properly be supervised from behind a closed door. The Appellant's account of a 'no lights' policy which required the door to be kept shut is fanciful. The Appellant did the exact opposite of what was required at Home 2 in order to prioritise his own needs. He had recently witnessed a disturbing incident at Home 2 but made no record of it, an incident that may well have been a precursor to what happened on the night of 6/7 November 2020. He kept no records at all that night.

105. Mr Serr argues that a thread running through this case is the Appellant's failure to take seriously the safeguarding needs of vulnerable children / young people. The Appellant demonstrates no error of law or fact in DBS' barring decisions. DBS accept the significant consequences of barring for this Appellant, but priority must be given to the needs of children and vulnerable adults. On the facts as contended by DBS, barring the Appellant from the children's and vulnerable adults' workforces has to be considered a proportionate response.

Analysis

Finding 1

106. DBS' arguments on this appeal assume that the Priory Group made a finding, in their disciplinary investigation, that the Appellant was asleep on duty at Home 1 (DBS argue that the allegation of sleeping on duty was 'found proven' by Priory Group). However, that is not correct. The Priory Group did not find that the Appellant was sleeping on duty. The finding made was that the Appellant was 'not adequately alert and aware of your surroundings' when working at Home 1 as a waking night support worker. Such a lack of alertness and awareness could be explained by sleep, but could also be explained by some kind of semi-conscious precursor to sleep or by being so immersed in a prayer experience that external stimuli did not penetrate the senses. The latter explanation describes, in our view, a less culpable failure than sleeping.

107. Unlike DBS' arguments on this appeal, their barring decision letter did not assume that Priory Group found that the Appellant was asleep on duty at Home 1. Nevertheless, the decision letter included a finding that the Appellant had been asleep on duty. Despite DBS' finding of fact being more precise than the employer's finding, and excluding arguably less blameworthy explanations for not hearing Home 1's doorbell, we are satisfied that this was not a mistaken finding of fact, nor was the finding undermined by legal error. We arrive at that conclusion for the following reasons:

(a) it is not disputed that TE was woken by the ringing of a doorbell that the Appellant did not hear. The Appellant gave oral evidence that there was no physical barrier between the lounge and the front door. Of themselves, these factors support the argument that the Appellant was, if not asleep, nearly asleep or so deeply focussed on some other activity that he was not aware that the doorbell had rung;

(b) while there is no direct written evidence from the young person who returned to Home 1 at about 4.30 a.m. the notes of interviews with two care workers report the young person's belief that the Appellant was asleep in the lounge (TE and CC). The absence of a statement from, or record of an interview with, the young person does not suggest that the care workers may have misunderstood, or fabricated, what the young person said to them. It is clear that the residents of Home 1 were vulnerable young people, and it is not difficult to understand why the managers of the home did not wish to drag a vulnerable young person into a disciplinary dispute between a staff member and home management. This was the young person's home, and its care workers performed a quasi-parental role. Getting the young person involved in the dispute would probably have entailed asking them which care worker should be

believed, which could easily have looked to the young person as having to take the unwelcome step of taking sides;

(c) the Appellant's evidence about the doorbell is contradictory and inconsistent. The notes of his interview with Home 1's manager record his statement that 'I will hear the bell if it is rung'. The day after that interview, the Appellant emailed the manager to confirm that he agreed with the note of the interview that had been supplied to him, adding that he may not have heard the doorbell because the TV in the lounge is always on. At this stage, the Appellant said nothing about the doorbell being faulty or quiet. It was not until the disciplinary meeting on 14 January 2020 that the Appellant claimed that the doorbell could only be heard 'very faintly' from the lounge. Sometime between the incident and the disciplinary meeting, Home 1's manager tested the doorbell and reported that it could be heard from the lounge without difficulty even in daytime. The only way to square the manager's evidence with the Appellant's would be if the manager, shortly after the incident, secretly replaced the doorbell with a louder one or secretly fixed a fault in the original doorbell. We consider it implausible that the manager would do such a thing, especially in the light of the Appellant's acceptance at interview that he would hear the doorbell in the lounge;

(d) we do not accept the Appellant's oral evidence that, when being interviewed by Home 1's manager, he did not understand questions asked about the doorbell (he told us he 'may not have heard the context of the question at the time'). If the Appellant misunderstood the question during the interview, he had the opportunity the next day to correct the interview record but did not do so even though he must have known that the record reported his statement that he would hear the doorbell (otherwise, he would not have sought to explain that the TV might have prevented him from hearing it);

(e) the Appellant argues that the young people's use of mobile phones, as an alternative to the doorbell, supports his argument that the doorbell was faulty or too quiet. We reject this argument. It is inconsistent with the Appellant's statement in interview that he would hear the doorbell in the lounge and a more plausible explanation is that young people used mobile phones to be let in to the home at night because this would avoid waking the sleeping night staff member or other young people;

(f) the Appellant argues that the credibility of TE's evidence is weakened by her failure to wake him (if she really thought he was asleep). In our view, the Appellant's failure, on his account, to speak to TE when she entered the lounge was equally, if not more,

surprising. TE was the sleeping staff member, the Appellant was the waking staff member. On the Appellant's account, TE's behaviour was very odd yet he did not respond to it. She interrupted her sleep and came into the lounge, on her own, just to look at him (the Appellant says he saw no young person with TE and did not know the doorbell had just rung). The Appellant's failure, on his account, to have said anything to TE further diminishes the credibility of his evidence in relation to events at Home 1;

(g) the Appellant's written evidence about the outcome of an investigation into an allegation of sleeping on duty made against another Home 1 support worker has no real probative value. Our task is to assess the evidence relating to this Appellant's case;

(h) there were inconsistencies between the Appellant's oral evidence and his earlier written evidence (and also within his oral evidence) about his praying position. In writing, the Appellant's case was that he was effectively immobile while praying on the sofa in the lounge and he gave oral evidence that, when TE entered the lounge, his only physical response was a lifting of the head. However, in response to Mr Serr's question whether he thought it was appropriate to lie on the sofa during working hours, he said 'in Africa, we do that, rolling on the floor thanking God, on the sofa it's the same thing'.

108. For the above reasons, we do not consider the Appellant's denial of the wrongdoing within Finding 1 to be credible. DBS' finding that the Appellant was asleep on duty was neither wrong nor irrational. DBS did not make a mistake of fact in finding that the Appellant was asleep on duty, rather than inattentive for some arguably less blameworthy reason such as being deeply immersed in prayer. Had the Appellant been inattentive for a reason other than the full unconsciousness of sleep, in our view he would have been restored to attentiveness by at least the third ring of the doorbell.

Findings 2 and 3

The written notes of the Appellant's informal conversation and interview with Home 2's manager

109. Much of the Appellant's case in relation to Findings 2 and 3 rely on his argument that the written notes of his informal conversation and interview with Home 2's manager were unreliable and incomplete. We address this general point first.

110. The notes of the conversation and interview both end with the Appellant's dated signature (and those of others present). There is no evidence that, as happened following the interview with Home 1's manager, the Appellant was subsequently given an opportunity to confirm the notes' accuracy.

111. The Appellant says that, before he was terminated as a member of Priory Group bank staff, he was not provided with copies of the written notes of the conversation and interview with Home 2's manager. We accept his evidence in this respect. Had copies been provided, or the Appellant's comments sought on the accuracy of the notes, we would have expected a paper trail (as there was for the Home 1 interview). Furthermore, the Home 2 management report of 14 December 2020 suggests that the Appellant's only opportunity to put forward his case was in the informal conversation and interview (when describing the Appellant's case, the report only mentions what he is reported to have said in the conversation and interview). That the Appellant was not given the opportunity to dispute the notes' accuracy, after signing them 'on the day', is also consistent with the Appellant's legal status as a member of bank staff (according to the management report, "in line with the bank worker policy, he is not entitled to be subject to a disciplinary procedure").

112. We find that the Appellant must have read the notes made of the informal conversation and interview before signing them on the days that they were conducted. But we also (a) find that he was not given any subsequent opportunity, before his termination as a member of bank staff, to reflect on, and challenge, the accuracy of the notes, and (b) note that in the heat of the moment - the end of the conversation and interview – it is plausible that the Appellant would not have been as well placed to identify any inaccuracies as he would have been if sent the notes for comment after the conversation and interview. For this reason, we exercise a degree of caution before relying on the contents of these notes (what this caution entails is explained below).

Finding 2

113. Finding 2 consists of two sub-findings. Sub-finding 2(a) is that the Appellant failed to support service users in line with their care plans. Sub-finding 2(b) is that the Appellant failed to follow safeguarding and monitoring procedures.

114. In relation to sub-finding 2(a), it is true, as the Appellant argues, that the young people's care plans have not been put in evidence (no party applied for an Upper Tribunal direction to require disclosure of the care plans). In one sense, therefore, the

Appellant makes a sound argument that DBS could not have made a legitimate finding that he failed to provide support in line with the young people's care plans when DBS did not know the content of those plans. However, if DBS' decision letter is read as a whole, it is clear that what they really meant by sub-finding 2(a) was that the Appellant could not have supported the young people in line with their care plans because he failed to take proper steps to obtain them, and that is how we approach finding 2(a).

115. In the Appellant's informal conversation with Home 2's manager, he reportedly said 'no' when asked if he had read the boys' paperwork and, in the subsequent interview, reportedly said he was not given the opportunity to sign the young people's paperwork. Since that is consistent with the Appellant's oral evidence, we accept the records as accurate in these respects.

116. The general impression conveyed by the interview record and management report is that it was the Appellant's sole responsibility to ascertain the contents of the young people's care plans. However, the information given to the LADO meeting said something different. The minutes say that "when new bank staff come in…documentation is provided…such as [young people's] risk assessments and support plans" and "staff must read and sign to confirm they have read all the paperwork". Surely, a signed document such as this would be retained for some period of time, but no such document was provided with the Appellant's referral to DBS nor to the LADO, and we have not been provided with any document showing that the Appellant was presented with 'paperwork' about the young people, which he signed to confirm it had been read. The management report also makes no mention of such a document. We can discount the possibility that the Appellant was presented with the paperwork but refused to read it (no reasonable social care provider would not allow such a person to continue to work for them). That leaves two possibilities. One is that the document containing the Appellant's signed confirmation that he had read the paperwork was not retrieved for inclusion in the management report of 14 December 2020 or LADO referral. The other is that proper procedures were not followed in the Appellant's case.

117. In our judgment, DBS erred in law in their analysis of the evidence by failing to take into account the absence of any documentary evidence that, in the Appellant's case, proper procedures for ensuring that staff were appraised of young people's care plans were followed. That was a relevant consideration that should have been factored into DBS' fact-finding analysis.

118. We consider it more likely than not that, in the Appellant's case, the absence of a document of the type just described is explained by proper procedures not having been followed at Home 2 rather than an administrative oversight in failing to retrieve such a document. The incident at Home 2 was considered very serious, demonstrated by the LADO referral and rapid convening of a multi-agency LADO meeting. Had there been a document evidencing that the Appellant was provided with, and had read, the young people's care plans, we are sure that a copy would have been included amongst the papers supplied to the LADO. Nothing in the LADO meeting minutes suggests that such a document was supplied by Home 2. On the contrary, the LADO minutes state that the Appellant did not "complete this form" (p.91), but without making any associated statement to the effect that the Appellant was provided with the paperwork / care plans but refused to read them or refused to sign the form. We also find it telling that Home 2's management report itemises fifteen "sources of evidence" without mentioning any documentary evidence that the Appellant had been provided with the young people's care plans (p.81).

119. We should add that we were not convinced by the Appellant's oral evidence that, at the start of each night shift at Home 2, he asked in vain to see the young people's care plans. This was not mentioned until a late stage in proceedings. Had the Appellant's attempts to see care plans been persistently rebuffed as described in his oral evidence, we are sure it would have been mentioned in either the informal conversation or interview with Home 2's manager (the Appellant does not argue that he made this point to Home 2's manager but she omitted to include it in her notes). It is more likely than not that, in this respect, the Appellant's oral evidence was a misguided attempt to bolster his case. However, this cannot affect our finding that, in the Appellant's case, normal procedures for ensuring that night staff were appraised of young people's support needs were not followed.

120. As we have said, we read DBS' sub-finding 2(a) as a finding that the Appellant failed to take proper steps to obtain the young people's care plans. In our judgment, that finding involved an error of law, and it was a mistake of fact. The most the Appellant could reasonably have been criticised for is failing to recognise that normal procedures had not been followed, and for failing to raise that with Home 2's management. We do not consider that to be capable of amounting to 'relevant conduct' for the purposes of the 2006 Act since the primary responsibility for ensuring that bank staff were properly informed about the needs of young people must have been that of Home 2's management.

121. Sub-finding 2(b) was that the Appellant failed to follow safeguarding and monitoring procedures. The failings identified by DBS were:

(a) failing to keep the office door open during the night shift (decision letter);

(b) failing to carry out hourly checks (decision letter);

(c) failing to carry out a visual check after hearing a young person use the toilet at about 2.30 am (BDMP document);

(d) failing to make records of activities during the night shift (BDMP document).

122. We reject the Appellant's argument that it was not open to DBS to make a finding that he failed to follow safeguarding and monitoring procedures because there was no evidence about what those procedures were. While the DBS were not provided with a document setting out the Priory Group's policies and procedures, Home 2's management report was structured by reference to, and cited, various Priory Group policies to do with, for example, positive behaviour support (p.84) and risk assessments and risk management (p.85). Moreover, probably the most significant alleged failure was that the Appellant did not follow an instruction to remain in the middle floor office with the door open. On the evidence provided to DBS, that instruction was given to the Appellant personally rather than being contained in written policies and procedures.

123. We shall first consider the Appellant's argument that his cleaning duties prevented him from remaining in the office on the middle floor of Home 2 for the initial part of his night shift.

124. It is self-evident that the Appellant could not be in the middle floor office, with the door open, when he was cleaning the ground floor. We think this is what the Appellant was getting at when he reportedly said, during his conversation and interview with Home 2's manager, that YP1 could have entered YP2's bedroom, without the Appellant being aware that this had happened, at any time before 1 a.m.

125. According to the notes of the LADO meeting on 11 November 2020, Home 2's manager informed the meeting that "cleaning duties were increased in response to COVID-19, but as [night staff] arrived at 9.30 pm and Day Staff don't finish until 10.00 pm, this should have taken place while other employees were still present" and "they

were then expected to work in the staff office…with the door open at all time" (p.97). In other words, night staff were expected to complete the handover process and do all the cleaning etc on the ground floor within 30 minutes. Unless only very perfunctory cleaning was required on the ground floor, which seems improbable if cleaning duties had been increased due to Covid-19, we find it difficult to understand how this would have been possible especially when, as must have happened from time to time, significant information had to be conveyed to night staff at handover.

126. Home 2's manager's comments about cleaning at the second LADO meeting, on 25 November 2020, are difficult to reconcile with her reported comments at the first LADO meeting. The minutes state that the manager informed the second LADO meeting that it had not always been possible to implement a new policy for two waking night staff at Home 2 and "instead waking night staff have been taken off cleaning duties once the day staff have left and request that the sleep in staff members takes over should they need to leave the corridor between both children's bedrooms" (p.102). The only reasonable interpretation of those words is that Home 2's manager informed the LADO meeting that waking night staff were now expected to stop cleaning once day staff had left so that they could locate themselves in the middle floor office. If what the manager reportedly said at the first LADO meeting was correct, there should have been no need to take night staff off cleaning duties when day staff left. All the cleaning etc. should all have been done by then.

127. In our judgment, DBS erred in law by failing, in their analysis of the evidence, to take into account Home 2's manager's clearly contradictory statements about the extent of nighttime cleaning duties at Home 2.

128. We find that the Appellant was not expected to have completed all his ground floor cleaning duties at Home 2 by the time that the day staff left at 10 p.m. In our view, it would have been an impossible task to do all the cleaning and conduct the handover in 30 minutes. It follows that we also find that Home 2 was operated in such a way that, for a certain period of time, no waking staff member would be in the middle floor office. The duration of that period would depend on how long it took the waking staff member to finish cleaning but the Appellant's evidence that it normally took him about 3 hours, that is until around 1 a.m. appears plausible.

129. However, our finding that Home 2 was operated in such a way that, for a period of time, the waking staff member could not be present in the middle floor office does not necessarily mean that sub-finding 2(b) was entirely mistaken. In our view, the

crucial issue concerns the door of the middle floor office, in particular the Appellant's reason for closing it at night.

130. According to Home 2's manager's note of the informal conversation with the Appellant, he was asked why he closed the door at 2 a.m. upon returning to the office. His response was that "the upstairs light is always off to discourage [a young person] from coming out of his room" (p.71). The manager did not respond to the Appellant's description of normal lighting practice on the middle floor. According to the note, the next thing the manager said was, "did you record the activities for the night?".

131. The note of the Appellant's interview with the manager describes a slightly different reason for his decision to close the office door. According to the note, the Appellant did not say that the office door was normally closed. Here, his words suggest that it was his decision to close the door but for the same reason as given in the conversation, which was to avoid distracting a young person. The manager then referred to an instruction said to have been given to the Appellant on 5 October 2020 to keep the door open at night to safeguard children who displayed sexualised behaviours. Assuming that such an instruction was in fact given, it implies that, normally, the office door would be shut at night (or at least that it was not consistently kept open as a matter of policy). Otherwise, the manager would not have needed to give the Appellant a specific instruction to keep the door open for a specific reason. The LADO minutes also report the manager's statement that staff are expected to work in the office "with the door open at all times". Again, if that was the required practice, why did the manager need to instruct the Appellant on 5 October 2020 to keep the office door open in order to safeguard young people who displayed sexualised behaviour? It could be explained by the Appellant having been known to keep the office door closed, against Home 2's policy, but there is no evidence that that was the case and, if it were the case, would surely have been mentioned in the management report.

132. Home 2's management report into the events of 6/7 November 2020 is a detailed examination of the incident. However, it makes no mention of the manager having given the Appellant a specific instruction on 5 October 2020 to keep the office door open to safeguard children who displayed sexualised behaviours. We find this surprising because, on our analysis, if such an instruction were given, the Appellant's failure to have followed would have been a more damaging allegation than any of the others made against the Appellant regarding his work at Home 2. The LADO minutes also contain no mention of a specific instruction not to shut the office door which, again, we find surprising. Instead, what both the management report and LADO minutes refer

to is the Appellant's alleged breach of Home 2's general policy that the office door should always be kept open at night.

133. In our judgment, DBS erred in law in their analysis of the evidence by failing to take into account a relevant consideration namely that neither the management report nor the LADO minutes state that the Appellant was given a specific instruction that the office door should be kept open to safeguard the two young people involved in the incident on 6/7 November 2020.

134. With the exception of the interview record, which is partially consistent with the Appellant's other evidence, his written and oral evidence has been consistent: the normal nighttime practice at Home 2 was for the office door to be kept shut in order to maintain darkness in the corridor outside the children's rooms.

135. We find that DBS made a mistaken finding of fact that the Appellant was instructed on 5 October 2020 to keep the office door open in order to safeguard young people who displayed sexualised behaviour. We found the Appellant's denial in oral evidence that he was given such an instruction credible because it was consistent with the weight of the written evidence. The instruction is only mentioned in the interview record which, as explained above, we treat with caution. Neither the management report nor the LADO minutes make any mention of this instruction. We find that surprising since, as we have said, the allegation that the Appellant ignored the instruction was particularly damaging and, if true, led directly to the incident that was the only reason for a management report having to be written, and a LADO meeting having to be held. No one apart from Home 2's manager claims that the Appellant was given a specific instruction to keep the office door open at night for a specific purpose. As we have said, the manager's other statements about open door practices are inconsistent with the claim that the Appellant was given this specific instruction. In evaluating the credibility of the manager's claim to have given the Appellant a specific instruction, we also take into account the manager's contradictory statements to the LADO meeting about how much time staff were expected to devote to nighttime cleaning duties.

136. Next, we consider the finding that the Appellant failed to follow a general instruction that, at Home 2, the office door was to be kept open at night. Such an instruction (or expectation) is referred to in the LADO minutes although, in the case of the first LADO meeting, it is described as part of a safeguarding strategy that included night staff finishing their cleaning by 10 p.m. which, as we have said, we do not accept was the case. The management report describes the Appellant's reasons for closing

the office door but does not say that, by doing so, he acted contrary to established procedures at Home 2. We find that surprising. We also find it surprising that the manager did not put it to the Appellant in interview or conversation that he had failed to follow Home 2's policy that the office door was to be kept open at night. For instance, according to the informal conversation record the manager asked the Appellant 'why did you close the office door?' and he replied to discourage a young person from leaving his room. If there was a general policy, that had been communicated to the Appellant, that the office door was to be kept open all night, the obvious next question would surely have been something like 'why didn't you follow our policy that the office door is to be kept open all night?'. While this was styled as an informal conversation, that did not prevent the manager from asking the Appellant about his knowledge of other policies (e.g. 'are you aware…you are supposed to read their paperwork?'). We note that the manager's interview with the Appellant took place on 18 November 2020. By this time, the LADO meeting had been informed by Home 2's manager that all night staff were expected to remain in the middle floor office all night, and this was described as a general expectation rather than a practice instituted in response to the incident on 6/7 November 2020. Despite that, the interview note does not record the Appellant being asked to explain why he failed to follow Home 2's policy that the office door should be kept open all night.

137. In our judgment, DBS erred in law, in its analysis of the evidence, by failing to take into account the features of the evidence described in the previous paragraph of these reasons.

138. If there was a general policy at Home 2 that the office door should be kept open all night, with the waking staff member in situ, we would have expected it to have been referred to in one of the internal Priory Group documents relating to the incident. It was only referred to in external documents (LADO minutes). We would also have expected the manager to ask the Appellant why he failed to comply with the policy, but she did not. And, if there were such a policy, its purpose would have been nullified by the requirement for the waking staff member to carry out cleaning activities on the ground floor during which it would have been impossible to also be in the middle floor office with the door open. For these reasons, we find it is more likely than not that the Appellant was not informed that, at Home 2, there was a policy that the office door was to be kept open all night. It follows that, by closing the office door at night, the Appellant cannot have failed to follow safeguarding and monitoring procedures.

139. The next breach of safeguarding and monitoring procedures relied on by DBS concerned hourly checks. At the hearing, Mr Serr, for DBS, seemed to concede that the Appellant was not under a standing instruction to carry out hourly checks of the young people during his night shift. That was consistent with the information provided to the LADO meeting by Home 2's manager. The manager informed the LADO meeting that "visual observations throughout the night" are only required "only…when incidents or behaviours have occurred to warrant it to avoid institutionalising the children unnecessarily". There is no evidence that the Appellant was required to carry out visual observations throughout the night / hourly of the two young people concerned. Since hourly checks were only required if specifically instructed, the Appellant's failure to carry out such checks cannot have been a failure to follow Home 2's safeguarding and monitoring procedures. DBS' finding that the Appellant, by failing to carry out hourly checks, failed to follow safeguarding and monitoring procedures at Home 2, was irrational given the almost total absence of supporting evidence (the only evidence in support was the Appellant's but he was not responsible for deciding on the content of Home 2's safeguarding and monitoring procedures). Accordingly, DBS erred in law by finding that he did so fail. Mr Serr argues that it does not matter whether hourly checks were required because the Appellant falsely claimed to have performed hourly checks. We do not accept this. The alleged breach of safeguarding procedures relied on by DBS was the failure to carry out hourly checks. If hourly checks were not required, the Appellant cannot have failed to follow safeguarding procedures by not doing hourly checks.

140. DBS also found that the Appellant's failure to check that a young person had returned to their bedroom, after using the toilet, was a breach of Home 2's safeguarding and monitoring procedures. There is no evidence that night staff at Home 2 were under a standing instruction to perform a visual check after a young person had used the toilet at night, to ensure that they had returned to their bedroom. It follows that DBS erred in law in finding that the Appellant's failure to perform a visual check was a breach of safeguarding and monitoring procedures. Given the absence of evidence to the contrary, we find that Home 2's safeguarding and monitoring procedures did not require the waking might staff member to carry out a visual check of a young person's room whenever the toilet was used at night.

141. The final matter is the finding that the Appellant failed to follow safeguarding and monitoring procedures by not making any records of his activities on the night of 6/7 November 2020. The Appellant accepts that he made no records that night. At the hearing, the Appellant's counsel conceded that not being able to find a pen was a weak

excuse. In our view, this amounts to a concession that finding 2(b), insofar as it relates to record keeping, was not mistaken. We also take into account that we found the Appellant's oral evidence about his reasons for not making records particularly lacking in credibility and evasive. For example, Upper Tribunal Member Smith had to ask the Appellant three times whether he asked the sleeping staff member for a pen and each answer, it seemed to us, was designed to avoid answering the question.

Finding 3

142. Finding 3 arose from the Appellant's reported admission, during the 'informal conversation' with Home 2's manager, that two weeks' previously one young person made a concerted attempt to enter the bedroom of another, which the Appellant prevented with the help of a member of the day staff who had just come on duty. The Appellant does not deny having made this admission nor does he deny that he did not to make a record of the incident.

143. The Appellant's oral evidence was that, on reflection, he should have documented the incident and not assumed that it was solely the day staff member's responsibility.

144. In the light of that concession, the Appellant's appeal, insofar as it relates to Finding 3, cannot succeed.

Conclusion

145. This appeal succeeds. The Upper Tribunal finds that DBS' barring decisions involved mistakes of law as described in the preceding section of these reasons.

146. If the Upper Tribunal allows an appeal against a DBS barring decision, section 4(6) of the 2006 Act requires the Upper Tribunal to either direct the Appellant's removal from the barred list/s or remit the matter to DBS for a new decision. We have given careful consideration to whether we should direct the Appellant's removal from the barred lists. Despite having found that many of the adverse findings of fact made and relied on DBS were flawed, we do not consider that this is an appropriate case in which the Upper Tribunal, rather than DBS, should decide whether the Appellant is to be barred from working with children and/or vulnerable adults. We therefore remit this matter to DBS for a new decision.

147. In deciding this appeal, we have carried out a thorough examination of the written and oral evidence. We therefore exercise our power under section 4(7)(a) of the 2006 Act to set out findings of fact on which DBS must base its new decision. Those findings are as follows:

(1) on the night of 13/14 December 2019, while working as a waking night support worker at Home 1, the Appellant was asleep on the sofa in the lounge of that home when, at or around 4 a.m., the sleeping night support worker TE entered the lounge;

(2) prior to the night of 6/7 November 2020, the Appellant had not been provided with, or invited to read, care and support plans for the young people resident at Home 2;

(3) had normal procedures been followed at Home 2, the Appellant would, prior to the night of 6/7 November 2020, have been provided with, or invited to read, care and support plans for the young people resident at Home 2;

(4) on the night of 6/7 November 2020, and on prior night shifts, the waking night member of staff at Home 2 was not expected to complete all cleaning and domestic tasks on the ground floor, and complete the day/night handover process, in the 30-minute period before day staff departed at 10.00 p.m.;

(5) on the night of 6/7 November 2020, the Appellant could not have been present in the office on the middle floor of Home 2 from 10 p.m. until the end of his shift without failing to complete his cleaning and other duties on the ground floor of Home 2;

(6) the Appellant was not on 5 October 2020 given a specific instruction by Home 2's manager that, during a night shift, he was required to keep the middle floor office open in order to safeguard young people who displayed sexualised behaviour;

(7) prior to the night of 6/7 November 2020, the Appellant was not informed that Home 2 had a policy that the middle floor office door was to be kept open all night;

(8) the Appellant was not instructed by Home 2's management that he was required, throughout his night shift on 6/7 November 2020, to conduct hourly checks of all or certain residents;

(9) the Appellant failed to make a written record of an incident that occurred at Home 2 about two weeks before the incident of 6/7 November 2020 involving the same two young people as were involved in that incident.

148. For the avoidance of doubt, the above findings of fact do not prevent DBS from making additional findings of fact provided that they do not conflict with the above findings.

149. Finally, we apologise for the delay in giving this decision. The Appellant's chosen career and, to some extent, his livelihood were at stake, and this is why we have spent a significant amount of time scrutinising the parties' cases and the evidence. This is reflected in these lengthy reasons for the Upper Tribunal's decision. However, it has still taken too long for the decision to be finalised, and this is the judge's responsibility whose ability to attend to the case has been inhibited by an absence from duties, and attendant backlog of work, while recovering from serious injuries sustained in an accident.

Upper Tribunal Judge Mitchell
Upper Tribunal Member Jacoby
Upper Tribunal Member Smith

Authorised for issue by the panel,
on 20 June 2025.

Typographical errors corrected under rule 42 of the Tribunal Procedure (Upper Tribunal) Rules 2008, on 16 July 2025.

Section 4 of the Safeguarding
Vulnerable Groups Act 2006.