Neutral Citation Number: [2025] UKUT 192 (AAC)
Appeal No. UA-2022-001357-V

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

MC

Appellant

- v -

DISCLOSURE & BARRING SERVICE

Respondent

Before:	**Upper Tribunal Judge Jones** **Member Mr John Hutchinson** **Member Ms Elizabeth Bainbridge**
Hearing date:	3 April 2025
Mode of hearing:	In person, Field house, London
Decision made:	16 June 2025
Representation:	
Appellant:	Mr Badar of counsel instructed by Sarker Solicitors
Respondent:	Mr Serr of counsel instructed by DLA Piper UK LLP

SUMMARY OF DECISION

No mistake of fact or law in two decisions of the DBS including the Appellant on the Adults' barred list ("ABL") based upon the same incident on 8 November 2021 when the Appellant ("MC") was acting as a care support worker for service user W. The Tribunal upheld the DBS's finding of relevant conduct that the Appellant caused emotional harm to service user W by preventing him from legitimately using the kitchen and threatening him with violence. Appeal against inclusion on the ABL dismissed.

Mistake of law in decision of the DBS dated 3 March 2023 to include the Appellant on the Children's barred list ("CBL"). There was no evidence to support any rational reason for the DBS to believe that the Appellant had engaged in regulated activity with children in the past nor that he might do so in the future. Appeal allowed and DBS directed to remove the Appellant from the CBL.

SAFEGUARDING VULNERABLE GROUNDS (65) *(Children's barred list 65.1; Adults' barred list 65.2)*

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

DECISION

The decision of the Upper Tribunal is that the Appellant's appeal against the first decision of the DBS dated 13 July 2022 is allowed in part. There was a mistake of law in including him on the Children's Barred List. The Tribunal directs that he be removed from the Children's Barred List. However, there was no mistake of fact nor law in the decision to include him on the Adults' Barred List. His inclusion on that list is confirmed.

The Appellant's appeal against the second decision of the DBS dated 3 March 2023 is dismissed. There was no mistake of fact nor law in the decision to include him on the Adults' Barred List. The decision to include him on that list is confirmed.

DIRECTIONS

1. **The DBS decisions of 13 July 2022 and 3 March 2023 to include the Appellant on the Adults' Barred List are confirmed.**

2. **The DBS is directed to remove the Appellant from the Children's Barred List.**

REASONS FOR DECISION

Introduction

1. The Appellant [or "MC"] appeals against two DBS decisions ["the Decisions"] to include him on the Adults' Barred List ["the ABL"] and/or the Children's Barred List ["the CBL"] pursuant to paragraphs 3 and 9 of the Safeguarding Vulnerable Groups Act 2006 ["the Act"].

2. The Decisions were made by the DBS separately and independently. They were based on two DBS investigations into the same events:

   (a) The first decision was made on 13 July 2022 to include MC on both the ABL and the CBL ["Decision 1"].
   (b) The second decision was made on 03 March 2023 to include MC on the ABL only ["Decision 2"].

3. The context as to how this unusual situation came about is that there was a second and later separate referral to the DBS in respect of the same incident. The DBS system did not, at the time, connect the second case with the original case. The cases were, therefore, dealt with separately with decisions reached, independently, by two different decision-makers. The Decisions were based upon on the similar, but not identical, material that was before them respectively

relating to the same events. For example, Decision 1 was made without viewing the highly relevant CCTV material but it was viewed and considered as part of Decision 2.

4. The Appellant was granted permission to appeal ["PTA"] by the Upper Tribunal ["UT"] on 18 December 2023 in respect of both Decisions and the cases were joined to be heard together.

5. This is the decision of the Upper Tribunal ["the UT" or "the Tribunal"] following the hearing of the appeal against both Decisions on 3 April 2025. The Appellant was represented by Mr Badar of counsel and DBS by Mr Serr of counsel. The Tribunal is grateful to them both for their written and oral submissions.

6. The structure of this decision, by reference to paragraph numbers, is as follows:-

Factual background

7. The DBS filed separate bundles of evidence in relation to the Decisions but these were consolidated in one final hearing bundle. Further, the Appellant filed a separate bundle in relation to the appeal. There were therefore two hearing bundles before the Tribunal.

8. Numerical references in square brackets, [1 etc.], are to page numbers of the DBS consolidated bundle in relation to both Decisions running to 287 pages, unless context dictates otherwise.

9. In broad summary the background to the appeal is as follows:

> (a) MC is a man in his early-30s. At the material time, MC was working as a health/care support worker – as an agency worker, via a private sector provider ["the Provider"] or "E Services" – supporting vulnerable adults (i.e. service users) in their homes.
>
> (b) One of those service users ["W"] was a man in his mid-30s with schizophrenia, autism spectrum disorder, and diabetes [41] [68]. W was at risk of drug misuse and self-harming behaviour [69], among other things. Significantly, W's care plan documentation expressly highlighted the importance of the following (among other things):
>
> (i) Support from staff to ensure W was "emotionally stable" [68].

(ii) Support regarding "routines with activities that will give [W] a sense of achievement and self-esteem… reduce frustration"… [and] allow [W] less time to ruminate and distract [W] from the use of drugs and self-harming behaviours" [68].
(iii) W feeling "safe, reassured and listened to" [68].
(iv) W having his "space" respected [69].
(v) Staff being there "to listen to whatever [W has] to say and not probe [him] with questions" [69].
(vi) Staff being "pro-active in anticipating when [W was] becoming low in mood or escalating signs of distress and engage [W] positively" [69].

(c) On 08.11.21, at around 9.40pm, there was an incident between MC and W ["the Incident"] in and around the kitchen at W's home. In essence, MC was alleged/found to have caused emotional harm to W by (inappropriately) (1) preventing W using the kitchen and (more importantly); and (2) threatening W with violence.

(d) The Incident was, later, looked into by the police and the Provider. There was, in particular, some CCTV footage, viewed by both the police and the Provider, which captured the Incident ["the CCTV Footage"]. W contacted the police, directly, about the Incident [86]. The CCTV Footage is important: the UT considered it with care and watched it several times before and during the hearing; It is addressed in greater detail below. The DBS submits that it is sufficient evidence, without more, to support the Decisions.

(e) Any potential criminal allegation was dealt with by way of "community resolution" including a letter of apology to W from MC [98] (which, unfortunately, is not in the Bundle). No further criminal action was taken. In addition, the Provider stopped using MC and/or "dismissed" him.

(f) Referrals were duly made to relevant bodies concerning safeguarding namely CQC and DBS. DBS decided to include MC on the barred lists in Decision 1 and Decision 2.

(g) MC appealed to the UT against Decision 1 on 9 October 2022. There was no separate appeal lodged against Decision 2 but the Tribunal made directions in December 2023 granting permission to appeal against both Decisions and joining the appeals.

10. In chronological order, the key material dates and events are (with references to the page numbers of the First Decision bundle in [] square brackets):

Late 2018 - MC started working as a support worker [83].

March 2021 - MC's work with the Provider started [42] [83].

08.11.21 - The Incident occurred (at around 9.40pm [60]).

Mid Nov (approx) - Alleged communication by MC, to the Provider's registered manager, about the Incident (including an alleged assertion that W had lied to the police about MC having threatened W during the Incident) [61].

06.12.21 - Incident report created by a manager ["GS"] [62].

06.12.21 - Police attendance; police viewed the CCTV Footage, with the Provider [61].

06.12.21 - MC was asked to leave the Provider and/or was "dismissed" [61], after the Provider formed a view (from the CCTV Footage) that, among other things, MC had "bullied and threatened" W, during the Incident, "without any obvious provocation", and had thereby abused his "position of trust" [61].

06.12.21 - Referral to adult safeguarding [75].

17.12.21 - Referral to DBS in respect of Decision 1 [36].

The DBS procedure in relation to Decision 1

05.01.22 - DBS "early warning" letter [24].

03.02.22 - MC's email in response ("the Initial Reps") [80].

11.05.22 - DBS "minded to bar" letter [28], with attachments [34].

05.07.22 - Written representations from a solicitor on behalf of MC ("the Reps") [83].

Decision 1

13.07.22 - DBS letter communicating Decision 1 (i.e. to include MC in both the CBL and the ABL). to MC ("the Final Letter") [88] (to be considered alongside the Barring Decision Summary, which sets out more fully the rationale of the DBS decision-maker [95]). In summary it stated:

"We are satisfied that you meet the criteria for regulated activity. This is because you worked as a Support Worker for E Services and previously applied for employment as a Healthcare Assistant and Support Worker with checks on both lists.

We have considered all the information we hold and are satisfied of the following:

> On 08/11/2021, whilst employed as a Support Worker for E Services, you caused emotional harm to service user W[] by preventing him from legitimately using the kitchen and threatening him with violence.

> Having considered this, DBS is satisfied you engaged in relevant conduct in relation to
> children and vulnerable adults. This is because you have engaged in conduct which
> endangered a vulnerable adult or was likely to endanger a vulnerable adult.
>
> It is also considered that you have engaged in relevant conduct in relation to children,
> specifically conduct which, if repeated against or in relation to a child, would endanger that
> child or would be likely to endanger him or her.
>
> We are satisfied a barring decision is appropriate. This is because W[] was particularly
> vulnerable due to his diagnosis of Schizophrenia, ASD and diabetes and required supported living accommodation, however you emotionally abused him by instigating
> unnecessary and unprovoked intimidating and threatening behaviour which caused
> emotional harm to W[] and prompted him to call the police. Police dealt with the matter by way of Community resolution including an apology letter to W[].
> …"

The DBS procedure in relation to Decision 2

> 07.05.22 - Second and separate referral (by a social worker/NHS trust) [220] [201], around this date, resulting in a second and separate DBS case being created ["DBS Case 2"].
>
> 15.06.22 - DBS "early warning" letter [201] in DBS Case 2.
>
> 23.12.22 - DBS "minded to bar" letter [205] in DBS Case 2, with attachments [211].
>
> 15.02.23 - MC email to confirm receipt and seek extra time [229]. Feb 2023 Exchange of email/letters about MC's request for extra time [230-235].
>
> 01.03.23 - DBS decision to proceed to make a decision [236].
>
> <u>Decision 2</u>
>
> 03.03.23 - A separate decision in the 2nd DBS Case was made ("Decision 2") and communicated in writing to MC. DBS letter communicating Decision 2 to MC ["Final Letter 2"] [237] (to be considered alongside the Barring Decision Summary ["Rationale Document 2"] [243]). The ultimate outcome was similar but not identical: MC would be included in the ABL only.

In summary the letter stated:

"We are satisfied that you meet the criteria for regulated activity. This is because you have been employed as a carer with [E Services at] Supported Accommodation in which you were required to care for a service user. The DBS are therefore satisfied that the test for regulated activity is met in relation to vulnerable adults.

We have considered all the information we hold and are satisfied of the following:

> On 08 November 2021, whilst employed as a carer whilst on night shift at E [Services] Supported Accommodation you have threatened and intimidated a service user, Mr W, which has resulted in his behaviours being provoked.

Having considered this, DBS is satisfied you engaged in relevant conduct in relation to
vulnerable adults. This is because you have engaged in conduct which endangered a
vulnerable adult or was likely to endanger a vulnerable adult.

We are satisfied a barring decision is appropriate. This is because it has already been
determined that it appeared that you engaged in relevant conduct which harmed a
vulnerable adult. This was on review of the evidence which demonstrated that whilst you were in a position of trust as a carer, you threatened a service user by invading their
personal space, telling them they must 'obey' and shouting at them. This has caused the
service user to feel intimidated as they have moved away, swore and called the Police. You received a Community Resolution Order from the Police and therefore apologised to the service user for your behaviours. You have been dismissed from your position. Your behaviours made the service user feel intimidated and threatened by your actions. The service user has been emotionally impacted by your actions.
…"

The procedure in relation to the Appeal to the UT

9 Oct 2022 - M's (UT10) application form presented to the UT [2], including his grounds of appeal ("the Grounds") [8] in relation to Decision 1.

12.10.22 - UT directions [21], in relation to Decision 1.

05.12.22 - DBS letter to UT [24], in relation to Decision 1.

27.07.23 - UT directions [118], in relation to Decision 1.

10.11.23 - DBS letter to UT [120], to seek extension of time to provide a response to MC's application. UT agreed to provide extra time [122].

27.11.23 - DBS letter to UT [123], to seek a further extension of time.

04.12.23 - DBS submissions [162], with clarification provided in relation to the CCTV Footage and the development/ issue relating to Decision 2.

11.12.23 - MC requested extra time to consider the development in relation to Decision 2 and the CCTV Footage [175].

12.12.23 - UT directions [176].

15.12.23 - DBS letter, providing additional evidence in relation to Decision 2 [177].

15.12.23 - MC written submissions for the oral permission hearing ("OPH") [179], including a chronology [191] and a transcript re the CCTV Footage ["the Transcript"] (193).

18.12.23 - The OPH. MC and his counsel attended; DBS did not (and was not required to) [197/198].

18.12.23 - UT granted permission to proceed with the Appeal [197], in relation to both Decision 1 and Decision 2 on the basis of the grounds set out (at para 12 in particular) in the submissions dated 15.12.23 ("the Grounds"). UT directions in relation to further disclosure and the Hearing [198].

22.01.24 - DBS provided further disclosure (i.e. in relation to Decision 2). No further grounds/response/evidence, or other documents, provided by MC (i.e. in relation to para 3 of the UT 19.12.23 directions [199]), whether within the time provided by the UT or (at the time of writing) at all. N/A No response from MC's representatives in relation to DBS correspondence attempting to agree directions. 04.04.24 UT directions [259]. TBC The filing of this skeleton.

10.06.24 The appeal originally listed for hearing but adjourned and re-listed for 3 April 2025.

The CCTV Footage

11. As was explained above, the first DBS decision-maker did not see or hear the CCTV Footage at the time Decision 1 was made. The decision-maker made the Decision based on other documentary material in the Bundle, including that which referred to and described the contents of the CCTV Footage. Significantly, in the

course of its consideration of the 2nd Case and making Decision 2, DBS was able to see and hear the CCTV Footage.

12. The CCTV Footage of the Incident on 8 November 2021 lasted about one and a half minutes and was made available for the parties and UT to consider in advance of the hearing and was played during the hearing, including during the Appellant's evidence, more than once.

13. Although there was some dispute as to the contents of the transcript prepared by the Appellant, and there were handwritten amendments made by the DBS, these are not significant. The amended transcript of the audio track of the CCTV Footage is set out below. Disputes of fact will be addressed in the fact finding section.

TIME	MC	W
21:41:07		[grating potatoes at kitchen counter]
21:41:10		
	[From outside kitchen] MC	
		Yeah
	What are you doing [inaudible]?	
21:41:15		[Walks towards door] Grating potato
	What?	[Leaning in the doorway]
		Grating potato
	Don't do that	
21:41:20	Why you need to do?	
	It's for the daytime	
		It's for tomorrow
	No you do it tomorrow	[Turns back returns to face the kitchen counter]

	[Enters kitchen] not today [following W]	I always
21:41:25	[approaches kitchen counter and faces W and touches the counter]	Do things in advance
	No, not [or “no, no”]	
		That’s the way [GS] told me, said I can do it
	No	
21:41:30		I’m not cooking nothing tonight
		Now please can you go away and
		Leave me alone
	What, I thought	[moves 2 small steps along counter, away from MC]
	you cooking	I’m not
21:41:35		Cooking I’m
		Doing it for Tomorrow
		Now can you please go away and leave
	Don’t don’t tell me	me alone
	Go away	
21:41:40		[GS] said I can do this
	Yeah but don’t	
	Don’t tell me go away	
	Don’t tell me	Yeah well
		You ain’t [GS]
21:41:45	Don’t tell me I’m not	[grates a potato]
	GS I’m just telling you	
	Something, you know,	

	You have to obey	
		Yeah well GS said I
21:41:50		Can do it like this
	He, He told you yeah?	Yeah
		I can do it in advance
	Are you a hundred per cent sure	
		Yes I'm a hundred percent, Now go away
21:41:55	Alright	
	Don't tell me go away	
	[inaudible]	
	Don't tell me to…to go away	
		Fuck off and go away
21:42:00	Don't tell me fuck off	[takes 6 small steps along counter]
	[takes 3 steps along counter covering a similar distance towards W] Don't tell me go away	
		Go away you
	[Points finger at W] I'm not gonna hear that ok	Fucking [inaudible]
		Fuck off and don't
21:42:05		Point your finger at me
	I'll point you my finger	
		Fuck off [continues grating]
	Don't tell me to go away	
		Fuck off
21:42:10	Who are you to tell me that	
		Fuck off

21:42:15	You have no respect	
	For people W [using W's first name]	Shut up
	[takes 4 steps away from W]	
	If you tell me that I…	
21:42:20	[takes 3 steps back towards W returning to similar position] **I… I will… I will**	
[**Emphasis Added**]	**Smash your nose here** [pointing again]	
		You do that and I will
	No, not me [or inaudible]	I will… [raises finger at MC]
		fuck it I'm Calling the police
21:42:25	Yes, just [turning to follow W]	[walks around and past MC and out of door]
	Call the police [follows W out kitchen]	No [inaudible] I'm
		Calling the police
	Yes, just go and call	
	The police	I'm calling the police
21:42:30	Yeah	
		[inaudible] You are a violent man
		[inaudible]
		[inaudible]

21:42:35		
	[inaudible]	
		[inaudible]…fucking police
	[inaudible] just call the police	
21:42:40		

Legal framework

14. There are, broadly speaking, three separate ways under Part 1 of Schedule 3 to the Act in which a person may be included on the Children's Barred List ('CBL') or Adults Barred List ('ABL'), which can generally be described as: (a) Autobar (for Automatic Barring Offences), (b) Autobar (for Automatic Inclusion Offences) and (c) Discretionary or non-automatic barring.

15. The third category applies in this case. The appeal concerns discretionary barring where a person does not meet the prescribed criteria (has not been convicted of specified criminal offences), but paragraphs 3 and 9 of Schedule 3 to the Act apply.

16. Paragraphs 3 and 9 of Schedule 3 to the Act, set out the provisions in relation to inclusion on the CBL or ABL. They provide that, following an opportunity for and consideration of representations, DBS "must" include a person on children's or adults' barred lists if:

    (a) it is satisfied that the person has engaged in relevant conduct, and
    (aa) it has reason to believe that the person is or has been or might in future be engaged in regulated activity relating to children / vulnerable adults, and
    (b) it is satisfied that it is appropriate to include the person in the list.

17. 'Relevant conduct' is defined under paragraphs 4 and 10 of Schedule 3 to the Act. Paragraphs 4(1) and 10(1) of the same, sets out the meaning of "relevant conduct". It includes: (i) "conduct which endangers a child / vulnerable adult or is likely to endanger a child / vulnerable adult"; (ii) "conduct which, if repeated against or in relation to a child / vulnerable adult, would endanger that child / vulnerable adult or would be likely to endanger him". Paragraphs 4(2) and 10(2) of the same, provides that conduct "endangers a child / vulnerable adult if" among other things it: (i) "harms" a child / vulnerable adult ; or (ii) puts a child / vulnerable adult "at risk of harm".

18. An activity is a "regulated activity relating to children" for the purposes of paragraph 2(8)(b) of Schedule 3 if it falls within one of the subparagraphs in paragraph 1 of Schedule 4 to the Act; that provision broadly defines "regulated activity" and includes, in relation to children, "any form of teaching, training or instruction of children, unless the teaching, training or instruction is merely

incidental to teaching, training or instruction of persons who are not children". An activity is regulated activity relating to vulnerable adults if it falls within paragraph 7. This includes the provision to an adult of healthcare, personal care or social work.

19. Section 4 of the Act provides for appeals to the UT from the DBS barring decisions:

> **4 Appeals**
> (1) An individual who is included in a barred list may appeal to the [Upper]1 Tribunal against– [...]
> (b) a decision under [paragraph 2, 3, 5, 8, 9 or 11]3 of [Schedule 3]4 to include him in the list;
> (c) a decision under [paragraph 17, 18 or 18A]5 of that Schedule not to remove him from the list.
> (2) An appeal under subsection (1) may be made only on the grounds that [DBS] has made a mistake–
> (a) on any point of law;
> (b) in any finding of fact which it has made and on which the decision mentioned in that subsection was based.
> (3) For the purposes of subsection (2), the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact.
> (4) An appeal under subsection (1) may be made only with the permission of the [Upper] Tribunal.
> (5) Unless the [Upper] Tribunal finds that [DBS] has made a mistake of law or fact, it must confirm the decision of [DBS].
> (6) If the [Upper] Tribunal finds that [DBS] has made such a mistake it must–
> (a) direct [DBS] to remove the person from the list, or
> (b) remit the matter to [DBS] for a new decision.
> (7) If the [Upper] Tribunal remits a matter to [DBS] under subsection (6)(b)–
> (a) the [Upper] Tribunal may set out any findings of fact which it has made (on which [DBS] must base its new decision); and
> (b) the person must be removed from the list until [DBS] makes its new decision, unless the [Upper] Tribunal directs otherwise.

20. As underlined above, an Appellant may appeal against the barring on the ground that the DBS has made a mistake:

> a. "on any point of law" (section 4(2)(a) of the Act).
> b. "in any finding of fact which it has made and on which the decision … was based" (section 4(2)(b) of the Act).

21. However, for these purposes "the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact" (section 4(3))

22. The only issues in this appeal therefore are whether there were any material mistakes of law or fact relied upon by the DBS in including the Appellant on the ABL and CBL.

23. The Court of appeal has most recently summarised the applicable law in *XYZ v DBS* [2025] EWCA Civ 191 at [18]-[29] as follows:

"The safeguarding regime

18. The DBS is a body corporate (section 87 of the Protection of Freedoms Act 2012 ("POFA")). It is not a servant or agent of the Crown (POFA, Schedule 8, paragraph 15(1)(a)). Barring decisions are part of the core functions of the DBS, and the Secretary of State is precluded from giving directions to the DBS in respect of any such core function (POFA, Schedule 8, paragraphs 8 and 14).

19. The arrangements governing the DBS's functions of protecting children (and vulnerable adults) are contained in the Safeguarding Vulnerable Groups Act 2006 ("the 2006 Act"). Schedule 3 to the 2006 Act provides, at paragraph 3:

" (1) This paragraph applies to a person if

a. it appears to DBS that the person
i. has (at any time) engaged in relevant conduct and
ii. is or has been, or might in future, be engaged in regulated activity relating to children and
b. DBS proposes to include him in the children's barred list.

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

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

a. it is satisfied that the person has engaged in relevant conduct
aa. it has reason to believe that the person is or has been or might in future be engaged in regulated activity relating to children, and
b. it is satisfied that it is appropriate to include the person in the list."

20. "Relevant conduct" is defined in paragraph 4 of Schedule 3 as including conduct of a sexual nature involving a child, "if it appears to DBS that the conduct is inappropriate." It also includes conduct which puts a child at risk of harm.

21. Teaching children is a regulated activity under section 5 and Part 1 of Schedule 4 to the 2006 Act. A person included in the children's barred list is prohibited from engaging in regulated activity relating to children (section 3 of the 2006 Act).

22. The requirement that, before making a barring decision, the DBS must afford the individual concerned the opportunity to make representations as to why they should not be included in the children's barred list, is addressed in more detail in paragraph 16 of Schedule 3. This provides, relevantly, in sub-paragraph (3) that:

"The opportunity to make representations does not include the opportunity to make representations that findings of fact made by a competent body were wrongly made".

Sub-paragraph (4) states that findings of fact made by a competent body are findings of fact made in proceedings before the Secretary of State in the exercise of the Secretary of State's functions under section 141B of the 2002 Act (i.e. proceedings before the TRA) or in proceedings before certain other specified professional regulators, including, for example, the General Medical Council, the General Optical Council and the Nursing and Midwifery Council.

23. The ambit of the role and functions of the DBS was explained by the Divisional Court in *R(SXM) v DBS* [2020] EWHC 624 (Admin), [2020] 1 WLR 3259 in these terms at [38]:

> "… it is clear that the function of the DBS is a protective forward-looking function, intended to prevent the risk of harm to children by excluding persons from involvement in regulated activities. The DBS is not performing a prosecutorial or adjudicatory role and it is not engaged in considering complaints from individuals and imposing punishments. It may, as part of its task, have to form a view as to whether a person has engaged in conduct likely to endanger a child or sexually inappropriate conduct, or the case may involve conduct posing a risk of harm. It will need also to consider questions as to whether it is appropriate to include the person on the children's barred list. However it is not there to receive and adjudicate upon complaints from individuals."

> That explains why information about whether a person's name is on the children's barred list is not publicly available. It is restricted to those who intend to employ or engage someone who would be involved in regulated activity with children. In *SXM* it was decided that even someone who alleged that they had been abused as a child by a person referred by a local authority to the DBS for determination as to whether they should be included in the children's barred list, had no status to seek information from the DBS as to the outcome of that referral.

24. Section 4 of the 2006 Act provides for a right of appeal against a barring decision to the UT, with the permission of the UT, on the grounds that the DBS has made a mistake on any point of law or in any finding of fact which it has made and on which the barring decision was based. If the UT finds that the DBS made such a mistake, it must either direct the DBS to remove the appellant from the barred list or remit the matter to the DBS for a fresh decision. If it takes the latter course, the UT may set out any findings of fact which it has made on which the DBS must base its new decision.

25. In determining such an appeal, the UT is not restricted to consideration of the information which was before the DBS decision maker. It has the power to hear oral evidence, and to make its own findings of fact and draw its own inferences from all the evidence before it. It will not defer to the DBS in factual matters but will afford appropriate weight to fact-findings by the DBS in matters that engage its expertise, such as the assessment of risk to the public: see *PF v DBS* [2020] UKUT 256 (AAC) at [51], approved by this Court in *Kihembo v DBS* [2023] EWCA Civ 1547 at [26].

26. In the present case, the UT accurately summarised the case law on the nature and extent of its "mistake of fact" jurisdiction under section 4(2)(b) of the 2006 Act at [39] to [47] of its determination. It referred, among other matters, to the decision in *DBS v JHB* [2023] EWCA Civ 982 in which it was confirmed by the Court of Appeal that a finding of fact may be "wrong" even if there was some evidence to support it or it was not irrational, if it is a finding about which the UT has heard evidence which was not before the DBS and the new evidence shows that the finding made by the DBS was wrong. In that case, the Court of Appeal held that the UT had erred by substituting its own evaluation of the evidence for that of the DBS decision-maker in circumstances where (i) the evidence was identical, and (ii) the UT had not held that the DBS had made findings which were not open to a reasonable decision-maker (i.e. irrational).

27. The UT also referred to the more recent case of *DBS v RI* [2024] EWCA Civ 95, in which a different constitution of the Court of Appeal found it difficult to discern the ratio of *JHB* save possibly that "it 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": see the judgment of Bean LJ, with which Males LJ and Lewis LJ agreed, at [33]. Males LJ, in his concurring judgment, with which Lewis LJ also agreed, indicated that the restrictive approach adopted in *JHB* should be confined to those cases where the appellant does not give oral evidence before the appellate tribunal, or gives no evidence relevant to the question whether they committed the relevant act relied upon. The UT quoted from his judgment where he said (at [49]):

    "In conferring a right of appeal in the terms of section 4(2)(b), Parliament must therefore have intended that it would be open to a person included on a barred list to contend before the Upper Tribunal that the DBS was mistaken to find that they committed the relevant act – or in other words, to contend that they did not commit the relevant act and that the decision of the DBS that they did was therefore mistaken. On its plain words, the section does not require any more granular mistake to be identified than that."

28. The UT directed itself in accordance with that approach. It first satisfied itself that whilst the DBS decision could have been better explained, and different findings could have been made, the findings made by the DBS were open to the decision maker on the evidence before them. It then considered further evidence, including the TRA decision, to ascertain whether any of those findings were mistaken ([88] and [89]).

29. For completeness, Paragraph 18 of Schedule 3 to the 2006 Act provides for the right of a person who is included in a barred list to apply to the DBS for a review of their inclusion (though the permission of the DBS is required to make such an application). However, sub-paragraph (3) provides that such an application can only be made after the end of the minimum barred period (which is prescribed by regulations, currently SI 2008/474) which in XYZ's case is 10 years."

Relevant general tests/principles

24. In order for the Appeal to succeed, under section 4 of the Act, the UT would need to reach a conclusion that DBS made a material mistake on a point of fact or law. The DBS relied on the "relevant conduct" gateway. It therefore needed to be "satisfied" of the following 3 things before barring MC (pursuant to the following paras of Schedule 3 to the Act):

    (a) First, under paras 3(3)(aa) and/or 9(3)(aa), MC was at the time, had been in the past, or might in the future be, "engaged" in "regulated activity" (relating to children and/or vulnerable adults).

    (b) Second, under paras 3(3)(a) and/or 9(3)(a), MC "engaged" in "relevant conduct" (as further defined under paras 4 and/or 10) ["Relevant Conduct"].

(c) Third, under paras 3(3)(b) and/or 9(3)(b), it was "appropriate" (and proportionate) to include MC on the barred list(s).

25. Indeed: if satisfied of the above 3 matters, DBS was required, by the Act, to include MC on the relevant lists.

26. In relation to relevant principles regarding factual mistakes, the UT may consider: *PF v DBS* [2020] UKUT 256 (AAC); *DBS v JHB* [2023] EWCA Civ 982; *Kihembo v DBS* [2023] EWCA Civ 1547; and *DBS v RI* [2024] EWCA Civ 95.

27. In relation to whether it is "appropriate" to include a person in a barred list, the UT has limited power to intervene. The same is clear from the Act (s.4(3)) and relevant case law. The scope for challenge, by way of an appeal, is effectively limited to a challenge on proportionality or rationality grounds. DBS is well-equipped to make safeguarding decisions of this kind (*DBS v AB* [2021] EWCA Civ 1575 (paras 43-44, 55, 66-75)).

28. At para 55 of *DBS v AB*, the Court also stated: "[The UT] will need to distinguish carefully a finding of fact from value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness. [The UT] may do the former but not the latter…"

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

30. When considering the Decision, the UT may need to consider both the Final Letter and Rationale Document ("Barring Decision Summary"). The two together, in effect, set out the overall substantive decision/reasons (see *AB v DBS* [2016] UKUT 386 (AAC) (para 35); *Khakh v ISA* [2013] EWCA Civ 1341 (paras 6, 20, 22)).

31. Classic statements of law such as that in *R(Iran) v Secretary of State for the Home Department* [2005] EWCA Civ 982 make clear that materiality (or procedural fairness) is an essential feature of an error of law and there is nothing in the Act which provides a basis for departing from that general principle (*CD v DBS* [2020] UKUT 219 (AAC)).

32. The DBS is not a court of law. Reasons need only be adequate. DBS does not need to engage with every potential issue raised. There are reasonable limits, too, in practice, as to how far DBS needs to go in terms of any duty to "investigate" matters or to gather further information, etc, itself.

33. If the UT finds that DBS made a material mistake of fact or law under section 4(2) of the Act, it is required under section 4(6) to either (i) direct that DBS removes the person from the relevant list(s) or (ii) remit the matter to DBS for a new decision. Where the UT does the latter, the UT may, under section 4(7), set out

any findings of fact, which it has made, on which DBS must then base any new decision. Following *AB*, the usual order will be remission back to DBS unless no decision other than removal is possible on the facts.

The grounds of appeal and the Appellant's submissions

The Appellant

34. The Appellant was granted permission to appeal on the following grounds drafted by his former counsel in December 2023:

> "…the DBS erred in fact and/or law in relation to the following five findings of fact in its decision, which were all clearly material/relevant because they informed the DBS's analysis of MC's conduct and the assessment of risk/appropriateness/proportionality, this incident being the only allegation relied upon by the DBS against MC:
>
> (1) The finding that W[] was *legitimately using the kitchen* and that MC's actions in challenging W[] and preventing him from so doing were therefore *unnecessary*/*inappropriate*/*without any provocation*. In fact, W[] was not *legitimately* using the kitchen because his care plan provided that he needed *staff supervision at all times* yet he had plainly been using (and wanted to continue using) the kitchen *alone*.
>
> (2) The finding that MC had *repeatedly invaded W[]'s personal/safe space*. In fact, MC maintained a reasonable distance to W[] at all times during the incident.
>
> (3) The findings that MC had said *he didn't care what the manager said*, and that MC's behaviour therefore showed an *attitude that he is entitled to disregard the care plans and instructions of management and enforce his own rules*. In fact, MC said no such thing and, indeed, once W[] had told MC that he was *a hundred percent* sure the manager had told him he was allowed to use the kitchen, MC actually said *alright* and stopped trying to tell W[] not to use the kitchen, showing that he was trying to follow what the management had said.
>
> (4) The finding that MC's conduct did, as a matter of fact, cause *emotional harm* to W[]. There was no, or at least insufficient, evidence in this case on which to base such a finding of fact on the balance of probabilities.
>
> (5) The findings that MC had *failed to report the incident* and later *concealed* his behaviour by suggesting *that W[] had lied to police about being threatened*. There was again no, or at least insufficient, evidence in this case on which to base such findings of fact.
>
> For completeness, in addition to those material factual errors, MC will contend that the DBS further and separately erred in the three ways identified below, although, following the observations at para 9(5) above, it may be that these submissions will ultimately fall away if the Tribunal agrees with the preceding submissions as to the alleged factual mistakes.
>
> (6) The DBS erred when finding that MC's conduct demonstrated *callousness and a lack of empathy* and therefore that MC had *a harmful attitude and lack of empathy*. In addition to the factual errors relied upon above, the DBS erred in law by failing to take into account the fact that MC had worked in the sector for several years without any allegations concerning his behaviour, which was unarguably relevant if he is said

to have such an essential and irremediable flaw in his character and, as the DBS accepted, MC's behaviour *occurred in circumstances that are not uncommon in regulated activity*.

(7) The DBS erred in law when finding that MC poses a *significant* risk of emotional harm to vulnerable adults. In addition to the errors already pleaded, the DBS failed to give sufficient reasons and/or reached a *Wednesbury* unreasonable finding that the risk of emotional harm was *significant* on the basis simply of a finding that it was considered *likely that MC could repeat his behaviour in future*.

(8) The DBS failed to give any, or any adequate, reasons for its finding in relation to the "transferability" of MC's behaviour in respect of children, as borne out by the second DBS decision not to include MC on the CBL.

35. In written submissions filed by his solicitors on 2 April 2025 for the hearing, the Appellant relied on three different grounds:

Issue 1: Whether the DBS applied the correct statutory test and evidential threshold in deciding to bar the Appellant, including whether it adequately considered mitigating evidence or contradictory accounts.

Issue 2: Whether the indefinite bar constitutes a disproportionate interference with the Appellant's rights under Article 8 of the European Convention on Human Rights ("ECHR"), and if less restrictive measures could achieve the aims of safeguarding.

Issue 3: Whether the DBS's process and decision letter meet procedural fairness requirements, including the duty to provide adequate reasons and consider the Appellant's representations.

36. In support of Issue 1, Mr Badar, for the Appellant, submitted that there is a lack of clear evidence that the Appellant's conduct satisfied the definition of "relevant conduct." The minor involvement of police and the absence of physical harm suggest that the DBS may have overstated the severity of the incident. The DBS must, on the balance of probabilities, be satisfied that the Appellant's conduct posed or was likely to pose harm. Where serious outcomes such as indefinite barring are at stake, rigorous scrutiny of evidence is required. The DBS appears to have taken the employer's account and alleged CCTV references at face value, without adequately exploring the Appellant's evidence, character references, or the limited police response. *Menon v Secretary of State for the Home Department [2005] EWCA Civ 1605* highlights that high-stakes decisions demand thorough evaluation of conflicting material. By failing to demonstrate such an evaluation, the DBS risked misapplying the statutory and evidential framework. The DBS's conclusion seems unsupported by a balanced review of evidence, calling into question whether the correct legal thresholds were applied.

37. In support of Issue 2 Mr Badar submitted that an indefinite bar from regulated activity interferes with the Appellant's right to private life under Article 8 ECHR, encompassing professional and personal development. The DBS's decision letter merely asserts that an indefinite bar is "necessary and proportionate," without

showing consideration of less restrictive alternatives. Given the minor nature of the police resolution and the Appellant's previously unblemished record, an indefinite bar is arguably excessive. A decision-maker must not interfere more than is strictly required to meet safeguarding objectives. The DBS failed to illustrate why no other measures short of a permanent bar could protect vulnerable individuals, making the decision disproportionate and incompatible with Article 8.

38. In support of Issue 3 Mr Badar submitted that the Appellant is entitled to a fair process and a fully reasoned decision, particularly given the significant restrictions now imposed. In *R. (on the application of Wright) v Secretary of State for Health* [2009] UKHL 3, the House of Lords emphasized that safeguards must be robust and fair when blacklisting care workers. The decision letters do not adequately engage with the Appellant's perspective, good conduct record, or the police's choice of a minimal sanction. A high-level re-statement of allegations does not meet the standard of fairness. No detailed explanation is given as to why an indefinite bar—rather than a time-limited bar or other safeguards—was chosen. This omission undermines the credibility and legality of the decision, indicating a lack of individualized consideration. Given the significant impact of a bar, the process followed by the DBS did not satisfy procedural fairness, and the decision letter fails to provide sufficiently detailed reasons.

Facts Found

39. The DBS relied on written evidence from witnesses and notes of the incident or reports of meetings contained in the bundle of evidence it filed and served which contained 287 pages. It included all the material relied upon by the DBS in making Decisions 1 and 2, as summarised above, and in defending the appeal as well as some of the material provided by the Appellant. Additional material provided by the Appellant was contained in the Appellant's bundle.

40. We have examined all the evidence in the case with care, both that which was before the DBS and that provided by the Appellant as part of his appeal (most of which was not available to the DBS at the time it made its Decision). We have not found it necessary to refer to every document.

41. We make findings of fact on the balance of probabilities as set out below. In light of these, we consider whether the DBS made mistakes of fact in accordance with the approach set out in *PF v DBS* and *DBS v RI*. The burden of proof remained on the DBS when establishing the facts and making its findings of relevant conduct in its barring decision. Thereafter on the appeal to the UT, the burden was on the Appellant to establish a mistake of fact (see *PF* at [51]):

> 'The starting point for the tribunal's consideration of factual matters is the DBS decision in the sense that an appellant must demonstrate a mistake of law or fact. However, given that the tribunal may consider factual matters for itself, the starting point may not determine the outcome of the

> appeal. The starting point is likely to make no practical difference in those cases in which the tribunal receives evidence that was not before the decision-maker.'

42. Furthermore, the UT stated in *PF*:

> 'In determining whether the DBS has made a mistake of fact, the tribunal will consider all the evidence before it and is not confined to the evidence before the decision-maker. The tribunal may hear oral evidence for this purpose…. In reaching its own factual findings, the tribunal is able to make findings based directly on the evidence and to draw inferences from the evidence before it...The tribunal will not defer to the DBS in factual matters but will give appropriate weight to the DBS's factual findings in matters that engage its expertise.'

43. However, it is not within our jurisdiction, when considering whether there have been mistakes of fact, to make our own evaluative judgments (for example, what was reasonable for the Appellant to do or whether there would be a risk of repetition or future harm). The proper evaluative judgements which should be made based upon the primary facts found are a matter for the DBS as the expert risk assessor. We would not interfere with risk assessments made by the DBS unless such judgments are based upon mistakes of primary fact or are irrational (contain a mistake of law).

44. We make findings of fact – both of primary facts and secondary facts (inferences from primary fact). We make the following findings on the balance of probabilities.

45. MC was the only witness from whom we heard oral evidence. We found him to be an honest and reliable witness and we accept his evidence and find it as fact on the balance of probabilities.

46. We accept the contents of MC's witness statement which he adopted as his evidence in chief as follows:

> "3. During my time as a Health Care Support Worker, I was employed by several healthcare providers. I worked with M Healthcare from December 2018 to March 2019, with G Healthcare from July 2019 until July 2020, with A Healthcare Services from July 2020 until October 2020, and with E Services Ltd from 16 March 2021 until 20 December 2021. Over these periods, I worked through various challenges, including the COVID-19 pandemic, and remained dedicated to helping those under my care.
>
> 4. On [1]8 November 2021, an unfortunate incident occurred between myself and a patient, [W], who I had been caring for at the time. I had looked after W on previous occasions, as well as other patients living in the same residence.
>
> 5. The issue that arose on that day involved W's eagerness to use the kitchen late at night to cook. The kitchen is located near the room of another patient, J, who lives downstairs and whose room is directly opposite the kitchen. Cooking in the kitchen during the night would likely disturb J, and as such, I advised him gently not to cook at that time. However, he refused my request repeatedly and was adamant on using the kitchen. In

an attempt to prevent him from disturbing J, I tried to stop him from cooking, which unfortunately led to an incident between us. He subsequently called the police.

6. I fully acknowledge and accept that my handling of this situation was inappropriate and unprofessional. I deeply regret my behaviour, which I recognise fell far below the standard expected of me in my role.

7. While my intention was to protect J from being disturbed, I understand that my approach in dealing with W was wrong. I had no intention of causing him any harm or distress, and I regret the way in which I handled the matter. I failed to maintain a balance in caring for both J and W, for which I am really sorry.

8. In response to the allegation that I did not show any remorse or empathy towards W following the incident, I want to clarify that I did apologise to him after the incident. I expressed my regret both verbally and in a written letter of apology to him. I never intended to excuse my actions, and I have taken full responsibility for what happened.

9. I want to acknowledge the incident that occurred, as I cannot deny that it happened. However, I want to provide further context regarding the specific word that has caused concern—the word "smash."

10. I want to be clear that this word was never meant with any bad intent. It was an accident, a slip of the tongue in the heat of the moment, and not something I was consciously aware of at the time.

11. I have never been, nor do I want to be, a violent person. My character and professional record reflect this. You can verify my background with any of the organisations I have worked with, and you will find no history of violence, aggression, or any criminal activity.

12. In fact, I have faced challenging situations in my role as a Health Care Support Worker, particularly with the patient in question, W. This incident was not the first time we have had a difficult interaction.

13. On a previous occasion, he used hurtful and discriminatory language towards me. He called me several offensive names and even went as far as to say that he did not want any Muslim to “control” him. I tried to remain calm and professional, telling him that I was simply there to do my job and that my religion had nothing to do with the care I provided.

14. However, W persisted and stated that he would never let any Muslim control his life. He even went so far as to threaten me, telling me that he would "put me in trouble."

15. After that incident, I did everything I thought was right. I reported the matter to both the management and the police. I felt threatened and vulnerable because of W’s comments, and I wanted to make sure that the situation was addressed through the proper channels.

16. Unfortunately, despite my efforts, the management did not take any meaningful action to resolve the issue. The police, however, have been diligent, and I have been contacted several times by officers to check on my well-being, showing that this was a serious matter.

17. Despite everything that had happened previously, I was still committed to providing W with the best care possible. I hold no personal grudges against him, and I believe in professionalism.

18. After the more recent incident, I took it upon myself to write an apology letter to W, expressing my regret for any distress caused. I wanted to mend the relationship and ensure that he knew I did not have any ill will towards him. W accepted my apology, which shows that there was understanding and resolution between us.

19. I understand that what happened—especially the use of the word “smash”— was a mistake, but I do not believe that this single moment of error reflects who I am as a person or a professional. I have worked for years in this field with numerous vulnerable individuals, and I have always carried out my duties with compassion and care. This one mistake should not overshadow all the positive contributions I have made and the many patients I have helped.

20. In that moment, I was trying to cool the situation, but I made an error in judgment when I said something I later regretted. The word “smash” slipped out during the heat of the moment, and as soon as I realised what I had said, I knew it was wrong. I never intended to hurt him physically or emotionally, and I deeply regret that it came across that way.

21. I want to emphasise that this was a slip of the tongue, not a reflection of my character or my intentions. I have always maintained a calm and professional demeanour in my work, and I care deeply about the well-being of my patients. I understand that this incident has raised concerns, but I urge you to consider my full record and the context surrounding this event. This was not a deliberate act of aggression—it was an unfortunate mistake, and I am truly sorry for it.

22. I know that as professionals, you have every right to consider barring me from continuing in this role, but I am asking for your understanding and leniency. I am only human, and like everyone else, I am not above making mistakes. However, I promise that this was an isolated incident, and it will not be repeated. I have learned from this experience, and going forward, I will be even more mindful of my actions and my words in challenging situations. I would never intentionally hurt or distress a patient, and I have always strived to provide the highest level of care.

23. Since the incident, I have reflected deeply on my actions and have learned from this experience. I am fully committed to ensuring that such an event will never happen again. If faced with a similar situation in the future, I would approach it differently, placing the safety and well-being of all my patients at the forefront. I now understand that assisting my patients in resolving such conflicts, rather than attempting to prevent them, is the correct course of action.

24. I would also like to emphasise that my previous record as a Health Care Support Worker demonstrates that I am not a risk to my patients.

25. Throughout my career, I have consistently shown my dedication to caring for my patients and ensuring their safety. I deeply regret the incident that took place on [1]8 November 2021, but I do not want this isolated event to define me or prevent me from continuing to provide high-quality care to those who need it. I am committed to using what I have learned from this experience to improve and provide even better care in the future…”

47. MC was cross examined by Mr Serr for the DBS. He gave the following evidence which we accept as reliable and established on the balance of probabilities.

48. MC was working dayshifts at the relevant time. He would look at the care plans of service users. He would keep a log every 2 hours of what they were doing. He had received training in September 2021 a couple of months before the incident. This included training in Conflict Management, safeguarding and de-escalation. It was common for service users to exhibit and demonstrate aggression, agitation and extreme emotion. W had been diagnosed with schizophrenia and had had history of drug misuse and self harm as well as recorded as being physically and verbally aggressive towards others. In his care plan it said that W needed support in setting up routines to distract him from drugs and self harm. In the care plans prepared in July and August 2021 it said that staff would offer to chat with W and respect his space.

49. MC had worked with W since around July 2021. In particular, he had worked with W since an earlier time when W had used a discriminatory epithet against him based on the fact MC was a Muslim. W had also previously told him that he did not like him and he would report him to the police and make him lose his job.

50. The day the incident happened, 8 November 2021, MC was working on day shift from 7am to 11pm and it occurred after 9pm. MC was tired. MC accepted that he dealt with W during the Incident that evening in a manner that was not consistent with the care plan and was quite aggressive and confrontational. MC accepted he said he would smash W's nose but he did not mean that and it was not a threat MC was intending to carry out. He accepted that it would be triggering to W as a vulnerable person diagnosed with schizophrenia and ASD (Autism Spectrum Disorder). MC accepted he shouted at W. MC said he was not that kind of person and it was just one of those days and it happened from the blue moon.

51. However, MC and W worked together after the Incident between 8 November 2021 and 6 December 2021 without any further problem.

52. MC said he did write the incident down in the incident book and report it to the manager at the time although there is no record of this produced by the company, Appellant nor DBS. The only record now available is when MC's manager GS wrote up specific incident report on 6 December 2021. GS's note began by describing what was seen on CCTV. The report then described the aftermath of the Incident:

> "06-Dec-2021 00:00
>
> Management was not aware of the situation when it happened so unable to take action until today (6/12/2021).
>
> W didn't report to management and staff did not report to management.

> However two weeks ago, Staff [MC] called registered manager saying the police visited and they wanted to talk to [W] but " isn't in. Staff asked what happened, MC Said he advised [W] to go to sleep when he was cooking but [W] lied to police that he was threatened.
>
> Manager GS asked Staff MC why he was prompting S to sleep when W was cooking? MC said well just a suggestion to him; but W has lied to Police. Manager GS told staff MC that if the police is already involved he will wait for them to do their investigation and let E know the outcome.
>
> Today (6/1 2/2021) the Police attended and Manager GS, was informed that the Police were around.
>
> Manager GS attended with the Safeguarding Lead (staff DI). DI who is in charge of access to CCTV. DI logged into the CCTV data base and provided the police the access, together they watched the Clip and after police provided the date of report as 8th of November 2021. The CCTV was checked for that day. It was then found that MC had bullied and threatened W without any obvious provocation-details of said threat are
>
> What action was taken?
>
> Police informed Staff MC, that they will refer to DBS. As soon as Police left, Staff DI asked MC to leave and sent a replacement staff."

53. MC accepted the accuracy of this note in cross examination. MC accepted that he did tell the manager GS that W had lied to the police by saying that MC had threatened him. MC accepted that his report to GS was not true and it was not fair – MC had threatened W and W had not lied when reporting this to GS. MC accepted he had lied to GS about the incident. MC was truly sorry and ashamed.

54. Based upon all the findings above we make a finding of fact that the findings of fact relied upon by the DBS set out in Decisions 1 and 2 are established on the balance of probabilities:

> "On 08/11/2021, whilst employed as a Support Worker for E Services, you caused emotional harm to service user W[] by preventing him from legitimately using the kitchen and threatening him with violence." [Decision 1]
>
> "On 08 November 2021, whilst employed as a carer whilst on night shift at E Supported Accommodation you have threatened and intimidated a service user, Mr W, which has resulted in his behaviours being provoked". [Decision 2]

55. There is no dispute that these actions amount to relevant conduct against a vulnerable adult for the purposes of the Act because they caused emotional harm to W. This is evidenced by W's behaviour during the Incident, W then calling the police and the other matters we explain below.

56. We accept the mitigation put forward by MC in his evidence about the Incident. Not only do we accept all MC's evidence as being honestly given and make a finding to that effect, we also accept that MC was clearly upset about events as

well as having to give evidence about them to the Tribunal. This was demonstrated by MC's body language throughout his evidence as well as his verbal expressions of remorse and contrition. He was clearly doing his best to assist the Tribunal despite the events being upsetting for him.

Discussion and Analysis

57. We begin by addressing the eight grounds of appeal on which the Appellant was granted permission to appeal before addressing the three grounds of appeal pursued at the hearing.

The 8 grounds of appeal for which permission was granted

Ground 1 – whether W had been "legitimately" using the kitchen etc

58. Ground 1 is set out at para 12(1) – and paras 16-21 – of the Appellant's Grounds of Appeal dated 15 December 2023.

59. We are satisfied that there was no mistake in any finding by the DBS that W was "legitimately" – at the material time – using the kitchen. Events need to be viewed in context. W's care plan documentation ["the Care Plan"] did refer to W needing "staff supervision at all times when helping with the cooking to avoid of the risk of accidents in the kitchen" [71]; to staff supervising W when he had "chosen" to cook his own meal [72]; and to staff staying with W at all times and advising him on health and safety measures around the kitchen to keep him safe [72].

60. But importantly: (a) W was not "cooking". He was merely preparing food. Moreover, he was simply grating a few potatoes. The essence of the relevant parts of the Care Plan was about keeping W safe while cooking (or doing other things in the kitchen). There was a very low risk of any injury (or other health and safety risk) arising from the limited and straightforward act of grating potatoes. Further, protecting W from such a risk was never said to have been a motivation of MC (he had referred to being allegedly concerned about his own safety in his initial response to DBS [29]; but then later, within the Reps and his evidence to the Tribunal, about noise and its alleged effect on another service user, namely J [86]).

61. Any such care plan would not be binding, on the service user (or at least service users with the kinds of issues W had), in the same way as it might be on relevant staff. Moreover, the Care Plan expressly stated (correctly and in line with the general but important principles relating to "less restrictive" practice by organisations such as the Provider and its staff) that "W may decide not to follow this plan" – i.e. that W was entirely permitted to make decisions and "choices" which may "contradict" the Care Plan [72], even if, objectively, viewed, they may be considered "unwise".

62. Further, such sections of the Care Plan need to be viewed in the wider context of the whole of the Care Plan. That included sections about the importance of:

maintaining emotional stability; routine activities; activities which gave W a sense of achievement, enjoyment, and self-esteem; activities and which reduce frustration and help distract/ mitigate against the risk of self-harm and/or drug misuse; W having a degree of freedom and independence; staff supporting W to do such activities [69] and dealing with him in a supportive and positive manner. In short, managing W's mental health had to be balanced against other risks (and was more important than any potential safety issue arising that evening from grating a few potatoes).

63. Further, the evidence indicates that W had in effect been given permission (to the extent any such permission was required) from GS to act in the way he was in the kitchen at the start of the Incident. Although W did ask to be left alone to continue with his task, it seems clear from the CCTV Footage that he did so, primarily, as a reaction to the inappropriate (and increasingly intimidating) nature/manner of MC's intervention. W's initial mood can be seen to have been settled and his initial response(s) to MC to have been constructive.

64. Second, MC was present in the building and, at the time, in the kitchen. He can be said to have been supervising or able to supervise sufficiently, given the low-risk nature of the task being undertaken.

65. Third, there was no mistake in DBS finding that MC had, in effect, sought to impose his own restriction or disregard the Care Plan. He did. The Care Plan permitted W to make his own decisions, and encouraged staff to support W in general and in relation to activities (such as those he was engaged in at the time) etc.

66. Fourth and importantly: any mistake of fact in relation to Ground 1 was not material in any event. The same overall outcome would have been reached. Irrespective of whether MC had some potential justification for "challenging" W's preparation of food in the kitchen that evening, he had no justification for what followed (or for the manner in which he had "challenged" W).

67. It is also be noted that Decision 2 did not seek to rely on any findings in relation to W having been "legitimately" using the kitchen at the relevant time. The Relevant Conduct was conceded to be problematic by MC in the context of the Appeal, irrespective of any consideration of these secondary matters relating to Ground 1.

<u>Ground 2 – whether MC "invaded" W's personal space etc</u>

68. Ground 2 is set out at para 12(2) – and paras 22-24 – of the Grounds dated 15 December 2023.

69. The UT watched the CCTV Footage. Contrary to the submissions set out in the Grounds, we find that MC did move into W's personal space, more than once, during the Incident. Again, events need to be viewed in their proper context. Personal space is a relative/contextual concept, with a significant subjective

element to it. Substantial weight ought to be given to the perspective of the person whose space is said to be being invaded. We factor in W's issues and vulnerabilities; including his need to feel safe, reassured, not to be "probed", and to have his space respected, etc.

70. Context also requires us to consider the tone and manner of the nature of MC's interactions during the Incident, including MC's body language, posture and positioning generally (including the fact that he did position himself square/front on to W), along with his words (and his tone/volume). The invitation from MC's original counsel to consider MC's movements without sound is to ignore the reality and importance of context and the interaction between relevant factors.

71. The time and location were also factors weighing against MC: this was in the heart of W's safe space – his home, his kitchen, and in the evening.

72. It is also helpful to consider the words, physical positioning and reactions of W, as things developed through the Incident. That, too, is part of the context, in which judgments about "personal space" ought to be weighed.

73. We are of the view that there was no need for the physical proximity MC engaged in.

74. Moreover, there was the repeated nature of MC's movements into W's personal space: (a) MC did it early on, moving at some pace, following W, into a position in which he was too close to W, and then remaining in it for too long.
(b) MC then started to turn away [at 21:41:55] but, just as he seemed to be about to leave W's personal space, turned back towards W and raised his voice and level of challenge etc.
(c) MC then followed W, as W actively sought to move away from MC along and towards the far corner of the counter (and as W was, demonstrably, becoming more and more agitated by MC's conduct), and pointed his finger, etc.
(d) MC then started to move out and away again; but then moved back in, yet again, to deliver his direct threat to "smash your nose here".
(e) Even after W's movements to escape (in order to call the police), MC continued to pursue him further (before leaving the room and the coverage of the CCTV).

75. The reference to "two tiles" of distance between MC and W needs to be considered in context. The tiles on the kitchen floor were not big tiles. The point is that MC was too close, when viewed from the reasonable perspective of W, in all the circumstances; MC did not keep himself at a reasonable distance at numerous points.

76. This ground, especially when viewed in its proper context, is ill-founded. It is not surprising that both decision makers independently came to the (rational and reasonable) view that MC had encroached on W's personal space. In any event, again, any mistake in relation to it would be immaterial, given the other elements

of the Relevant Conduct and, in particular, the direct threat of physical abuse/assault.

Ground 3 – whether MC had no regard to what the manager had said etc

77. Ground 3 is set out at para 12(3) – and paras 25-27 – of the Grounds dated 15 December 2023.

78. It seems to be clear from the CCTV Footage that MC did not, in fact, say to W, expressly, that he didn't care what the manager (GS) had said.

79. In any event any finding that MC's overall behaviours showed an attitude that he was entitled to disregard the Care Plan and/or instructions of management and/or enforce his own rules is in fact not mistaken. It is well-supported by the Relevant Conduct, including MC's words: "Don't tell me I'm not [GS] – I'm just telling you something… you have to obey" etc. Indeed, the apparent acceptance by MC, part-way through the Incident, that W was entitled to use the kitchen for the purposes he was using it at the time, is an aggravating factor. MC's conduct thereafter was/is, as a result, more problematic and more culpable: it was then about, it seems, his authority and his perceived ability/right to enforce the same on W (W has to "obey". MC will, in effect, force W into it, and threaten W with direct violence).

80. Again, any such mistake would be immaterial, given the other elements of culpable conduct. Nor does it seem to have been a feature of Decision 2.

Ground 4 – whether MC had caused "emotional harm" to W etc

81. Ground 4 is set out at para 12(4) – and paras 28-31 – of the Grounds dated 15 December 2023.

82. There was no mistake of fact: it is clear from the CCTV Footage that MC caused at least some emotional harm to W. No more is required. We are satisfied that the inference can and (in practice) must be drawn from the footage and W's reactions (within it) to MC's interventions and from the fact that W did indeed then contact the police.

83. If more evidence was required, there is more: in what appears to be another incident report [225] (before the decision-maker in Decision 2 but not Decision 1) ["the Other Report"], there is evidence that W remained agitated for some time after the Incident and after calling police, including after the "night staff" arrived and asked him whether he was "okay".

84. Once again: it would not be material in any event – the Relevant Conduct had the clear and obvious potential to cause significant emotional harm to W (and put him at risk of a wider deterioration in his mental health with all the adverse consequences which could follow – drug use, self-harm, etc). That would be

sufficient to fall within the definition of harm for the purposes of relevant conduct within the Act.

Ground 5 – whether MC failed to report and/or concealed his conduct etc

85. Ground 5 is set out at para 12(5) – and paras 32-35 – of the Grounds dated 15 December 2023.

86. It is clear from the CCTV Footage that W was, as we have found as fact, threatened with direct physical violence by MC and he was caused emotional harm. As some mitigation we have also accepted MC's account that despite this – he did not intend to carry through with his threat even though he made it.

87. We have also accepted that it is more likely than not, on the evidence, that MC indicated to the Provider that W had lied about having been threatened by MC:

(a) There is the record set out in the Incident Report by GS [63], repeated and maintained in the formal referral to adult safeguarding [79]. It was stated there (twice, in effect) that MC had "said" that W had "lied to police that he was threatened" [79].

(b) There is also the following record within the Other Report [225]: "[W] told the staff that he is going to call the police. Staff tell him to carry on. [W] went to his room staff could hear him on phone saying. The other staff is trying to control him and he went to say the staff want to break his noise [sic] which was big lie. When [W] finish the phone call, he…".

88. MC, accepted in his own evidence that he had lied when he said to GS that W had lied about being threatened. MC's own statement to GS must, objectively viewed, have been false/misleading.

89. The obvious inference is that it was an attempt by MC to downplay and/or conceal the level of his own culpability. MC appears to have sought to minimise the seriousness of matters elsewhere too – describing it (merely) as his "little mistake", for example, in his initial response [29].

90. Thus, the finding(s) by DBS in Decision 1 that this was an aggravating factor was not mistaken. It does not appear to have been relied on in any event in Decision 2.

91. It will noted that there was no challenge to this finding in the Reps [85]; nor in the initial grounds [8]; nor was there any reference to it in MC's initial response [29]. MC accepted it in his oral evidence.

92. While the challenge was made in the Grounds: it was a limited attempt to undermine the DBS finding; there has never been a positive (or detailed or persuasive) case advanced on behalf of MC; and no supportive evidence has been provided by MC.

93. Again, even if there had been a mistake regarding this aggravating factor, it would be immaterial in any event; because MC did make the threat and that was the finding of relevant conduct made by DBS in Decision 1 and 2. The attempt by MC to seek to cover it up is an aggravating factor but DBS could/may have barred him without relying on such an aggravating factor.

Ground 6 – whether MC had demonstrated "callousness" etc

94. Ground 6 is set out at para 13(6) of the Grounds.

95. It follows from the Relevant Conduct (and the CCTV Footage) that, in all the circumstances, MC had demonstrated "callousness" and a "lack of empathy" during the Incident. MC had an inappropriate attitude about how he was entitled to act during the Incident; one that appeared incompatible with the obligations relating to regulated activity.

96. It is relevant that MC was relatively experienced in providing care and had been trained on relevant matters – but that tends to make MC's conduct during the Incident more culpable, overall, as much as it might otherwise be said to be a factor in support of MC in a more general sense.

97. DBS cannot be said to have failed, in any material respect, to have had regard to MC's previous record. The DBS was entitled to decide that it was not sufficient mitigation, such as to find he presented a continuing risk. Irrespective of any previous good or competent conduct more generally, MC had, in effect, been caught on CCTV. The DBS was entitled to find at the time it made Decisions 1 and 2 (July 2022 and March 2023) that any evidence of remorse, insight, etc, was too limited and/or unpersuasive so as to reduce or eliminate the risk he posed of causing harm.

Ground 7 – whether there was a "significant risk" of future harm etc

98. Ground 7 is set out at para 13(7) of the Grounds.

99. In light of the CCTV and the Relevant Conduct, MC, we are satisfied that it was reasonable for the DBS to conclude that MC posed "a" significant risk of future harm to vulnerable groups, especially given the insufficient evidence regarding insight, remediation, etc; and the inconsistent explanations he provided to DBS at the time of the barring decisions. The level of that risk was a matter for DBS to consider, as part of its assessment of the appropriateness of including MC on the barred list(s).

100. Sufficient reasoning was provided by DBS, when the whole of the Decisions, and the associated rationale documents, are taken properly into account. The DBS Decisions as to the risk MC posed were not irrational.

101. The DBS was entitled to take into account when making its expert risk assessment that the Incident was serious and aggravated. MC was agitated, invading W's personal space and threatening serious violence against a vulnerable user. Thereafter MC told a lie to GS about what W had said. This is troubling as MC sought to cover up or minimise the Incident and it cannot be said that this was said in the heat of the moment. The DBS was entitled to take this into account as demonstrating a lack of insight by MC and raising a significant risk of repetition.

102. The extent of the future risk MC posed would only be found to contain a mistake of law if it was irrational. We are satisfied it was not. The Tribunal gives weight to the DBS's role as the expert assessor of risk. While we take into account the substantial mitigation set out below, which we consider in relation to proportionality, and the remorse the Appellant undoubtedly feels about the Incident, we do not consider that the DBS was bound to find that he posed no future risk of harm to vulnerable adults.

103. There was no mistake of law in the DBS concluding that MC posed a significant risk of future harm. It was premised on findings of fact which contained no mistakes of fact.

Ground 8 – in relation to the "transferability" to children etc

104. Ground 8 is set out at para 13(8) of the Grounds. The Appellant submits that there was an error of law in relation to Decision 1 because there was no evidence from which it could be inferred he posed a risk of harm to children in the future or that the risk of harm to adults was transferrable to children. He had never committed relevant conduct against children and so should not have been included on the CBL in Decision 1.

105. Decision 2 cannot be relied on by MC in the way referred to in or suggested by the Grounds. Significantly, the DBS made no substantive decision on the transferability of the risk of harm to children in relation to the CBL in Decision 2. It never got that far because that decision-maker was not first satisfied that the (pre-requisite) "test for regulated activity" (as it is sometimes referred to) in relation to children was met. We address below whether that was the correct decision and whether there was a mistake in law in including the Appellant on the CBL in Decision 1.

106. However, whether or not the test for regulated activity with children was engaged, in relation to Decision 1 the DBS would have been entitled to include MC in the CBL as well as the ABL, having regard to the broad definition of Relevant Conduct within the Act (as including conduct which "if repeated against or in relation to children" would, in effect, be likely to put that child at risk of harm) among other things.

107. It is not in dispute that there was no evidence that MC had in past committed relevant conduct against children. The DBS relied upon their assessment MC

posed a risk of harm to children in the future (harm which if repeated against children would constitute relevant conduct). We accept the risk to children was rationally assessed and transferable for the reasons the DBS relied upon in Decision 1. The transferability to children could reasonably be inferred from MC's attitude towards a vulnerable adult in his care. The DBS's reasoning contained in the final decision letter in Decision 1 was rational:

> "Given your behaviour driven by a belief that you are entitled to behave in a harmful manner towards service users with a lack of empathy with those in your care, it is considered likely that you could repeat your harmful behaviour in regulated activity with children. Repeating this behaviour would cause emotional harm and therefore it is appropriate to include you on the Children's List."

The three grounds of appeal pursued at the hearing

108. Turning to the three grounds of appeal (described as Issues) pursued at the hearing: as indicated above, there appears to be no substantive challenge to the core facts relating to the Incident itself; the focus, instead, is on procedural fairness, the reasonableness of the decision, and the proportionality of the barring decisions. Each of these are arguments that there was a mistake of law in the Decisions.

Issue 1 : Whether the DBS applied the correct statutory test and evidential threshold in deciding to bar the Appellant, including whether it adequately considered mitigating evidence or contradictory accounts.

Issue 3: Whether the DBS's process and decision letter meet procedural fairness requirements, including the duty to provide adequate reasons and consider the Appellant's representations.

109. The first two issues are alleged errors of law alleging the DBS failed to apply the correct statutory thresholds or failed to provide procedural fairness in making its Decisions.

110. These grounds are taken together and dismissed.

111. MC has not disputed the core factual matrix in these proceedings. He makes no substantive challenge to his relevant threatening behaviour relating to the Incident. That lack of challenge on the facts was/is not surprising given, among other things, the evidence within the Bundle relating to the CCTV Footage and the "community resolution".

112. The DBS decision-maker had not had direct access to the CCTV Footage at the time of Decision 1 (due to an issue with the way the Provider had tried to provide it [96]). But it was/is sufficiently clear, from the documentation in the Bundle and MC's lack of challenge, that: (1) both the Provider and the police did watch it and relied directly on it and (2), moreover, MC, had essentially been caught "red-

handed" by the CCTV Footage. The first account of what the CCTV Footage showed was set out in the relevant incident report [60], re-iterated in the referral to safeguarding [77]. The CCTV Footage was then viewed by the DBS when making Decision 2.

113. The UT has now had the opportunity to view the video which it has considered with some care together with the transcript. Among other things, it was/is clear that MC had multiple opportunities, during the Incident, to "de-escalate" or take a different approach, but had chosen not to. The Appellant's conduct was more culpable given the particular issues (and needs) that W, as a result of his conditions, had and was known to have had (as detailed in the care plan documents in the Bundle). MC's conduct fell short of reasonable or professional standards.

114. The actual CCTV Footage provides additional support for the Decision. It appears to be materially consistent with the accounts provided in the Bundle (relied on by DBS). MC is likely to have used the word "smash" 'your nose' rather than "burst", during the Incident, when threatening W; but that difference was/is not material. It is also possible to observe "body language" and tone of voice, etc. It is also clear from the CCTV Footage that, at the material time, W was not even cooking (or seeking permission to cook) in the kitchen; he was merely preparing (by peeling/grating potatoes or similar) so that he would be in a position to cook the following day (and was explaining that to MC).

115. Moreover, the evidence indicates that MC's culpability was compounded by subsequent events:, MC positively sought to mislead the Provider by alleging (falsely) to GS that W had lied to the police about being threatened by MC [61] [77].

116. The DBS did not err in finding that MC had committed relevant conduct in the ways found in relation to Decision 1 and 2 during the Incident. It applied the correct threshold in doing so and there was no error of law.

117. Rather than seek to challenge core factual matters, MC relies on alleging the DBS failure to consider or take into account contradictory or mitigating factors as a purported error of law. The challenge is put as a lack of procedural fairness.

118. In the Initial Reps, MC made it clear at the outset that he "cannot deny the incident that has happened" [27]. Instead, MC, in essence, sought to claim there were some mitigating circumstances (referring to an alleged earlier incident with W and matters arising from it; and referring to an alleged "slip of tongue" [sic] by MC during the Incident) and sought to deny he had had any intention to actually hurt W.

119. The UT notes, however, that there was no mention or hint, within the Initial Reps, of any purported concern from MC about noise, and the impact of noise in relation to any other resident (namely, J) at the property, and/or any motivation to assist/protect any other resident. The UT also notes that MC appeared to

minimise the Incident, referring to it as "this little mistake of mine". There is also, the UT will note, no indication (in the references/records of the CCTV Footage, to take the most obvious example) that noise or potential issues relating to other residents was something raised by MC with W, at the material time, as the (or even as a) reason for MC's acts.

120. The UT notes the following in particular from the Reps [83] (written, it seems, by a solicitor):

(a) It was stated that MC "admits and accepts" that his handling of the Incident was "unprofessional" and "wrong". It also appears to have been accepted that MC's conduct actually caused (at least some) "emotional distress" to W [85].

(b) The purported concern about noise being created by W using the kitchen – and purportedly seeking to protect another resident from such noise – was raised for (apparently) the first time. Even if there was an element of truth to it, the DBS was entitled to find it would still not be sufficient to justifying the manner in which MC conducted himself and engaged with W. The same would be true, too, in relation to any earlier incident with W using discriminatory language (and both mitigating points continue to be maintained by MC).

(c) However, there is no repeat of the original excuse relied on by MC in the Initial Reps (i.e. that assertion that MC was "scared", or similar, as a result of an alleged earlier incident with W).

121. For the reasons set out above, the DBS did not err in not taking the mitigating factors now relied upon into account at the time of making its Decisions. There was no error of law.

122. Nonetheless, in light of the evidence now heard during the hearing, we do accept that MC was initially motivated during the Incident out of concern for the noise created and for J's welfare and that MC had suffered from discriminatory language used against him by W in the past. This is some mitigation which we consider below in relation to proportionality.

123. The DBS made no other errors of law relating to procedural fairness. It did take into account the employer's account and alleged CCTV, and it did adequately explore the Appellant's evidence, character references, or the limited police response. *It rejected the material relied on by the Appellant for sufficient and rational reasons*. It conducted a rational evaluation of all the evidence and properly applied the statutory and evidential framework. The DBS's conclusion was supported by a balanced review of evidence and the correct legal thresholds were applied.

124. To the extent MC submits that DBS "should have" taken the Reps "into account", it is clear, from any fair reading of the Bundle (including the Barring Decision Summary as well as the Final Letter) that DBS did take the Reps into account in making both Decision 1 and Decision 2. In the end, DBS did not consider them

to be sufficiently persuasive. DBS was reasonably entitled to take such a view, in all the circumstances, for the reasons it gave.

125. While it is true that MC did not, other than the Incident, have a history of known misconduct or concerning behaviour etc, the proven conduct was sufficiently serious, in and of itself, in the circumstances, to readily justify the Decision.

126. There was/is no legal obligation, on DBS, to give people proven to have engaged in relevant conduct a "second chance" (in order, for instance, to "bring" their "attitude within the required standard [9]). A key focus for DBS is, properly, on the vulnerable people (and of taking adequate steps to protect them from a risk of harm) that those participating in regulated activity are trusted to look after.

127. The point made by the Appellant about the police decision/outcome lacks any sustainable merit. DBS clearly took that outcome into account. The police and DBS have substantially different roles, aims and processes; and, of course, the standard of proof that the police need to operate to is markedly higher than that which applies to DBS and the UT.

128. To the extent that is submitted that Decision 1 or 2 is "unreasonable" or procedurally unfair, this is not made out. The DBS decisions (as contained in the Final Decision Letters and Barring Decision Summary documents) provided sufficient reasons and took into account the relevant material on behalf of the Appellant. There was no error of law.

Issue 2 Proportionality issue: *Whether the indefinite bar constitutes a disproportionate interference with the Appellant's rights under Article 8 of the European Convention on Human Rights ("ECHR"), and if less restrictive measures could achieve the aims of safeguarding.*

129. Mr Badar submitted that an indefinite bar from regulated activity interferes with the Appellant's right to private life under Article 8 ECHR, encompassing professional and personal development. The DBS's decision letters merely assert that an indefinite bar is "necessary and proportionate," without showing consideration of less restrictive alternatives. Given the minor nature of the police resolution and the Appellant's previously unblemished record, an indefinite bar is excessive and disproportionate. A decision-maker must not interfere more than is strictly required to meet safeguarding objectives. The DBS failed to demonstrate that no other measures short of a permanent bar could protect vulnerable individuals, making the decision disproportionate and incompatible with the Appellant's Article 8 right to respect for his private life.

130. We considered this to be the most difficult ground of appeal and one which concerned us the most. Ultimately, however we have decided to dismiss it.

131. The findings of fact in relation to the Incident are effectively conceded and established on the balance of probabilities and they amount to "relevant conduct" within the relatively broad definition provided by the Act.

132. We are satisfied that it was rational for the DBS to conclude at the time of making the Decisions that the conduct was indicative of serious – and concerning – underlying attitudinal issues (including a marked lack of empathy) of a type likely to be relatively difficult to remediate (and incompatible with regulated activity).

133. Similarly, we are satisfied that it was rational for the DBS to conclude, given the proven conduct, MC posed "a" risk of harm, in that he might repeat the conduct in the future. The assessment of the level of that risk as significant was/is, in accordance with the authorities set out above, generally a matter for DBS not the UT, so long as it was a rational evaluation.

134. Mr Serr for the DBS submits that on any reasonable and objective view it was appropriate and reasonably necessary (and therefore proportionate) to include MC on the barred lists in order to achieve DBS's legitimate (and important) safeguarding aims. DBS conducted the necessary "balancing act" exercise. DBS had regard to the adverse impact that a barring decision may well have on MC's right to respect for private life (including his ability to gain employment in regulated activity). He argues that it was entirely open to DBS to conclude that there was insufficient evidence of sufficient "insight" from MC (which is conceptually different to "remorse") or "remediation". He contends that there was no less-restrictive measure available, sufficient to achieve the legitimate aim, or to maintain confidence in the wider safeguarding regime; DBS did not, for example, have any power to implement the options (e.g. a suspension, additional training) raised by MC in the Reps [85].

135. Mr Serr also argues that although MC has referred to being barred for "life", that is too simplistic a representation. In reality, there would be an opportunity for DBS to carry out a review of the Decision, in due course, and/or if there were a sufficiently material change in circumstances. The review of his inclusion on the list can take place if there is a change of circumstances – pursuant to paragraphs 18 or 18A of Schedule 3 to the Act.

136. Having now heard all the evidence, and making our own assessment of proportionality, we accept these submissions. The decision to include the Appellant on the ABL was proportionate and did not constitute any breach of MC's right to respect for his private life (privacy) for the purposes of Article 8 ECHR.

137. We accept that there are a number of mitigating factors in relation to the Incident and the impact on MC himself:

In relation to the Incident:

a.) The Incident on 8 November 2021 was a one off and a short lasting incident.
b.) MC was tired after a long shift and W did swear at him which was provoking.
c.) While MC did make the threat of violence towards W, MC did not intend to carry out violence.
d.) There was also provocation from W from the previous incident – where MC suffered discriminatory verbal abuse from W.

e.) MC was partly motivated by protecting J from noise at the time of the incident.
f.) MC honestly, although mistakenly, believed W's care plan prevented W from chopping potatoes in the kitchen.
g.) While there was some emotional harm caused to W, W accepted MC's apology and continued to work with him for several weeks.
h.) MC says he did report the incident to management – and sent whatsapps - although there is no record of this.

Impact on MC
i.) MC lost his job at the time due to the dismissal by his employer, the Provider, E Services.
j.) There was a Police intervention and MC received advice via the community resolution.
k.) He had an unblemished record of working in care for at least 3 years.
l.) He had provided two good character witnesses.
m.)While the DBS was reasonably entitled to decided MC posed a risk of further harm in the future it was not found to be very high.
n.) Some insight and remorse were shown by MC around the time in the apology letter subsequently sent to W.
o.) MC has shown remorse and insight during the appeal proceedings in evidence to the Tribunal – he repeatedly apologised and expressed his shame.
p.) There will be a serious and significant impact upon MC of barring – he will not be able to engage in regulated activity so long as he is included on the list.
q.) He was a truthful and honest witness who made reasonable concessions when giving evidence. He was clearly distressed during the hearing at his own conduct.

138. Nonetheless we consider the barring Decisions to include MC on the ABL to be proportionate bearing in mind the following aggravating factors:

a) The threat of violence against W was a serious instance of relevant conduct;
b) It was committed against a particularly vulnerable adult, W who suffered from a number of conditions.
c) It did cause emotional harm to W.
d) MC did lie to his manager when saying W lied to police – and this was aggravating.
e) The DBS was rationally entitled to make the risk assessment as to future harm that MC posed – significant risk – this was a rational evaluation.
f) MC has not provided any demonstration of undergoing further training or therapeutic work or demonstrating further insight into the Incident.
g) When asked during the hearing, MC could not answer the question as to how or why he would not repeat his actions if a similar incident reoccurred.
h) MC was regretful – but lacked insight as to why the incident happened and what had provoked him even if he was remorseful.

139. It is accepted that barring represents an interference with a person's private life for the purpose of Article 8 of the European Convention on Human Rights (ECHR) but the question is whether it is proportionate. We consider that there was no mistake of law in the barring decision based upon the findings made at the time, and as now made following the hearing, on the grounds of proportionality.

140. In summary, the proportionality of DBS's decisions to include individuals on the barred lists should be examined applying the tests laid down by Lord Wilson in *R (Aguilar Quila) v Secretary of Stage for the Home Department* [2012] 1 AC 621 at para 45:

> …But was it "necessary in a democratic society"? It is within this question that an assessment of the amendment's proportionality must be undertaken. In *Huang v Secretary of State for the Home Department* [2007] 2 AC 167, Lord Bingham suggested, at para 19, that in such a context four questions generally arise, namely:
>
> a) is the legislative objective sufficiently important to justify limiting a fundamental right?
>
> b) are the measures which have been designed to meet it rationally connected to it?
>
> c) are they no more than are necessary to accomplish it?
>
> d) do they strike a fair balance between the rights of the individual and the interests of the community?

141. These four questions were later developed by Lord Sumption in *Bank Mellat* [2013] UKSC 39 at 20:

> … the question [of proportionality] depends on an exacting analysis of the factual case advanced in defence of the measure, in order to determine (i) whether its objective is sufficiently important to justify the limitation of a fundamental right; (ii) whether it is rationally connected to the objective; (iii) whether a less intrusive measure could have been used; and (iv) whether, having regard to these matters and to the severity of the consequences, a fair balance has been struck between the rights of the individual and the interests of the community.

142. In assessing proportionality, the Upper Tribunal has '…to give appropriate weight to the decision of a body charged by statute with a task of expert evaluation' (see *Independent Safeguarding Authority v SB* [2012] EWCA Civ 977 at [17] as set out above). However, we must conduct our own assessment of proportionality afresh rather than simply review the DBS's assessment.

143. We are satisfied that each of questions a)-d) should be answered in favour of inclusion on the ABL being proportionate based on the findings that the DBS made at the time (and those findings are confirmed because we have found they contained no mistakes of fact).

144. On the basis of the findings that the DBS made and we have upheld, we are satisfied that it was proportionate and reasonably necessary to bar MC from

regulated activity with vulnerable adults in order to achieve the public interest in the (important and) legitimate safeguarding aim.

145. There is no real question that the public interest and legislative objective of safeguarding vulnerable groups is sufficiently important to justify the interference with private life that barring constitutes and that barring is rationally connected to protecting those groups.

146. We are satisfied that no other measures were available sufficient to adequately safeguard the risk of future harm that the DBS rationally decided that MC posed. We are satisfied that the DBS was entitled to consider that the Appellant presented a risk of harm to vulnerable adults at the time of the decision based upon the findings as originally made and upheld by us. The decision that the Appellant posed a risk of repeating similar acts at the time of the Decisions was also rational. We find that the DBS's evaluation of the future risk continues to be rational as at the time of the hearing.

147. We are therefore satisfied that barring was necessary and struck a fair balance between MC's right to a private life and the interests of the community. The DBS expressly carried out the "balancing act" exercise required. Based on the findings we are satisfied for ourselves that barring strikes a fair balance, notwithstanding the impact that it has had and will have upon the Appellant.

Allowing in part the appeal against Decision 1 – inclusion on the Children's Barred List

148. During the hearing, a further ground of appeal emerged which was clearly arguable.

149. The Appellant argues that his inclusion on CBL as part of Decision 1 contained a mistake of law. The DBS decided that there was reason to believe that MC had been engaged in regulated activity with children in the past for the following reason set out in the decision letter dated 13 July 2022 in relation to Decision 1:

> 'This is because you worked as a Support Worker for E[] Services and previously applied for employment as a Health Assistant and Support worker with checks on both lists.'

150. The Barring Decision Summary for Decision 1 states:

> "MC applied for the position of Support Worker/HCA. One of the agencies he has previously worked for recruits HCA's for hospitals and therefore TRA is met for children".

151. Mr Serr submitted that the test for regulated activity with children was therefore satisfied on this basis.

152. He referred us to *A v Disclosure and Barring Service* [2025] EWCA Civ 124 (14 February 2025)at [22]:

> 22.A referred to the "Disclosure and Barring Service Regulated Activity and TRA [Test for Regulated Activity] guidance ("guidance") to its operational staff which he had not previously seen before it had been included in the 'Authorities Bundle' for this Court. He drew our attention to paragraphs 3.7 and 3.8 dealing with the "might in the future" test. The DBS advice was that the likelihood need to be "more than fanciful". Whilst the threshold was low, "there must be evidence upon which to base this assessment. It cannot be based on speculation alone." Further, according to paragraph 3.9 of the Guidance: "Where the legislative criteria for regulated activity with children are not met due to frequency, temporary or occasional work or supervision factors, consideration should be given as to whether it would be reasonable to conclude that the individual satisfies the TRA on the basis that they may carry out the activity often enough, not on a temporary or occasional or without supervision in the future.". Further, A submitted that paragraphs 4.28 and 4.29 of the guidance were relevant to his situation. They provide that:
>
> > "4.28. If an individual has undergone training or achieved a qualification that relates to regulated activity that is group specific, then the TRA can be satisfied on the basis of 'might in the future' in relation to that group. "
> > 4.29. If an individual has obtained a qualification or undergone training within the context of employment with a specific vulnerable group, it is unlikely this information alone would support the assessment that the individual 'Might in the Future' engage in regulated activity with the other group."

153. Pursuant to paragraph 3 of Schedule 3 to the Act, the DBS may only include MC on the CBL if it has reason to believe that the person is or has been or might in future be engaged in regulated activity relating to children.

154. We disagree with the DBS submissions. There was no evidence before the DBS then or now from which the DBS might rationally have had reason to believe that MC had or might in the future be engaged in regulated activity relating to children. The risk in the future that MC might work with children was fanciful or speculative (and not relied upon by the DBS) and there was no evidence which might give DBS reason to infer that MC had worked in regulated activity with children in the past. The facts of *A v DBS* can be distinguished and they relate to future risk rather than the past reality of working in regulated activity with children.

155. The evidence which we accept is that MC had only ever worked in regulated activity with adults in the past through his work for various care agencies. He had not applied for clearance to work with children – it was simply a default decision made by one agency he worked for either to seek clearance for children because the agency provided Health Care Assistants (HCAs) for hospitals. MC was not even working for the agency that sought checks for children at the time of the barring decisions. He had never expressed any intention to work with children in the future. There was insufficient evidence before the DBS from which it might have reason to believe that MC had been or might in future be engaged in regulated activity with children.

156. This was a mistake of law by the DBS. The explanation for why the second decision maker came to a different view in March 2023 and did not include him on the CBL - is contained at page 243 of the bundle in relation to Decision 2 in March 2023:

> "There is no evidence to suggest that MC has previously worked with children in the past and will work with children in future. On this basis the test for regulated activity is not in relation to children."

157. The DBS provided no evidence at the hearing suggesting that the Appellant had or might in future engage in regulated activity with children. We therefore allow the appeal against his inclusion on the CBL as part of Decision 1.

158. We direct that MC be removed from the CBL on the basis of this mistake of law. However, we uphold that part of Decision 1 that MC be included on the ABL because there was no mistake of fact nor law in the making of that decision.

Conclusion

159. The decision of the Upper Tribunal is that the Appellant's appeal against the first decision of the DBS dated 13 July 2022 is allowed in part. There was a mistake of law in including him on the Children's Barred List. The Tribunal directs that he be removed from the Children's Barred List. However, there was no mistake of fact nor law in the decision to include him on the Adults' Barred List. His inclusion on that list is confirmed.

160. The Appellant's appeal against the second decision of the DBS dated 3 March 2023 is dismissed. There was no mistake of fact or law in the decision to include him on the Adults' Barred List. The decision to include him on that list is confirmed.

Judge Rupert Jones
Judge of the Upper Tribunal

Authorised by the Judge for issue on 16 June 2025