Neutral Citation Number: [2025] UKUT 219 (AAC)

Appeal No. UA-2022-000763-V

RULE 14 Order:

Pursuant to rule 14(1) of the Tribunal Procedure (Upper Tribunal) Rules 2008, it is prohibited for any person to disclose or publish any matter likely to lead members of the public to identify the appellant or any other individuals referred to in these proceedings.

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

FR

Appellant

- v -

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Nicholas Wikeley, Upper Tribunal Member Mr John Hutchinson and Upper Tribunal Member Dr Elizabeth Stuart-Cole

Hearing date(s): 12 June 2025
Mode of hearing: Oral hearing at the Employment Tribunal venue, Leeds

Representation:
Appellant: In person
Respondent: Mr Richard Ryan (counsel) instructed by DBS Legal Services

On appeal from:
DBS registration number: 00933910962
DBS Decision Date: 20 July 2021

Judicial summary

Safeguarding Vulnerable Groups Act 2006 - section 4(2)(b) – appeal on mistake of fact – Upper Tribunal heard oral evidence and made its own assessment of evidence

– material mistakes of fact – appeal allowed and case remitted to Disclosure and Barring Service for new decision to be made.

DECISION

The decision of the Upper Tribunal is to allow the appeal under section 4 of the Safeguarding and Vulnerable Groups Act 2006.

The decision of the Disclosure and Barring Service dated 20 July 2021 was based in part at least on material mistakes in its findings of fact.

Accordingly, the Upper Tribunal, pursuant to section 4(6)(b) and (7)(b) of the 2006 Act:

- **remits the matter to the DBS for a new decision; and**
- **directs that the Appellant remain on the barred lists until the DBS makes its new decision.**

REASONS FOR DECISION

Introduction

1. This appeal is about whether the decision by the Disclosure and Barring Service (the "DBS") to include the Appellant's name on both the Adults' Barred List and the Children's Barred List (the "Barring Decision") involved one or more mistakes of fact (or errors of law).

2. The DBS's Barring Decision in question was made on 20 July 2021 under the Safeguarding Vulnerable Groups Act 2006 (the "2006 Act").

The Rule 14 Order

3. We confirm the Rule 14 Order in this case, which is intended to protect the anonymity and privacy of all those concerned.

A summary of the background to the Barring Decision

4. The Appellant has worked in the care sector for many years. The DBS based its Barring Decision on its findings about two incidents involving the Appellant in her role as a live-in carer for vulnerable adults. The first incident concerned a fall suffered by Teresa, a vulnerable 93-year-old lady for whom the Appellant was acting as live-in carer. We call this 'the fall incident'. The second incident, about six months earlier, concerned the administration (or rather the non-administration) of medication for another service user, James, for whom the Appellant had also been acting as live-in carer. We call this 'the medication incident'.

5. Neither Teresa nor James were the service users' real names in this case – we use these pseudonyms to reflect the Rule 14 Order. Likewise, when we refer to other individuals in the course of this decision, we also use pseudonyms rather than those persons' real names. Lastly, in any document that refers to the Appellant either by her name or by her initials we have changed this to read simply "the Appellant".

The Upper Tribunal oral hearing

6. We held an oral hearing of the Appellant's appeal on 12 June 2025 in Leeds. The Appellant appeared in person and was unrepresented. Her husband and a friend attended to provide moral support. The DBS was represented by Mr Richard Ryan of counsel.

The legal framework for barring decisions

7. In this part of the decision, we summarise the legal framework governing barring decisions. Schedule 3 to the 2006 Act provides for several ways in which a person's name may be included by the DBS on a barred list. In the present case the DBS relied upon the 'relevant conduct' gateway, which (as regards the Adults' Barred List) required the DBS to be 'satisfied' of three things, namely:

    a. that the Appellant was at the relevant time, had in the past been, or might in future be 'engaged' in, 'regulated activity' in relation to vulnerable adults;

    b. that the Appellant had 'engaged' in 'relevant conduct'; and

    c. that it was 'appropriate' to include the Appellant on the Adults' Barred List.

8. If the DBS was satisfied of all three matters above, it was required by the 2006 Act to place the Appellant's name on the Adults' Barred List. There are equivalent provisions governing inclusion in the Children's Barred List.

9. Section 4 of the 2006 Act sets out the circumstances in which an individual may appeal to the Upper Tribunal against the inclusion of their name in either or both of the barred lists. An appeal may be made only on grounds that the DBS has made a mistake on any point of law or in any finding of fact which it has made and on which the Barring Decision was based (see section 4(1) and (2)). Section 4(3) provides that, for the purposes of section 4(2), whether it is "appropriate" for an individual to be included in a barred list is "not a question of law or fact" and so, to that extent at least, is non-appealable. An appeal under section 4 may only be made with the permission of the Upper Tribunal (see section 4(4)).

10. The relevant principles regarding factual mistakes have been set out in several recent decisions of the Court of Appeal, which are binding on the Upper Tribunal (see *DBS v JHB* [2023] EWCA Civ 982; *Kihembo v DBS* [2023] EWCA Civ 1547; and *DBS v RI* [2024] EWCA Civ 95 and see also the Upper Tribunal's decision in *PF v DBS* [2020] UKUT 256 (AAC)).

11. As to whether it is "appropriate" to include a person in a barred list, the Upper Tribunal has only limited powers to intervene, as noted above. This is clear from the section 4(3) of the 2006 Act and the relevant case law. The scope for challenge by way of an appeal is effectively limited to a challenge on proportionality or rationality grounds. Thus, at paragraph [55] of *DBS v AB*, the Court of Appeal cautioned:

> "[The Upper Tribunal] will need to distinguish carefully a finding of fact from value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness. The Upper Tribunal may do the former but not the latter…".

12. The Court of Appeal added at paragraph [43] of *DBS v AB*:

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

13. In the subsequent Upper Tribunal case, *AB v DBS* [2022] UKUT 134 (AAC), the Upper Tribunal decided (albeit in the context of a case that was based on the 'risk of harm' rather than the 'relevant conduct' gateway) that *DBS v AB* meant that the Upper Tribunal could consider, on appeal under the 2006 Act, a finding of fact by DBS that an individual poses "a risk" of harm but not a DBS assessment of the "level of the risk posed" (see [49]-[52] and [64]).

14. When considering appeals of this nature, the Upper Tribunal "must focus on the substance, not the form, and the appeal is against the decision as a whole and not the decision letter, let alone one paragraph…taken in isolation": *XY v ISA* [2011] UKUT 289 (AAC), [2012] AACR 13 (at [40]). As such, when considering the Barring Decision, the Upper Tribunal may need to consider both the final decision letter and the internal document headed 'Barring Decision Summary' that is generated by DBS as part of its decision-making process. The two documents together, in effect, set out the overall substantive decision and reasons (see *AB v DBS* [2016] UKUT 386 (AAC) at [35] and *Khakh v ISA* [2013] EWCA Civ 1341 at [6], [20] and [22]).

15. The statement of law in *R (Iran) v Secretary of State for the Home Department* [2005] EWCA Civ 982 indicates that materiality and procedural fairness are essential features of an error of law. There is nothing in the 2006 Act which provides a basis for departing from that general principle (*CD v DBS* [2020] UKUT 219 (AAC)).

16. Finally, unless the Upper Tribunal finds that the DBS has made a material mistake of fact or law, it must confirm the decision of the DBS (see section 4(5) of the 2006 Act). If the Upper Tribunal finds that the DBS has made such a mistake it must either direct the DBS to remove the person from the list or remit the matter

to DBS for a new decision. Following *DBS v AB* [2021] EWCA Civ 1575, the usual final order will be remission back to DBS unless no decision other than removal is possible on the facts. If the Upper Tribunal remits a matter to DBS under section 4(6)(b), the Upper Tribunal may set out any findings of fact which it has made (and on which the DBS must base its new decision) and the person must be removed from the list until the DBS makes its new decision, unless the Upper Tribunal directs otherwise.

The Disclosure and Barring Service's decision to bar the Appellant

17. The DBS's decision was based on two composite allegations, one relating to the fall incident and the other to the medication incident. Within the composite allegations there were several separate findings which we identify as such. In its final decision letter of 20 July 2021, the DBS recorded that it was satisfied of the following allegation in relation to the fall incident:

> On 6 August 2020, whilst working as a Live In Care Giver for [a private care agency], you repeatedly neglected Teresa, a 93 year old female service user in your care, who suffers from dementia, has mobility issues, and requires personal care, assistance with meals and medication. You did this by:
>
> - Sleeping on duty, resulting in Teresa leaving her house unsupervised and falling over (Finding 1);
> - Failing to provide appropriate assistance to Teresa following this fall, including leaving Teresa whilst she was on the floor outside to attend to the washing (Finding 2); and
> - Refusing to provide an off duty Private Ambulance Driver with up-to-date medical information for him to assess Teresa's condition, when he was attending to her following her fall (Finding 3).

18. The DBS's final decision letter also recorded that it was satisfied of the following allegation in relation to the medication incident:

> On 2 February 2020, whilst working as a Live In Care Giver for [a care agency], you neglected James, a male service user (age and vulnerabilities unknown), by:
>
> - Failing to provide him with his morning medication (Finding 4); and
> - Failing to notify the next Live in Care Giver [Karen] during handover, or the on call person at [the care agency], that you had not given James his morning medication (Finding 5).

19. The final decision letter then went on to explain in some detail why the DBS had concluded that in all the circumstances it was appropriate to make the Barring Decision in relation to the Appellant.

The Appellant's grounds of appeal

20. The Appellant advances nine grounds of appeal, helpfully identified as follows by the DBS in its written response to the Appellant's appeal:

> a. In regard to Finding 1, there was an error of fact because the Appellant did not sleep on duty on 6 August 2020; Teresa must have left the property when the Appellant went outside to hang out washing (Ground 1)
>
> b. In regard to Finding 2, there was an error of fact because the Appellant checked Teresa for injury, going into the house to get a blanket, umbrella and pillow to make Teresa comfortable/responsive (Ground 2)
>
> c. In regard to Finding 3, there was an error of fact because the ambulance driver insisted the Appellant provide the client file so the Appellant refused for confidentiality reasons (Ground 3)
>
> d. In regard to Findings 4 and 5, there was an error of fact because the Appellant had been locked out of the digital application allowing her to issue medication and record it accurately and the other carer arrived early so the Appellant asked her to issue and record it instead (Ground 4)
>
> e. In regard to Findings 4 and 5, there was an error of fact because the Appellant received a verbal, not written warning (Ground 5)
>
> f. In regard to Findings 1-3 there was an error of law because the DBS (i) failed to obtain additional information in the form of written accounts from the witnesses of the events on 6 August 2020 and (ii) relied solely on [the Adult Social Care] email account (Ground 6)
>
> g. In regard to all the findings, there was an error of law because the DBS failed to take a rational approach to the evaluation of evidence and/or failed to reconcile conflicting evidence in an adequate way (Ground 7)
>
> h. In regard to Findings 1-3 there was an error of law because the DBS failed to give adequate consideration to the Appellant's evidence that she reported Teresa's past falls and episodes of leaving the house (Ground 8)
>
> i. There was an error of law because the decision to place the Appellant on the lists was disproportionate (Ground 9).

21. We start, however, with some general observations about the Appellant's oral evidence.

The Appellant's oral evidence

22. The oral hearing of this appeal before the Upper Tribunal took a morning session (from 10.30 until 13.00). For most of that time (approximately 2 hours) we heard

sworn evidence from the Appellant, who was subject to extensive cross-examination by Mr Ryan, as well as to questions from the panel. We therefore had ample opportunity to assess the Appellant's oral evidence, albeit we accept it was given in a stressful environment and that the Appellant was being asked about events that occurred nearly five years ago.

23. The Appellant is a very expressive individual who harbours a deep sense of injustice about the way that she has been treated both by her former employer and by the DBS. We found her to be a caring and compassionate individual. For the reasons we go on to explain, we also find that she was placed in an almost impossible situation with regard to acting as live-in carer for Teresa. We say "almost impossible" because she was being asked both to monitor Teresa and to do the various household / domestic tasks such as the washing and cleaning. Based on both the manner and the content of her oral evidence, we found that the Appellant did not always make wise decisions but was rather prone to taking the view that 'she knew best' when in fact she was sometimes making a decision that she was not qualified to make.

The fall incident

Introduction

24. As noted above, we acknowledged that the Appellant was put in a very difficult position with regard to acting as live in carer for Teresa. The Appellant started her role in May 2020. Her contracted hours were 8 a.m. until 10 p.m., but she had to do substantial care at night too, and was kept awake for a period of 4 or 5 weeks before a night-time carer was put in post. The Appellant suggested to Teresa's social worker that Teresa really needed 1-2-1 personal care. The Appellant also made recommendations about installing a sensor mat and fitting a chain to the front door (see e.g. e-mails of 29 May 2020 at p.95) but these safeguards were not put in place. In the Appellant's words at our hearing, "the agency told me to shut up and pushed me aside". In written representations the Appellant referred to Teresa having had a total of 21 falls during her period of live-in care (p.85).

The care agency's account

25. The care agency's summary of the fall incident in its referral to the DBS (p.50) read as follows:

> Safeguarding called the office around 13.15 to say a client was outside and had fallen. The neighbours were with client. One neighbour went to get [the Appellant] as she knew they had a live in caregiver.
>
> The neighbour found [the Appellant] fast asleep in bed, in her nightclothes.

> When [the Appellant] did come outside, she did not take control of the situation, at times she left the client and said she was going to check on the laundry.
>
> An off duty private ambulance driver was assessing the situation and decided that the client was not hurt and they should get her indoors as it is very hot.
>
> Once inside and the client was sitting in her chair, [the Appellant] went to the kitchen and shut the door. As the medic was concerned the client would leave the property again he asked [the Appellant] to leave the door open.

26. At this stage we simply note that the off duty private ambulance driver referred to in this passage was a neighbour. There is simply no evidence that he was a 'medic' properly so called, although he is described in the papers as a first responder.

27. The summary in the care agency's referral was mainly based on two documents. The first was a report by the agency's live in care manager who we call Nicola. This document is undated, but we accept it as being broadly contemporaneous. The second was an e-mail sent to Nicola by Susan from the council's Adult Social Care (ASC) team. This was timed at 14:31 on the day of the fall incident.

28. Nicola's report was mostly concerned with the implementation of the decision to terminate the Appellant's placement with immediate effect. As regards the incident itself, the report read as follows:

> At about 1.30pm on 6th August I had a phone call from Susan from the council's ASC team to inform me that there had been an incident involving the Appellant and Teresa. She explained that Teresa had left the house unaccompanied, walked down the path a bit turned a corner and fell on the grass verge. This was witnessed by a member of the ASC staff who works from home opposite Teresa's house. The staff member went to get the Appellant and found her in bed asleep still in her night clothes. Susan went on to tell me that the Appellant seemed disinterested in the situation and did not volunteer any information about Teresa that might have helped. The Appellant did not call an ambulance a neighbour did. 2 other off duty medical staff arrived. One was an off duty ambulance driver who asked Teresa's name, date of birth etc. The Appellant gave him an old care file from the previous agency and said she could not show him Teresa's details.
>
> At this point the ASC staff member went back to her house as there were lots of people helping.
>
> ASC advised me that this has been raised as a safeguarding and suggested that the Appellant needed to be replaced as soon as possible.

> As I was arranging for another Carer to replace the Appellant, Susan called me again saying the off duty ambulance driver had contacted her saying that the Appellant was more worried about the washing than about Teresa and not interested about Teresa. He also said that a few days previous he had seen Teresa leave the house and the Appellant drag her back inside by her arm.
>
> Susan suggested that the Appellant needed to be removed from the placement immediately.

29. Susan's account, as set out in her e-mail to Nicola, was as follows:

> As discussed I was alerted by a colleague who lives near Teresa that a neighbour had knocked on her door and alerted her that Teresa had gone out through her door leaving it open. Another neighbour was with Teresa and she turned the corner so they followed and by this time Teresa had fallen on the floor on a grassy bank. There were a few people around her so my colleague went back to the house as she knew she had a live in carer and shouted but got no answer, she shouted again and got no answer so she went in and found the carer still in bed in her night clothes fast asleep. She woke the carer up and told her Teresa had gone out and had fallen over. My colleague observed that the carer came out but did not take ownership of the situation and did not let them know that Teresa had dementia and really didn't get involved standing back. My colleague left at this point as there were a number of people there (including some off duty health professionals) and they had called ambulance.
>
> I then had a further call from a gentleman who is a private ambulance driver who is also a first responder and he and a nurse checked Teresa over and got her off the ground as she had no pain and no apparent injuries and given how hot it was outside they wanted to get her inside. This gent told me that on a few occasions the live in carer wandered off and said she was checking the washing and displayed no interest or concern for the client. In his professional opinion he advised that this care worker is not a responsible carer. He also advised that when he asked the care worker what the lady's name and date of birth was she did not know the answer. He asked her for the details for the care agency and she brought out an old folder from a previous agency with old details. When they looked through and asked for other details the care worker then told them she did not have any more as they are all on a portal and she couldn't show him. He also told me that when they brought Teresa indoors the carer went into the kitchen and closed the door and he was concerned that Teresa would go out again so he opened the door and asked her to leave it open. He asked me to contact the GP as they had stopped the ambulance from coming as there was no apparent need. This gent also told me that a few days ago he witnessed Teresa going outside and saw the carer dragging her back by the arm.

30. We now turn to consider the Appellant's account of events.

The Appellant's account

31. The care agency documents provided to the DBS included a short note of the conversation that took place between Nicola and the Appellant on the day in question:

> Nicola: please can you tell me, in your own words, what happened today.
>
> The Appellant: Teresa had had her breakfast and was sitting in her chair. I went outside to the garden to hang up the wet washing on the washing line.
>
> Nicola: Did you leave the kitchen door and back door open. *I asked this as I could see that with the kitchen door and back door open she would have had a clear line of sight to Teresa.*
>
> The Appellant: Yes, the doors were open. When I came back in there was a lady in the hall who told me that Teresa was outside and had had a fall. I went to Teresa and wanted to pick her up and bring her home. The neighbours disagreed and called an ambulance. I did not call an ambulance as a man was already calling. I went back to the house to get Teresa some blankets and cushions to make her comfortable. Teresa told people that she felt fine and she wasn't in pain. Teresa wanted to get up but the neighbours refused to let her up in case she had hurt herself. I was then asked to get Teresa an umbrella to use as a sunshade. Teresa was able to sit up by herself but the neighbours kept pushing her back down and Teresa started to get agitated. 2 nurses arrived and we managed to get Teresa into the house. The ambulance was cancelled as Teresa was in no pain. I then gave Teresa some cakes and a bun.
>
> Nicola: Did you call the GP?
>
> The Appellant: Yes, the GP will be visiting at some time today or maybe tomorrow I don't know when.

32. In her response to the DBS's minded to bar letter, the Appellant gave the following account of events (we have corrected references to 5 August to 6 August):

> On 6 August between 11am and 12 midday, I had washed the client and given her breakfast and medication and she sat on the sofa which is close to the front door. While I was in the garden hanging out the washing, she got up and opened the front door and went out and she fell. The neighbour saw this and informed me. I was wearing my African wrap and the neighbour thought this was a nightgown and assumed that I had been sleeping. They reported this to my care agency and I was dismissed on the 6 August. I have since written to my employer apologising for the incident, but I have not had a reply.

33. The Appellant gave a similar account in her first witness statement (at p.102):

> I went out to hang washing because it was a lovely sunny day (35 degrees) for between 2-5 minutes and somebody pressed the door bell (I ran in from the back yard to answer the door) and she told me that Teresa have had a fall outside, I ran out wrap my wrapper African printed material round me and quickly ran outside to Teresa's aid, I found her lying on the floor - I asked her if she was alright? - she responded that she was alright, I quickly checked for any injury and could not find any injury, I quickly ran into the house to get blanket, umbrella and pillow so as to make her comfortable - she said she did not want the blanket because it is too hot.

34. She gave a similar account at our oral hearing, where she explained that she had been "in the back garden hanging out the washing. That was why I needed the sensor mat. I left Teresa at the breakfast table. I was outside drying clothes – I then opened the door and a woman said 'your client is outside'. I reassured Teresa and went back for a pillow, umbrella and blanket. I stayed with her. I asked a woman to help her stand up to go back to the house. The ambulance man interrupted and asked for her file. He went in the house and picked it up. He gave the impression he had rung for an ambulance." The Appellant categorically denied that she had been found asleep: "I met the woman in the living room. She did not see me sleeping. They described my attire as a nightie – it was 30 degrees C – you were allowed to wear something comfortable…. The village women said I was in a nightie and so had probably been asleep." The Appellant stated that it was a "total misdescription" to say she had been found asleep: "I was standing up – she did not find me asleep."

35. In answer to questions from the panel, the Appellant described her employer's falls policy, namely that you do an assessment by checking if the client is communicating. If they are responding, then you reassure them "and that is what I did: I put her in the recovery position and got the pillow etc while we were waiting for the ambulance to arrive … I was waiting 40 minutes for the ambulance to arrive. I got a neighbour to help me stand the lady up and took her back in. I went back in twice while waiting for the ambulance." She added that she did not know the male neighbour was an ambulance driver. "He phoned my employer and the police. He interrupted my responsibility."

Finding 1

36. Finding 1 is that the Appellant neglected Teresa by sleeping on duty, resulting in Teresa leaving her house unsupervised and falling over.

37. There is no dispute in this case that Teresa left her home unsupervised and fell over. The real dispute is over whether the Appellant's failure to supervise Teresa was because she was asleep on duty or because she was in the garden hanging out the washing.

38. We can understand why the DBS reached the conclusion that the Appellant was asleep at a time when she should have been on duty. On the face of it at least, the care agency's account is both compelling and damning. The allegation is put at its highest in the e-mail from Susan of the ASC team to Nicola at the agency, which refers to "my colleague … shouted but got no answer, she shouted again and got no answer so she went in and found the carer still in bed in her night clothes fast asleep. She woke the carer up and told her Teresa had gone out and had fallen over." There is, however, no other separate evidence to corroborate this claim – the other references to the Appellant being found asleep all stem from this one claim.

39. However, we have very real concerns about the reliability of this evidence, essentially for the following reasons.

40. First, this is a classic case of hearsay evidence. There is no witness statement or note, signed or otherwise, from the ASC team member who was one of Teresa's neighbours. We are being asked to take effectively as gospel an account which is at best second-hand and cannot be properly tested.

41. Second, we think there is a real possibility that the neighbours jumped to an incorrect conclusion based on the Appellant's attire on the day in question – we accept that it was entirely possible that her African wrap may have been mistaken for night clothes.

42. Third, we consider that there is an inherent contradiction in the criticisms being levelled against the Appellant. The care agency and the DBS both assert that the Appellant was found sleeping on duty, and yet both also state that she neglected Teresa by seeming to be more concerned about the washing. Whether she was indeed concerned about the washing is a matter we go on to deal with in relation to Finding 2. However, just assuming for present purposes that the Appellant was indeed overly concerned with the washing, it is difficult to see how that is consistent with the narrative that she was asleep. Thus, the claim that she was too concerned with the washing actually supports the Appellant's case that that was the task with which she had just been engaged in.

43. We therefore consider that there is a material mistake of fact in Finding 1. We find that the Appellant was not asleep when Teresa went outside unsupervised and had a fall. However, we do find the Appellant was at fault by not supervising Teresa closely enough when the Appellant was hanging out the washing, especially given what she knew about Teresa's propensity to wander.

Finding 2

44. Finding 2 is that the Appellant had neglected Teresa by failing to provide her with appropriate assistance following this fall, including leaving Teresa whilst she was on the floor outside to attend to the washing.

45. There is in truth relatively limited hard evidence to support this finding, at least in the terms in which it has been put. Nicola's report recounts Susan's observation that her ASC colleague (so evidence at least at third hand) thought the Appellant "seemed disinterested [sic] in the situation and did not volunteer any information about Teresa that might have helped. The Appellant did not call an ambulance a neighbour did." Nicola also reported Susan's message that the off-duty ambulance driver had said the Appellant "was more worried about the washing than about Teresa and not interested about Teresa." We acknowledge, however, that there is a more detailed account in Susan's e-mail to Nicola on the afternoon in question.

46. The Appellant appears to have been criticised for "not taking ownership of the situation". However, the group of neighbours in question (who seemingly included at least one nurse) in effect assumed control of the situation, including calling an ambulance and it appears later cancelling the ambulance when they were satisfied that one was not actually needed. Thus, the most obvious type of assistance which could be provided had been supplied by the neighbours. The Appellant provided some direct assistance by way of making Teresa comfortable with a pillow and bringing out an umbrella as a sunshade. The Appellant told us that she was not worried about the washing, and we see no reason why she should have been, given the fact it was a very hot and sunny day.

47. We have reached the conclusion that this finding is questionable at best. Given the close involvement of the various neighbours it is difficult to see what else the Appellant could have done by way of the provision of appropriate assistance. We therefore conclude that Finding 2 was not made out and involves a mistake as to the facts. However, that is not to say that the Appellant's actions were not without criticism. For example, she told us that she helped put Teresa in the recovery position, when that is not an appropriate action following a fall because of the risk of a spinal injury.

Finding 3

48. Finding 3 is that the Appellant had neglected Teresa by refusing to provide the neighbour who was an off duty Private Ambulance Driver with up-to-date medical information for him to assess Teresa's condition, when he was attending to her following her fall.

49. We can deal with this third and last finding in relation to the fall incident fairly shortly. Again, the DBS case is premised on rather sketchy information. Nicola's report simply states that the neighbour in question "asked Teresa's name, date of birth etc. The Appellant gave him an old care file from the previous agency and said she could not show him Teresa's details." Susan's e-mail stated that the gentleman in question "advised that when he asked the care worker what the lady's name and date of birth was she did not know the answer. He asked her for the details for the care agency and she brought out an old folder from a previous agency with old details. When they looked through and asked for other details the care worker then told them she did not have any more as they are all on a

portal and she couldn't show him." The DBS's case, in reliance on this limited evidence, was that the Appellant was being deliberately obstructive.

50. The Appellant's case is rather different. She was plainly well aware of the importance of client confidentiality. She did not know the off-duty ambulance driver and knew neither his line of work nor that he was a first responder. She states that she told him Teresa's name and date of birth but the male neighbour ignored her. She also asserts that he went into the bungalow and came out with the previous care agency's hard copy care file which he had found in the kitchen.

51. Having read the documents on file and the Appellant's representations, and considered her oral evidence, we have formed the view that the off-duty ambulance driver adopted a somewhat overbearing manner in relation to the Appellant. We do not consider it likely that the Appellant refused to disclose Teresa's name or date of birth – it was evident in any event that Teresa was both a very elderly and a very vulnerable individual. We have seen no evidence to contradict the Appellant's further response that up-to-date details were held on the current care agency's portal. We are furthermore not satisfied that there was any up-to-date medical information which would have been of use to those assisting Teresa and which the Appellant wrongly held back.

52. We therefore find the DBS made a material mistake of fact in relation to Finding 3.

The medication incident

Introduction

53. The second allegation relates to the medication incident on 2 February 2020 and is based on two findings by the DBS, namely that the Appellant failed to provide James with his morning medication (Finding 4); and that she failed to notify the next live-in carer [Karen] during their handover, or the on-call person at [the care agency], that she had not given James his morning medication (Finding 5).

54. There is only limited evidence about this incident. Aside from the Appellant's own written (and oral) evidence, there are only two documents of note. The first is a note that Nicola from the care agency made, recording the details that Karen provided in her complaint to the agency (made on 3 February 2020) about the poor handover the previous day. The second is a detailed minute of an investigatory meeting Nicola held with the Appellant on 6 February 2020. This process resulted in the care agency giving the Appellant what was described by the employer as a verbal warning (p.71). In one sense, and strictly speaking, a 'verbal warning' could be either written or oral. However, as a matter of common usage we take this to mean the Appellant was given an oral rather than a written warning by her employer – certainly there is no evidence in the appeal file of a written warning. The employer's referral to the DBS described (in answer to a question about previous disciplinary action) how the Appellant had "missed

administering a client's medication during a handover, investigatory meeting held. Retrained in medication" (p.49).

Finding 4

55. It is not in dispute that (a) James was due to have his morning medication between 9 a.m. and 10 a.m.; and (b) the Appellant did not administer his medication within that window or at all.

56. The Appellant's explanation (both at the time of the investigatory meeting and subsequently) for the failure to administer James's medication was that she had been locked out of the mobizio system (the on-line software package used to record care actions taken) and so could not sign in. She said she knew she was not allowed to administer medication without a record being made of that action. She said that she waited until the next carer (Karen) arrived at about 11 a.m. so she could tell her about the medication and instruct the new carer to administer the medication.

57. The Appellant was asked at the investigatory meeting why she had not phoned the on-call number at the agency for advice. He response was that she did not call anyone as it was handover day and a new live-in carer was due to arrive in any event. We have to say we find that to be an unsatisfactory response. The Appellant was also asked at the investigatory meeting whether she understood that missing medication was a form of neglect and comes under abuse to the client. We find her response to be telling:

> The Appellant told me that this is not abuse, that it is a matter of being locked out of mobizio. *The Appellant got very angry towards me. I ask the Appellant to calm down so I could explain that medication not being administered at the correct time can have some serious consequences which is why missed medication is a safeguarding matter under neglect and abuse.*
>
> *I explained that it was The appellant's responsibility to administer the morning medication between 9 and 10am. The Appellant repeatedly said that 11am is still morning and she handed it over to the other carer. The Appellant should have been working until 1pm so would still have been responsible at 11am. The Appellant did not agree with this. At one point I did have to stop the Appellant from talking about the other Carer by pointing out to her that this meeting was about the Appellant not administering medication.*
>
> *The Appellant and I discussed that she should have called the office if she could not see her activities to get advice and that she could have administered medication and written on her visit notes what medication was administered, the dose and the time. The Appellant would have found all this information on the original boxes. The Appellant felt that as she had handed over the medication to the other Carer it absolved her from any wrongdoing.*

> *When speaking to the other Carer she said that she had to ask the Appellant for a handover as the Appellant had her coat on and ready to leave the placement at 11am. The Appellant did not handover morning medication to other Carer. This was only noticed because the other Carer found James's breakfast in the microwave which made her question whether medication had been administered.*

58. We find this to be an accurate account of their conversation. It is virtually contemporaneous (being drafted following a meeting just four days later) and detailed. The Appellant's answers reflect the attitude we noticed in relation to her oral evidence, namely her almost unshakeable conviction that, whatever the circumstances, she knew best. However, her responses do not bear out that degree of self-confidence. It is no answer to say that 11 a.m. is still morning when medication is due to be administered between 9 and 10 a.m. The failure to ring the on-call office – the default advice in any such situation – was again symptomatic of the attitude that the Appellant knew best.

59. We identified just one factual mistake in the DBS's findings which relates to Ground 5. The DBS referred to the Appellant having been given a written warning by her employer. As noted above, there is some ambiguity about that but on the balance of probabilities we find that it was an oral warning (albeit referred to unhelpfully as a 'verbal' warning). However, we do not consider that error to be material in all the circumstances. The simple fact of the matter is that the Appellant failed to provide James with his morning medication on 2 February 2020.

60. We therefore find no material mistake of fact or error of law in relation to Finding 4.

Finding 5

61. Finding 5 was that the Appellant had failed to notify the next live-in carer (Karen) during their handover, or the on-call person at the care agency, that she had not given James his morning medication.

62. The Appellant does not dispute that she did not notify the on-call person at the care agency that she had not given James his morning medication. Her explanation is that she had no reason to do so as she had told Karen that she had not given James his morning medication. Finding 5 therefore turns on whether the Appellant did indeed so advise the new carer. There are conflicting accounts on this point from Karen and the Appellant respectively.

63. Karen's account is recorded in the contemporary note made by Nicola as to Karen's complaint about the poor handover:

> The Appellant left at 11.15. When Karen asked for a handover the Appellant said you have been here before the only change is Client's medication is

> now in original boxes and not in blister packs… Karen didn't know if Client had had morning meds… The Appellant said she left early after asking Karen if that's okay. The Appellant took gloves with her. The Appellant did not give James his medication on Sunday morning as she couldn't sign in or see the medication on the activities. She said she handed this over to Karen but Karen knew nothing about this and said the handover was very poor and the Appellant was ready to leave as soon as she arrived. The Appellant had her coat on and was worried about missing her train.

64. Furthermore, as noted by Nicola in the minute of the investigation meeting, the failure to administer the morning medication "was only noticed because the other Carer found James's breakfast in the microwave which made her question whether medication had been administered".

65. The Appellant's account is very different. It is summarised in her written representations (e.g. at p.244):

> Accusation about medication
> This accusation is not in line with the process I had been trained on, namely that you cannot give medicines to a client if you do not have a means of recording that you have done available. In this instance, the electronic application was not available to me and no alternative means of recording what I had given to the client, James, had been provided to me. I was due to hand over to another colleague at 2pm. However, she arrived early at around 10:15am to take over from me. I explained that I had not administered the morning medicines to James for the reasons outlined above, and I asked her to do so as she had access to the necessary electronic application. We both left James at around 1pm and my understanding was that she had given him his medicines.

66. We do not consider on the balance of probabilities that there is any mistake of fact in the DBS's Finding 5. It relies on a detailed contemporary complaint made by the new live-in carer. We can see no reason why Karen would have fabricated her account and gone to the trouble of visiting the care agency office to make that complaint. That report also contains a level of detail, for example as to Karen finding James's breakfast still in the microwave, which adds to its overall credibility.

67. We therefore find no material mistake of fact or error of law in relation to Finding 5.

Other matters

68. There are two other matters that we must refer to, albeit that they do not directly relate to any of the five findings made by the DBS which are discussed above. The first relates to the removal of Teresa's catheter and the second concerns the Appellant's conviction in the magistrates' court.

69. First, we were somewhat concerned about the account we heard of the removal of Teresa's catheter. Teresa had been hospitalised for a period following an earlier fall and was then discharged to her home in March 2020 with a catheter fitted. The Appellant helped Teresa regain her independence in dealing with her continence and at some point removed her catheter. The circumstances in which this happened are not entirely clear. The Appellant's written evidence was that she had discussed the matter with Teresa's GP and with the care agency before removing the catheter (p.113: the GP/ agency "said if that is okay with me I should go ahead"), but we got the impression from her oral evidence that she had removed the catheter of her own initiative and only informed the GP after the event. We recognise that catheter removal is a skilled task (as the process can result in damage to the bladder or urethra) which should ordinarily be carried out by a doctor or nurse and not by an unqualified care assistant. We are not in a position to make a definitive finding either way on this issue but given the case is being remitted to the DBS for a fresh decision it is appropriate to leave the matter to the DBS to consider further in any event.

70. Secondly, the PNC records show that in July 2023 the Appellant pleaded guilty in the magistrates' court to the offence under section 7 of the 2006 Act of seeking to engage/offering to engage/engaging in regulated activity from which she was barred. It was recorded that she had made two applications to work in positions working with children/ vulnerable adults. She was sentenced to a fine with costs and a victims surcharge payable. The applications in question were made in November 2021 and December 2021. This was after she had received the DBS final decision letter in July 2021, which had made it clear that if she engaged or sought to engage in regulated activity she would be committing an offence. Obviously, given the timeline, the DBS was not aware of the guilty plea and conviction when it made its Barring Decision.

71. We explored this issue with the Appellant in questioning by the panel, as had Mr Ryan. We have to say that the Appellant gave us a confused and confusing account which was difficult to follow and make sense of. She said that she had been receiving assistance with her Upper Tribunal appeal from an unqualified non-professional person, who had written to the DBS on her behalf seeking clarification as to the nature of the roles from which she was barred. She told us that this individual had received no response from the DBS, despite waiting four months, and so wrote again to the DBS in the Appellant's name but using her unqualified representative's work address. It is difficult to reconcile this account with the PNC record. We recognise that the Appellant may well have not had the benefit of professional advice in the proceedings in the magistrates' court, but the fact remains that we cannot go behind the guilty plea and the conviction for the section 7 offence relating to the two applications detailed in the PNC record.

Disposal

72. We allow the Appellant's appeal against the DBS's final decision letter dated 20 July 2021. We find there are material mistakes of fact in relation to Findings 1, 2 and 3. However, we find no material mistakes of fact in relation to Findings 4 and

5. It is not appropriate for the Upper Tribunal to direct the DBS to remove the Appellant from the barred lists. Rather, the case must be remitted to the DBS for a fresh decision in the light of our findings above and any further findings made by the DBS. Whilst that process is ongoing, we direct that the Appellant remain on the barred lists.

Conclusion

73. The Upper Tribunal therefore concludes that the Barring Decision by the DBS was based in part at least on a material mistake in the findings of fact. In those circumstances we do not need to consider whether the decision involved an error on any point of law. As such, we allow the appeal and quash the Barring Decision. We remit the matter to the DBS for a new decision and direct that the Appellant remain on the Adults' Barred List and the Children's Barred List in the meantime.

Nicholas Wikeley
Judge of the Upper Tribunal

John Hutchinson
Specialist Member of the Upper Tribunal

Elizabeth Stuart-Cole
Specialist Member of the Upper Tribunal

Authorised by the Judge for issue on 1 July 2025