



Neutral Citation Number: [2025] UKUT 302 (AAC)
Appeal No. UA-2024-001132-V

**IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER**

Between:

PEO

Appellant

- v -

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Citron, Ms Smith and Ms Jacoby

Hearing date: 10 July 2025

Hearing mode: Field House, Breems Buildings, London EC4

Representation:

Appellant: by Oliver Renton of counsel, instructed by Slater Heelis

Respondent: by Rosalind Earis of counsel, instructed by DLA Piper

The Upper Tribunal has made an order prohibiting publication of any matter or disclosure of any documents likely to lead members of the public directly or indirectly to identify the Appellant and 23 other persons (page 242-243 of UT bundle)

SUMMARY OF DECISION

SAFEGUARDING VULNERABLE GROUPS: Findings of fact (65.9)

This appeal centred on events in an assisted living home where the appellant worked as a night support worker, over three days in April 2023. The Upper Tribunal found that the Disclosure and Barring Service had made mistakes in findings of fact about the appellant's interactions with service users in the course of those incidents, and that those mistaken findings were material to the Disclosure and Barring Service's decisions to include the appellant in the barred

lists. The Upper Tribunal accordingly allowed the appeal and remitted the matter to the Disclosure and Barring Service for a new decision.

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

DECISION

The decision of the Upper Tribunal is to **ALLOW** the appeal. The Respondent made a mistake in findings of fact it made and on which its decisions (DBS reference DBS6191 01011031802) of 14 May 2024 (adults' barred list) and 19 August 2024 (children's barred list) to include PEO in the barred lists were based.

The Upper Tribunal **REMITs** the matter to the Respondent for a new decision, which must be based on the findings of fact referred to in paragraph 33 of the "Reasons" section below.

PEO must be removed from both barred lists until the Respondent makes its new decision.

REASONS FOR DECISION

This appeal

1. This is an appeal against the decisions ("**DBS's decisions**") of the Respondent ("**DBS**") dated 14 May 2024 (adults' barred list) and 19 August 2024 (children's barred list) to include PEO in the respective barred lists.

The legislation underlying DBS's decisions

2. DBS's decision of 14 May 2024 was made under paragraph 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 (the "**Act**"). This provides that DBS must include a person in the adult's barred list if
 - a. it is satisfied that the person has engaged in relevant conduct,
 - b. it has reason to believe that the person is, or has been, or might in the future be, engaged in regulated activity relating to vulnerable adults, and
 - c. it is satisfied that it is appropriate to include the person in the list.
3. Under paragraph 10, "relevant conduct" for the purposes of paragraph 9 includes conduct which endangers a vulnerable adult or is likely to endanger a vulnerable adult; and a person's conduct "endangers" a vulnerable adult if he (amongst other things)

- a. harms a vulnerable adult
 - b. causes a vulnerable adult to be harmed
 - c. puts a vulnerable adult at risk of harm or
 - d. attempts to harm a vulnerable adult.
4. DBS's decision of 19 August 2024 was made under paragraph 3 of Schedule 3 to the Act. This provides that DBS must include a person in the children's barred list if
 - a. it is satisfied that the person has engaged in relevant conduct,
 - b. it has reason to believe that the person is, or has been, or might in the future be, engaged in regulated activity relating to children, and
 - c. it is satisfied that it is appropriate to include the person in the list.
5. Under paragraph 4, "relevant conduct" for the purposes of paragraph 3 includes conduct which, if repeated against or in relation to child, would endanger that child or would be likely to endanger them; and a person's conduct "endangers" a child if he (amongst other things)
 - a. harms a child
 - b. causes a child to be harmed
 - c. puts a child at risk of harm or
 - d. attempts to harm a child.

Jurisdiction of the Upper Tribunal

6. Section 4(2) of the Act confers a right of appeal to the Upper Tribunal against a decision by DBS under paragraph 9 and 3 of Schedule 3 (amongst other provisions) only on grounds that DBS has made a mistake
 - a. on any point of law;
 - b. in any finding of fact on which the decision was based.
7. The Act says that "the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact" (section 4(3)).

DBS's decisions

8. DBS's decision letters stated that
 - a. it was satisfied of the following:
 - i. on (Sunday) 2 April 2023 PEO administered medication to service user AW without the authorisation to do so and knowing he was suspended from administering medication; PEO then instructed the agency member of staff to falsify the MARs sheet;
 - ii. during the night of 1-2 April 2023 PEO failed to carry out the required checks (sic) on Mr JS and falsified the care documents to state that JS was settled in his room when JS was not present and instead was staying with his family;
 - iii. on (Monday) 3 April 2023 PEO neglected those in his care by not getting JS ready for his daily outgoing, including not ensuring JS was showered and dressed with a packed lunch and by not providing personal care to service user VA;
 - iv. that PEO engaged in relevant conduct in relation to vulnerable adults and to children;
 - b. PEO's behaviour raised significant concerns in relation to PEO's irresponsible and reckless pattern of behaviour, and in relation to PEO's callousness/lack of empathy with others;
 - c. PEO was considered to pose a significant risk of harm.

The appeal to the Upper Tribunal

9. Permission to appeal was given by the Upper Tribunal (Judge Citron) on the grounds put forward by PEO's solicitors in their letter to the Upper Tribunal of 13 August 2024, being
 - a. DBS made an error in a finding of fact that PEO
 - i. administered medication to a service user whilst suspended; and

- ii. did not provide personal care to a service user; and
 - b. DBS was wrong to find that it was proportionate to bar PEO from working with vulnerable adults.
10. PEO gave evidence (under oath) at the hearing of his appeal, including via cross examination and answering questions from the panel.

Documentary evidence in the Upper Tribunal bundle

11. In addition to DBS's decision letters, evidence in the bundle of 267 pages included:
- a. the referral from the organisation that employed PEO at the time of the incidents, to DBS; this
 - i. showed PEO as being born in 1986 i.e. he was in his late 30s at the time of the incidents in question;
 - ii. showed PEO's job title as night support worker;
 - iii. described the place where PEO worked at the time of incidents as a supported living environment for six adults with autism, learning disabilities and dementia; it said there were a range of needs from full personal care to prompts and support; three residents lived upstairs and three downstairs;
 - b. employer's investigation report dated 19 April 2023;
 - c. investigation meeting of 12 April 2023 – notes;
 - d. statement of deputy manager dated 3 April 2023 - states that
 - i. when she arrived at 7:50 am on 3 April 2023 to complete a medication competency on PEO, VA came out of her room and asked for a cup of tea; her continence pad was clearly full and her pyjamas were soaking;
 - ii. AW told her that PEO had given him his medication the previous evening; the deputy manager asked the agency staff that was on shift for a statement; he said that PEO had done the medication but the agency worker signed for it;

- e. email of Monday 3 April 2023 at 4:49 pm headed “Medication last night”, as follows:

At 9:30 pm, the resident came to me that he wants his medication, I went to the office and brought the key. I opened the medication box and brought out the file to check the type of medication to give the resident. That same time, PEO came upstairs and acted as if he has been giving them the medication for a while and I allowed him because he is a permanent staff while I am an agency. PEO removed the medications from the sachet, gave it to the resident and he told me to sign after and I said no that I need to count the medication first before signing it.

I made sure I counted medications before signing so as to avoid error and there was an error in what PEO told me and what I counted. He told me the paracetamol is 20 and I counted 18 and I wrote 18.

- f. electronic notes (on the employer’s system) in respect of JS from 1 and 2 April 2023; a note by PEO on Sunday 2 April just before 8 am states: “JS in his bedroom settled and hand over done by day staff no issue”;
- g. JS’s care plan: this included a title of “My mobility”; this included the following statements:
- i. “I need support at all times when accessing the community and travelling to places; due to covid guidelines, I am not attending any day services at this present time; Mondays: I attend drama club with my mother where I have my tea. I return home 9.30 pm”
 - ii. “Planned outcomes; for me to continue to attend my weekly day services for as long as I wish to; ... to develop my independence and skills in preparing packed lunches and getting my clothes organised for each day ...”
 - iii. “How to achieve outcomes; ... for my support staff to prompt me to prepare my own packed lunch. I will ask the staff what I need ...; for my support staff to check that I have my packed lunch, monies, and appropriate clothing (work clothes) for the day”;
- h. a statement by someone (who appears to be a staff member) dated 18 April 2023 saying that, from what they could remember

of Monday 3 April, she arrived just before 8 am and stripped VA's bed off and wiped it down, as it was wet;

- i. 12 May 2023 letter from PEO's employer with outcome of disciplinary hearing; this concluded that
 - i. PEO administered medication to AW without authorisation on 2 April 2023; it said this had been brought to the attention of management by AW and confirmed independently by the agency worker;
 - ii. PEO failed to carry out the required checks and falsified information in relation to JS on 1-2 April; PEO could have read on the electronic notes that JS was staying overnight at his mother's;
 - iii. on 3 April, JS was not left showered or appropriately dressed, and without a lunch pack, despite this being a detailed requirement in his care plan as detailed in the electronic note system;
 - iv. on 3 April, VA presented to the deputy manager with urine and faeces at 7:50 am, and her bed was wet and needed stripping.
- j. PEO's representations dated 5 July 2024;
- k. DBS's barring decision summary document.

PEO's position/evidence

- 12. In this section, we summarise PEO's evidence about the incidents in question, and their context.
- 13. PEO joined the staff of the assisted living home in 2019 and worked with residents on the first floor (who generally had more severe needs than those on the ground level).
- 14. The organisation that employed PEO at the time of the incidents, had taken over management of the assisted living home earlier that year (in 2023). Following this change in management, PEO was told there were counting errors in his administration of medication; he was therefore suspended from administering medication; he was told his competency would be

reviewed. The suspension occurred about four months before the incidents in question.

15. Just before the incidents in question, VA, one of PEO's regular patients on the first floor, had returned from hospital, and was not well enough to return upstairs, so was staying on the ground floor. PEO was moved to the ground floor to supervise VA; an agency worker went on the first floor.
16. PEO was told the agency worker would administer medication (as PEO was suspended from doing so). But PEO was asked to show the agency worker where the keys for the medication cupboard were, and to support the agency worker. PEO watched the agency worker administer medication, and advised him to count it. PEO did not himself administer medication.
17. PEO did not challenge DBS's fact finding at [8a ii.] above. PEO's account is that the handover notes from the previous shift stated that all the residents were settled; PEO simply repeated this in his notes (without going in to JS's, or any other resident's, room, to check) because he did not want to disturb them sleeping. PEO said this failure to go into the sleeping residents' rooms and check on them was a mistake on his part; he said he overestimated the independence of the residents on the ground floor. He says information on the electronic note system was not available to him.
18. PEO accepted DBS's fact finding at [8a iii.] above as regards getting JS ready for his day out and provide him with a packed lunch; PEO said that he did not know this had to be done; it was not stated on any handover notes.
19. PEO had worked with VA for four years but never gave her 'personal care', as this was done by female members of staff. PEO's account of the day in question was that VA came out of her room at 7 am and asked for a cup of tea; PEO did this and sat with her on the sofa; his shift ended at 8 am; PEO gave his handover to the day staff; VA was not soiled; the norm was that

VA in fact changed herself and, if necessary, PEO would clean her bedding and provide a fresh pad and clothes.

Did DBS make a mistake in the finding of fact at [8a i.] above (administering medication etc)?

20. We find that the management of the supported living home had created a virtually unworkable situation whereby PEO, the night-support employee on site at the time, who had knowledge and experience of where medication was kept at the assisted living home and how it was to be administered to residents, had had his authorisation to administer medication suspended (and was on a personal instruction plan to ensure his skills in this area were up to scratch) - and yet the person relied on to administer medication that night was an agency worker who had comparatively little knowledge or experience in this area. The outcome was that PEO had, in effect, to tell the agency worker what to do as regards administering medication, without doing it himself. DBS's factual finding was therefore mistaken: it was the agency worker who administered the medication, albeit under PEO's guidance and with his assistance.
21. In coming to this conclusion, we have preferred PEO's evidence (written, and orally at the hearing) over the short written accounts of the deputy manager and of the agency worker (see [11d ii. and 11e] above). We found PEO's evidence on this matter coherent, plausible and believable. In contrast, the deputy manager was not present at the incident itself; her account was based on what she said the service user had told her; on the circumstances as presented (in our view, coherently) by PEO, it is easy to see why a service user may have felt, or perceived, that PEO was administering the medication, as he was involved (inevitably, due to the situation created by management, as described above) in helping in its administration. As the deputy manager did not appear as a witness before us, we had no opportunity to hear her questioned on her account. The agency worker was, of course, present at the incident; but given the choice between PEO's evidence, which was coherent and subjected to cross examination, and that of someone who we had no opportunity to see respond to questioning, we preferred the former.
22. Counsel for DBS invited us to give credence to the agency worker's evidence because it did not cast him in a very positive light (the evidence at [11e] above is not wholly coherent, but seems to imply that the agency worker signed for the medication even though the agency worker "allowed

him” i.e. allowed PEO to give it); however, without having the agency worker as a witness before us, such that we could make some meaningful judgement as to his character (and so how bothered he was about being cast in such a light), this was not a point that weighed very much in the balance for us.

23. Counsel for DBS also stressed the weakness of PEO’s opinions as to why the deputy manager (and the staff member responsible for the evidence at [11h] above) would have wanted to say untrue things about him: PEO gave his view that this was because he had criticised practices at the assisted living home, and this was resented by management there. This point, again, did not weigh very heavily in the balance for us: our primary task is to decide if DBS made a mistake in this finding of fact; the fact that PEO, who we found generally credible and coherent on this point, could not fully explain something outside his personal knowledge - why another person (who did not appear before us to give evidence) had a different account of things - was not a decisive point for us.
24. We acknowledge that the employer’s investigation (see [11i i.] above) came to a different factual conclusion; but as they did not appear to have any evidence we did not, and as the authors were not available to give evidence and answer questions before us, this made little difference in our consideration of all the evidence before us.

Did DBS make a mistake in the finding of fact at [8a iii.] above (as regards PEO neglecting those in his care on Monday 3 April 2023 by not providing personal care to service user VA)?

25. We find that (for good reasons) it was not the norm for PEO to provide ‘personal care’ to service user VA (as VA, who was female, wanted this to be provided by female staff); and, more generally, that PEO was adequately providing care for VA on the morning of Monday 3 April 2023, and not neglecting her care; DBS thus made a mistake to find otherwise.
26. In coming to this conclusion, we have (again) found PEO’s evidence on the matter to be coherent, plausible and believable. We do not necessarily disbelieve the short written accounts of the deputy manager and the other support worker (see [11d i. and 11h] above) (namely, that shortly before 8 am, VA came out of her room needing personal care; and her bed needed changing); but this was “snapshot” evidence (in relation to the question of whether PEO was adequately caring for VA that morning) – and as we have had the benefit of PEO’s evidence about the context (in particular, his

longstanding and good caring relationship with VA), we do not think it correct to infer from this snapshot evidence that PEO was not adequately caring for VA at the time. It seems to us more likely, even if we accept the accuracy of the written accounts of the deputy manager and the other staff worker, that the situation (of a service user needing to be changed) arose in the normal course and not a result of PEO's negligence.

Were DBS's mistakes in findings of fact material, given DBS's other (unchallenged) factual findings?

27. It seems to us that DBS relied on all its factual findings in coming to its decisions; this can be seen in its identification of a "pattern of behaviour" (see [8b] above). To put it another way, we see nothing in DBS's decision letters, or in its "barring summary document, to indicate that the factual finding at [8a ii.] above, and/or that at [8a iii.] above in relation to JS's daily outgoing, was alone sufficient to justify its decisions.
28. Furthermore, we are able on the basis of the evidence before us to make further contextual findings about the incidents in DBS's "unchallenged" factual findings, namely
 - a. as regards the incident in DBS's finding at [8a ii.] above, we find that
 - i. PEO assumed at the time, on the basis of what he had been told by the day staff in the "handover" on the evening before, that all the residents were on site and in their beds; this turned out to be a false assumption, in the case of JS;
 - ii. PEO failed to go into JS's room (or indeed the rooms of any other of the ground floor residents he was looking after that night) during the course of the night to check that they were alright; he assumed they were sleeping safely, unless something alerted him to the contrary;
 - iii. when PEO wrote in the electronic record that JS was "in his bed settled" on the morning of Sunday 2 April, this was not

because PEO was knowingly recording something false, but rather the outcome of points i. and ii. above; and

- b. as regards DBS' finding at [8a iii.] above in relation to JS's daily outgoing, we find that
 - i. PEO did not in fact know that JS had to be prepared for a daily outgoing that day;
 - ii. PEO had not been told about this duty in the handover from the day staff;
 - iii. PEO had not, in fact, consulted JS's care plan on this matter; but if he had, he would have read that due to covid guidelines, JS was not attending any day services at the present time (see [11g i.] above).

- 29. In making these contextual findings, we have (again) found PEO's evidence on these matters to be coherent, plausible and believable. We note that PEO did not try to diminish his failure to check on JS during the course of the night; or that he should have prepared JS for his daily outgoing.
- 30. These contextual findings about DBS's "unchallenged" factual findings reinforce us in the view that DBS's mistakes in its findings at [8a i.] and [8a iii.] above were material to its decisions.

Conclusion and disposal of the appeal

- 31. It follows that, in our view, DBS made mistakes in findings of fact on which its decisions were based.
- 32. Given this, we are required either to direct PEO's removal from the barred lists, or to remit the matter to DBS for a new decision. In *DBS v AB* [2021] EWCA Civ 1575, the Court Appeal said, at [72]:

Unless it is clear that the only decision that the DBS could lawfully come to is removal, the matter should be remitted to the DBS to consider. If, therefore, there is a question of whether it is appropriate to include a person's name on a barred list, the appropriate action under section 4(6) of the Act would be to remit the matter to the DBS so that it could decide the issue of appropriateness.

33. Given that in this case it is undisputed that PEO should have checked on JS overnight on 1-2 April, and should have got him ready for his outgoing on 3 April, but did not, there is at least a question of whether it would be appropriate to include PEO in the barred lists; we accordingly must remit the matter to DBS for a new decision (on both lists). DBS must base that new decision on the findings of fact made by us in this decision, and set out at [20], [25] and [28] above, as well as on its unchallenged previous factual findings, as set out at [8a ii.] and [8a iii.] (as regards JS) above.
34. PEO must be removed from the barred lists until DBS makes its new decision: this is the “fallback” position under the Act, and we decline to direct otherwise.
35. In the circumstances, there is no point our addressing the “disproportionate” ground of appeal, as DBS will be making a new decision, based on the facts as we have found them.

**Zachary Citron
Judge of the Upper Tribunal**

**Rachael Smith
Suzanna Jacoby
Members of the Upper Tribunal**

Authorised by the Judge for issue on 5 September 2025