



Neutral Citation Number: [2025] UKUT 372 (AAC)
Appeal No. UA-2022-000957-V

**IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER**

Between:

SZ

Appellant

- v -

DISCLOSURE AND BARRING SERVICE

Respondent

**Before: Deputy Upper Tribunal Judge Hansen
Tribunal Members Elizabeth Bainbridge and Matthew Turner
Hearing date(s): 23 October 2025
Mode of hearing: Remote oral hearing via CVP**

Representation:

Appellant: Mr M Walker, CILEX Lawyer

Respondent: Mr A Serr of Counsel, instructed by DLA Piper UK LLP

On appeal from the Disclosure and Barring Service ("DBS")

DBS Ref No: DBS6191 00985820887

Decision Date: 18 June 2024

RULE 14 ORDER:

By an order made on 4 November 2024 pursuant to rule 14(1) of the Tribunal Procedure (Upper Tribunal) Rules 2008, the Upper Tribunal has prohibited any person to publish or reveal the names of any of the following:

- (a) SZ, who is the Appellant in these proceedings;**
- (b) any of the patients or staff mentioned in the documents or during the hearing;**

or any information that would be likely to lead to the identification of any of them or any member of their families in connection with these proceedings.

Any breach of this order is liable to be treated as a contempt of court and may be punishable by imprisonment, fine or other sanctions under section 25 of the Tribunals, Courts and Enforcement Act 2007. The maximum punishment that may be imposed is a sentence of two years' imprisonment or an unlimited fine.

SUMMARY OF DECISION

Safeguarding Vulnerable Groups (65.8 – Proportionality)

Safeguarding Vulnerable Groups Act 2006 – section 4(2)(a) – Appellant’s case was that barring order was disproportionate because a less intrusive measure was available in the form of an order from another regulator – Upper Tribunal considered for itself whether decision was proportionate and decided it was.

Safeguarding Vulnerable Groups (65.9 – Findings of Fact)

Safeguarding Vulnerable Groups Act 2006 – section 4(2)(b) – Appellant challenged a number of the findings of fact made by the DBS on which its decision was based – Upper Tribunal assessed the evidence, including limited new evidence, and found no material mistakes.

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 OF THE UPPER TRIBUNAL

This decision is given under section 4 of the Safeguarding Vulnerable Groups Act 2006:

The decision of the Upper Tribunal is to dismiss the appeal by the Appellant. The decision of the DBS taken on 18 June 2024 to retain the Appellant’s name in the Children’s and Adults’ Barred Lists did not involve a material error on a point of law or fact. The DBS decision is confirmed.

REASONS FOR DECISION

1. This is an appeal against the decision of the Disclosure and Barring Service (“DBS”) dated 18 June 2024 to retain the Appellant, SZ, in the Children’s and Adults’ Barred Lists.
2. In this decision we refer to people by their initials in order to preserve the anonymity required by the Rule 14 order above and intend no disrespect.

Background

3. The factual background is as follows. The Appellant is a Registered Nurse who has been registered as a mental health nurse with the Nursing and Midwifery Council (“NMC”) since 2010.

4. At the relevant time, the Appellant was working as a Charge Nurse and designated safeguarding officer in the employment of a private healthcare provider at a specialist hospital for service users with complex mental health issues. She was employed in this role from 18 May 2020 to 23 March 2021.
5. Allegations were made by two members of staff that, on various dates between May 2020 and February 2021, the Appellant had failed to treat service users with dignity and respect and acted in an unprofessional manner, as set out further below. This triggered a safeguarding investigation conducted by the employer's Lead Nurse. Both of the employees who had made the allegations were interviewed as part of the investigation in February 2021, as were a number of other employees.
6. The Lead Nurse, having conducted her investigations, recommended that a disciplinary hearing be convened. That took place over 2 days, on 16 and 23 March 2021, and resulted in the Appellant's summary dismissal for gross misconduct. She appealed that outcome and an appeal hearing took place on 22 April 2021 but the decision to dismiss was upheld on 27 April 2021.
7. The Appellant was referred to the DBS on 5 May 2021 and the same allegations were referred to the NMC. On 2 June 2021 the NMC imposed an 18 month interim conditions of practice order. This enabled the Appellant to continue in practice as a nurse but under supervision and subject to a number of other conditions, including that she was not to be the sole nurse on duty on any shift and was not to be the nurse in charge on any shift.
8. The interim order, as the name suggests, was not a final outcome for the case; it was a protective measure put in place by the NMC while it worked towards a final outcome. At that stage the case examiners had not yet decided whether there was a case to answer. However, the interim assessment which led to the conditions of practice order had concluded that there was "a risk of harm and a real risk of repetition".
9. The conditions of practice order was reviewed and continued on 1 November 2021.
10. In the meantime the Appellant had begun a new job at a different hospital as a mental health nurse in July 2021 and she worked there without incident until March 2022.
11. A Minded to Bar letter was sent by DBS on 14 December 2021 in the following terms:

"Based on the enclosed information, it appears, on the balance of probabilities, that:

On unspecified dates between May 2020 and February 2021 you failed to treat patients with respect by:

- Using the term 'bastard' towards and about patients;
- Using an offensive, raised middle finger gesture towards a patient;
- Throwing a bottle of disinfectant at a patient;
- Speaking to and/or shouting at patients in a general inappropriate or bossy manner;

On unspecified dates between May 2020 and February 2021 you acted in an intimidating and threatening manner towards staff;

On 04/10/2020 you failed to complete safeguarding reports in relation to an incident between two patients;

On the night shift of 19/20 November 2020 you instructed staff to place a sofa across a fire exit door to prevent patients from accessing the communal lounge area. The sofa remained in this position for several hours resulting in staff failing to provide timely personal care and undertake routine general observations;

On more than one occasion between May 2020 and February 2021 you instructed staff to falsify documentation relating to personal care and observations being completed;

On unspecified dates between May 2020 and February 2021 you intentionally neglected patients' care needs and instructed others to do so;

On unspecified dates between May 2020 and February 2021 you slept yourself and supported other staff to sleep whilst on duty during non-break time."

12. Representations were sent on behalf of the Applicant in response to the Minded to Bar letter on 4 March 2022, which enclosed, inter alia, the interim order review decision 2 November 2021, a reflective statement and a number of positive testimonials. The allegations were disputed in their entirety by the Appellant and the DBS were invited to await the outcome of the NMC fitness to practise process before moving to a final decision.

13. The DBS did not wait for the outcome of the NMC process but sent a final Decision letter on 9 March 2022 which confirmed the findings as set out in the Minded to Bar letter. The Final Decision Letter included the following:

"The DBS is satisfied you have engaged in conduct which harmed or could harm children and vulnerable adults. This is because you have acted in an abusive manner and failed to demonstrate respect towards vulnerable adults in your care. You were a charge nurse, however, demonstrated poor and abusive practice and encouraged others to do the same. You failed to provide timely personal care to patients, made derogatory comments to and about patients, falsified records, slept on duty and supported others to do the same. You instructed staff to place

a sofa over a fire floor restricting residents from entering the communal lounge where you and others were resting despite being on duty, causing a health and safety issue and resulting in patients not receiving timely care and observations.

... Having reviewed the most recent Interim Conditions of Practice review, the DBS notes that the decision states 'In all the circumstances, the panel has concluded, on the basis of the information before it, that there remains a risk of harm. Accordingly, the panel concluded that due to the seriousness of the allegations in this matter an interim order remained necessary on the grounds of public protection. The panel determinate that an interim order is also otherwise in the public interest to maintain public confidence in the professions and to declare and uphold proper standards of conduct'. The NMC further states 'The panel considered, based on the nature of the allegations, there also remains a risk of repetition. The panel was mindful of the fact that the allegations concern a period where you were employed as the nurse in charge'. The DBS therefore concludes that the NMC does consider that you poses [sic] a risk of harm and that this is reflected in the need for continued conditions of practice.

You have provided a number of character references from your current employment which commenced in July 2021. These references attest that you perform well in your role as a nurse, that you have a good manner with both patients and staff and provide timely care including personal care to all patients. One reference refers to your conduct as exemplary. There is no reason to doubt the authenticity of these references and the DBS therefore finds that these are credible. The DBS notes, however that you remain under NMC Conditions of Practice whilst your Fitness to Practice proceedings are ongoing. Under these conditions you are unable to work as a charge nurse, must not be the sole nurse on duty and must report to a clinical supervisor at least once a month to discuss your performance and behaviour. You are therefore aware that you remain under close scrutiny and would be expected to act accordingly meaning that this period of employment may not accurately reflect your genuine attitudes or behaviours. For this reason, these references do not lessen the concerns previously held by the DBS.

The DBS finds that if you were to remain in regulated activity with vulnerable adults without the conditions currently imposed on you, there is a likelihood that you would repeat your abusive and neglectful behaviours, placing vulnerable adults at risk of physical and emotional harm. This view is supported by the NMC Interim Conditions Panel whereby it is stated that 'the panel has concluded, on the basis of the information before it, that there remains a risk of harm'. The DBS is therefore satisfied that it is an appropriate decision to include you on the Adults' Barred List. ...

The DBS accepts that the incidents did not involve children, however, the proven behaviours; neglecting personal care needs, verbal abuse, consequences of falsifying records and a lack of respect are wholly transferable to roles with children. If these behaviours were to be repeated against a child this may result in physical or emotional harm. The DBS therefore concludes that you do pose a risk to children and that it is appropriate to include you on the Children's Barred List.

... The DBS notes that you are currently subject to NMC Conditions of Practice which provides some temporary safeguarding within nursing roles. This does not however, provide any protective measures to regulated activity outside of nursing where you are considered to pose an equal level of risk to vulnerable groups. This cannot therefore be considered an adequate safeguarding measure.

Having fully considered the interference in your rights, against the likelihood of future harm to vulnerable group and the absence of adequate existing safeguarding measures to mitigate that risk, the DBS is now satisfied that it is an appropriate and proportionate measure to include you in the Children's Barred List and the Adults' Barred List..."

14. The Appellant sought permission to appeal against that decision from the Upper Tribunal but her application was stayed to await the final outcome of the NMC referral.
15. The NMC decision was finally issued on 18 August 2023 and the findings were as follows:

"That you a registered nurse;

1. On 28 December 2020 verbally and/or physically abused Patient B by;
 - (a) Shouting at him. [PROVED]
 - (b) Saying words to the effect of, "you are a bastard". [PROVED]
 - (c) Saying words to the effect of, "Look at the mess you have made". [PROVED]
 - (d) Throwing a bottle of spray towards him. [NOT PROVED]
2. Failed to treat Patient B with dignity and/or respect by;
 - (a) Not changing Patient B for around 45 minutes after he had been incontinent and requested a change, on a date unknown in November 2020; [PROVED]
 - (b) Not changing Patient B in private on 28 December 2020. [NOT PROVED]
3. On a date unknown verbally abused Patient B by saying words to the effect of, "do you think your wife would want someone depressed like you". [NOT PROVED]

4. On an unknown date in November 2020 failed to treat Patient B with dignity and/or respect by;
 - (a) Preventing access to the lounge. [PROVED]
 - (b) Failing to change his sanitary pad. [NOT PROVED]
 - (c) Saying to colleagues words to the effect of, "He has a toilet in his bedroom, he should know how to use the toilet". [PROVED]
5. On 26 January 2021 verbally abused Patient E by;
 - (a) Shouting at him. [NOT PROVED]
 - (b) Saying words to the effect of, "stop being stupid". [NOT PROVED]
 - (c) Saying words to the effect of, "you are a bastard". [NOT PROVED]
6. On an unknown date in November 2020 failed to treat Patient A with dignity and/or respect by;
 - (a) Holding the door closed preventing Patient A entering the lounge. [PROVED]
 - (b) Blocking Patient A's entrance to the lounge using a sofa preventing the door to open. [PROVED]
 - (c) Placing a bed sheet over the observation panel of the door preventing Patient A from looking through the door into the lounge. [PROVED]
7. On 28 January or 31 January 2021 failed to treat Patient A with dignity and/or respect by instructing Colleague 2 to frighten them. [NOT PROVED]
8. On one or more occasions on dates unknown verbally abused patients by;
 - (a) Shouting at them. [NOT PROVED]
 - (b) Telling them words to the effect of, "shut up". [PROVED]
 - (c) Calling them words to the effect of, "bastard". [PROVED]
 - (d) Saying to them words to the effect of, "fuck you" and/or "fuck off". [PROVED]
9. On one or more occasions on dates unknown physically abused patients when escorting them by;
 - (a) Putting pressure on their arms. [NOT PROVED]
 - (b) Putting pressure on their backs. [NOT PROVED]
10. On one or more occasions between June and October 2020;
 - (a) Slept whilst on duty. [PROVED]
 - (b) Encouraged Colleague 1 to sleep whilst on duty. [PROVED]
 - (c) Encouraged Colleague 1 not to trust colleagues who did not sleep outside of their break. [NOT PROVED]
11. On 4 October 2020 bullied and/or intimidated Colleague 1 into not completing an IRIS report by;
 - (a) Shouting at her. [NOT PROVED]

(b) Telling her words to the effect of, “that if you report what had happened, management would come down to the unit and possibly fire you”. [NOT PROVED]

(c) Saying words to the effect of, “you are acting stupid to risk losing your job”. [NOT PROVED]

12. Your actions at charge 11 above showed a lack of integrity in that you placed the interests of a colleague above those of residents in your care. [PROVED]

13. On or after the 4 October 2020 failed to complete a safeguarding report relating to the incident that occurred between Patient A and Patient B. [PROVED]

14. On an unknown date in January 2021 bullied and/or intimidated Colleague 1 by;

(a) Shouting at her. [NOT PROVED]

(b) Saying words to the effect of, “you are being disrespectful”. [NOT PROVED]

(c) Saying words to the effect of, “you can deal with him (as in Patient B) if he becomes challenging”. [NOT PROVED]

15. On a date unknown inaccurately recorded incident summaries in Patient A’s care plan by;

(a) Copying and pasting earlier incident summaries, and/or [NOT PROVED]

(b) Altering the dates. [NOT PROVED]

16. Your actions in charge 15 were dishonest in that you deliberately sought to mislead others into believing that the incident summaries were correct when you knew that they were not. [NOT PROVED]

17. On 19 December 2020 encouraged and/or instructed Colleague 1 to alter patients’ physical observation readings so that their score could be calculated to read as 0. [PROVED]

18. Your actions in charge 17 were dishonest in that this was an attempt to mislead others into believing that patients’ physical observations were accurate knowing that they were not. [NOT PROVED]

19. On one or more occasions on dates unknown failed to follow Patient C’s care plan by using pull up sanitary pads instead of a ‘Kylie’. [PROVED]

20. On one or more occasions on dates unknown failed to follow Patient D’s care plan by placing a second sanitary pad across his genitals. [PROVED BY ADMISSION]

21. In relation to charge 19 and/or 20 failed to;

(a) Update Patient C's care plan and/or Patient D's care plan accordingly. [NOT PROVED]

(b) Recommend that Patient C's care plan and/or Patient D's care plan be adjusted accordingly. [PROVED BY ADMISSION in relation to Patient D, PROVED in relation to Patient C]

22. On an unknown date in January 2021 failed to follow Patient B's care plan by requesting that Colleague 1 order Patient B a pizza. [NOT PROVED]"

16. The Panel's determination ran to 111 pages. The allegations which the NMC panel found proved were 1(a), (b), (c), 2(a), 4(a), (c), 6(a), (b) (c), 8(b), (c), (d), 10(a), (b), 12, 13, 17, 19, 20 and 21. Although the final decision of the NMC was not made available in these proceedings until August 2023, the NMC's factual findings had in fact been made in December 2022 following an 8-day hearing. There had then been a further 5-day hearing in August 2023 to deal with impairment and sanction. As is clear from the findings set out above, some of the allegations were found proven, others were not proved but the panel were satisfied that SZ's fitness to practice was (and remained) impaired by reason of her misconduct and she was given an 18-month conditions of practice order in the following terms:

"For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must restrict your practice to one substantive employer. This must not be an agency.
2. You must neither be the nurse in charge of a shift, or the sole nurse on duty during a shift at any time.
3. You must ensure that you are indirectly supervised. Your supervision must consist of working at all times on the same shift as, but not always directly observed by, another registered nurse.
4. You must work with your line manager, mentor or supervisor to create a personal development plan (PDP). Your PDP must address the following areas:
 - Integrity;
 - Duty of candour;
 - Responding to challenging behaviour; and
 - Effective communication with patients and colleagues.

You must provide a copy of this PDP to your NMC case officer prior to any review hearing. This report must show your progress towards achieving the aims set out in your PDP.

5. You must meet with your line manager, mentor or supervisor on a monthly basis to discuss your performance and conduct, as well as your progress with your PDP, in particular in relation to the following areas:

- Integrity;
- Duty of candour;
- Responding to challenging behaviour; and
- Effective communication.

6. You must provide a report from your line manager, mentor or supervisor commenting on your conduct and performance generally, and with specific reference to the following areas:

- Integrity;
- Duty of candour;
- Responding to challenging behaviour; and
- Effective communication.

You must provide a copy of this report to your NMC case officer prior to any review hearing.

7. You must maintain a reflective log in relation to your clinical practice, providing your ongoing reflections on any incidents which arise which relate to the issues identified in this case and to the areas identified in your PDP. You must also produce a reflective statement, setting out your further reflections on, and insight into, the events giving rise to these proceedings.

You must provide a copy of both the reflective log and the reflective statement to your NMC case officer prior to any review hearing.

8. You must keep the NMC informed about anywhere you are working by:
 - a) Telling your NMC case officer within seven days of accepting or leaving any employment.
 - b) Giving your NMC case officer your employer's contact details.
9. You must keep the NMC informed about anywhere you are studying by:

- a) Telling your NMC case officer within seven days of accepting any course of study.
- b) Giving your NMC case officer the name and contact details of the organisation offering that course of study.

10. You must immediately give a copy of these conditions to:

- a) Any organisation or person you work for.
- b) Any employers you apply to for work (at the time of application).
- c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

11. You must tell your NMC case officer, within seven days of your becoming aware of:

- a) Any clinical incident you are involved in.
- b) Any investigation started against you.
- c) Any disciplinary proceedings taken against you.

12. You must allow your NMC case officer to share, as necessary, details about your performance, your compliance with and/or progress under these conditions with:

- a) Any current or future employer.
- b) Any educational establishment.
- c) Any other person(s) involved in your retraining and/or supervision required by these conditions”.

17. Subsequent to the NMC decision the DBS determined to undertake a Paragraph 18A review. Following that review, a minded to retain letter was sent to SZ on 11 April 2024.

18. The Appellant responded on the same date and then sent a further response on 9 May 2024. The terms of each of those responses are significant and are considered in more detail below but in short, she continued to deny the NMC’s findings and in fact questioned the fairness of the investigation that had led to those findings.

19. A final decision determining that it was appropriate and proportionate to retain SZ on the Adults’ Barred List and the Children’s Barred List was made on 18 June 2024 (“the June 2024 Decision”). The June 2024 Decision began by noting

the findings of the NMC contained in its 18 August 2023 decision and distilled from the decision of the NMC those allegations which the NMC panel had found proved, namely 1(a), (b), (c), 2(a), 4(a), (c), 6(a), (b) (c), 8(b), (c), (d), 10(a), (b), 12, 13, 17, 19, 20 and 21 from the list set out in paragraph 15 above. The June 2024 Decision then continued as follows:

“... 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.

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 having considered the NMC findings along with your representations DBS is satisfied that you have repeatedly emotionally abused the patients in your care by swearing at them and calling them names. Further to this, you have failed to carry out basic duties required of you as a nurse, such as, personal care, observations checks, filling in necessary paperwork, reporting incidents and encouraging others not to report them, restricting access to patients, and also by sleeping on duty and encouraging your staff to also sleep on duty. Your behaviour is likely to have caused significant emotional harm and if it were to be repeated it would always be likely to cause harm.

Despite the findings made by the NMC, you have continued to deny all the charges against you and dispute that you were given a fair opportunity to represent yourself during the hearings. You also challenge the investigation undertaken by the NMC, stating it is flawed and argue that they had no evidence to make their findings.

DBS dismisses this, the NMC are a competent body, who undertake a thorough investigation before hearings take place. During the hearing the panel were presented with evidence from the witness but also from you. You were asked questions and had ample opportunity to respond, of which you did. At the time of the hearing you were represented by the Royal College of Nursing who were also present at the hearing. Also, there is no evidence to suggest that you have appealed the outcome of the NMC.

Your responses to the minded to retain letter from DBS are similar to those that you gave during the NMC hearing and reflect best practice and what processes should be followed. It is clear you know and understand best practice and how you should behave as a nurse. However, you have not addressed all of the findings against you and the ones you have addressed you have flatly denied occurred.

DBS accepts the findings of the NMC as findings of fact. You have not provided any evidence or mitigation to support your denials that the behaviour occurred. You have also been inconsistent in your account of following care plans. DBS and the NMC accepted that the deviation from the care plans was done in the best interests of each patient and not to their detriment, however during the NMC hearing you denied deviating from care plans and instructing other staff to do the same. Within your representations you accept the NMC finding and state that this was done to the benefit of the patients. This places doubt on your credibility.

Having considered your representations, DBS still have concerns that you have repeatedly failed to recognise your behaviour and the impact of it on others. It is quite clear you know the role and expectations of you, however, DBS are satisfied that you have failed to put this into practice. DBS are also satisfied that you have repeatedly demonstrated a lack of regard for the patients in your care and failed to prioritise them above yourself and your colleagues.

DBS have reviewed their risk assessment and there are no changes to the findings.

Significant concerns remain in that you have an attitude that would endorse harmful behaviour; DBS are satisfied that your behaviour relates to an attitudinal concern such as that you believe your behaviour is a legitimate solution for achieving your goals but also that you appear to think that 'you know best'. Whilst you are very aware of best practice and how a nurse should behave, as demonstrated within your answers during the NMC hearing and again to DBS within your representations, you have not put this knowledge and your experience of 13 years of being a nurse into practice. DBS are satisfied that you have cut corners during your shifts and encouraged your staff to do the same in order for you to have an easier shift, to the detriment of the patients in your care.

DBS are also satisfied that you were involved in blocking the door to the corridor leading to the communal lounge so that a patient could not gain access but also in using the sofa to block access to the communal lounge to two patients. You continue to deny all knowledge of this which is not plausible given that you stated you could not identify the location on the photograph and that you had worked at the care home for some time, therefore it is likely that you would have recognised the location.

DBS are also satisfied that despite your denials, you have encouraged staff to sleep on duty regularly, inferring that there was a culture of sleeping outside of breaks. Further to this DBS remain of the view that you encouraged staff to falsify observation documents so that the readings would be 0, again which appears to be a result of your poor clinical competence.

DBS have significant concerns that you are callous and lack empathy. You have demonstrated a distinct lack of regard for the patients in your care by shouting and swearing at them regularly. You were willing to leave one patient soiled in his own urine for approximately 45 minutes whilst you knew that this was a trigger for the patient and would have caused him emotional stress. In addition, you stated to other staff, 'he has a toilet, he should know how to use it', however you were fully aware the patient had dementia and was unable to use the toilet unassisted, as you reiterated to the NMC panel. Demonstrating a lack of empathy for the patient.

Finally, DBS still have significant concerns that you have demonstrated an irresponsible and reckless pattern of behaviour. You have demonstrated a pattern of not following policies and procedures, not following care plans and encouraging other staff to do the same and sleeping on duty yourself. The NMC stated that your behaviour had fallen well below of what would be expected and required of an experienced nurse. Whilst it is acknowledged that you have engaged with the NMC, DBS are satisfied you have failed to prioritise the patients above yourself and your colleagues.

It is acknowledged that you have previously worked in regulated activity as a nurse for approximately 13 years with no other reported concerns. You have provided good references from colleagues and ex colleagues who all vouch for your caring nature and professionalism. It has also been acknowledged that during the NMC proceedings the main witness stated that they had seen you, at times, communicating well with patients, chatting with them, and laughing with them. It is also noted that the deviation from the care plan appeared to be with the patients' best interests taken into consideration.

DBS accept that whilst you are included on both Barred Lists you are unable to prove yourself and adhere to the conditions of the NMC practice order, however, concerns remain that if you were to work in wider regulated activity and if you were faced with similarly challenging behaviour you may go on to repeat your previous abusive behaviour.

It is acknowledged that the behaviour did not occur against children, however if it were to be repeated against a child there is the potential for the behaviour to be equally if not more damaging to a child. It is likely that when working with children, you would be faced with similar challenging behaviour and the DBS cannot be assured that you would not attempt to cut corners or be verbally and emotionally abusive towards children also.

In considering proportionality retaining you in both Barred Lists will significantly restrict your employment opportunities and any volunteering opportunities you may wish to pursue. You have stated within your representations that the bar on both lists has already impacted you

financially and your ability to provide for your family. DBS also recognise that being included in both Barred Lists is significantly damaging for your reputation and acknowledges the stigma that comes with being barred.

It is acknowledged that you have been a nurse for 13 years and it is likely that you have put a significant amount of time and money into gaining your qualifications and training. Retaining you on both Barred Lists will also hinder you from abiding by the conditions imposed on you by the NMC and will interfere with you being able to maintain your professional registration with the NMC. Therefore, DBS acknowledges that retaining you on both barred lists is a significant interference with your rights under Article 8 of the European Convention on Human Rights.

However, the NMC Conditions of Practice Order covers only you working in regulated activity as a nurse and not wider regulated activity. You also have no cautions or convictions, therefore there are currently no sufficient safeguards in place.

DBS must take into consideration not only the rights of the referred individual but also of vulnerable groups who are at the risk of potential harm. The DBS must consider the risks that you pose across the entire regulated activity workforce and not just in nursing. The NMC consider that you require an element of supervision due to your previous harmful behaviour, and the DBS cannot be assured that if you were to undertake another role in regulated activity, outside of nursing, that this supervision of you would be in place in order to protect vulnerable groups from harm. As such, given that you have failed to recognise your behaviour, understand the impact, and have repeatedly emotionally harmed patients in your care with the ongoing risk of repetition, in the absence of any other satisfactory safeguards for wider regulated activity, DBS are satisfied that it is both appropriate and proportionate to retain you in both the Adults' Barred List and Children's Barred List.

As a result, we retained your name in the Adults' Barred List using our barring powers as defined in Schedule 3, paragraph 9 of the Safeguarding Vulnerable Groups Act 2006 (SVGA).

As a result, we also retained your name in the Children's Barred List using our barring powers as defined in Schedule 3, paragraph 3 of the Safeguarding Vulnerable Groups Act 2006 (SVGA)".

20. The June 2024 Decision having been made, the outstanding application for permission to appeal against the original 2022 barring decision became academic, and the Appellant appealed against the June 2024 Decision on 26 June 2024. Thus, whilst we have set out the background in some detail above, the focus of the appeal is now on the June 2024 Decision which is the decision which keeps the Appellant on the two barred lists and which she needs to challenge. To that end, amended grounds of appeal were filed on or about 7 January 2025 but the appeal was then stayed again as there was at that time a

pending decision of a Presidential panel of the Upper Tribunal on the proper approach to proportionality in the DBS-context.

21. The decision in that case, *KS v Disclosure and Barring Service* [2025] UKUT 045 (AAC), was given on or about 7 February 2025 and by a decision dated 24 June 2025 UTJ Citron granted permission to appeal based on the amended grounds of appeal which are in the following terms:

“1. The DBS erred in law as follows:

Error of law

2. The DBS decision to place the Appellant on the barred lists was disproportionate and wrong, in that:

2.1. The relevant conduct of the Appellant was adjudicated on by her regulator, the Nursing and Midwifery Council (“the NMC”). The NMC is the statutory regulator of registered nurses, with the overriding objective of public protection. It is therefore the primary protector of the public in relation to registered nurses. Public protection includes protection of vulnerable adults and children. The NMC concluded that the conduct now relied on by the Respondent in placing the Appellant on the barred lists, was not so serious that protection of the public required her permanent removal from the Register of Nurses. In its Barring Decision Process [679], within which the Respondent carried out an assessment of risk, the Respondent has failed, in all the circumstances, to give the NMC’s finding in respect of public protection adequate weight.

2.2. Further, in finding that permanent removal was not required, the NMC found the following mitigating factors in relation to the Appellant’s actions:

2.2.1. The misconduct was contained within a single workplace setting and was confined to a period of a few months.

2.2.2. No similar concerns were raised in her lengthy career prior to this episode or in the eight months of nursing practice subsequent to the incident.

2.2.3. There were very positive testimonials in relation to her previous and subsequent nursing career attesting to her good character, professionalism and high standards of practice, including her kindness to patients, compassion and dedication.

2.2.4. The incidents could therefore be regarded as out of character within an otherwise excellent and well-regarded nursing career.

2.2.5. The incidents took place within a contributory context of significant pressures in the workplace environment at the time,

including the demanding clinical environment, staffing pressures, high levels of agency staff, her being the only registered nurse on shift, and the effects of the COVID-19 pandemic on the Ward and on her personally.

2.2.6. She had demonstrated significant remorse and had undertaken training relevant to the areas of concern to strengthen her practice.

2.2.7. She had demonstrated some insight although this required further development.

2.2.8. She had demonstrated herself willing to take further steps to strengthen her practice.

2.3. The Respondent has failed to give those mitigating factors sufficient weight, particularly in the context of the NMC's finding in relation to public protection.

2.4. The Appellant, had, as found by the NMC, worked with vulnerable patients after the matters took place for a period of 8 months without repetition of the misconduct found proven and without any misconduct at all.

2.5. That work constitutes an extended period of monitored practice, through which the Appellant has remediated her misconduct. Both the NMC and the Respondent were provided with evidence attesting to the Appellant's good conduct within that employment, from both the Appellant's line manager, and the Service Manager of the employer. The Respondent has failed to give that period of work, and the evidence of good conduct within it, sufficient weight. In light of that significant period of work without further misconduct, the Respondent's assessment of risk is wrong.

2.6. The Appellant has reflected further in writing [Appendix 1], fully accepted her wrongdoing and has accordingly demonstrated developed insight. As a result of that process of reflection, acceptance and development of insight, the Respondent's assessment of risk is wrong.

2.7. The Appellant has refreshed the training [Appendix 2] noted by the NMC, in a continuing demonstration of developed insight. In doing so, she has minimised the risk of any repetition, and consequently the Respondent's assessment of risk is wrong".

22. The reference to Appendix 1 in para 2.6 of the Grounds is a reference to a further piece of reflective practice dated 1 January 2025. This was not before the DBS at the time of the decision under challenge but is now relied on by the Appellant as an important piece of evidence. We shall return to this topic in due course. The reference to Appendix 2 is a reference to a number of CPD

certificates dated 6 January 2025 in areas including “Safeguarding adults at risk of abuse” and “Cultivating compassionate care for patients, service users and residents”.

The Law

23. The DBS is a body corporate charged with the function of making barring decisions to ensure the protection of children and vulnerable adults. 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").
24. The 2006 Act is intended to ensure the protection of children and vulnerable adults and it does so by providing that the DBS may include persons within a list who are barred from engaging in certain activities with children or vulnerable adults.
25. The Appellant's name has been included in both the Adults' Barred List and the Children's Barred List but the provisions relating to adults are mirrored for children and there being no material difference between the two sets of provisions we will set out only the provisions relating to adults.
26. By s.2(1)(b) of the 2006 Act the DBS must maintain the adults' barred list. Part 2 of Schedule 3 applies for the purpose of determining whether an individual is included in the adults' barred list.
27. Part 2 of Schedule 3 distinguishes between automatic inclusion in the adults' barred list and inclusion subject to consideration of representations. The present case falls within the latter category.
28. There a number of gateways under Schedule 3 to a person's name being included on a barred list. In this case the DBS rely on the “relevant conduct” gateway. By virtue of paragraph 9 of the Third Schedule DBS must include a person in the adults' 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 vulnerable adults, and
 - (b) it is satisfied that it is appropriate to include the person in the list.
29. If DBS proposes to add a person to the adults' barred list because it appears that the person has (at any time) engaged in relevant conduct, and is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, then it must give that person an opportunity to make representations as to why he should not be included in the adults' barred list.
30. Relevant conduct is defined in paragraph 10 of Schedule 3. So far as is material to the present appeal, paragraph 10 provides as follows:

10(1) For the purposes of paragraph 9 relevant conduct is—

- (a) conduct which endangers a vulnerable adult or is likely to endanger a vulnerable adult;
- (b) conduct which, if repeated against or in relation to a vulnerable adult, would endanger that adult or would be likely to endanger him;

...

(2) A person's conduct endangers a vulnerable adult if he—

- (a) harms a vulnerable adult,
- (b) causes a vulnerable adult to be harmed,
- (c) puts a vulnerable adult at risk of harm,
- (d) attempts to harm a vulnerable adult or
- (e) incites another to harm a vulnerable adult.

31. By s.5(2) a reference to regulated activity relating to vulnerable adults must be construed in accordance with Part 2 of Schedule 4.

32. Paragraph 7 of Part 2 to Schedule 4 provides as follows:

Each of the following is a regulated activity relating to vulnerable adults—

- (a) the provision to an adult of health care by, or under the direction or supervision of, a health care professional,
- (b) the provision to an adult of relevant personal care,
- (c) the provision by a social care worker of relevant social work to an adult who is a client or potential client,
- (d) the provision of assistance in relation to general household matters to an adult who is in need of it by reason of age, illness or disability,
- (e) any relevant assistance in the conduct of an adult's own affairs,
- (f) the conveying by persons of a prescribed description in such circumstances as may be prescribed of adults who need to be conveyed by reason of age, illness or disability,
- (g) such activities—
 - (i) involving, or connected with, the provision of health care or relevant personal care to adults, and
 - (ii) not falling within any of the above paragraphs, as are of a prescribed description.

(2) Health care includes all forms of health care provided for individuals, whether relating to physical or mental health and also includes palliative care and procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition.

(3) A health care professional is a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

33. By s.3(3)(a) a person is barred from regulated activity relating to vulnerable adults if he is included in the adults' barred list.

34. Section 4 confers the jurisdiction on this Tribunal to entertain appeals against barring decisions by the DBS. Section 4 provides as follows:

4 Appeals

(1) An individual who is included in a barred list may appeal to the Upper Tribunal against—

...

(b) a decision under paragraph 2, 3, 5, 8, 9 or 11 of Schedule 3 to include him in the list;

(c) a decision under paragraph 17, 18 or 18A of that Schedule not to remove him from the list.

(2) An appeal under subsection (1) may be made only on the grounds that DBS has made a mistake—

(a) on any point of law;

(b) in any finding of fact which it has made and on which the decision mentioned in that subsection was based.

(3) For the purposes of subsection (2), the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact.

...

(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.

35. We referred in paragraph 17 above to the fact that the June 2024 Decision arose out of a paragraph 18A review conducted by DBS following the final NMC decision. It can be seen that the right of appeal extends to a decision under paragraph 18A not to remove a person from a barred list. For completeness, paragraph 18A of Schedule 3 provides:

- (2) DBS may, at any time, review the person's inclusion in the list.
- (3) On any such review, DBS may remove the person from the list if, and only if, it is satisfied that, in the light of—
 - (a) information which it did not have at the time of the person's inclusion in the list,
 - (b) any change of circumstances relating to the person concerned, or
 - (c) any error by DBS,it is not appropriate for the person to be included in the list.

36. The role of the Upper Tribunal on appeal is to consider if the DBS has made a mistake on any point of law or in any finding of fact. As is clear from the statutory scheme, 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 with children or vulnerable adults is a matter for the DBS.

37. We were referred to a number of cases on the nature and extent of the Upper Tribunal's "mistake of fact" jurisdiction, in particular *PF v Disclosure and Barring Service* [2020] UKUT 256 (AAC) at paragraph [39] where the panel stated:

"There is no limit to the form that a mistake of fact may take. It may consist of an incorrect finding, an incomplete finding, or an omission. It may relate to anything that may properly be the subject of a finding of fact. This includes matters such as who did what, when, where and how. It includes inactions as well as actions. It also includes states of mind like intentions, motives and beliefs."

38. In *Disclosure and Barring Service v AB* [2021] EWCA Civ 1575, in the context of discussing the Upper Tribunal's power to make findings of fact under section 4(7) of the 2006 Act, Lewis LJ noted at [55] that:

"... the Upper Tribunal may set out findings of fact. It 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".

39. It is common ground that one way, but not the only way, to show a mistake of fact is to call further evidence that was not before the DBS to show that a finding by the DBS was wrong and that a different finding should have been made. Thus the mistake does not have to have been one on the evidence before the

DBS. It is sufficient if the mistake only appears in the light of further evidence or consideration: see e.g. *PF* at [42].

40. In a case where the appellant gives evidence, "the evidence before the Upper Tribunal is necessarily different from that which was before the DBS for a paper-based decision. Even if the appellant can do no more than repeat the account which they have already given in written representations, the fact that they submit to cross-examination, which may go well or badly, necessarily means that the Upper Tribunal has to assess the quality of that evidence in a way which did not arise before the DBS" (per Males LJ in *Disclosure and Barring Service v RI* [2024] EWCA Civ 95 at [55]).

41. In fact, as we explain below, the Appellant chose not to give oral evidence in this case, and we therefore need say no more about this particular topic.

42. We turn finally then to the law in relation to proportionality which we can deal with very shortly. A mistake of law includes making a decision to include a person on a barred list that is disproportionate or otherwise in breach of that person's rights under Article 8 of the European Convention on Human Rights. It is common ground that the decision to include SZ in both barred lists engaged her Article 8 Convention right. However, that is a qualified right, which permits interference that is "in accordance with the law", as would be the case here, provided that interference is "necessary in a democratic society" in the interests of protecting the health of children and vulnerable adults and/or protecting their rights and freedoms. That requires a proportionality analysis. Applying *KS*, it is for us to reach our own decision on whether the decision was proportionate, rather than simply carry out a rationality or *Wednesbury* assessment of the DBS's decision on proportionality. However, in carrying out our own assessment, we must give appropriate weight to the DBS's decision as the primary decision-maker. *KS* confirms that in considering proportionality in this context we should apply the established the 4-stage test derived from *Bank Mellat v Her Majesty's Treasury (No 2)* [2014] AC 700. As explained by Lord Sumption at [20]:

"... the question 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. These four requirements are logically separate, but in practice they inevitably overlap because the same facts are likely to be relevant to more than one of them".

43. He then referred to Lord Reed's formulation of the concept of proportionality, saying there was nothing in it with which he would disagree. Lord Reed said this at [74]:

“... it is necessary to determine (1) whether the objective of the measure is sufficiently important to justify the limitation of a protected right, (2) whether the measure is rationally connected to the objective, (3) whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective, and (4) whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter. ... I have formulated the fourth criterion in greater detail than Lord Sumption, but there is no difference of substance. In essence, the question at step four is whether the impact of the rights infringement is disproportionate to the likely benefit of the impugned measure”.

44. It is common ground between the parties that the legislative object of the barring scheme (protecting children and vulnerable adults) is sufficiently important to justify the limitation of a protected right so that, where there has been conduct that endangers or is likely to endanger children or vulnerable adults, a barring decision is in principle rationally connected to that legislative object. The focus of this appeal so far as concerns proportionality is therefore on limbs (3) and (4) of the 4-stage test in the *Bank Mellat* case.
45. In *Wilson v First County Trust (No 2)* [2004] 1 AC 816 at [61], the House of Lords decided that the test has to be applied “by reference to the circumstances prevailing when the issue has to be decided”. In DBS cases, that means the date of the decision under appeal: *SD v Disclosure v Barring Service* [2024] UKUT 249 (AAC).

The Hearing and Course of Argument

46. The hearing was a remote oral hearing conducted via CVP. The Appellant was represented by Mr Walker. The DBS was represented by Mr Serr. We are grateful to both of them for their helpful submissions.
47. As noted above, the Appellant chose not to give evidence. Whilst this decision is readily explicable by virtue of the fact that the Appellant has been recovering from a medical condition which meant that she was hospitalised from 13 July 2025 until 27 August 2025, and we draw no adverse inference against her, in practice it meant that we did not have any account from her or an opportunity to test her levels of insight, reflection and remorse.
48. Both parties provided helpful skeleton arguments. Building on his Grounds of Appeal, Mr Walker made clear that his principal challenge was to the proportionality of the June 2024 decision, and his main submission was to the effect that the sanction imposed by the Appellant's regulator, the NMC, should have been recognized by DBS as a less intrusive measure which would adequately protect children and vulnerable adults whilst allowing the Appellant to remain in her chosen profession. Secondly, and relatedly, he contended that in going further and including the Appellant in both barred lists, the June 2024

decision did not strike the necessary fair balance between the rights of the individual and the interests of the community, particularly having regard to the mitigating factors identified by the NMC which persuaded the panel to impose a conditions of practice order rather than a suspension or strike-off. Finally, Mr Walker identified a number of discrete challenges to certain findings made by the DBS, which, it is said, fed into the proportionality analysis conducted by the DBS, and are said by the Appellant to be mistakes of fact. On this basis it is said that DBS made “material errors of fact that had the effect of rendering the decision disproportionate”. The particular mistakes of fact alleged are as follows:

- (1) Firstly, the Appellant challenged the finding at internal page 4 of the decision letter which said as follows: “It is quite clear you know the role and expectations of you, however DBS are satisfied that you have failed to put this into practice”.
- (2) Secondly, on the basis that an omission to find a fact can be a mistake of fact, the Appellant challenged the fact that DBS had failed to make any specific finding in relation to the 8-month period of supervised practice that the Appellant had undertaken between July 2021 and March 2022 which showed, so it was said, that the Appellant had changed her behaviour, thereby allaying any concerns that her misconduct might be repeated.
- (3) Thirdly, it was said that DBS was wrong to conclude or remain concerned that the Appellant “had an attitude that would endorse harmful behaviour” in the light, in particular, of her reflective practice piece dated 1 January 2025 which, so it was said, demonstrated insight, reflection and remorse.

49. The Upper Tribunal cannot enlarge the scope of an appeal beyond the grant of permission (see e.g. *Disclosure and Barring Service v JHB* [2023] EWCA Civ 982) but Mr Serr did not object to Mr Walker’s formulation of the issues in this way and we were content to proceed on the basis that the permission grant was sufficient to encompass all the points that Mr Walker sought to argue. Although the Grounds of Appeal and the Appellant’s Skeleton Argument deal with proportionality first, as did Mr Walker in his oral submissions, we consider it more logical to deal with proportionality *after* we have considered the alleged mistakes of fact because any mistakes which were made might materially affect the proportionality exercise. We propose to treat the alleged mistakes of fact as the three limbs of what we will call Ground 1 and the issue of proportionality as Ground 2.

50. In assessing the rival arguments, we have had the benefit of the practical knowledge and experience that the specialist members bring to this jurisdiction.

Analysis and Conclusions

51. The decision of the DBS dated 18 June 2024 is the starting point for our consideration of this appeal. That decision has to be read fairly as a whole and we remind ourselves that 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 Independent Safeguarding Authority* [2011] UKUT 289 (AAC). Further, when considering the barring decision, the Upper Tribunal may need to consider the Barring Decision Process document alongside the final barring decision as the two together set out the overall substantive decision and reasons: see e.g. *AB v Disclosure and Barring Service* [2016] UKUT 386 (AAC) at [35]. We turn then to Ground 1.
52. Ground 1: Mistakes of Fact? Given that we heard no evidence from the Appellant, she faces an uphill task in persuading us to conclude that the DBS made the alleged or any errors of fact. The only new evidence, that was before the DBS, is the two reflective practice pieces prepared by the Appellant dated respectively 14 August 2023 and 1 January 2025. Although the first reflective piece was available by the time of the June 2024 Decision, the parties agreed that it was not put before the DBS. We will deal with this evidence and each of the alleged errors of fact in turn, but our overarching conclusion on this Ground was that it was devoid of any merit. The Appellant’s submissions amounted to little more than a disagreement about the evaluation of the evidence, and were based on one or two paragraphs in the decision letter looked at in isolation.
53. The DBS is not bound by any findings of a regulator such as the NMC but can take them into account and decide what weight to attach to them: see *XYZ v. Disclosure and Barring Service* [2025] EWCA Civ 191. In the present case, and unsurprisingly in the circumstances, DBS adopted the factual findings of the NMC. Those findings revealed a pattern of serious misconduct over an extended period in a hospital environment where the Appellant was dealing with highly vulnerable service users. The Appellant verbally abused patients calling them bastards, she failed to treat them with dignity and respect (including failing timeously to change a patient who had become incontinent and requested a change), she barred access to the lounge with a sofa, she slept on duty, she prioritized a colleague’s interests over the needs of her patients and she failed to complete a safeguarding report. We are entirely satisfied that the material considered by the DBS permitted each of the findings it made on the balance of probabilities, including its assessment that the Appellant knew what constituted best practice but had failed to put that practice into effect and had displayed an attitude that presented a continuing risk of harmful behaviour towards children and vulnerable adults. We are also entirely satisfied that the decision of the DBS contained intelligible reasons sufficient to enable the Appellant to know why her representations were of no avail: see e.g. *Khakh v Independent Safeguarding Authority* [2013] EWCA Civ 1341 at [23]. We have set out above the relevant parts of the decision of the DBS.
54. We accept that the Appellant had produced positive testimonials from her new employer speaking to her dedication and professionalism, that she had worked without further incident in a new hospital for 8 months before her dismissal in

March 2022, and that the NMC had found some mitigation as identified in paragraphs 2.2.1 to 2.2.8 of the Grounds of Appeal.

55. However, none of that alters what the Appellant had done and the DBS were, in our judgment, entitled and clearly right to remain laser-focused on that catalogue of misconduct, of the most serious kind, that had persisted over many months, despite the Appellant's knowledge of best practice, and to draw the conclusions that they did, in particular as to the continuing risk which the Appellant posed to children and vulnerable adults. The DBS has an expertise in risk assessment and there was clearly a solid evidential basis for the risk of harm which they identified.
56. The further, limited new material put before us, consisting of the two reflective pieces dated 14 August 2023 and 1 January 2025, does not begin to persuade that we can or should come to any different findings, particularly on the important issues relating to the continuing risk that she posed to children and vulnerable adults and the lack of any real insight, reflection or remorse.
57. The parties agreed that neither of those pieces were available to the DBS when it made its decision but we can of course still consider that evidence, provided of course that it is relevant to the circumstances at the time of the decision under challenge. Having done so, we regard this material as being of no real weight at all in the context of the case as a whole and it does not begin to persuade us that the DBS made any error of fact in its findings. Rather, it shows that the Appellant has "flip-flopped" between acceptance and vehement denial of the findings of the NMC panel. Further, her reflective pieces have to be considered in their proper context. The reflective piece from August 2023 was expressly prepared for the sanction hearing. The NMC panel had by then made its findings and this piece was prepared in the shadow of the sanction hearing and was obviously designed to minimize the sanction. It may have played well to that audience in that context but we do not accept that it is demonstrative of genuine insight, reflection or remorse. The second reflective piece was annexed to the amended grounds of appeal and clearly designed to fill a perceived gap in the Appellant's case. Again, we were entirely unpersuaded that it was demonstrative of genuine insight, reflection or remorse even now, let alone as at the date of the decision under challenge. That conclusion is borne out by the Appellant's two responses to the minded to retain letter. In her first response dated 11 April 2024 she not only questioned the fairness of the process which had led to NMC's findings (e.g. "I believe there were flaws in the investigation process that led to the unfair portrayal of my actions"), she also "vehemently" refuted a number of the most serious findings and said "I stand firm in my denial of these allegations" which she described as "false". Her further response dated 9 May 2024 reiterated the fact that she "vehemently" denied the NMC's findings. Those two responses are, in our judgment, demonstrative of the Appellant's attitude as at the date of the decision and are entirely inconsistent with the suggestion that she had changed and had genuine insight into her misconduct.
58. We regret to say that we consider each of the reflective pieces of evidence to be entirely self-serving and not a reflection of genuine insight, reflection or

remorse on the part of the Appellant. They do not provide any basis for concluding that the DBS made any erroneous findings of fact.

59. Against that background, we can deal with each of the alleged errors of fact very briefly.

60. *Alleged mistake of fact (1)*. We detect no error here. This was really an evaluative judgment based on the proven facts. As at the date of the decision, the Appellant was still in denial, notwithstanding almost a year having passed since the final outcome decision of the NMC. Insofar as the Appellant is critical of the fact that the DBS did not explicitly weigh in her favour as evidence of changed behaviour the period between July 2021 and March 2022 when she worked without incident at another hospital, it is in our judgment important to recall that the NMC had found as at August 2023 that the Appellant's fitness to practice remained impaired. This was specifically noted in the BDP document. In any event, the decision letter acknowledged that the Appellant had "worked in regulated activity as a nurse for ... 13 years with no other reported concerns" and had a number of positive testimonials but was clearly entitled to conclude, as it did, that "you have repeatedly failed to recognize your behaviour and the impact of it on others" and that whilst "you know your role and expectations of you ... you have failed to put this into practice", particularly given what they legitimately assessed as being "an irresponsible and reckless pattern of behaviour" in the light of the findings of the NMC.

61. *Alleged mistake of fact (2)*. We were entirely unpersuaded by this point, which was in substance a reasons challenge. DBS did not have to engage with every issue raised by the Appellant but in our judgment it did engage with the main points relied on by the Appellant and neither its findings of fact nor its conclusions based on those findings can be impeached. We see nothing in the complaint that the DBS should have dealt in terms with the fact that the Appellant had worked without further incident in a new hospital for 8 months from July 2021 until February 2022. DBS acknowledged that the Appellant had otherwise worked without incident over the course of a 13 year career in nursing but came to the legitimate conclusion that very significant concerns remained notwithstanding her employment history. That conclusion was obviously open to the DBS on the facts, given the serious and multi-faceted nature of the misconduct, a fortiori when one recalls that the NMC had concluded that that her fitness to practice remained impaired in spite of the mitigating factors it identified, including that period of service under a new employer. The DBS did not need to deal with this specific point in its decision. In any event, even if we had concluded otherwise, omitting to make a specific finding on this point was not a material mistake in the sense of one that affected the outcome. That short period of supervised practice under the strict conditions imposed by the interim conditions of practice order does not begin to justify a finding that the Appellant had reflected upon her misconduct and gained real insight into her previous misconduct, particularly given the steadfast denials that she maintained in her responses to the minded to bar letter.

62. *Alleged mistake of fact (3)*. For the reasons we have already given in paragraphs 52-58 above, we reject the contention that the evidential effect of one or both of the Appellant's reflective pieces is such that the DBS assessment of the ongoing risk posed by the Appellant to children and vulnerable adults is wrong. Her responses to the minded to bar letter are only consistent, in our judgment, with a lack of acceptance and a lack of meaningful insight. In any event, risk assessments of this kind are the staple of the work undertaken by DBS and fall squarely within its expertise, and there is no legitimate basis for disturbing that assessment.
63. We detect no mistakes of fact in the decision of the DBS and reject Ground 1 and each of its limbs. For completeness, we should also say that even if we had found that the DBS had made any or all of the alleged mistakes of fact, we would have concluded that none were material, and that it is inevitable that DBS would have come to the same barring conclusion given the seriousness of the Appellant's proven misconduct.
64. Ground 2. There are three aspects to the proportionality challenge. The first is at stage (iii) of the analysis, adopting the 4-stage test from *Bank Mellat*, and involves the suggestion that the conditions of practice order imposed by the regulator was a suitable less intrusive measure that could have been used without unacceptably compromising the achievement of the objective. The second aspect of the challenge is at stage (iv) and the suggestion that overall the decision did not strike the necessary fair balance, a fortiori, so it said, when proper weight is given to the mitigating factors identified by the NMC in their sanction decision. The third aspect of this challenge was contingent on success in relation to one or more limbs of Ground 1; had the Appellant succeeded in showing a mistake of fact, it may have opened the door to an argument that the alleged error(s) served to undermine the proportionality analysis conducted by DBS. Having failed on that score, we say no more about this aspect of the challenge and focus on the issues arising under stages (iii) and (iv) of the proportionality analysis.
65. Less intrusive measure? As noted in *KS* at [61], there are only ever three options available to the DBS: "It may: (a) include the person in one of the lists, but not the other; (b) include the person in both lists; or (c) decide not to include the person in either list. It has no power to limit the extent to which the bar applies. It cannot apply a temporary bar whilst it investigates or limit the scope of the bar to specified types of regulated activity. Nor can it permit a person to engage in regulated activity but subject to conditions". It is for that reason that Mr Walker relies on the conditions of practice order imposed by the NMC as the less intrusive measure.
66. In *KS* the Upper Tribunal touched on this point without deciding it at [62]-[63] where it said this:

"62. Ray Short argued in his grounds of appeal that:

7. ... Many of the concerns relate to clinical practice and do not translate into everyday life or other work ...

That raises the question whether relying on a bar by the NMC on KS working as a nurse would be an acceptable less intrusive measure than including her in the barred lists. That is based on an assumption that NMC was better placed than DBS or, by implication, the Upper Tribunal to investigate and decide the factual matters in dispute.

63. We have decided, for three reasons, that this is not an appropriate case to decide whether it would be permissible to rely on NMC's decision as a less intrusive measure. First, as we explain at [66] below, there is no final decision of NMC regulating KS's work. Second, we heard limited argument on whether DBS is permitted to rely on protection by another regulator as being sufficient if the nature of the risk posed justifies it. Third, even if it is permissible in principle, it would not be acceptable to rely on a decision by NMC as a less intrusive measure in this case. We say that, because we do not accept the premise of Ray Short's argument that the concerns are limited to clinical work and do not translate to other work".

67. In the later case of *SLS v Disclosure and Barring Service* [2025] UKUT 129 (AAC) at [49], the Upper Tribunal said this:

"We do not ... accept that a less intrusive measure has to be one that DBS can provide. DBS has only two options: to include or not to include a person in a barred list. Given its limited powers, it would never be able to provide a less intrusive measure. That measure must always be provided by someone else, possibly another regulator".

68. We asked Mr Serr whether, leaving to one side for a moment the particular facts of this case, he accepted, at least in principle, that the less intrusive measure could be provided by another regulator such as the NMC. His response was to say, "never say never", but he submitted that it was likely to be a very rare case where such a measure would be sufficient to render it disproportionate to include a person in a barred list. In making that submission, he drew our attention to the observations of Andrews LJ in XYZ about the "*different aims and considerations*" in play as between the TRA panel in that case and the DBS and the fact that they "serve different public interests and perform different functions", although they may overlap to an extent. As Andrews LJ said in that case, and the observation applies with equal force to the NMC, "One is concerned with a person's professional conduct and fitness to be a teacher" (or nurse as in this case); "the other is concerned with an evaluation of whether they pose a present or future risk to children" (and vulnerable adults).

69. We have decided that it is unnecessary to decide, in the abstract, whether it would be permissible to rely on a decision of the NMC as a less intrusive

measure when considering the proportionality of a DBS barring decision because even if it is, in principle, permissible, it would not be acceptable to rely on the NMC's conditions of practice order as a less intrusive measure in this case for at least three reasons.

70. Firstly, it was a time-limited order of 18 months duration. Secondly, and more importantly, it was limited to the nursing context and the Applicant's conduct as a nurse; it would not stop her, for example, carrying out regulated activity in other roles and contexts (e.g. a teaching assistant or volunteer within schools). Thirdly, and equally importantly, some of the misconduct that was proved against her by the NMC was not specific to clinical practice and would translate into everyday life and work or volunteering in other areas of regulated activity.
71. Fair balance? We have set out above the consideration of proportionality undertaken by DBS. Clearly the effect that the barring order has on the Appellant is significant. However, even accepting the points in her favour and the mitigating factors identified by the NMC, her case has to be put into the balance with the protection of the vulnerable, and given the nature of her proven misconduct and the potential impact of a repetition of that conduct on children and vulnerable adults, we are in no doubt that the balance has to be struck in favour of protecting children and vulnerable adults.
72. For all those reasons, we find that the DBS's decision was proportionate.
73. The decision of the Upper Tribunal is therefore to dismiss the appeal of the Appellant.
74. The decision of the DBS taken on 18 June 2024 to retain the Appellant's name on the Children's and Adults' Barred List did not involve any mistake on a point of law and nor was it based on any material mistakes in its findings of fact.
75. The decision of the DBS is therefore confirmed.

**Deputy Upper Tribunal Judge Hansen
Tribunal Member Elizabeth Bainbridge
Tribunal Member Matthew Turner**

Authorised for issue on 30 October 2025