Neutral Citation Number: [2025] UKUT 416 (AAC)
Appeal No. UA-2024-001622-V

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

HZ

Appellant

- v -

DISCLOSURE & BARRING SERVICE

Respondent

Before:	**Upper Tribunal Judge Jones** **Member Mr Roger Graham** **Member Mr John Hutchinson**
Hearing date:	11 November 2025
Mode of hearing:	In person, Field house, London
Decision made:	12 December 2025
Representation:	
Appellant:	Ms Libby Anderson of counsel instructed by the Royal College of Nursing
Respondent:	Mr Ashley Serr of counsel instructed by the DBS

SUMMARY OF DECISION

No mistake of fact or law in the decision of the DBS to include the Appellant on the Adults' barred list ("ABL"). Appeal against inclusion on the ABL dismissed. Inclusion on the Children's barred list involved a mistake of fact and law. The Tribunal directs removal from the CBL.

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

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

DECISION

The decision of the Upper Tribunal is that the Appellant's appeal against the decision of the DBS dated 16 April 2024 (and confirmed on 29 July 2024) is dismissed in part and allowed in part. There was no mistake of fact nor law in the decision to include and retain her on the Adults' Barred List. Her inclusion

on that list is confirmed. There was an error of fact and law in HZ's inclusion on the Children's Barred List. The Tribunal directs that she be removed from that list.

REASONS FOR DECISION

Introduction

1. The Appellant (or "HZ") appeals against the decision of the Respondent (the Disclosure and Barring Service or "the DBS") made on 16 April 2024 to include her on the Children's Barred List ("the CBL") and Adults' Barred List ("the ABL") pursuant to paragraphs 3 and 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 ("the Act"). The DBS confirmed its decision in a Final Decision to retain the Appellant on both lists on 29 July 2024 after receiving further information supplied on behalf of the Appellant. Together, the decisions of 16 April and 29 July 2024 constitute "the barring decision" or "the Decision".

2. HZ appealed to the Upper Tribunal ("the UT" or "the Tribunal") on 28 October 2024. The Appellant was granted permission to appeal ("PTA") by the Tribunal on 24 April 2025 in respect of the Decision on the grounds set out below. Orders were made by the Tribunal on 18 January 2025 under Rule 14 of the Tribunal Procedure (Upper Tribunal) Rules ("the Rules") directing that the Appellant's and other witnesses' names be anonymised and no information be published or disclosed that would identify them.

3. As part of its Decision the DBS made a finding that HZ had committed relevant conduct as defined under the Act, namely that while working as a staff nurse in a hospital, she restricted patient X's movement by tying a blanket across her to the rails of her bed on 30 January 2023.

4. In December 2024 HZ was acquitted by a jury at a Crown Court of a criminal charge in relation to this incident (knowingly or recklessly ill treating the patient). Proceedings before the fitness to practise panel of the Nursing and Midwifery Council ("NMC") are ongoing and the case examiners are yet to decide if there is a case to answer against her and charges should be brought for misconduct. In the mean time HZ is subject to an interim conditions of practice order which places restrictions on her ability to work as a nurse. The ongoing NMC proceedings are no obstacle as a matter of law to this appeal being decided and the Appellant does not seek a stay of this appeal pending their conclusion. Further, there is no automatically suspensive effect of her appeal to the Tribunal: she remains barred from working in any form of regulated activity with children or vulnerable adults (which would include nursing) pending determination of this appeal.

5. The Tribunal held a hearing of the appeal against the Decision on 11 November 2025. The Appellant was represented by Ms Anderson of counsel and the DBS by Mr Serr of counsel. The Tribunal is grateful to them both for their written and oral submissions.

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

Factual background

7. The DBS filed a 950 page bundle of evidence in relation to the Decision which incorporated the evidence on behalf of the Appellant, including witness statements for these proceedings and transcripts of the evidence given in the Crown Court, which had been served on the Tribunal.

8. Numerical references in square brackets, [1] etc., are to page numbers of the updated bundle running to 950 pages, unless context dictates otherwise.

Undisputed Chronology

9. A background chronology is as follows:

2006 HZ joined NMC Register
2006-2010 HZ worked as a nurse in Care Homes
8 Oct 2010 HZ begins employment as NHS nurse
21 Jan 2023 Patient X admitted to hospital
29/30 Jan 2023 Restraint incident takes place
30 Jan 2023 HZ placed on restricted duties [264] & reported to Police & Safeguarding
6 Feb 2023 Disciplinary investigation begins
3 Apr 2023 Disciplinary investigation report completed [265-275]
16 May 2023 Disciplinary Hearing (part 1) [392-405]
27 Jun 2023 Disciplinary Hearing (part 2) [392-405]
5 Jul 2023 HZ 1st dismissal by the NHS Trust [406-410]
1 Aug 2023 HZ referred to DBS [245-247]
11 Sep 2023 DBS Early Warning letter [234-237]
29 Sep 2023 Disciplinary appeal hearing
3 Oct 2023 HZ charged with ill-treatment/wilful neglect by care worker
4 Oct 2023 Trust overturns original dismissal at appeal [411-415]
23 Nov 2023 NMC Interim Hearing – outcome Interim Suspension Order [390-391]
31 Jan 2024 First SOSR hearing date (cancelled)
14 Feb 2024 DBS Minded to Bar letter [238-243]
10 Apr 2024 HZ 2nd dismissal by the NHS Trust
25 Apr 2024 HZ appeals against dismissal
27 Jun 2024 Dismissal overturned at disciplinary appeal hearing
29 Jul 2024 DBS Final Decision letter
28 Oct 2024 UT10 & supporting documents lodged
Dec 2024 HZ acquitted after trial at the Crown Court
24 Apr 2025 Permission to appeal granted at permission hearing

The DBS Decision

10. HZ's employer, the NHS Trust, referred the matter to the DBS on 1 August 2023.The DBS considered the referral and sent her an 'early warning' letter on 11 September 2023 and thereafter sent the Appellant a 'minded to bar' letter on 14 February 2024 which invited her representations in reply which she then gave.

11. The DBS rejected the Appellant's representations in its Final Decision Letter dated 16 April 2024 which was confirmed on 29 July 2024 following the receipt of further information. The Decision letter of 29 July 2024 confirmed that the DBS retained the Appellant on the CBL and ABL and stated as follows:

> "Findings
> We considered all the information we hold and are satisfied that:
>
> you restricted a patient's movement by tying a blanket across them to the rails of their
> bed 29-30/01/2023
>
> DBS remains 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 remain satisfied a barring decision is appropriate. This is because whilst the DBS appreciate that you are currently subject to criminal prosecution and an NMC investigation,
> we are unable to defer our decision indefinitely. The DBS has a duty to safeguard children
> and vulnerable adults and any decision made is independent of that made by the NMC and
> the courts. You have the right to request a review of this decision at any time if information,
> which we did not have at the time of your inclusion, becomes available in the future, such
> as at the conclusion of the prosecution or the NMC investigation.
>
> You have also been given the opportunity, via the invitation to submit representations and
> the subsequent allowance of late representations, to challenge the evidence and DBS findings, your Article 6 (ECHR) rights have therefore not been violated.
>
> Whilst it's acknowledged that you are currently suspended from your nursing duties and it's suggested this is a sufficient safeguard, the DBS has a duty to consider the wider workforce of regulated activity with children and vulnerable adults in its entirety. It's reasonable to consider that you may seek work or volunteer in other regulated activity

roles, outside of nursing, during your suspension.

Whilst you have stated you don't work with children in your role as a nurse, the training certificate's provided show you have completed a course on Child Protection, indicating that you either require this for future nursing roles or that you intend to work/volunteer with children in the future.

It's acknowledged that no statement was ever taken from Patient X, that no original photographs exist of the restraint and that no one saw the restraint take place. It's also acknowledged that there were other staff who had access to the Patient and that the Patient could have entangled herself, however there is professional medical opinion that the patient couldn't have tied the blanket herself to the bed rails. There is also no reason to doubt the credibility of your colleagues who witnessed the patient in the position they did, or that they exaggerated what they had seen.

The evidence showed that when you were told the Patient had been found in a blanket tied
to the bed rails, you replied "yes, I was trying to save her cannula for her medication". You
later provided a statement in which you stated you "tried to secure the patient, to keep her
safe and prevent her from pulling off her oxygen." You later stated in interview that you
were referring to the use of bed rails as a restraint, however it's considered unlikely you
wouldn't have used these before in your career and you failed to explain how the use of
bed rails would have prevented the patient from trying to remove her oxygen or cannula,
your account is therefore not deemed credible.

It's acknowledged that you appealed the decision to dismiss you and that whilst the appeal
panel noted other people could have had access to the patient, it appears more likely than not that you were responsible for the restraint. Your partial admittance showed that you implemented the restraint in order to get your paperwork complete before you finished your
shift and you had not understood the restraint to be wrong until you were challenged about
it.

The DBS is therefore satisfied that you disregarded the welfare of a patient, failed to treat
her with dignity and respect and placed your own needs first. You therefore placed the
patient at risk of being emotionally and physically harmed.

It's acknowledged that you have worked in various care provision environments since 2002
and that there had been no concerns about your behaviour during this time. However, given your most recent behaviour, despite your experience and training, the DBS are satisfied that vulnerable adults could be at risk of physical and emotional harm from you.

> A review of the training certificates provided show the courses you completed were taken
> before 2023, prior to the incident of concern and therefore don't mitigate your future behaviour.
>
> The likelihood of you repeating your behaviour is therefore considered high, given you acted contrary to your training and experience. The potential level of harm, if you repeated
> your behaviour, is significant and the DBS is satisfied your behaviour indicates the need to
> retain the preventative mechanism in order to protect vulnerable adults.
>
> In consideration of the Children's Barred List, concerns are that if you were faced with similar situations in the future, whereby you were responsible for the care and wellbeing of children, that you would disregard your training and neglect their welfare needs by placing your own needs first, behaviour which will always endanger a child. The DBS is satisfied it's also appropriate to retain your name on the Children's Barred List.
>
> The interference with the human rights of those concerned has been considered (Article 8 - European Convention on Human Rights). You have a right to a private and family life. It is clear that a decision to bar you has the potential to have a detrimental impact on that right
> as it could well limit your future employment opportunities (given your career as a nurse)
> and as such impact on your finances and therefore your family life. It is also acknowledged
> that there may be a personal impact due to the potential stigma attached to such action. However consideration needs to be made of the vulnerable people you could be responsible for in the wider workforce, as they enjoy equal rights.
>
> Having considered all of the facts in this case the DBS is satisfied there is a future risk to
> those vulnerable people with whom you could have responsibility for and the DBS is satisfied the level of future harm would have a significant negative impact on those vulnerable adult in terms of their emotional and physical wellbeing, such an impact outweighs the detrimental impact that a bar has on you right to a private life.
>
> The DBS is satisfied the decision to retain you on the adults and children's lists is therefore legitimate, suitable, necessary and reasonable. The legitimate aim being the protection of the vulnerable people whom you could have responsibility for in regulated activity."

The Appeal to the UT and grounds on which permission was granted

12. The Appellant lodged at the Tribunal a notice of appeal against inclusion on the ABL and CBL dated 28 October 2024.

13. In summary, her grounds of appeal are that there were mistakes of fact in the finding of relevant conduct and mistakes of law in the DBS failing to take account relevant evidence in making the Decision, proceeding to bar notwithstanding the NMC proceedings and that the Decision was disproportionate..

14. On 24 April 2025 , the UT granted permission to proceed with the appeal, on the grounds set out in notice of appeal and counsel's skeleton argument as follows:

> "In all the circumstances, the decision of the Disclosure and Barring Service ("DBS") to include HZ on the Adults' Barred List and Children's Barred Lists was wrong in that:
>
> Mistake of fact
>
> 1. The DBS materially erred in fact in finding that HZ:
>
> a. Implemented the restraint in order to complete paperwork before the end of the shift;
>
> b. Disregarded the welfare of the patient;
>
> c. Failed to treat the patient with dignity and respect;
>
> d. Placed her own needs first;
>
> e. Put the patient at risk of emotional/physical harm;
>
> f. Intends to work/volunteer with children in the future; and
>
> g. Poses an ongoing risk to vulnerable adults or children.
>
> Mistakes of law
>
> 2. The DBS materially erred in law in that the DBS was not in possession of all relevant material when making its findings of fact having refused to wait for the outcome of the criminal proceedings;
>
> 3.The DBS failed to take into account matters which it ought to have done, or failed to give adequate weight to those matters, including:
>
> i. HZ's recent training in DOLS (deprivation of liberty)/moving and handling/adult safeguarding.
>
> ii. the gaps in the evidence provided by the employer.
>
> iii. the inconsistencies in the evidence provided by the employer.
>
> iv. the fact that the photographs of the restraint had been recreated after the fact.
>
> v. there is no, or no sufficient evidence or reasoning to support the finding that HZ is likely to repeat the conduct alleged in the referral form;
>
> vi. there is no, or no sufficient evidence or reasoning to support the finding that HZ poses an ongoing risk to vulnerable adults and children;
>
> 4. The decision to include HZ on the Adults' Barred List and Children's Barred List was, in all the circumstances, disproportionate."

Legal framework

Barring decisions

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

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

17. Paragraphs 3 and 9 of Schedule 3 to the Act, set out the provisions in relation to inclusion on the CBL/ABL. By virtue of paragraphs 3(1)(a)/9(1)(a) the respective paragraphs apply to a person if—
(a) it appears to DBS that the person —
(i) has (at any time) engaged in relevant conduct, and
(ii) is or has been, or might in future be, engaged in regulated activity relating to children / vulnerable adults; and
(b) the DBS proposes to include him in the children's / adults' barred lists.

18. Paragraphs 3(3)/9(3) respectively provide that, following an opportunity for and consideration of representations, the DBS "must" include a person on the children's / adults' barred list if:
(a) it is satisfied that the person has engaged in relevant conduct, and
(aa) it has reason to believe that the person is or has been or might in future be engaged in regulated activity relating to children / vulnerable adults, and
(b) it is satisfied that it is appropriate to include the person in the list.

19. An activity is a "regulated activity relating to children / vulnerable adults" for the purposes of paragraphs 2(2)(b) / 8(s)(b) of Schedule 3 if it falls within one of the subparagraphs in paragraphs 1, 2 and 7 of Schedule 4 to the Act; that provision broadly defines "regulated activity" and includes, in relation to children or vulnerable adults, the provision of teaching, training, healthcare, personal care or social work.

20. 'Relevant conduct' in relation to children / vulnerable adults is defined under paragraphs 4 / 10 of Schedule 3 to the Act respectively. Paragraphs 4(1) / 10(1) define the meaning of "relevant conduct". Paragraphs 4(1)/10(1) include: (a) "conduct which endangers a child / vulnerable adult or is likely to endanger a child / vulnerable adult"; (b) "conduct which, if repeated against or in relation to a child / vulnerable adult, would endanger that vulnerable adult or would be likely to endanger him". Paragraphs 4(2) / 10(2) provides that conduct "endangers a child / vulnerable adult if" among other things it: (a) "harms" a child / vulnerable adult ; or (b) puts a child / vulnerable adult "at risk of harm".

The UT's jurisdiction on appeal

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

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

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

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

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

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

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

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

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

    " (1) This paragraph applies to a person if

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

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

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

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

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

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

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

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

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

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

    "… it is clear that the function of the DBS is a protective forward-looking function, intended to prevent the risk of harm to children by excluding persons from involvement in regulated activities. The DBS is not performing a prosecutorial or adjudicatory role and it is not engaged in considering complaints from individuals and imposing punishments. It may, as part of its task, have to form a view as to whether a person

has engaged in conduct likely to endanger a child or sexually inappropriate conduct, or the case may involve conduct posing a risk of harm. It will need also to consider questions as to whether it is appropriate to include the person on the children's barred list. However it is not there to receive and adjudicate upon complaints from individuals."

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

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

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

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

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

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

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

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

Relevant general tests/principles

26. In order for the appeal to succeed under section 4 of the Act, the UT would need to reach a conclusion that DBS made a material mistake on a point of fact or law. The DBS relied on the "relevant conduct" gateway. It therefore needed to be "satisfied" of the following 3 things before barring HZ (pursuant to paras 3 and 9 of Schedule 3 to the Act):

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

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

    (c) Third, under paras 3/9(3)(b), it was "appropriate" to include HZ on the barred lists.

27. Indeed, if satisfied of the above three matters, the DBS was required, by the Act, to include HZ on the relevant lists.

Mistakes of fact and the UT's fact finding jurisdiction

28. In relation to relevant principles regarding factual mistakes, the UT has the benefit of a line of authorities: *PF v DBS* [2020] UKUT 256 (AAC); *DBS v JHB* [2023] EWCA Civ 982; *Kihembo v DBS* [2023] EWCA Civ 1547; and *DBS v RI* [2024] EWCA Civ 95. The jurisdiction for the Tribunal to consider an appeal based on a mistake of fact was considered in *PF v DBS* and approved by the Court of Appeal in *DBS v RI*. A three-judge panel in *PF* stated at [51]:

a) In those narrow but well-established circumstances in which an error of fact may give rise to an error of law, the tribunal has jurisdiction to interfere with a decision of the DBS under section 4(2)(a).
b) In relation to factual mistakes, the tribunal may only interfere with the DBS decision if the decision was based on the mistaken finding of fact. This means that the mistake of fact must be material to the decision: it must have made a material contribution to the overall decision.
c) In determining whether the DBS has made a mistake of fact, the tribunal will consider all the evidence before it and is not confined to the evidence before the decision-maker. The tribunal may hear oral evidence for this purpose.
d) The tribunal has the power to consider all factual matters other than those relating only to whether or not it is appropriate for an individual to be included in a barred list, which is a matter for the DBS (section 4(3)).
e) In reaching its own factual findings, the tribunal is able to make findings based directly on the evidence and to draw inferences from the evidence before it.
f) The tribunal will not defer to the DBS in factual matters but will give appropriate weight to the DBS's factual findings in matters that engage its expertise. Matters of specialist judgment relating to the risk to the public which an appellant may pose are likely to engage the DBS's expertise and will therefore in general be accorded weight.
g) The starting point for the tribunal's consideration of factual matters is the DBS decision in the sense that an appellant must demonstrate a mistake of law or fact. However, given that the tribunal may consider factual matters for itself, the starting point may not determine the outcome of the appeal. The starting point is likely to make no practical difference in those cases in which the tribunal receives evidence that was not before the decision-maker.

Assessment of risk

29. As set out above, the UT has a full jurisdiction to identify and correct a mistake of fact. An assessment of risk however is generally speaking for the DBS, and what is and is not a fact should be considered with care. In *DBS v AB* [2021] EWCA Civ 1575*,* Lewis LJ stated at [43] and [55]:

> '43. By way of preliminary observation, the role of the Upper Tribunal on considering an appeal needs to be borne in mind. The Act is intended to ensure the protection of children and vulnerable adults. It does so by providing that the DBS may include people within a list of persons who are barred from engaging in certain activities with children or vulnerable adults. The DBS must decide whether or not the criteria for inclusion of a person within the relevant barred list are satisfied, or, as here, if it is satisfied that it is no longer appropriate to continue to include a person's name in the list. The role of the Upper Tribunal on an appeal is to consider if the DBS has made a mistake on any point of law or in any finding of fact. It cannot consider the appropriateness of listing (see section 4(3) of the Act). That is, 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.
> …
> 55. Section 4(7) of the Act provides that where the Upper Tribunal remits a matter to the DBS it "may set out any findings of fact which it has made (on which DBS must

> base its new decision)". It is neither necessary nor feasible to set out precisely the limits on that power. The following should, however, be borne in mind. First, 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. By way of example only, the fact that a person is married and the marriage subsists may be a finding of fact. A reference to a marriage being a "strong" marriage or a "mutually-supportive one" may be more of a value judgment rather than a finding of fact. A reference to a marriage being likely to reduce the risk of a person engaging in inappropriate conduct is an evaluation of the risk. The third "finding" would certainly not involve a finding of fact. Secondly, an Upper Tribunal will need to consider carefully whether it is appropriate for it to set out particular facts on which the DBS must base its decision when remitting a matter to the DBS for a new decision. For example, an Upper Tribunal would have to have sufficient evidence to find a fact. Further, given that the primary responsibility for assessing the appropriateness of including a person in the children's barred list (or the adults' barred list) is for the DBS, the Upper Tribunal will have to consider whether, in context, it is appropriate for it to find facts on which the DBS must base its new decision.'

30. Therefore, the Court of Appeal in *AB* at [43] considered that the assessment of risk is essentially a matter for the DBS unless factually or legally flawed ie. premised upon a mistake of fact or in itself irrational or unreasonable.

Proportionality

31. In relation to whether it is "appropriate" to include a person in a barred list, the UT has no jurisdiction nor power to intervene. This is clear from s.4(3) of the Act and relevant case law as set out above.

32. The scope for challenge on appeal is effectively limited to a challenge on proportionality or rationality grounds. The starting point is that the DBS is well-equipped to make safeguarding decisions of this kind (see *AB* at paras 43-44, 55 & 66-75).

33. The proper approach to proportionality in barring appeals was conveniently summarised in the recent case of *KS v Disclosure and Barring Service* [2025] UKUT 045 (AAC):

a) Whether a decision is disproportionate is an issue of law: *R (Royal College of Nursing) v Secretary of State for the Home Department* [2011] PTSR 1193 at [104] and *B v Independent Safeguarding Authority (Royal College of Nursing intervening)* [2013] 1 WLR 308 at [14] (para 46).

b) 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) (para 43).

c) Proportionality is distinct from appropriateness. This means that proportionality sets the limit to what may be appropriate. It is never appropriate for DBS to make a decision that is disproportionate. It does not, though, occupy the whole space covered by appropriateness. In other words, DBS need not find it appropriate to bar just because it would be proportionate to do so (para 47).

d) As Lord Neuberger explained in In re *B (Care Proceedings: Threshold Criteria)* [2013] 1 WLR 1911 at [84], it is well established that a court entertaining a challenge to an administrative decision, i.e., a decision of the executive rather than a decision of a judge, must decide the issue of proportionality for itself – see the statements of principle in *R (SB) v Governors of Denbigh High School* [2007] 1 AC 100, paras [29-30] and [63], and in *Belfast City Council v Miss Behavin' Ltd* [2007] 1 WLR 1420, paras [12-14], [24-27], [31], [42-46] and [89-91] (para 48).

e) As safeguarding appeals under the Act are a first judicial consideration, the UT may consider proportionality for itself (para 48).

f) In carrying out its assessment of proportionality: the Upper Tribunal is not undertaking a rationality or Wednesbury assessment. It is not concerned with the process followed by DBS (para 50).

g) The Upper Tribunal must have regard to DBS's statutory role as the primary decision-maker. This is consistent with the Upper Tribunal having to decide proportionality for itself. It makes the decision but takes account of DBS's analysis when doing so (para 53).

h) The Upper Tribunal must make its own analysis of proportionality, but in practice it will have the benefit of argument from the parties, at least if the appellant is represented (para 54).

i) In determining proportionality, Lord Reed's four stage test from *Bank Mellat v Her Majesty's Treasury (No 2)* [2014] AC applies:

(1) Whether the objective of the measure is sufficiently important to justify the limitation of a protected right (DBS's objective, in the most general terms, is to protect children and vulnerable adults from harm by those entrusted with their care in regulated activity. That objective is sufficiently important to justify interfering with the barred individual's exercise of their Article 8 Convention right (para 58);

(2) Whether the measure is rationally connected to the objective (DBS's decision under the barring scheme prohibits the barred individual from engaging in regulated activity, which is rationally connected to the objective of the scheme (para 59);

(3) Whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective (DBS has no power to limit the extent to which the bar applies. It cannot apply a temporary bar while it investigates the case 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. The trigger for acting is governed by SVGA. It may not include a person in a list unless and until the statutory conditions are satisfied,

but once they are satisfied, DBS is under a duty to include the person in either or both lists (para 61);
(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 (This involves a balancing exercise between the severity of the effects on the barred individual's exercise of their Article 8 Convention right and the importance of the objective of barring them from regulated activity. This is a matter of judgement (para 71).

34. It was said in the *Belfast City Council* case that '[i]f [a] local authority exercises [a] power rationally and in accordance with the purposes of the statute, it would require very unusual facts for it to amount to a disproportionate restriction on Convention rights' (per Lord Hoffman at [16]).

Mistakes of Law

35. When considering appeals of this nature, the UT "must focus on the substance, not the form, and the appeal is against the decision as a whole and not the decision letter, let alone one paragraph…taken in isolation": *XY v ISA* [2011] UKUT 289 (AAC), [2012] AACR 13 (para 40). When considering the Decision, the UT may need to consider both the Final Letter and Rationale Document ("Barring Decision Summary"). The two together, in effect, set out the overall substantive decision/reasons (see *AB v DBS* [2016] UKUT 386 (AAC) (para 35); *Khakh v ISA* [2013] EWCA Civ 1341 (paras 6, 20, 22)).

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

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

The UT's powers to grant remedies on allowing appeals

38. If the UT finds that the DBS made a material mistake of fact or law under section 4(2) of the Act, it is required under section 4(6) to either (i) direct that the DBS removes the person from the relevant list(s) or (ii) remit the matter to DBS for a new decision. Where the UT does the latter, the UT may, under section 4(7), set out any findings of fact, which it has made, on which DBS must then base any new decision. Following *AB*, the usual order will be remission back to DBS unless no decision other than removal is possible on the facts.

The Appellant's submissions

<u>Submissions on behalf of the Appellant</u>

39. The Appellant was granted permission to appeal on the grounds of appeal set out in her notice of appeal and skeleton argument identified by the UT as set out above.

40. In submissions for the hearing drafted by Ms Anderson of counsel dated 30 October 2025, the Appellant relied on the following arguments in support of the grounds.

Ground 1 – mistake of fact

41. Ms Anderson submitted that the sum of the DBS findings is that HZ restrained patient X by tying her to the bed and that she did so in order to complete paperwork by the end of the shift, placing her own needs first and thereby disregarding the welfare of the patient, failing to treat the patient with dignity and respect and putting the patient at risk of emotional and physical harm. HZ has consistently denied that any of this occurred and has maintained that everything she did was done in the patient's best interests.

42. Numerous witnesses were spoken to in the course of the disciplinary investigation and then in the police investigation. Many of the key witnesses also gave evidence at HZ's criminal trial, which took place at the Crown Court in December 2024. The witness evidence was fully considered and tested at trial over the course of four days and the trial resulted in an acquittal. Transcripts of the Crown Court witness evidence were obtained on behalf of the Appellant and provided to the UT as documents relied upon by the Appellant:

    A. JP, healthcare assistant [652-677]
    B. EK, healthcare assistant [677-709]
    C. LN [709-722]
    D. JC [722-751]
    E. SC, matron [752-774]
    F. DC B, Officer in the Case [774-781]
    G. SB, expert [784-818]
    H. HZ [819-909]

43. Ms Anderson argued that although the criminal proceedings operate to a higher standard of proof, namely that the jury must be 'sure' of guilt before convicting, rather than the balance of probabilities, the not guilty outcome is still indicative of the lack of strength in the allegations against HZ. An acquittal should be persuasive and any determination by the DBS which is inconsistent with an acquittal should be carefully considered and reasoned.

44. She submitted that the fact of the Crown Court acquittal, although not binding on the DBS in the same way as a conviction, lends support to HZ's account that she did not disregard the welfare of the patient, fail to treat the patient with dignity and respect, place her own needs first, put the patient at risk of physical/emotional harm, or restrain the patient so that she could go and complete paperwork.

45. It is submitted that the nature and extent of the evidence that was heard in the trial, and how well that evidence stood up to scrutiny, is nevertheless invaluable in weighing up what actually happened and whether HZ did in fact tie the patient to her hospital bed as alleged. This evidence is absolutely key.

46. On behalf of the Appellant, Ms Anderson submitted that the transcripts of evidence disclose the following:

    A. Numerous and significant inconsistencies in the evidence of the crown's witnesses which fatally undermine the assertion that HZ tied the patient to the Bed.

    B. Notable gaps in the available evidence, for example, key witnesses who were not even identified and so were not asked to provide statements.

    C. An alternative explanation provided by the Appellant, which was explored in far greater depth than was possible within the disciplinary investigation and/or the face of the on referral papers, and which is logical and plausible.

47. These matters are addressed in greater detail below. In light of those matters, she submitted that the allegation that HZ tied the patient to the bed, and all the other factual conclusions that flow from that, were not findings of fact that could be found to the balance of probabilities on all the available evidence and that accordingly the DBS fell into mistake of fact.

48. The DBS's barring decision process summary ("BDP") document relies heavily on what is described as the Appellant's 'partial Admittance' [470], finding 'whilst no one saw the restraint take place and other colleagues had access to the patient, [HZ] gave a partial admittance which indicates that more likely than not she carried out the restraint.' [471]. It is submitted that the assertion that HZ gave a partial admittance is mistaken. From the wording of the BDP document, it seems that the 'partial admittance' is the factor that tipped the Respondent over the balance of probabilities threshold, when in fact this was not the case.

49. To the contrary, it is contended that HZ has consistently stated that she did not tie the patient to the bed. her account has been consistent at every stage of the internal investigation, criminal proceedings (in her defence statement [910-917] and evidence at trial) and DBS Proceedings (witness statement and exhibits [576-624]). The suggestion that she admitted to having done so, either directly or tacitly, is incorrect. When HZ provided her account of the night shift on 29 January 2023, she stated:

    'I could only imagine the horror that could occur such as the patient getting hypoxic and falling from the bed […] I tried to secure the patient, to keep her Safe and prevent her from pulling off her oxygen […] I have never used the Method of restriction before to keep a patient safe but I was put in a dire situation where I got overly worried of the patient harming herself.' [290-291]

50. Ms Anderson submitted that this was not an admission to tying the patient to the bed, but rather to using the bed rails to keep the patient in the bed for her own

safety in circumstances where this would not normally be done. HZ explained that she used the word 'restriction' because her 'understanding is that the bed rails could be classified as a Method of restriction' [para 48, 585]. The meaning of restraint/restriction was further explored in the course of the trial and the matron, SC, confirmed that bed rails were a form of restriction [770] and also gave evidence that she would not use the term 'restriction' to describe a patient's limbs being tied to a bed rail but described that as a form of 'restraint' [772]. That being the case, it would make sense for HZ to have been referring to the use of bed rails rather than the act of tying the patient's limbs to the bed rail when she referred to 'method of restriction'.

51. The DBS's Barring Decision Process Summary ('BDP') document states:

> 'HZ later provided a statement in which she didn't specifically mention using the blanket but did state she "tried to secure the patient, to keep her safe and prevent her from pulling off her oxygen. During the night when the patient removed her oxygen the tubing managed to go around her neck, so I was afraid of this event repeating itself. I have never used the method of restriction before to keep a patient safe, but I was put in a dire situation where I got overly worried of the patient harming herself." (flag 4.3 Appendix 2). [HZ] later stated in interview that she referring to the use of bed rails, however it appears unlikely she would not have used these before in her career Therefore her account that this is what she meant is discredited.' [469]

52. HZ was questioned at length about her use of the bed rails in the course of her trial in the Crown Court, both with respect to this patient and previously in her practice [examples: (xic) 860-863, 866-867, 870-871, (xx) 883, 898-904]. When questioned about her previous use of the bed rails, HZ stated as follows:

> "Q. What did you hope to achieve by keeping the bed rails up at that stage rather than putting Them down?
> A. So, when went there i, the bed rails was something that you can just click to put down,
> So when i put them down and the way she was moving i felt it wouldn't work. So, i had
> to put it back up.
> Q. You said that you did that in order to keep the patient safe. What were you hoping to
> Achieve? Why did you think that putting or keeping the bed rails up would keep her safe?
> A. To prevent her from falling, or, yes from falling out of bed.
> Q. Can i ask you to have a look at page nine please of the bundle that, yes that you've got
> in front of you. Continuing your statement. 'i have never used the method of restriction
> before to keep a patient safe, but i was put in a dire situation where i got overly worried
> of the patient harming herself.' First question, what was the method of restriction that
> you were referring to then?

A. It was the use of bed rails on a confused patient.
Q. Had you used bed rails before your shift of the 29 to the 30 january or not?
A. Yes.
Q. Why are you saying i've never used the method of restriction before to keep the patient
safe?
A. There's an assessment that as a nurse you do to see if your patient, if you can use the
bed rails or not. So, ordinarily you would not use bed rails on a confused patient."

53. In cross-examination during her Crown Court trial, HZ was pushed as to exactly how the fact of the bed rails being up would have protected the patient. She gave the following explanation:

> "Q. Well, i'm asking the question again, how would putting side rails up on the bed stop the patient moving in the bed and getting tangled, how would that help?
> A. Okay, i'll explain that to you.
> Q. Yes.
> A. I think the nature of the tubing it goes on the ears, so i don't know how it happens, like I think my colleague one of the witnesses said before it would get in her neck. In any event, that i had out those bed rails and she came out or fell with the tubing in her
> neck it means she was going to be strangled by it and i didn't want that to happen.
> Q. I'm sorry to labour the point [HZ], i still don't quite understand, perhaps it's
> me, how putting the bed rails up would stop the patient moving around inside the bed,
> It wouldn't would it?
> A. No, that one wouldn't. But for her to come out of bed with wrapped tubing around her neck would have been more dangerous. So, i decided to keep the bed rails up."

54. Ms Anderson submitted that, from the above exchange, it is clear that HZ was not saying that she Had never used bed rails before in the course of her practice as a nurse, but that she had never used them in this manner, that is, on a confused patient. She did so in this case to Prevent a patient, who was known for getting tangled up, from the risk of rolling or falling out of bed, getting a tube wrapped around her neck, and strangling herself.

55. Matron, SC, confirmed that caution would be needed in using bed rails with a confused Patient, and it is submitted that this supports the appellant's case. She explained as Follows:

> 'if somebody was confused or had delirium, we would have to be very cautious how we Use those, because people will move around in their beds, frail people, and people that Are confused can put their legs through the gaps. They can become trapped.' [771]

56. Ms Anderson argued that there would have been no sense in the Appellant tying the patient to her bed right at the end of her shift, especially given the high

turnover of staff at that time, doubling the risk of someone seeing the patient and noticing the restraint. Also, if the Appellant had done this for her own convenience, it would make more sense to have done that far earlier in the shift, rather than only minutes before going off shift. This would have been bizarre behaviour from her. HZ had already provided a high level of service throughout the shift, and indeed throughout the many years of her previous employment.

57. She contended that the Appellant's demeanour when first confronted with the allegation, and subsequently at police interview, was indicative of shock rather than guilt. For example:

A. The Appellant explained at trial that she was shocked into numbness when the matron phoned her to ask for an account of the night shift [893]:

"Q. You accepted when i showed you the photographs earlier, didn't you, that tying a patient to the bed in that manner is completely unacceptable and not something a nurse should do, do you agree?
A. Yes.
Q. So, when you heard from matron on the phone the words she was tied to the bed, were you not shocked-
A. Yes, i was.
Q. -at that point?
A. I was.
Q. Yes. But you didn't say to matron something like oh my god what are you talking about, how did that happen, did you?
A. What shocked me more was she already came to make an allegation against me when i knew nothing about it. It made me go numb, i didn't know, i was shocked more by that.
Q. Well, [HZ] you didn't say to the matron, did you during that conversation, i don't know anything about that, meaning tying her to the bed. You didn't say that to her, did you?
A. I told her i didn't know about that. I knew about her moving about possible leading to how she was found."

B. HZ gave evidence at trial that when she was shown the photographs at her police interview, she 'was in shock. I did not expect to see, I had not imagined because all that I could do was to imagine how that patient was found. May be from working with confused patients before, I did not picture what I saw in my mind at home. It was very upsetting to me why somebody, especially my colleagues, could think I could have done that to a patient.' [866].

C. She also questioned whether she had been shown those photos before, or whether she had been shown different photos, because she did not recognise them [873-875].

58. Ms Anderson submitted that if HZ had tied the patient to the bed, she would not have responded in the same shocked way. It would have been obvious from the outset that somebody Would notice the patient tied to the bed and that questions would be asked, and HZ would have known exactly what she was being asked about and what she had done. Her reaction was not consistent with this.

59. If the Appellant was not responsible for restraining the patient by tying her to the bed, then either the patient must have got herself into that state, or else somebody else must have been responsible. Those are the only options.

60. Ms Anderson argued that neither of these options was fully explored at the internal investigation stage, and as such, were not properly considered by the DBS in making the barring decision. However:

A. Other people/members of staff did have access to the patient. There were day shift staff arriving from 07:00am and night shift staff were around until 07:30am when their shift ended.

B. It was assumed that HZ was the last person to see the patient which is why the focus was on HZ. However, a doctor had seen her at 06:50am and there was no issue of restraint raised by the doctor; plainly the doctor would have a) noticed and b) raised any issue over restraint, if there was an inappropriate restraint in place. There is no evidence of any kind that HZ saw the patient again after that time. If HZ did not see patient after the doctor saw her, it could not have been her who tied the patient to the bed.

C. An observations sheet was completed. There was an observation at 08:00am After HZ had left her shift at around 07:40am. No issue raised in respect of restraint at that stage (exh hz/5 [613]).

D. The patient was known to have a tendency to entangle herself in her tubes/bedding. This was a recognised issue which the members of staff were concerned about and took particular care to prevent:

i. Around 06:40, HZ recorded that the patient had pulled out her cannula and was very restless, kicking and removing her linen (exh hz/2 [605-605])

ii. JP gave the following evidence at trial: ‘it looked as though she’d tried To get out of the what she was in and tangled – and got tangled in the Process.’ [665].

iii. EK confirmed in her evidence at trial that the patient had slipped down The bed before and had removed her oxygen tube before [697]. She also gave evidence that the patient had been on the ward for a while and this was a known problem, because every time she removed her oxygen the nurses had to replace it [683].

iv. At trial, JC stated ‘she was wrapped like a cocoon, with the oxygen tubing and the catheter wrapped around the shoulder and the leg’ [723].

v. SJ gave a witness statement which was read at trial, which contained the Following ‘I don’t believe the tubing was deliberately tied to her, it was tangled’ [930].

vi. It is also of note that the patient was confused, delirious, and suffering From flu as well as a kidney infection, which may have contributed to The kicking and

moving in bed, leading to entanglement – it is entirely possible that she became entangled through her own movement.

61. Ms Anderson contended that the possibility of the patient entangling herself and/or the possibility that some other party was responsible for restraining her makes it less likely that the Appellant was responsible, such that it cannot be found on the balance of probabilities.

Risk of harm to children

62. Ms Anderson noted that the DBS's BDP document reads '[HZ]'s training records indicate an intent to work with children given she has completed a child protection course, she could also attempt to work with children in wider regulated activity'. [482].

63. She argued that it is erroneous to suggest that the Appellant intends to work or volunteer with children in the future because she is not qualified to nurse children and only ever intends to work with adults. The mere fact of HZ's completed child safeguarding training is not indicative that she intends to work with children in future. This is standard mandatory CPD (continuing professional development) commonly completed by healthcare professionals. The inference that it indicates an intent to apply to work with children in the future is not justified on the evidence.

64. Ms Anderson submitted that there is no identifiable risk of harm to children in any event. The alleged incident occurred in a clinical setting, did not involve children, and there is unlikely to be any opportunity for HZ to repeat any of the behaviours described outside of her general adult nursing role, so it could not be repeated against children.

<u>Ground 2 – error of law: making the decision prior to the outcome of criminal proceedings</u>

65. Ms Anderson argued that the DBS fell into material errors of law in that it refused to wait for the outcome of the criminal proceedings and therefore was not in possession of all relevant material when making its findings of fact. The refusal to wait and the decision to make its findings on incomplete facts were irrational in the circumstances. In the representations made on behalf of the Appellant on 22 July 2024 [441] the Royal College of Nursing ("RCN") invited the DBS to 'pause its final decision to await the outcome of the ongoing criminal and NMC fitness to practise proceedings.'

66. The final decision letter [461] deals with this invitation briefly, as follows:

> 'we remain satisfied a barring decision is appropriate. This is because whilst the DBS appreciate that you are currently subject to criminal prosecution and an NMC investigation, we are unable to defer our decision indefinitely. The DBS has a duty to Safeguard children and vulnerable adults and any decision made is independent of that made by the NMC and the courts'.

67. The final decision letter was drafted in July 2024. The Crown Court trial took place in December 2024. Ms Anderson submitted that this would have been a finite, rather than an indefinite, postponement of the decision for a particular purpose. The DBS would have had to wait only a matter of months before coming to their decision but chose not to do so. Although the criminal proceedings operate to a higher standard of proof, namely that the jury must be 'sure' of guilt before convicting, rather than the balance of probabilities, the not guilty outcome is still indicative of the lack of strength in the allegations against HZ. An acquittal should be persuasive and any determination by the DBS which is inconsistent with an acquittal should be carefully considered and reasoned.

68. She submitted that the fact of the crown court acquittal, although not binding on the DBS in the same way as a conviction, lends support to HZ's account that she did not disregard the welfare of the patient, fail to treat the patient with dignity and respect, place her own needs first, put the patient at risk of physical/emotional harm, or restrain the patient so that she could go and complete paperwork.

69. Whilst it is correct that the DBS makes decisions independently, as a body it does not have investigatory powers and is reliant upon the information provided by other organisations, and should gather, assess and robustly evaluate that information in order to come to its own findings In this case, she submitted that the DBS should have been aware of the wider extent and improved quality of evidence that would be available as a result of the criminal proceedings, and should have waited for that trial to conclude in order to obtain transcripts of the evidence.

70. The fact that the DBS then sought a four month stay to obtain evidence in relation to the criminal proceedings shows that they recognised the importance and relevance of the outcome in the criminal proceedings. The stay would have allowed the DBS to address this error, which should not have occurred in the first place.

<u>Ground 3 – error of law: failure to take matters into account</u>

71. Ms Anderson submitted that the DBS failed to take into account matters which it ought to have done, or failed to give adequate weight to those matters, including:

    A. HZ's recent training in DOLS/moving and handling/adult safeguarding.

    B. The gaps in the evidence provided by the employer.

    C. The inconsistencies in the evidence provided by the employer.

    D. The fact that the photographs of the restraint had been recreated after the fact.

Recent training in DOLS/moving and handling/adult safeguarding

72. Ms Anderson argued that the Appellant has provided evidence of recent training in topics pertinent to the concerns raised. Specifically, the disciplinary appeal

identified a need for the Appellant to complete further training in safeguarding and use of bed rails to address the residual concerns, and she duly did so.

73. The only reference to the DOLS training in the BDP document is at [484] which simply notes that the certificate has been received 'certificate (flag 7.4) deprivation of liberty safeguards (DOLS) 11/07/2024'. It does not comment upon the training or analyse it or pass any kind of judgment about it. The element of analysis is notable by its absence. This certificate post-dates the incident. This is relevant because the DBS criticised other evidence of training because they pre-dated the incident:

'a review of the training certificates provided show the courses [HZ] complete were taken before 2023, prior to the incident of concern and therefore don't mitigate [her] future behaviour.' [488].

74. She submitted that merely noting the existence of the certificate, with no analysis or comment, does not demonstrate that the DOLS training was adequately taken into account in the decision making process. It was not properly considered and insufficient weight, if any, was attached to it as a result.

Gaps and inconsistencies in the evidence

75. The barring decision process document states:

'a full review of the investigation has been undertaken and it has been determined that the report is a thorough, fair, balanced, impartial and objective consideration of all available evidence in relation to this allegation which has included professional opinion from both the matron, senior nurses and the head of physiotherapy.' [468]

76. Ms Anderson submitted that this assessment fails to take account of the significant gaps in the evidence provided by the employer:

A. The eyewitnesses only saw part of what occurred and so could not provide the full picture.

B. There is, understandably, no statement from the patient herself – this is not a criticism as such, but it does create a lacuna in the evidence.

C. The fact that the photographs were not contemporaneous but were recreated, which creates the possibility for error or incorrect recollection.

D. There are no statements from various key eyewitnesses, who in some cases have not even been identified. For example, there is no statement or interview from the doctor who saw the patient at 06:50 before the appellant's shift ended and there is no statement from the worker who did the 08:00 observation.

77. The disciplinary appeal hearing held on 29 September 2023 also concluded that there were several errors in the investigation [414]:

A. ‘your silence when the incident was shared with you, along with the implications, was construed as admitting to the allegation which is why the investigation focussed on you, rather than if there was anyone else who could have done this.’

B. ‘there was no consideration of the possibility that someone else could have done this.’

C. ‘no photo was taken of the patient at the time – and i do accept this was appropriate given the patient’s health; however witnesses have confirmed that this is how the patient was found so corroborated this, this means however there is a risk that these were over-dramatised, given the situation.’

D. ‘it was assumed the patient did not have capacity – however there was no attempt to speak to her, and we note from your account that the patient’s daughter said she was self-caring before admission.’

78. The disciplinary appeal overturned the initial dismissal, concluding as follows:

‘the investigation focused on you and as a result, the findings and the outcome from the disciplinary hearing, on the balance on probability, did not provide the benefit of The doubt in relation to you, especially where there were other members of staff who had access to the patient.’ [414]

79. ABT, who was the chief strategy and transformation officer at the Trust in 2023, and who sat on the panel which heard the appellant’s disciplinary appeal, has acknowledged both the gaps in the evidence provided by the employer and the flaws in the investigation. She has provided a witness statement [625-627] in which she states the following:

A. ‘I recall that there was evidence that a doctor had seen the patient before HZ’s shift had ended. Disappointingly, a statement from the doctor was not taken, nor was the doctor interviewed as part of the investigation. It is my view, however, that had the doctor witnessed anything untold the doctor would have reported this at the time and raised concerns. No concerns were raised by the doctor. I do not know why the doctor’s evidence was not taken.’ [para 9, 626]

B. ‘evidence was available that there were other members of staff around the patient at the time of the alleged harm. I am not aware of statements having been taken from these individuals.’ [para 10, 626]

C. ‘the photographs presented at the hearing, i recall, were reenacted and were not of the patient herself. There were no pictures taken of the alleged incident.’ [para 11, 626]

D. ‘I recall that other failings in regard to the handling of the investigation were identified when the matter progressed to court, for example, from recollection, the police were not notified of the appeal outcome.’ [para 13, 626]

80. In light of the disciplinary appeal conclusions and ABT's evidence Ms Anderson contended that the assessment of the investigation report in the BDP document was not correct. It is unclear why the DBS preferred the conclusions of the earlier disciplinary hearing, which was overturned on appeal, to the conclusions of the disciplinary appeal itself.

81. The BDP document records that the appeal decision was 'based on the panel being unable to confirm that no other staff had access to the patient during the timeframe concerned' and goes on to state 'therefore whilst the appeal panel noted other people could have had access to the patient, it appears more likely than not that [HZ] was responsible for the restraint' [470]. This is the opposite conclusion to that drawn by the disciplinary appeal panel.

82. Ms Anderson submitted that the DBS also failed to give adequate weight to the limited credibility and reliability of the witnesses, whose evidence is critical to the concerns, but who only saw part of what occurred.

Re-created photographs

83. As set out above, the disciplinary appeal hearing identified the risk that the photographs had been over-dramatised given the situation.

84. Ms Anderson submitted that there was confusion even amongst the NHS staff as to how the patient was tied. JP, who first discovered the patient, was not interviewed in the first instance. Matron SC, did not see the patient herself but was given that a description by JP. JP then provided a statement on 13 February 2023 [301]. At trial, there was some dispute as to the accuracy of the recreated photographs, with JP stating that they were an accurate reflection of what she saw [655] and LN disagreeing [711]. She contended that recreated photos, based from memory, in a fraught situation such as this, will be inherently less accurate and less reliable than a contemporaneous photo would be.

Failure to take account of matters relating to risk

85. Ms Anderson submitted that there is no, or no sufficient evidence or reasoning to support the finding that HZ is likely to repeat the conduct alleged. The DBS have not provided a rationale to explain what the likelihood of HZ repeating the behaviour against a child and/or vulnerable adult in regulated activity is; or what is the likely and/or potential level of harm if the behaviour is repeated. As such, the DBS has not complied with its internal master casework guidance, May 2019, page 11 of 19, section 4.

86. She submitted that there is no, or no sufficient evidence or reasoning to support the finding that HZ poses an ongoing risk to vulnerable adults and children. In assessing the future risk to adults and children posed by the appellant, she argued that consideration should be given to how the risk transpired, what the Appellant's circumstances were at the time, if the circumstances had any impact on the level of risk created, and the likelihood of the risk reoccurring the future which will include consideration of any changes in the appellant's circumstances

including her insight, remediation, support received, and current personal circumstances compared to how they were then.

87. Ms Anderson accepted that HZ had, at the material times, been engaged in regulated activity with vulnerable adults. However, she has never been involved in regulated activity in relation to children and has no intention to do so. The mere fact that she has completed CPD training, such as child protection courses, should not be taken as an indication that she will in the future attempt to work with children. Child protection is arguably relevant to any adult working in any line of work and this is a standard CPD course which is very commonly required for healthcare professionals, regardless of whether they work directly with children or not.

88. She submitted that there is no, or no sufficient evidence or reasoning to support the finding that HZ poses an ongoing risk to children for the following reasons:

    A. There is no identifiable risk to children.

    B. The alleged incident occurred in a clinical setting, did not involve children, and there is unlikely to be any opportunity for any of the behaviours described to be repeated outside of her general adult nursing role, so it could not be repeated against children.

    C. The appellant does not intend to work or volunteer with children in the future because she is not qualified to nurse children and only ever intends to work with Adults. If she does not intend to engage in regulated activity with children, it is Hard to see how she could pose a risk to children.

<u>Ground 4 - proportionality</u>

89. Ms Anderson submitted that barring the Appellant was disproportionate in all the circumstances, when considered in the context of all relevant and accurate facts, and that this constitutes an error of law. (a disproportionate or irrational barring decision may Constitute a material error of law (*Khakh v Independent Safeguarding Authority [2013] EWCA Civ* 1341)).

90. She argued that the right to employment falls within the ambit of article 8 of the ECHR. Any interferences with an individual's right to respect for private and family life must be 'necessary in a democratic society', or in other words, proportionate. The leading case on the application of the proportionality principle is *R (Quila and Others) v Secretary Of State For The Home Department* [2011] UKSC 45. In that case the Supreme Court set down the following principles in relation to the amendment of Legislature by the Secretary of State, but which have general application to the actions of any state body:

    A. There being an 'interference' for the purposes of article 8(1), the burden of Justifying that interference falls on the secretary of state;

    B. The requirements of proportionality remain those identified by Lord Bingham in *Huang v SSHD* [2007] 2 AC 167 ('the Huang questions'), being:

1. Is the legislative objective sufficiently important to justify limiting a fundamental right?

2. Are the measures which have been designed to meet it rationally connected to it?

3. Are they no more than necessary to accomplish it?

4. Do they strike a fair balance between the rights of the individual and the interests of the community?

91. She submitted that the relevant questions are therefore:

A. Is placing the appellant on the relevant barred list no more than necessary to accomplish the legitimate aim of protecting vulnerable adults and children?

B. Does placing the appellant on the relevant barred list strike a fair balance between the rights of the individual and the interests of the community?

92. Ms Anderson argued that now and in the future, the Appellant poses no risk to children and/or vulnerable adults. This being the case, vulnerable adults and children do not need protecting from the appellant and barring her is more than is necessary to accomplish that aim.

93. She submitted that placing the Appellant on the barred lists does not strike a fair balance between her rights and the interests of the community. In considering this point, the following circumstances are relevant:

A. The facts as asserted by the Appellant.

B. The lack of risk of repetition.

C. The appellant was acquitted following Crown Court trial.

D. HZ is of good character.

E. HZ is an experienced and highly qualified individual over 20 years' experience as a nurse. She has sought out additional training and qualifications improve her own performance and the performance of her colleagues. For example, she wishes to complete a masters' level psychological well-being course.

F. She has provided a large number of certificates showing recent training and CPD that she has completed, including in dols, designated safeguarding Adults lead level 3, and preventing falls [442-456, 628-633] and also a log of Articles that she has read in furtherance of her own professional development [634-641].

G. HZ has provided various testimonials which describe her compassion, good clinical sense, empathetic and warm bedside manner, strong leadership ability and professionalism:

i. MC, transfusion specialist nurse [642-645]
ii. CF, a registered nurse [646-648]
iii. JP, a HCA [649-650]
iv. SO [919]

H. Including the Appellant on the ABL and CBL has a profound and disproportionate effect upon her because it prevents her from following not only her career of choice, at which she had previously been successful, but also precludes her from working in many other jobs for which employers require DBS checks even though they do not constitute regulated activity for the purposes of the Act. This has had a very significant financial impact upon the Appellant.

I. HZ is currently subject to NMC proceedings. She is currently subject to an interim conditions of practice order (reduced from interim suspension following her Crown Court acquittal), and as such it is submitted that this in itself is a protective measure. The reduction in interim order suggests that the NMC responded positively to the acquittal and view the prima facie risk as reduced. It would be wrong to conclude that because an interim order is in place, that HZ does present a risk. It is important to note that the NMC have not made any findings of fact at this stage; the order made reflects an assessment of the risk when considering the prima facie case whereas these proceedings have moved beyond that.

94. She submitted that given the Appellant's account as to this incident, and given the acquittal in the crown court, the passage of time since this incident, and the various CPD courses she has completed, it would be disproportionate in all the circumstances to bar her.

95. With respect to this ground and for the avoidance of doubt, it is of course accepted that the question of appropriateness falls solely within the remit of the Disclosure and Barring Service. However, the question of proportionality is one which may be considered by the UT and the Appellant does submit that including her on the ABL and CBL as a result of these allegations is neither proportionate nor reasonable, and that the Respondent's decision therefore fell into error.

Mistakes and materiality

96. Ms Anderson submitted that these errors of fact and law go beyond the generous ambit within which reasonable disagreement is possible, and on the basis of the Appellant's account, they are plainly wrong, and the DBS was not entitled to make those findings on the Balance of probabilities. They therefore constitute mistakes for the purposes of *DBS v JHB* [2023] EWCA Civ 982.

97. She submitted that the errors described above were material to the decision.

Facts Found

Evidence received and approach to evidence

98. The DBS relied on written evidence from witnesses, notes of the incident or reports of meetings and the disciplinary investigation and outcome contained in the bundle of evidence it filed and served which contained 950 pages. The bundle included all the material relied upon by the DBS in making the Decision and in defending the appeal as well as all of the material provided by the Appellant.

99. The evidence relied on by the DBS included: that from the Appellant's former colleagues working on the night and day shifts on 29-30 January 2023; internal disciplinary, fact-finding and dismissal meetings; investigation reports and appeal proceedings conducted by managers on behalf of the NHS Trust; emails notes of what witnesses and HZ had said; correspondence; and other material.

100. As we note below, none of the witnesses relied on by the DBS made formal witness statements containing statements of truth, nor gave oral evidence nor were cross examined in these proceedings (although some of them gave evidence in the Crown Court proceedings and we have transcripts of evidence of EK, LN, JC, SC, DC B, and SB). Their evidence before us was made up of written reports from internal investigations and meeting, notes or correspondence and therefore contained untested hearsay. This is a matter to take into account when considering its reliability and the weight it is to be given.

101. The Appellant relied upon: her own witness statement; her contemporaneous accounts given in correspondence and during disciplinary proceedings with her employer; the Crown Court transcripts of evidence given by her and other witnesses; representations sent to the DBS; and oral evidence given to the Tribunal by the Appellant and ABT. In contrast to the DBS witnesses, the Appellant gave oral evidence and was cross examined in these proceedings, as was witness ABT. When considering its weight, we take into account that the Appellant's evidence was tested in these proceedings.

102. We have examined all the evidence in the case with care, both that which was before the DBS and that provided by the Appellant as part of her appeal (much of which was not available to the DBS at the time it made its Decision). We have not found it necessary to refer to every document. It goes without saying that all subsequent written and oral evidence of the Appellant was not available to the DBS when making its Decision.

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

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

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

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

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

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

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

Appellant's evidence

107. HZ was one of the two witnesses from whom we heard oral evidence. We found her to be a witness whose evidence was reliable on peripheral matters but not as far as her evidence on the core allegation of restraining patient X.

108. We do not accept HZ's written or evidence that she did not restrict patient X in the manner alleged. We reject her key denial as being unreliable on the balance of probabilities. This is for the reasons set out below.

The email enquiry

109. We begin by setting out the email that HZ's manager and medical matron, SC, sent to her on the evening of the incident, 30 January 2023 at 18.44:

> "Dear [HZ],
>
> Possible restraint of patient on the shift of 29/01/23
>
> I was contacted today by the ward manager of S[] ward who informed me the a patient in side room 23 was found by the day staff in a blanket, tied to the bedrails.
>
> As discussed by telephone today, I have raised this incident with the Director of Nursing and our Safeguarding lead. A safeguarding referral has been made about the incident. There will be a Trust investigation. During this time you cannot remain in a clinical role or remain unsupervised on night shifts. C[] will liaise with you to provide a Mon - Fri rota, along with non-clinical responsibilities.

We will write to you with further details of the investigation. As discussed this morning, please provide a statement of this incident to me at your earliest convenience. If you require additional support, please contact me. Many thanks"

The contemporary account from HZ

110. HZ provided an initial response to the email which is undated but according to the disciplinary notes was sent on 2 February 2023 [290-291/396]. HZ provided her first written account in response to this email titled 'An Account of my night shift on the 29th of January'. It is her most contemporaneous written account relating to the incident. Within the statement HZ said the following:

"I was allocated to look after side room patients, who comprised of an end-of-life patient, one unwell patient, two confused patients and others who were stable. At handover the day nurse indicated the need to start IV fluids for a patient who was inside SR23, as soon as the family leave.

Before the daughter left, she asked me to administer the fluids as she wanted to make sure her mum was receiving this treatment before she went home. I adhered to the daughters request and started the administration of the fluids. As I was connecting the fluids to the patient the patient's daughter stated she was concerned about her mother who she thought was hallucinating, and that she wanted to speak to the doctor about the matter the following day. I reassured her, then she left to go home.

Upon doing observations I noticed the patient was desaturating. I reconnected her back onto the oxygen which she had been persistently taking off during the shift. At this point the nurse in charge had also come to see the patient and reconnect her back to the oxygen, she suggested the close monitoring of the patient, in a bay with other patients but it was impossible to follow this through because the patient was infectious. I could check on my other patients since we all decided to work as a team through the night.

When I left to go and help insert cannulas of two patients whom the day team had failed, the nurses and the health care assistants working with me checked on the patient and helped reposition her. When attended to the patient in the morning to assess the saturation, she was still persistent in removing the oxygen, which I suspected caused her to become more restless. I stayed with the patient after sitting her up with the aid of the health care assistant I was working with. The saturation raised to the required range, so I reassured the patient, but she seemed more confused than the previous night.

I left her to go attend to a patient who was deteriorating, I called the on-call doctor who promised to come after MET call. I also decided to call the next of kin and inform her on her mother's condition. The next of kin told me that her mother was on R [Ward] not S [Ward] and thought I was discussing a wrong patient. I apologised consistently for her not being informed when her mother was moved. She asked a lot of questions about her mother's condition in an upset frantic manner, but later calmed down and was thankful that I informed her about her mother's condition. She stated that she would visit the next the day.

I immediately went back to check the patient in SR23 who had pulled out her cannula and was bleeding from the site. At the same time, she had taken her oxygen off and was desaturating again. Unfortunately, everyone was busy at that time on the ward. The NA working with told me she had to go and finish back rounds on the bay and I also had other patients to change and reposition. Those who were doubles. The NA

[nursing assistant]'s finished rounds at almost 7:00AM at handover time, the Nurses were also busy. I was under pressure at this point with all that was happening at that time, I could only imagine the horror that could occur such as the patient getting hypoxic and falling from the bed. The patient was elderly and looked very frail even though the daughter said she was fully independent before admission.

The daughter of the patient in SR23 appeared to have high hopes that her mother would return to her baseline. Assessing the condition of the patient, with how confused she was and the incidents that kept occurring it was more important to keep her safe. I could not get bloods from her or even think of inserting another cannula because she would not comply. Before I left the patients room to go and check the other patients, and administer their antibiotics, I tried to secure the patient, to keep her safe and prevent her from pulling off her oxygen.

During the night when the patient removed her oxygen the tubing managed to go around her neck, so I was afraid of this event repeating itself. I have never used the method of restriction before to keep a patient safe, but I was put in a dire situation where I got overly worried of the patient harming herself. The other 3 bays also had confused patients who needed close monitoring so it was difficult for anyone to help me at that point.

It is very unfortunate that I find myself in this situation at a time that I am supporting a colleague whose place of work is being sued after a patient fell on her shift and broke a hip then later died of hospital acquired pneumonia. Another friend has just been to court to answer for an incident that took place on her shift where the patient fell, and the family held her responsible for the death which occurred several months later.

I sincerely apologise for the incident which took place. I did not mean any harm to the patient but for her to be safe throughout my shift. When I finished attending to the other patients it was already well after 7AM, with day nurses waiting for side room hand over. I left the ward when it was 07:40 hours. I always advocate not only to look after my patients when working but all patients on the ward. That is why I had to go and insert the cannulas for the patients in the other bays, which were left from the day and the site manager failed to insert."
[emphasis added]

Evidence given to the Upper Tribunal

111. The contents of HZ's witness statement dated 10 October 2025 stated relevantly as follows:

"Account of Events
26. I was working a bank shift on 29th January night shift. Any employee of the Trust can sign up for bank shifts. You can book yourself on the system or can be called on to work when there are staff shortages. This could be in your own ward, or on other wards.

27. I was working on S[] ward, but I normally work on M[] ward which is where I had been assigned since 2018.

28. S[] Ward cares for primarily elderly patients who could have a range of general medical needs. There were three bays on the ward. I think there were around 25 patients.

29. At the start of the Shift, I was assigned a total of six patients, all of whom were in single side rooms. This meant that I could not see all patients in one glance and would instead need to go from room to room to check on them.

30. There were four nurses working on this shift, the Nurse-in-Charge (NIC) who was a permanent member of the team in S[] Ward, another bank staff nurse, an agency staff nurse and me. In addition to this there were three health care assistants (HCAs) on shift whose duty was to look after each of the three bays on the wards.

31. I was not assigned a HCA to assist me with caring for the patients in the side rooms. Instead, it was said by the NIC that it was normal ward allocation to have three healthcare assistants allocated to the bays who would also have two patients each from the side rooms to look after.

32. As a fall prevention measure, the ward practised “bay tagging” where a staff member
would be present at all times to watch over patients at high risk. This made it difficult for HCAs to be available to support patients in the side rooms as they were allocated to patients at high risk of falling in each of the bays (1-3). The side rooms did not have bay tagging.

33. At the start of my shift, I received a handover from the day staff nurse. I was told that in side room 23 (‘SR23’) was a confused patient, with influenza (‘Patient X’). Patient X was still in SR23 as the Infection Control Team (ICT) had not given her the ‘all clear’. She required the ‘all clear’, before she was placed on the main ward to avoid any infection of other patients.

34. The day nurse informed me that Patient X had been seen by the doctor earlier that day and had been prescribed intravenous (‘IV’) fluids, but these had not yet been administered. It was indicated to me that this should be administered as soon as the family member with her left.

35. I was concerned to be told that Patient X seemed very confused, I queried why a confused patient was being nursed in a side room but was told that this was due to a delayed assessment from the ICT. The delay being due to the weekend.

36. Following the handover, I recall that I went round to see my patients to ensure I introduced myself and informed them that I would be their nurse for the night. It was at this point that I noticed Patient X’s daughter sitting in the room with her mother. As is my usual style, I went in, introduced myself and had a quick chat with her regarding her mother.

37. Patient X’s daughter asked me to administer the IV fluids, as she wanted to make sure that her mum was receiving this treatment before she went home. I adhered to the daughter's request and started the administration of the IV fluids. During the conversation with Patient X’s daughter, I recall that she told me that she was concerned about her mother whom she thought seemed to be hallucinating and that she wanted to speak to the doctor the following day. I reassured her that since Patient X had already been seen by the doctor that day, I would monitor Patient X and would call the on-call doctor should there be any concerns. I explained that in the meantime, I had to do my initial assessment myself and check her observations to get a clear insight into what was going on. I also expressed that Patient X would be seen the following day during the Monday doctors’ rounds. Patient X’s daughter then left.

38. As recorded in the Chart, I checked on Patient X at 8pm and 10pm. I have recorded that she was mildly confused (recorded as MC) both times.

39. I also did observations on Patient X twice during the Shift. It is difficult to tell from the chart, but they seem to have been recorded at around 22.10 and 6.40am. Observations include checking temperature, heart rate, breathing rate, blood pressure, alertness, and pain levels.

40. Upon doing observations, in the morning of 30th January 2023, I noticed that Patient X was desaturating. Desaturating is the reduction in the percentage of oxygen in the blood. I reconnected her back on to the oxygen (via nasal tube) which she had been persistently taking off during the shift. At that point, I informed the nurse in charge and called the on-call doctor for patient review.

41. My priority with Patient X was to initiate the administration of the prescribed IV fluids, which had been requested by the medical team, and her daughter. I did this at the start of the shift.

42. At the beginning of the shift, I had asked the NIC whether Patient X could be moved to an open bay to ensure that she would be more visibly monitored. The NIC declined the request stating, the same reason that I received at handover, that the ICT had not reassessed her yet. The NIC insisted to me that she would assist with checking and monitoring Patient X to ensure that she would be safe.

43. It was evident pretty quickly that the management of Patient X was going to be quite difficult. I recall that Patient X kept trying to get out of bed and was repeatedly wrapping herself with IV and oxygen tubes. I distinctly recall that on some occasions the oxygen tubing would end up around her neck. It was clear that Patient X would need close monitoring. Between the NIC, the HCA and I, we regularly re-positioned Patient X and ensured that the oxygen and the IV fluids were on throughout the night. I recorded in my notes above about repositioning her, her confusion, that she was restless, that she was kicking, and that she was removing everything around her, including the lines.

44. As well as attending to Patient X, I also gave the required care to all of my other five patients.

45. I noticed at the beginning of my shift that there were bed rails attached to Patient X's bed. I believe at that time; the use of bed rails was in the best interests of Patient X as it was appropriate and proportionate to the falls risk posed. Patient X was at risk of falling out of the bed due to her confusion.

46. There was no HCA allocated to work just on the side rooms throughout the shift neither was I able to place Patient X on a high visibility area within the main ward bays, so I continued with the use of bedrails.

47. I am not trained in restraints. As general nurses, we do not use restraint methods. If faced with challenging patients, we usually get the support of mental health nurses.

48. My understanding is that the bed rails could be classified as a method of restriction. The more confused a patient gets, the higher the risk of using bed rails. The risk is higher as if they decide to climb out of bed, over the rails, then there is more of a risk of falling. If a patient is confused, and is in a side room, then they may need 1:1 care. I did not have the option of 1:1 care for Patient X during the Shift. I decided to leave the bed rails on, because Patient X was so restless, and I wanted to try to prevent her

rolling out of the bed. The patient was being nursed on a bed with bed rails already when I came on shift.

49. Having made that decision to keep the bed rails on, I had to manage with increased frequency of visual observation on Patient X as she was not able to use a nurse call bell and was at risk of falling. I informed the NIC, as I was aware that this could be interpreted as a form of restriction. The use of bed rails was the only restriction I used on Patient X during the Shift.

50. When I attended to Patient X at, in or around, 05:00 on 30th January 2023, I noticed that she had become more restless, very unsettled and seemed more confused. I realised the need to escalate her condition to the doctor on call. I, however, first needed to ensure that I practice effectively and promote safety by checking and recording her vital signs. I recall taking a set of observations, but I did not record them as I knew that they were inaccurate because she was so agitated. I then took another set when she had calmed down, and these are the ones recorded in the Observation Chart. She was desaturating at the time. This result raised my concerns because she was on oxygen, so I immediately called the on-call doctor. The doctor confirmed that they would come to review the patient. I informed the NIC.

51. Immediately after calling the doctor, I called the HCA (EK) and asked her to help me make Patient X more comfortable and sit her up in bed. She helped me and then excused herself as she needed to go and help with the comfort rounds for the other patients that she was looking after in the main bay. I stayed with Patient X until her saturation levels were raised to the required range.

52. I then left Patient X for a short period of time to check on other patients and upon coming back I realised that she had pulled her cannula out. Since the patient had pulled out her cannula, the connection of the tubing from the intravenous fluid bag (which had nearly finished) to the patient was now disconnected.

53. I went back to check Patient X in SR23 who had pulled out her cannula and was bleeding from the site. At the same time, she had taken her oxygen off and was desaturating again. Unfortunately, everyone was busy at that time on the ward. The HCA working with told me she had to go and finish back rounds on the bay, and I also had other patients to change and reposition, including patients who require two people to complete personal care. The HCAs finished rounds at almost 7:00AM (handover time). The Nurses were also busy. I was under pressure at this point with all that was happening at that time, I could only imagine the horror that could occur such as the patient getting hypoxic and falling from the bed. Patient X was elderly and looked very frail even though the daughter said she was fully independent before admission.

54. The daughter of the Patient X in SR23 appeared to have high hopes that her mother would return to her baseline. Assessing the condition of the patient, with how confused she was and the incidents that kept occurring it was more important to keep her safe. I could not get bloods from her or even think of inserting another cannula because she would not comply. My note of this how she was through the morning set out above (entry at 6.40am).

55. Before I left Patient X's room to go and check the other patients, and administer their antibiotics, I tried to make sure I left Patent X in safe position. I wanted to prevent her from pulling off her oxygen. During the night when the patient removed her oxygen the tubing managed to go around her neck, so I was afraid of this event repeating itself. I would not normally use bed rails for this type of patient, but I felt I had no choice to try to keep her safe. I was worried of the patient harming herself. The other three bays

also had confused patients who needed close monitoring, so it was difficult for anyone to help me at that point.

56. At, or around, 06:00 one of my other patients also appeared to be deteriorating ('Patient Z'). I called the on-call doctor again and asked the doctor to attend to the Patient X and Patient Z. The doctor responded but was unable to come straight away due to her attending to a medical emergency, I recall that the doctor promised to come to the ward straight after. I was not with the doctor when they saw Patient X.

57. By this time, it was getting towards handover time to the day shift, and I had some outstanding jobs to complete. I continued with my morning tasks, including administration of specific prescribed medication, changing patients to maintain their dignity and repositioning them as well as checking and recording their vital signs. This was completed in between checks of Patient X.

58. I checked and assessed Patient X's condition again at, or around, 06:30. At this point, I found that she had finally settled and appeared to be asleep. This was the only time that I observed her to be asleep throughout the whole shift. Whilst my note above is timed at 6.40, this related to the morning, as opposed to that specific time. I could have included in the entry that she was sleeping, but I left this out, probably because I was busy, and I was more concerned about ensuring there was a note about her restlessness and removing her cannula.

59. However I recall verbally handing over to the morning nurse that Patient X was asleep and that she had been seen by the doctor. When the on-call doctor came to review the two patients (Patient X and Patient Z) whom I had escalated, I was busy in the side rooms with my other patients' medication due between 06:00 – 06:30. I eventually saw and spoke to the doctor, at, or around, 06:50 when they were updating patient notes at the nurses' station. The note made by the doctor is set out above.

60. The doctor communicated to me the plan for both patients, including that they had no concerns for Patient X. The doctor's only comment in regard to Patient X was that she was asleep and appeared comfortable at that time, her oxygen saturation was within the target range and so was her blood pressure. The doctor would have used the observations from the Observation Chart. I recall that when I mentioned to the doctor the need for Patient X's cannula to be replaced, the doctor said that Patient X did not need more intravenous fluids and so there would be no need to insert another cannula. At this time the previous bag of the fluids, which was almost finished, was still hooked up on a drip stand by Patient X's bedside in her room.

61. As discussed with the on-call doctor, I had made a telephone call to the daughter of Patient Z (the second deteriorating patient) to inform her of the changes in her mother's condition. I confidently did this as I believed that it was in line with the requirements of the NMC Code of Professional Standards (prioritise people, practise effectively and preserve safety). This was a difficult phone call, the daughter raised concerns about her mother having been transferred to S[] Ward from R[] Ward (another ward within the Trust) without her knowledge. Following hearing this I looked at the patient's notes. In order to promote professionalism and trust, I needed to check when and why the patient was moved from R[] to S[Ward to enable me to accurately respond to her questions. I explained the reasoning and the daughter eventually understood. I mistakenly made a record of this in Patient X's notes so it appears at the entry at 06.30 on 30th January 2023 (Exhibit HZ6).

62. The start of the handover to the morning shift was due to commence at 07:00 and so I continued with my morning duties. When it was my turn to hand over my patients,

I did this by physically going into their rooms with the day nurses checking and showing them the charts as routinely done. However, as I was taking the nurse to Patient X's side room, she was called to see a patient who was about to fall in another part of the ward. This nurse therefore asked me to hand over from the bay where she was, so she could keep an eye on the patient at risk of falling. The nurse explained that she had no HCAs allocated to support her, as yet, so she was on her own; I understood the predicament at that time.

63. I recall that this day nurse (Nurse MO) who I was handing over to permanently worked on the S[] Ward. The nurse told me that she knew Patient X and had looked after her several times through that admission. I gave the nurse a full handover about Patient X emphasising her increased confusion, risk of falling, desaturating and the doctor's review.

64. After the handover, I went to the nurse's station where I continued to complete my nursing evaluation before I left to go home at, around 07:40.

65. At, or around, 11:40 on 30 January 2023 I received a call from the Matron.

66. The Matron informed me that Patient X had been found wrapped in bedclothes, with a twisted intravenous line, oxygen tubing and a catheter tube tightly around her body. This did not necessarily surprise me, because of how Patient X had been throughout the Shift, confused, unsettled, moving in the bed a lot, pulling out IV and 02 lines, and twisting them round her.

67. The Matron also informed me that there would be an investigation into the matter because an allegation of improper restraint was made against me. I was totally shocked when she said this to me.

68. I understand that Patient X was found at 8.15am. I did not see the patient as described by the Matron. She was not in that position when I last saw her. At no point during the course of the Shift had I used any materials or medical equipment to restrain Patient X. I left my shift at about 7.40am.

69. Patient X was seen by a doctor at 6.50am. I did not see Patient X after this time. Another colleague completed the Chart at 8am (as set out above). Neither of them reported any sort of restraint.

70. The matron then phoned me later in the afternoon that same day, she asked me to write a statement giving a detailed account of my shift. I put together a statement. In this statement, I referred to using a "method of restriction". When I said this, I was referring to the continued use of bedrails..."

112. HZ gave limited supplementary evidence in chief. HZ was cross examined by Mr Serr for the DBS. The most relevant oral evidence related to her account of the incident. In summary, her evidence was as follows. No one else was assigned to Patient X's sideroom, SR23, other than her and Nursing Assistant EK, on the night shift in question, albeit that supervising nurse UU also had overall responsibility that night. Patient X had been quite confused, tried to leave her bed, had pulled out her canula and oxygen throughout the night. Patient X was a difficult patient who required a high level of care. As Patient X had deteriorated and become more confused in the morning HZ had called the doctor to escalate the issue. The doctor visited patient X, although not in HZ's presence, but spoke to HZ when updating the notes which she did at 6.50am. HZ was not present

when Patient X was discovered at around 8.15am. HZ says she was first contacted at around 11.30am when matron, SC, telephoned her and woke her up from sleep (HZ having finished a night shift). SC said to HZ that the patient had been found wrapped in blankets and tubing of medical devices around her but did not mention about the blanket being tied to the bedrails at the time. HZ was unsurprised because the patient had been twisting and moving during the night and wrapping herself in tubing so that was nothing new and did not surprise her. At this time HZ thought that the patient could have wrapped herself around. When she wrote her first and contemporary written account of the night shift she was doing so because she had been asked to give an account of the shift.

113. HZ explained the meaning of the contemporaneous written account in her witness statement and oral evidence to the Tribunal consistent with her explanation in her initial disciplinary interview, meetings and Crown Court evidence in chief and cross examination. In summary she explained that when she wrote 'I tried to secure the patient…I have never use the method of restriction before to keep a patient safe…' she was referring to using bedrails with a confused patient. She accepted that she would have used bedrails on many occasions with patients but never before with a confused patient – with whom there may be a greater risk because they may try to get out of the bed and face a higher risk of a fall given the bedrails. She accepted that the bedrails were already up for Patient X when she came on shift and that they were only lowered when Patient X was offered care or treatment but otherwise the rails were raised.

114. She had explained this in brief at the conclusion of her written evidence to the Tribunal namely, her witness statement.

ABT's evidence

115. ABT provided a witness statement and gave oral evidence in support of HZ's appeal. She was the chief strategy and transformation officer at the NHS Trust and chaired the disciplinary appeal panel which overturned HZ's dismissal. Her statement includes the following:

> "7…At the appeal I recall that it was found that, on the balance of probabilities, HZ was not in the vicinity of the patient at the time of the alleged harm. This was because HZ had handed over and was no longer on shift.
>
> 8. At the appeal hearing, I recall that evidence was presented of HZ's good practice in the many years prior to the alleged harm and her manager's evidence supported this. Additionally, the daughter of the patient who was alleged to have been harmed by HZ commended HZ's practice and quality of care and this was acknowledged by the Chief Nurse [SC], chair of the appeal panel. HZ also provided good reflection at the hearing.
>
> 9. HZ gave evidence that she had seen and spoken to the patient during her shift. I recall that there was evidence that a doctor had seen the patient before HZ's shift had ended. Disappointingly, a statement from the doctor was not taken, nor was the doctor interviewed as part of the investigation. It is my view, however, that had the doctor witnessed anything untold the doctor would have reported this at the time and raised concerns. No concerns were raised by the doctor. I do not know why the doctor's evidence was not taken.

10. I do not recall the specific details but evidence was available that there were other members of staff around the patient at the time of the alleged harm. I am not aware of statements having been taken from these individuals.

11. The photographs presented at the hearing, I recall, were reenacted and were not of the patient herself. There were no pictures taken of the alleged incident.

12. In my view the decision to dismiss HZ was unfair and it was right to have been overturned and to reinstate her role at the Trust.

13. I recall that other failings in regard to the handling of the investigation were identified when the matter progressed to court, for example, from recollection, the Police were not notified of the appeal outcome…."

116. We are satisfied that ABT was an honest and reliable witness. We were impressed by her and are very grateful that she attended the hearing and gave oral evidence. We accept that criticisms can be made of the evidence available. Nonetheless, we were not able to place great weight on her beliefs and opinions as to whether the quality of the evidence in the case revealed a mistake of fact in the DBS's finding of relevant conduct against HZ. This is because we have to reach our own reasoned conclusion when assessing all the evidence and making findings of fact on the balance of probabilities.

Findings of fact

117. Based upon all the evidence considered above we make a finding of fact that the finding of relevant conduct relied upon by the DBS, and as set out in the Decision, is established on the balance of probabilities:

> On 30/01/2023 whilst employed as a staff nurse at the hospital HZ restricted a patient's movement by tying a blanket across them to the rails of their bed.

118. The Appellant has not established any mistake of fact in relation to the DBS's finding on the balance of probabilities. There is no dispute that it amounts to a finding of relevant conduct as a matter of law (causing a risk of harm ie. physical, emotional or psychological harm to Patient X). In coming to this conclusion we have had regard to the following evidence, facts and reasons.

119. The most plausible and more likely explanation, as we find, is that contained disciplinary findings and in HZ's first and contemporary written account itself.

120. We reject HZ's account, as set out in her written and oral evidence given in disciplinary proceedings, the Crown Court and DBS and in her written and oral evidence to the Tribunal. We find it to be unreliable regarding the key allegation. We accept the DBS's case on the balance of probabilities in light of the evidence, facts and matters detailed above.

121. In essence, we agreed with the DBS that there are three sources of evidence which support its finding of relevant conduct and establish that there was no mistake of fact contained therein:
(1) The common-sense inference to be drawn from the circumstances.

(2) The reaction of HZ initially, orally and in writing.
(3) The initial decision of the employer to dismiss.

The inference to be drawn

122. On 29 January 2023, HZ came on duty on S[] Ward at 7pm. She was assigned to Patient X in sideroom 23 [822-823]. Healthcare assistant EK was assigned to HZ [680].

123. On HZ's account, patient X was difficult to manage. She was restless and prone to remove her cannula [585-588, para 50-54].

124. HZ requested that EK assist her just before 6am with Patient X, specifically to help HZ in repositioning patient X as she had moved her oxygen tubing [680-684/281/318/925].

125. The difficulty with handling Patient X is also evidenced in the notes made by HZ (the judge in the Crown Court observed that the notes were "a shambles"- [926], including a reference to a wholly different patient appearing in X's notes at [615] - see [588]):

"1.30am appears to be at risk of falls" [605].
"0600 pulled cannula out" [617].
"6.40am Appears very restless this morning. Pulled out cannula. Unable to place another one as she is kicking and removing everything around her, including lines Reassured"-
[605-606].

126. HZ had called the on-call doctor as she was concerned about X. The doctor did visit X but not in the presence of HZ. This was around 6.30am and the doctor's note is timed at 6.50am [615]. It is reasonable to assume that X was not restrained when visited by the doctor at or around 6.50am. She is discovered around about 8.15am at the latest by the day staff (there is some debate around this precise time) who found her to be severely restrained ("like a cocoon") [543/659/711/723].

127. JC said "her arms had been tied to the head end and foot end, and she had been – or was wrapped in like a cocoon in a sheet, with the oxygen tubing and the catheter wrapped around the shoulder and the leg" [723] and "she had sheets and blankets tied to her wrists, tied to the bed, and then there was a blanket that was around her, like a cocoon" [735].

128. It cannot be reasonably inferred that Patient X could have restrained herself in this way either deliberately or accidentally when wriggling or flailing around a bed. The patient was in a frail state and it would have been physically almost impossible for anybody to tie themselves up in the fashion in which she was found. This was the view of SB the expert called in the criminal proceedings [813 and 817]:

"I think when seen to this extent, where the tying of the bedclothes are, certainly this is restraint beyond restriction for her own good, the restriction I would see as the oxygen tubing and the IV tubing that clearly restricts anybody, in terms of unless it's on a mobile basis. This I see as being restraint, to clarify."

129. Therefore, the question is who else could it have been if not HZ that restrained Patient X. It was HZ who was charged with her care. It was HZ who had recorded that she was restless, who had been forced to address her positioning on a number of occasions and who had asked for help from EK with her positioning and her cannula. There is no evidence at all that anyone else interacted with X after approximately 6.50am until she was discovered [273].

130. It is fair to record that others had potential access to X (there were 7 people on duty in total on the night shift, including HZ-[278] and there is no record of the total number of staff on the dayshift). However, the window of time when X must have been restrained was narrow and only EK and UU had appeared to provide any care to X at all other than HZ during the night shift that ended at 7.30am [278-279]. EK and UU had no cause at all to restrain her. So far as it is suggested that it was some unnamed member of the day staff who restrained X after 7.30am, again this is very unlikely. It was the day staff in the form of JP, JC, LN and the ward manager that found her and tried to release her from the restraint sometime around 8.15am [927-929]. It is very unlikely that another member of day staff would have restrained patient X shortly after starting their shift.

131. The possibility of another health care worker restraining X may have led to HZ's acquittal or the jury may not have been satisfied on the criminal standard of proof that HZ knowingly or recklessly ill-treated Patient X. Nonetheless, on the balance of probabilities the Tribunal finds that it was more likely than not HZ who restrained X as alleged.

The Initial reaction of HZ

132. HZ was telephoned by the Matron, SC, at 11.39am that morning. SC told HZ that X had been found tied to a bed. We accept that HZ was being woken from sleep after a long night shift but HZ's reaction was of some weight - we accept that she did not appear shocked or surprised and did not deny knowing anything about it as would be expected – [893/933]. Further we accept on the balance of probabilities that HZ stated "she had been trying to save the cannula for medication"[934].

133. Irrespective of our findings as to the phonecall that HZ had with SC, HZ was requested to provide a statement by the Matron on 30/1/23. The request is detailed in the email above at 18.44 [39]. It states "I was contacted today by the ward manager of [S] ward who informed me the [sic] a patient in side room 23 was found by the day staff in a blanket, tied to the bedrails".

134. HZ was cross-examined extensively on her first written account of 2 February 2023 in the criminal trial – [894-904] and in the hearing before us. The key passage from her account is underlined above and repeated as follows:

> "Before I left the patients room to go and check the other patients, and administer their antibiotics, I tried to secure the patient, to keep her safe and prevent her from pulling off her oxygen.
>
> During the night when the patient removed her oxygen the tubing managed to go around her neck, so I was afraid of this event repeating itself. I have never used the method of restriction before to keep a patient safe, but I was put in a dire situation where I got overly worried of the patient harming herself. The other 3 bays also had confused patients who needed close monitoring so it was difficult for anyone to help me at that point."
>
> .

135. We are satisfied that this voluntary account given by HZ, and written proximate to the incident, without the input of professional advice, represents the facts on the balance of probabilities. The account can only reasonably be read in context as an admission to the restraint of Patient X. HZ's assertion that the account refers to the use of bedrails on a confused patient, as given multiple times and set out above, is very unlikely - [901/903]. This is for the following reasons.

136. HZ's explanation that in her account she was referring to the use of bedrails on a confused patient as the method of restriction or restraint is very unlikely. The written account set out in full above, provides a full and substantial apology, it is written in response to a direct allegation contained in SC's email of HZ being suspended from duty on the basis of patient X being wrapped in a blanket tied to bedrails. HZ's gives a motivation (however understandable but misguided) for why she acted as she did – under pressure of other demanding patients and work at the time. It gives the timing window for the incident at around the handover from night to day staff shifts – from 7am -7.40am. The written account makes no mention of using bedrails. It does not explain how or why use of bed rails would prevent the patient from pulling off her oxygen (bedrails would only reduce the chance of a patient getting out of bed but would not prevent the patient pulling out the cannula nor the oxygen as to do so would not require the patient getting out of bed. Patient X had been pulling the oxygen and cannula out while remaining in bed). In contrast, the method of restraint that Patient X was subjected to would have prevented her pulling out her oxygen.

137. The Appellant's explanation does not explain how use of bedrails would prevent oxygen tubes from going around her neck because this could be done while the patient remained in the bed. In contrast the restraint used would prevent the patient having access to her hands to do so. HZ's explanation, only given after she had received trade union advice, does not explain why her account says 'I tried to secure the patient'. This implies she took active steps – rather than passively keeping up bedrails that were already in place. Her account that, 'I have never used that method of restriction before' implies more likely than not that this was an unusual thing to occur rather than the use of bedrails which HZ accepted in oral evidence that she regularly used. The explanation that it was bedrails for a confused patient that made this a unique occurrence is therefore highly unlikely. A reasonable reader of the written account, when read as a whole and in the context of the email sent to which it replied, would come to the conclusion on the balance of probabilities that HZ was accepting she had wrapped Patient A in a blanket which she had tied to the bedrails.

The Initial Decision of the Employer to Dismiss

138. The dismissal letter dated 5 July 2023 comprehensively sets out the evidence and conclusions [407-408]. The reasons for dismissal and the findings contained within it are rational and sensible. The reasoning and findings analysed the evidence then available to the NHS Trust. This reasoning has not been undermined by the further evidence that we have received on this appeal. It is worth setting out in full because we agree with it:

> "• That you were responsible for the patient care of patient X on bed 23 [S] Ward from 19:30 Sunday 29th January 2023 to 07:30 Monday 30th January 2023 'the night shift'.
> • Healthcare assistant EK supported you with the physical care of the patient twice during 'the night shift' and also completed rounding checks at 00:00, 02:00, 04:00 and 06:00.
> • Nurse UU (NIC) provided intermittent support during 'the night shift' to patient X in regard to replacing oxygen nasal specs.
> • All other registered nurses and HCA staff on duty on S[] Ward either did not provide care to or were not responsible for patient X during 'the night shift'.
> • The patient records show that you completed a Care Plan Evaluation at 01:30 (30/01/23) where you highlighted that Patient X "appears to be at risk of falls" and "verbally communicates. Appears confused". No action is documented as a result of these observations. However, you documented that the patient was "repositioned in bed", "incontinence care given", "ongoing IV fluids" and "fully assisted with personal care".
> • Your training record shows you were up-to-date with Falls Champions Study Day 19/10/22, Mental Capacity Act Training 26/04/22, Moving and Handling Training level
> 2 20/04/22 and Safeguarding Adults level 2 07/04/22.
> • The patient record shows that at 06:00 you document that patient X "appears very restless this morning. Pulled out cannula. Unable to place another one as she is kicking and removing everything around her including lines".
> • The patient record shows that you called a doctor at 06:40 because you were concerned for the patient.
> • Doctor ZK reviewed the patient at 6:50 and was not concerned, as they considered the patient to be stable and they did not recall anything other than what they had documented in the notes.
> • St[] stated that he queried with Senior Sister SJ who would have responsibility for a patient at the start of and end of a shift and was informed that night staff have responsibility until the end of the paid shift at 07:30 or when full handover is taken from the nurse taking over the patients.
> • You stated that you handed over patient X to Nurse MO at 07:00 and then wrote notes until you left the ward at 07:40. MO stated that during handover, as she had been walking over to bed 23, she had been called away to assist with a patient that was trying to climb out of bed and therefore she did not complete the handover or see the patient prior to being notified of concerns that the patient had been found restrained.
> • JP stated she discovered the patient at approximately 8:15 and alerted JC. JC recalls being alerted around 07:45-08:00. It was raised that there is a discrepancy in the time reported by these two witnesses. St[] was questioned in

relation to this and rationalised that JC's recollection of timing may differ, as she gave an approximate timing using a reference point based on when JP usually started shift and how soon after she had called JC after she had commenced her shift (approx. 10 minutes). JP confirmed she started shift at 8am on the date in question and therefore 8:15 was the more reliable time to consider that the patient had been discovered by JP and JC was alerted shortly afterwards.

• A timeline of events relating to patient X for 'the night shift' was provided by St[] and this established that the patient would have been restrained after 6:50 (when they were seen by Doctor ZK) and 8:15 (when they were discovered by JC).

• You submitted a statement on 2nd February 2023 that appeared to be admitting to restraint of the patient and set out that your motivation was to prevent patient X from removing their oxygen and from falling. However, when you met St[] for interview on 6th March 2023 you explained that your statement was made under the understanding that the concern was in relation to the use of bed rails and that you were not aware that the concern was in relation to the patient being found tied to the bed by a blanket, with tubing wrapped around them.

• Medical Matron SC stated that she contacted you by telephone at 11:39 on 30th January 2023 and that she told you patient X "had been found by the day staff wrapped in a blanket that was tied to the bed rails" and that you replied 'yes, I was trying to save her cannula for her medication'. SC stated that when she informed you that this was restraint and not acceptable that you went quiet. SC was interviewed twice during the investigation and was clear that she had informed you during the telephone call on 30th January 2023 that the patient had been found in a blanket tied to the bedrails.

• You also stated that you would have not said 'I was trying to save the cannula' to SC and stated that there was no need to 'save the cannula' as there was no further medication required to be given to patient X..

• You raised that at 08:00 the rounding chart for patient X had been completed by MO. St[] put forward that this was not patient contact and instead related to the drug round that would be given anytime between 8am and 10am. St[] sought confirmation on this from MO and she had stated that she had not seen patient X during the shift until she was informed that they had been found restrained.

• Your staff side representative raised on your behalf that you would not have not [sic] attempted to handover patient 23 at the bedside if you had been the one to restrain her. She also asked the panel to consider any reason why you would have restrained the patient at the end of your shift.

• You stated that "It took more than 45minutes for an unwell patient who was handed over to both the NIC and nurse looking after her, to have not been attended, before the patient was discovered by JP at 08:15 hours. Could anyone have gone into the patient's sideroom and restrained the patient?" St[] stated that he had established that Doctor ZK had documented the patient to be stable at 6:50 and that nurse MO had been called to prioritise care to a patient who was at risk from falls during handover at 07:00 and therefore MO had not seen the patient before they were found at 08:15. St[] raised that he had no evidence to suggest that anyone else had an interaction with or motivation to restrain the patient between 6:50 and 8:15."

139. We agree with this analysis of the most contemporary evidence for the reasons given therein which we have also had the opportunity to consider ourselves. None of that evidence or reasoning has been disturbed by the subsequent evidence produced. We adopt this analysis of the evidence as our findings. It also explains why the written note in the rounding chart for the patient stated to be timed at 8am, which stated that patient X was comfortable, could have related to a much later time closer to 10am after the patient had been found restricted and then untied and released.

140. The conclusions were set out at the end of the dismissal letter [409]:

> "I weighed up the evidence and I have upheld allegation 1 on the balance of probabilities that you did restrain the patient through tying a blanket to the bedrails. I carefully considered the timeline of events and your initial statement to SC[], Medical Matron in which you stated "I tried to secure the patient, to keep her safe and prevent her from pulling off her oxygen. During the night when the patient removed her oxygen the tubing managed to go around her neck, so I was afraid of this event repeating itself. I have never used the method of restriction before to keep a patient safe... " I noted that you had later indicated that this statement was made in relation to the use of bed rails. However, as bed rails would not have prevented the patient from pulling off their oxygen and SC[] was interviewed twice and clear that you had been informed verbally that the concern related to the blankets tied to the bedrails on balance I concluded that you were aware at the time of your initial statement that the concern related to the restraint of patient X through the tying of a blanket to the bed rails and that your statement had been made in admittance of this. I considered that it was inconclusive whether the oxygen tubing had become tangled or had also been used as part of the restraint. It is my conclusion that at the time that you made your statement that you did not recognise that tying the blanket was wrong or constituted restraint and had done so in an attempt to prevent the patient from removing their oxygen and from falling whilst you completed paperwork. However, when you were informed that your actions constituted restraint and that this was a serious concern that would be formally investigated by the Trust and the Police you changed your version of events. This also raises concern with your honesty and integrity."

141. Again, we agree with the analysis, reasoning and conclusions reached. We adopt them as our findings. The initial findings of the employer that led to HZ's dismissal were cogent following a reasonably thorough disciplinary investigation. It also explains that HZ did not understand that what she had done was so serious at the time – hence she initially made the admission and then retracted it when she realised how seriously it was being treated. It explains HZ's motive for engaging in the relevant conduct at the end of a long shift.

142. We find the appeal findings reached by ABT and the Chief Nurse to be less persuasive-[619-623]. They appear to apply a very high standard of proof, rely on the less likely supposition that someone else could have tied up the patient and raise the unfair criticism that Patient X was not interviewed/photographed when she was elderly and extremely frail, may well have lacked capacity and died shortly afterwards.

143. We should also note that we are sorry to have to make these findings. There is much that can be said in mitigation of HZ's conduct and we set out the mitigating factors when considering proportionality below.

Discussion and Analysis

144. We begin by addressing the grounds of appeal on which the Appellant was granted permission to appeal before addressing the submissions as grounds of appeal pursued at the hearing.

Ground 1: Mistake of Fact

145. We do not find there to be any mistake of fact in the DBS's finding of relevant conduct for the reasons set out above in our fact finding. We dismiss this ground of appeal.

Ground 2 – error of law: making the decision prior to the outcome of criminal proceedings

146. We are not satisfied that the DBS fell into material errors of law by refusing to wait for the outcome of the criminal proceedings and therefore was not in possession of all relevant material when making its findings of fact. The refusal to await the criminal verdict and the decision to make its findings on the evidence it had before it was not irrational in the circumstances.

147. The DBS considered all the information provided by HZ in the disciplinary proceedings as well as barring process. It was entitled to proceed to make a barring decision prior to the criminal proceedings accords with the statutory scheme as explained in *XYZ v DBS*– there was no statutory bar on the DBS doing so in principle and it was not an irrational exercise of discretion in this case. To the contrary, there was a statutory justification and public interest in the circumstances of this case– the need for urgent protection and safeguarding of vulnerable groups which required the DBS to consider whether it could or should await the criminal proceedings.

148. The DBS was entitled to take into account that criminal proceedings would not be determinative of the barring decision – as they operate on a different standard of proof. An acquittal would not mean that the finding of relevant conduct on the balance of probabilities would be wrong as a matter of fact or law. Further the criminal offence with which HZ was charged is not coterminous with the finding of relevant conduct – the former would require a conclusion on HZ's level of intent or mental state (mens rea) – the offence requires a person's knowledge or recklessness as to the ill treatment they have committed - a finding of relevant conduct does not require the same ingredients – it only requires that a person harms or causes a risk of harm to a vulnerable adult.

149. Likewise, although applying the same standard of proof, NMC fitness to practise proceedings may relate to different charges or allegations of misconduct, may take substantially longer to conclude and any sanctions would only relate to

nursing rather than regulated activity generally. The Appellant accepts it was not a mistake of law to proceed to make a barring decision prior to NMC proceedings concluding in this case (indeed it has not sought to adjourn this appeal pending their conclusion). There is a statutory justification and purpose for doing so – see *XYZ* – and the DBS exercised its discretion rationally in this case.

150. Therefore the DBS was entitled to reject the representations made on behalf of the registrant on 22 July 2024 [441] by the RCN who invited the DBS to 'pause its final decision to await the outcome of the ongoing Criminal and NMC fitness to practise proceedings.' The final decision letter [461] deals with this invitation briefly but rationally, as follows:

'we remain satisfied a barring decision is appropriate. This is because whilst the DBS appreciate that you are currently subject to criminal prosecution and an NMC investigation, we are unable to defer our decision indefinitely. The DBS has a duty to safeguard children and vulnerable adults and any decision made is independent of that made by the NMC and the courts'.

151. This was a rational exercise of its discretion to proceed to make a barring determination (particularly given that the DBS can revisit its decision on review, under paragraph 18 or 18A of Schedule 3, following a change of circumstances such as the outcomes and evidence in other sets of proceedings). There was no error of law in the DBS proceedings to make a barring decision when it did. This ground of appeal is dismissed.

Mistakes of Law - Ground 3 – error of law: failure to take matters into account

152. The DBS was reasonably entitled to find the allegation proved on the balance of probabilities notwithstanding the Appellant's representations given the evidence, facts and matters set out above. It considered the matters raised before it at the time such as the gaps in the evidence and representations made on behalf of the Appellant (see its final decision letter and BDP summary document). It considered both the disciplinary appeal findings reversing the Appellant's decisions and the representations from the RCN and the Appellant's lawyers. It rejected them as providing a reason to undermine its finding of relevant conduct on the balance of probabilities for the reasons given in the final decision and the BDP document. It made no error of law.

153. In any event, any error could not be material. The Tribunal has had the opportunity to consider all the evidence in this case – not simply that available to the DBS, the Crown Court or the disciplinary proceedings. That material has all been considered and we have decided there was no mistake of fact in the DBS's finding of relevant conduct. This ground of appeal is dismissed.

Other errors of law – Ground 4 rationality and proportionality

154. We do not accept that there is any mistake of law based upon the barring decision being disproportionate nor irrational. We find that the Decision was proportionate and rational.

Rationality

155. When reaching its decision, the DBS relied on a risk assessment that HZ may repeat her behaviour if she were allowed to work with vulnerable adults again in the future in circumstances where she had not fully acknowledged her harmful behaviour. In this regard the DBS noted that the circumstances in which HZ's behaviour occurred are not uncommon in regulated activity:

> "…The likelihood of you repeating your behaviour is therefore considered high, given you
> acted contrary to your training and experience. The potential level of harm, if you repeated
> your behaviour, is significant and the DBS is satisfied your behaviour indicates the need to
> retain the preventative mechanism in order to protect vulnerable adults.
>
> In consideration of the Children's Barred List, concerns are that if you were faced with
> similar situations in the future, whereby you were responsible for the care and wellbeing of children, that you would disregard your training and neglect their welfare needs by placing your own needs first, behaviour which will always endanger a child. The DBS is satisfied it's also appropriate to retain your name on the Children's Barred List."

156. The DBS was entitled to conclude that such a person may pose an ongoing risk to vulnerable adults in regulated activity. This cannot be described as being irrational or in defiance of logic, let alone to such a degree that no sensible person who had applied their mind to the question could have arrived at the same conclusion.

157. Irrationality was described by Lord Diplock in *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, [1984] 3 All ER 935 at [410] as follows:

> "By "irrationality" I mean what can by now be succinctly referred to as "Wednesbury unreasonableness". … It applies to a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it."

158. We are satisfied that the DBS risk assessment was not irrational – particularly in circumstances where HZ has continued to deny her conduct. Thus, she has demonstrated no insight or attempt to remediate the risk she poses. Since HZ continues to deny/minimise her actions, it follows that she cannot have fully reflected on or sought to address what drove that behaviour.

159. Whilst the DBS's requirement to bar was engaged under paragraphs 3 and 9 of Schedule 3 of the Act irrespective of whether HZ was regarded as posing an ongoing risk, the DBS was entitled to conclude that someone who responded to the challenging behaviour of a vulnerable adult by restraining them unlawfully posed an ongoing risk, particularly once regard was had to HZ's continuing denial/minimisation of her actions.

160. Even leaving aside the fact that unless a decision of the DBS is legally or factually flawed, the assessment of (and, by extension, the extent of) the risk presented by a person is a matter for the DBS (per Lewis LJ at [43] of *AB*), the DBS's analysis is rational in light of HZ's continued denial of what amounted to an unlawful restraint upon a vulnerable adult. We have found her denial to be unreliable and have rejected her explanation as set out above. This means that the DBS made no mistake of fact or law in finding there a likelihood / high risk of a repeat of the conduct.

161. The same applies to the DBS's assessment of risk of transferability to children.

162. HZ's behaviour amounts to relevant conduct for the purposes of the Act and the DBS having regard to relevant conduct per se cannot be irrational.

Proportionality

163. In carrying out its assessment of proportionality the Upper Tribunal is not undertaking a rationality assessment of the DBS's decision proportionality but making our own assessment. We are not concerned with the process followed by the DBS in assessing proportionality but makes the assessment afresh for itself (*KS* at para. 50).

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

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

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

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

> … the question [of proportionality] depends on an exacting analysis of the factual case advanced in defence of the measure, in order to determine (i) whether its objective is sufficiently important to justify the

limitation of a fundamental right; (ii) whether it is rationally connected to the objective; (iii) whether a less intrusive measure could have been used; and (iv) whether, having regard to these matters and to the severity of the consequences, a fair balance has been struck between the rights of the individual and the interests of the community.

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

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

169. On the basis of the finding that the DBS made and we have upheld, we are satisfied that it was proportionate and reasonably necessary to bar HZ from regulated activity with vulnerable adults in order to achieve the public interest in the (important and) legitimate safeguarding aim.

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

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

172. The DBS was entitled to disregard suspension of HZ from nursing by the NMC as providing sufficient safeguard as: a) it only applied to nursing and not all regulated activity; and b) it was temporary in nature – an interim measure pending the outcome of proceedings. Likewise, the DBS would have been entitled not to rely on the NMC's current interim conditions of practice order as not being sufficient protection to safeguard vulnerable groups. It is unknown how long the order will be in place for and what the outcome of NMC proceedings will be.

173. In so far as striking a fair balance is concerned, the question is whether, balancing the severity of the effects of barring on the rights of the Appellant against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter. In circumstances where the objective of the barring decision is the protection of vulnerable adults, there are other sectors in which HZ can work and no other effects of barring (accepting that

there are serious effects upon her of the loss of her ability to work in nursing or other regulated activity) are raised, the effect of barring on the rights of the Appellant does not outweigh the objective of the barring decision in this case.

174. We consider the barring Decision to include HZ on the ABL to be proportionate because it strikes a fair balance bearing in mind the following aggravating and mitigating factors:

Mitigating

a) We accept the mitigating matters set out above in the Appellant's submissions as to the impact of barring upon HZ and do not repeat them.
b) HZ previously had an unblemished record in the care sector which she had worked in for 18 years. She had a number of positive character references and testimonials.
c) Patient X was confused, restless, prone to pull out her cannula and oxygen and difficult to handle.
d) It happened at the end of a long (12-hr) night shift, and the incident occurred when HZ was under pressure of work with many difficult patients to handle and few staff to assist her.
e) Despite this, HZ did not intend to cause patient X harm even if she acted carelessly and without lawful justification by restraining her in this fashion.
f) HZ was genuinely doing what she thought would assist and secure Patient X and prevent her from taking out her canula or oxygen and deteriorating.
g) There is no evidence of actual harm caused to the patient although there was an obvious and significant risk of harm being caused by restraining Patient X in this manner.
h) HZ did not understand at the time that what she was doing was wrong (although this is also aggravating because it demonstrates a lack of requisite professional knowledge and insight).
i) There is a significant impact of barring being the loss of her ability to practice as a nurse since July 2024 which will continue as a result of the barring being upheld (irrespective of the outcome of NMC proceedings). There is a loss of employment and her longstanding profession as well as a significant financial impact (although there was no evidence that HZ cannot obtain a similarly paid employment outside of regulated activity.
j) HZ has lived with the stress of the four sets of somewhat overlapping proceedings relating to the incident taking place over three years since January 2023; the employer's disciplinary proceedings (in which she was ultimately vindicated on appeal); the criminal proceedings (in which she was also vindicated in acquittal at the Crown Court); the NMC proceedings (which are ongoing); and these barring proceedings in which she has been unsuccessful. These longstanding and multiple proceedings together represent a very serious set of sanctions and will undoubtedly have had a significant financial and emotional impact upon HZ. The stress placed upon her must be very significant.

Aggravating

a) She was trained in the use of restraint / restriction and deprivation of liberty. HZ was under a duty not to deprive liberty unlawfully by using an unauthorised restraint method. She failed to take reasonable care at the very least.
b) HZ caused a risk of harm to a very vulnerable patient who died two days later (although there is absolutely no suggestion that anything HZ did caused or hastened that death or that the patient was caused actual harm by HZ).
c) The use of this method of restraint was a serious error that could have given rise to a real risk of serious harm to patient X as well as a loss of dignity.
d) We have upheld the DBS finding that HZ disregarded the welfare of a patient, failed to treat her with dignity and respect and placed her own needs first. HZ therefore placed the patient at risk of being emotionally and physically harmed.
e) HZ did not give a reliable account either to her employer, the DBS or the Tribunal regarding the incident. She has consistently continued to rely on denials over a long period of time which we have rejected.
f) The DBS was rationally entitled to make the risk assessment as to future harm that HZ posed – this was a rational evaluation based on the lack of recent training and in light of the Tribunal's own assessment of HZ's lack insight, reflection or subsequent remediation or training.

175. We are therefore satisfied that barring was necessary and struck a fair balance between HZ's right to a private life and the public interest in safeguarding. The DBS expressly carried out the "balancing act" exercise required. Based on the findings, and in light of all the evidence now received, we are satisfied afresh for ourselves that the barring decision strikes a fair balance, notwithstanding the impact that it has had and will have upon the Appellant.

176. We also take into account all the mitigating factors set out above. We have a significant level of sympathy for the circumstances in which HZ finds herself. We recognise and understand the pressures placed upon HZ throughout her employment, the stressful nature of the barring proceedings and appeal and the impact upon her of barring. We know that this decision will come as a very serious disappointment to her

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177. We have accepted above the DBS's reasoning in its decision letter that if HZ's conduct were repeated in relation to a child it would endanger that child (harm a child or put a child at risk of harm) – see paragraphs 4(1)(b) and 4(2)(a)/(b) of Schedule 3 to the Act. Therefore it would be lawful for the DBS to conclude that HZ could be included in the CBL on the basis of committing relevant conduct for the purpose of paragraph 3(3)(a). The risk of harm being transferrable from child to adult or vice versa is sometimes called the transferability argument. There was therefore no mistake in its reasoning in the decision letter:

> "In consideration of the Children's Barred List, concerns are that if you were faced with similar situations in the future, whereby you were responsible for the care and wellbeing of children, that you would disregard your training and neglect their welfare needs by placing your own needs first, behaviour which will always endanger a child. The DBS is satisfied it's also appropriate to retain your name on the Children's Barred List."

178. We would also have found that it was proportionate to include her on the CBL on the same basis we have explained in relation to the ABL above.

179. However, it is important to distinguish these conclusions from the prior statutory requirement that in order for HZ to be included on the CBL, the DBS must have 'reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to children' per paragraph 3(3)(aa) of Schedule 3. We accept that this is a low threshold for the DBS to satisfy.

180. In *A v Disclosure and Barring Service* [2025] EWCA Civ 124 (14 February 2025) the Court of Appeal stated at [22]:

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

181. Following this authority, we are satisfied that there was a mistake of fact and law in including HZ on the CBL. This is because the test for regulated activity with children under paragraph 3(3)(aa) of Schedule 3 was not met on the evidence before the DBS and the reasoning it relied upon. There was no reliable evidence relied on by the DBS at the time it made the barring decision or presented to us subsequently that would give the DBS reason to believe that HZ might in the future be engaged in regulated activity with children. The only matter the DBS relied upon was as follows:

> "Whilst you have stated you don't work with children in your role as a nurse, the training certificate's provided show you have completed a course on Child Protection, indicating that you either require this for future nursing roles or that you intend to work/volunteer with children in the future."

182. We are satisfied that this was insufficient evidence from which the DBS could rationally have reason to believe that the Appellant might work in regulated activity with children in the future. This is supported by the DBS's own guidance at paragraph 4.29 where it accepts that obtaining a qualification or undergoing training alone is unlikely to support the assessment that an individual might engage in regulated activity with the other group.

183. We accept the submissions and evidence on behalf of the Appellant that the only evidence relied upon by the DBS was a training course HZ had taken but which was mandatory for her to complete in her job as an adult nurse. We accept HZ's evidence that she had never previously worked with children nor applied to work with them or taken active steps to do so. There is no evidence of her having any paediatric training or skills or experience. We accept her evidence that she had no intent to work with children. We are satisfied there was an error of fact and law in the DBS concluding the test for regulated activity in relation to children was met. We direct removal of HZ from the CBL.

184. That is not to say that the public would not be protected if circumstances changed. If HZ were in future to apply to work in regulated activity with children, a DBS check and certificate would be required and at that point the DBS might have evidence of a desire or intent to work in regulated activity with children. That might trigger a further barring decision to include her on the CBL albeit that would be entirely a matter for the DBS who would have to consider all the material and the relevant statutory tests.

Conclusion

185. The decision of the Upper Tribunal is that the Appellant's appeal against the barring Decision of the DBS dated 16 April 2024 and 29 July 2024 is dismissed in part and allowed in part. There was no mistake of fact or law in the decision to include and retain her on the Adults' Barred List. The decision to include her on that list is confirmed. We find that there was a mistake of fact and law in HZ's inclusion on CBL and direct removal of her from that list.

Judge Rupert Jones
Judge of the Upper Tribunal

Authorised by the Judge for issue on 12 December 2025