Neutral Citation Number: [2025] UKUT 417 (AAC)
Appeal No. UA-2024-001498-V

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

DWH

Appellant

- v -

DISCLOSURE & BARRING SERVICE

Respondent

Before:	**Upper Tribunal Judge Jones** **Member Ms Josephine Heggie** **Member Dr Elizabeth Stuart Cole**
Hearing date:	2 December 2025
Mode of hearing:	By video, CVP
Decision made:	12 December 2025
Representation:	
Appellant:	Ms Jennifer Agyekum of counsel instructed by Wilkin, Chapman & Rollits Solicitors
Respondent:	Mr R Ryan of counsel instructed by DAC Beachcroft LLP for 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 and DBS decision confirmed. There was a mistake of fact and law in his inclusion on the Children's barred list ("CBL"), we allow his appeal in this regard and direct his 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 barring Decision of the DBS dated 22 July 2024 is dismissed in part and allowed in part. There was no mistake of fact or law in the decision to include him on the Adults' Barred List. The decision to include him on that list is confirmed. We find that there was a mistake of fact and law in DWH's inclusion on Children's Barred List and direct removal of him from that list.

REASONS FOR DECISION

Introduction

1. The Appellant (or "DWH") appeals against the decision of the Respondent (the Disclosure and Barring Service or "the DBS") made on 22 July 2024 to include him 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").

2. DWH appealed to the Upper Tribunal ("the UT" or "the Tribunal") on 22 October 2024. The Appellant was granted permission to appeal ("PTA") the Decision by the Tribunal on 19 May 2025 on the eight grounds of appeal set out below.

3. As part of its Decision the DBS made a finding that DWH had committed relevant conduct as defined under the Act, namely that on 9 February 2023 while volunteering on a ward of a hospital he entered the room of a male patient and attempted to look at / make contact with the patient's genitals by unbuttoning his pyjama bottoms before being disturbed by a noise from outside of the patient's room.

4. The Tribunal held a hearing of the appeal against the Decision on 2 December 2025. The Appellant was represented by Ms Agyekum of counsel and the DBS by Mr Ryan of counsel. The Tribunal is grateful to them both for their written and oral submissions.

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

Factual background

6. The DBS filed a 187 page bundle of evidence in relation to the Decision which incorporated the evidence subsequently served on behalf of the Appellant, together with that relied on by the DBS at the time it made its decision.

7. Numerical references in square brackets, [1] etc., are to page numbers of the updated bundle running to 187 pages, unless context dictates otherwise.

Chronology

8. A background chronology is as follows. Matters are undisputed unless otherwise stated.

9. In September 2021 DWH commenced study on the Level 3 Extended Diploma in Health and Social Care at a college ("the College"). As part of a placement, he volunteered at a University Teaching Hospitals NHS Trust ("the Trust") in a hospital.

10. DWH started volunteering at the Trust on 10 February 2022. He began volunteering by providing a meet and greet service before moving to the Ear Nose and Throat Department. He then moved on to the Oncology Day Care Department and Ward [A] (adult only ward). During his time at the Trust his supervisor was RHP, a Voluntary Services Manager.

11. On the morning of 9 February 2023 DWH was asked by a senior nurse to report to RHP's office.

12. There is a dispute about what occurred during their conversation which we make findings about below. The Appellant's account is as follows. Amongst other things, DWH states that during this meeting with RHP, he was told that an allegation of sexual assault had been made by a patient. He was asked whether he had interacted with any male patients and asked whether he had gone under the bedsheets of any patients. He denied any wrongdoing.

13. It is not in dispute that he was sent home and asked to provide an account of his whereabouts that morning, which he did. ([p.48] and further email screenshots provided by the Appellant at [164]-[166]).

14. The incident was reported to the police on 9 February 2023. No further action was taken.

15. On 27 February 2023 the Local Authority Designated Officer ("LADO") held an Initial Multi Agency Allegation Meeting via Microsoft TEAMS [93-97].

16. On 28 March 2023 RHP wrote to DWH stating that the investigations had confirmed that he entered the male patient's cubicle and that as DWH had failed to disclose this, the Trust had terminated his volunteer placement with immediate effect.

17. DWH was not invited to and did not attend any disciplinary investigation or hearing by the Trust.

18. On 16 May 2023 a LADO final meeting review took place where the allegation is said to have been substantiated [p.98-103].

19. On 26 May 2023 RHP wrote to DWH stating that the allegation had been substantiated, that DWH could not return to the Trust as a volunteer and that he would be referred to the DBS.

20. Prior to the alleged matter on 9 February 2023, there had been no concerns with regard to DWH's conduct. He had only received positive feedback (see placement visit review sheets dated 16.3.22, 29.11.22 and 7.2.23).

21. On 7 March 2024 on behalf of DWH, his solicitors wrote to the Trust and to the College to make a Subject Access Request "(SAR"). In particular, a request was made for notes, minutes and records, copy of investigations undertaken, CCTV footage, witness statements and evidence regarding the alleged incident.

22. On the same date, DWH's solicitors wrote to the DBS informing it that there were serious concerns about the Trust's handling of the investigation into the alleged incident. It was also highlighted that DWH had not been provided with a copy of the investigation and evidence nor had he been provided with an opportunity to respond to the investigation. A request was made for the DBS to pause its inquiries until DWH had received the requested information and then could correspond with the DBS [p.47].

23. On 25 April 2024 DWH's solicitors chased the Trust and the College with regard to the SAR. There was no response.

24. On 14 May 2024 the DBS sent DWH the minded to bar decision [p.17-22]. The DBS invited DWH to send representations in response by 11 July 2024.

25. On 10 July 2024 DWH's solicitors wrote to the DBS explaining that they still had not received any disclosure from the Trust and that they had only received some disclosure from the College that same afternoon. A request was made for the DBS to delay making its decision until DWH had received all of the relevant disclosure so that an informed response could be provided. [p.49]

26. On 22 July 2024 the DBS sent DWH a letter confirming its decision to include him on the children's and adult's barred lists.

The DBS Decision

27. The DBS in its Final Decision Letter dated 22 July 2024 confirmed that the DBS would include the Appellant on the CBL and ABL and stated as follows:

> "We are satisfied that you meet the criteria for regulated activity. This is because you volunteered within the [] Centre of Oncology.
>
> We have considered all the information we hold and are satisfied of the following:
>
> That on 9 February 2023 whilst volunteering on Ward [A] of the [] Centre of

Oncology, you entered the room of a male patient and attempted to look at/make contact with the patient's genitals by unbuttoning his pyjama bottoms before being disturbed by a noise from outside of the patient's room

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

It is also considered that you have engaged in relevant conduct in relation to children, specifically conduct which, if repeated against or in relation to a child, would endanger that child or would be likely to endanger him or her.

We are satisfied a barring decision is appropriate. This is because on 9 February 2023 whilst volunteering on Ward [A] of the [] Centre of Oncology, you entered the room of a male patient and attempted to look at/make contact with the patient's genitals by unbuttoning his pyjama bottoms before being disturbed by a noise from outside of the patient's room. As a result of your behaviour, the victim experienced some degree of emotional harm as he felt the need to report the behaviours. The DBS is also satisfied that it is reasonable to conclude that should the behaviours be repeated in the future, a similar or more significant level of harm would likely be present.

The DBS has relied upon a Structured Judgement Process (SJP) risk assessment tool when considering the risk of future harm it appears you may pose to vulnerable groups. The evidence provided indicates that you have attempted to take advantage of the opportunities presented to you by virtue of the voluntary position you held on the ward. Specifically, that you attempted to unbutton the pyjama bottoms of a vulnerable adult with the intention of looking at/touching the vulnerable adults genitals. In considering these behaviours, the DBS is also satisfied that you have attempted to exploit the trust that would have been placed within you by vulnerable adults in your care, again by virtue of the role which you held. Whilst it is not clear what your motivation was, the DBS is satisfied that you attempted to deceive the victim in an attempt to gain some form of personal gain/gratification. There is no evidence which would appear to demonstrate that you have considered the negative consequences which may have been present for either the vulnerable adult or yourself. In considering all of the above, the DBS is satisfied there is clear information which would indicate that you hold an exploitative attitude and that this attitude is linked to the harmful conduct which has been present.

Additionally, in considering the behaviours exhibited by you, the DBS is satisfied that you have shown an inability, disinterest or unwillingness to empathise with the vulnerable adult in this case. It does not appear that you have considered the impact of your behaviour from the perspective of the vulnerable adult or if you had done, it does not appear you considered this to be relevant or you chose to prioritise your own needs above those of the vulnerable adult. Whilst it is acknowledged this had been an isolated incident, the DBS is satisfied that your behaviours are serious enough to warrant definite concerns in regards to the risk of future harm you appear to pose.

The DBS has considered that the behaviours exhibited by you were carried out whilst you were volunteering in a hospital. In considering this it is acknowledged that by virtue of your role you would have had the opportunity to engage with vulnerable adults and children alike. The evidence which has been provided indicates that the inappropriate behaviours which have been exhibited by you,

were carried out in respect of a vulnerable adult. Taking this into consideration the DBS is satisfied that you have attempted to carry out inappropriate behaviours in respect of vulnerable adults, with no evidence of any responsibility, insight or remorse. As such, the DBS is satisfied that it is appropriate to include you on the Adults' Barred List.

Whilst the behaviour was not carried out in respect of children, it is considered that the role which you held would have allowed you to gain access to children. As it is unclear what your motivation was the DBS has been unable to identify the driving factors behind it and therefore cannot be confident you would not repeat your behaviour in the future in respect of children. The DBS has arrived at a conclusion that you have acted in an opportunistic and exploitative manner with the intention of gaining some form of self-gratification. The DBS is of the belief that the evidence provided supports a finding that you would likely repeat the behaviours, should you be given the opportunity, in respect of children due to your apparent exploitative and opportunistic behaviours. As such, the DBS is satisfied that it is appropriate to include you on the Children's Barred List.

The DBS has considered that a decision to include you on the Adults' Barred List and/or the Children's Barred List would likely have a significant impact on your future employment and voluntary opportunities. It is also acknowledged that this may have a detrimental impact on your ability to earn an income or pursue a career path which involves working with/volunteering with vulnerable groups. It is noted that as you have volunteered within the healthcare sector and it is likely that you will have gained valuable knowledge and experience which may not be fully utilised should you need to choose a different career path. The DBS is aware that inclusion on the barred list(s) can bring with some social stigma, however it is considered that inclusion is not widely available and would usually only come to attention on future Enhanced Disclosure and Barred List (EDBL) checks or when the individual themselves chooses to disclose it to any other third parties. In summary, the DBS has considered that inclusion on the barred list(s) would be a significant interference with your Article 8 Human Rights.

Nevertheless, the DBS has a statutory function to protect vulnerable groups from risk if future harm. It is acknowledged that as a result of your behaviours you were subject to a disciplinary process and were dismissed and that your behaviours were also considered by the local authority. It is noted within the evidence provided that the victim in this case did not support any further police involvement and you therefore did not come to the attention of the police. In considering how the disciplinary process concluded and the lack of involvement from other agencies, the DBS is not satisfied that there are currently any suitable safeguarding measures in place which would protect vulnerable groups from risk of future harm adequately. As such, the DBS is satisfied that it is proportionate action to take to include you on both the Adults' Barred List and the Children's Barred List…"

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

28. The Appellant lodged at the Tribunal a notice of appeal against inclusion on the ABL and CBL dated 22 October 2024.

29. In summary, his 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 barring Decision.

30. On 24 April 2025 , the UT granted permission to appeal, on the grounds set out in the notice of appeal and counsel's skeleton argument as set out below.

Legal framework

Barring decisions

31. 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.

32. 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.

33. 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)/9(1) 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.

34. 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.

35. 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.

36. '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) set out the meaning of "relevant conduct". It includes: (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) provide 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

37. 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.

38. 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).

39. 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)).

40. 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.

41. 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

42. 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 DWH (pursuant to paras 3 and 9 of Schedule 3 to the Act):

(a) First, under para 3/9(3)(aa), DWH 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), DWH "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 DWH on the barred lists.

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

Mistakes of fact and the UT's fact finding jurisdiction

44. 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

45. 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.'

46. 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

47. 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.

48. 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).

49. 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).

50. 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

51. 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)).

52. 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)).

53. 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

54. 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

55. The Appellant was granted permission to appeal on eight grounds of appeal set out in her notice of appeal and skeleton argument which are set out above.

56. In submissions for the hearing drafted by Ms Agyekum of counsel dated 17 November 2025, the Appellant relied on the following arguments in support of the grounds.

Ground 1 - The DBS has made a material mistake of fact in finding that DWH engaged in relevant conduct.

57. Ms Agyekum argued that DWH has denied and continues to deny the allegation in its entirety (see email screenshots dated February 2023 at [164]-[168] and paragraphs [20]-[22] of the Appellant's witness statement). Consequently, the DBS's finding that he engaged in relevant conduct is a material mistake of fact in its decision making. Therefore, there is no proper basis for the DBS to include DWH on the barred lists.

Ground 2 - The DBS has erred in law by failing to make any findings of fact based upon evidence when making its decision

58. She submitted that under the heading "How we reached this decision", the DBS's final decision to bar simply states "We have considered all the information we hold and are satisfied of the following: That on 9 February 2023 whilst volunteering on [Ward A] of [the Hospital] of Oncology, you entered the room of a male patient and attempted to look at/make contact with the patient's genitals by unbuttoning his pyjama bottoms before being disturbed by a noise from outside of the patient's room." [50-51]. The DBS then goes on to state that having considered the above, that it is satisfied that DWH has engaged in relevant conduct in relation to adults and children and that a barring decision is appropriate. There is no reference to any of the information provided by the Trust and/or how this information was assessed. There is no reference to any CCTV, any witness statements or reports or the weight that was given to any of this information.

59. The later disclosed Barring Decision Summary does not take the matter any further forward [117-134]. There is still no proper analysis of the information provided.

60. Ms Agyekum contended that the DBS has failed to engage with its obligation to establish the facts and consider this matter to the requisite standard- i.e. on the balance of probabilities.

61. This is a procedural error making the decision materially unfair.

Ground 3 - The DBS has made a material error of law in its consideration of this matter through reliance on summaries of incredible information

62. Ms Agyekum argued that the information that the DBS has relied on to make its decision is fundamentally flawed and unreliable.

63. The DBS has an obligation to carry out its role in a way that is procedurally fair. Consequently, the DBS was required to consider the evidence before it and decide whether that information was reasonable and/ or adequate for it to reach a fair decision.

64. The information provided by the Trust consisted of the DBS referral, the LADO-Allegation Meeting Record, the LADO-Final Meeting Record and a Young Health Champions Pastoral Support Report [24]. As above, it is not evident what weight was given to any of this information.

65. However, within the documents it is clear that the Trust and consequently the DBS had relied upon CCTV which has never been seen by DWH or the DBS. There is no reference to the CCTV showing what has been alleged.

66. The LADO Final Meeting report states that there has been reliance on witness statements from witnesses who were present at the time [41]. However, there were no witnesses to the alleged incident, only the victim who did not specifically identify DWH. Indeed, the DBS did not have any witness statements before it when making its decision. The DBS was provided with summaries of information which were largely summaries of anonymous hearsay and anonymous assumptions. It is also unclear why this matter was referred to the LADO as it has no jurisdiction in these matters. The LADO's role is to deal with investigations in relation to allegations relating to children.

67. In any event, within the LADO meeting which substantiated the allegation it is recorded that "The outcome is that they believe that although there is no tangible evidence, they believe that there is a probability of the allegation happening." (emphasis added) And that "…all who were asked believe it could have happened". [41]

68. There was an acknowledgment at a local level that there was no tangible evidence that DWH acted as alleged. The DBS has then gone on to make its decision based on this fact and unreliable summaries of anonymous hearsay.

69. She submitted that this is a material procedural error which affected the substance of its decision.

Grounds 4 and 5 - The DBS has made a material error of fact and/or law in concluding that DWH was subject to disciplinary proceedings.

70. Within its final decision letter, the DBS has concluded that "It is acknowledged that as a result of your behaviours you were subject to a disciplinary process and were dismissed." [p.52].

71. Ms Agyekum pointed out that DWH was not subject to any disciplinary investigation or disciplinary process. He was sent home on 9 February 2023 and informed by letter in May 2023 that the allegations had been substantiated.

72. Consequently, she argued that the DBS was under a mistaken belief that DWH had been subject to a disciplinary process in which he would have seen the purported evidence against him, had an opportunity to respond to it and defend against the allegations. The fact of his engagement in a disciplinary process would have been an important part of the DBS's assessment of the veracity of the allegation.

73. Indeed, it was highlighted by the Chair in the LADO initial meeting on 27 February 2023 that "The trust will now consider under what process they would complete an internal investigation. An investigation and outcome is necessary to inform the LADO conclusion and this must be recorded. It is also necessary as [DWH] must have the right to reply to the allegation. p [37] (emphasis added).

74. She submitted that it is evident that it was identified that DWH must have a chance to engage meaningfully in an investigation in order for a proper conclusion to be made. However, even after this instruction, this never occurred.

75. Consequently, the DBS's conclusion that DWH had engaged in a disciplinary process is a mistake of fact which is material to the DBS's decision.

<u>Ground 6 - The DBS failure to give DWH an opportunity to provide informed representations was an error of law</u>

76. Ms Agyekum relied upon schedule 3 paragraphs 3(2) and 9(2) of the Act, which provide that the "DBS must give the person the opportunity to make representations as to why he should not be included…" in the children's and adults' barred lists respectively. Paragraph 16(1) states that "A person who is, by virtue of any provision of this Schedule, given an opportunity to make representations must have the opportunity to make representations in relation to all of the information on which DBS intends to rely in taking a decision under this Schedule".

77. She noted that on 7 March 2024 and subsequently on 10 July 2024 solicitors on behalf of DWH wrote to the DBS to make it clear that: 1) there were concerns about the Trust's investigation; 2) that DWH had not seen or had an opportunity to respond to that investigation; 3) that DWH had requested and was awaiting receipt of that information; and 4) as a consequence, on both occasions a request was made for a delay to the DBS's decision so that DWH could make a response based on the purported evidence. The DBS did not extend time for DWH to make representations and went on to make its final decision.

78. She submitted that under schedule 3 paragraphs 3(2), 9(2) and 16(1) of the SGVA, the DBS should have waited for the receipt of the information contained within the investigation before it made its decision. This was even more important knowing that DWH had not had the opportunity to respond at a local level.

79. Fairness required DWH to be provided an effective opportunity to make representations on all of the information upon which the DBS was relying. This made a material difference to the fairness of the decision because: (a) the right to make representations is fundamental to natural justice; and (b) a failure to afford such opportunity deprived DWH of the opportunity of having the DBS fairly consider whether it is appropriate for him to be included in a barred list. Appropriateness is a question in respect of which no right of appeal lies to the Upper Tribunal (s 4(3) SVGA 2006). Thus, this was an error of law (*SM v Disclosure and Barring Service* [2025] UKUT 86).

Ground 7 -The DBS erred in law in its consideration of risk

80. Ms Agyekum argued that in light of the above identified errors of fact and/or law, the DBS's secondary findings relating to the risk that DWH poses and the subsequent barring decisions were also consequently, errors of fact and/ or law.

Ground 8 - The DBS has erred in law in concluding that DWH should be included on the children's barred list

81. Finally she submitted that the DBS has made a further error in its analysis relating to the inclusion on the children's barred list. Contrary to what has been stated by the DBS, the role which DWH held would not have allowed him to gain access to children now or in the future.

82. It is irrational to extrapolate such a risk from the facts of this case. It is submitted that this is a material error of fact which goes to the decision to include DWH on the children's barred list.

Conclusion

83. In light of the above Ms Agyekum submitted that the barring decision is both wrong in law and fact. Consequently, the Upper Tribunal is invited to direct that DWH be removed from both barred lists.

Facts Found

Evidence received and approach to evidence

84. The DBS relied on written evidence from witnesses in the form of notes of the incident or reports of meetings and the disciplinary process and outcome contained in the bundle of evidence it filed and served which contained 187 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 subsequently provided by the Appellant.

85. The evidence relied on by the DBS included is addressed below.

86. 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. Their evidence before us was made up of written reports from internal investigations and meeting, notes or correspondence and therefore contained untested hearsay. As well as hearsay, the witnesses other than RHP were not identified to the Appellant so could be considered to be anonymous in the sense of unknown to him.

87. This is a matter to take into account when considering its reliability and the weight it is to be given.

88. The Appellant relied upon: his own witness statement and oral evidence given to the Tribunal; his contemporaneous accounts given in emails and other correspondence; representations sent to the DBS by his solicitors about absences or failures in the Trust investigation process. In contrast to the DBS witnesses, the Appellant gave oral evidence and was cross examined in these proceedings,. When considering its weight, we take into account that the Appellant's evidence was tested in these proceedings.

89. We have examined all the evidence in the case with care, both that which was before the DBS and that provided by the Appellant as part of his appeal (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.

90. 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.'

91. 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.'

92. 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).

93. 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

94. DWH was the only witnesses from whom we heard oral evidence. We found him to be witness whose evidence was reliable on peripheral matters but not as far as his evidence on the core allegation of relevant conduct.

The contemporary account from DWH

95. DWH provided an initial response to the enquiry of RHP in a sequence of five emails he sent her which are dated 9, 11, 14, 15 and 17 February 2023 [164-168]. Within the emails he gave his most contemporaneous account of events as follows:

> "Date 9 Feb 2023, 12:25
> See security details
>
> Hi [RHP], I went into Ward [A] today and I first checked the Dani centres and restocked them. M[] then asked me about sticking some posters up which I then did (on the board). I helped B[], (I believe that's her name) to load the cutlery. Spoons, forks and knives in a plastic sleeve. I then went to bed 8 and stood outside it whilst I was speaking to two female patients with P[] (the domestic cleaner). At no point did I speak to a Male patient today, nothing whatsoever. I used the toilets twice (by myself) and did nothing else. God's honest truth, nothing whatsoever. I did NOT interact with a male patient today. I would like to know what will happen further.
>
> 11 Feb 2023, 19:03
> See security details
>
> Hi [RHP], sorry to email you on a Saturday, although placement was only 2 hours on Thursday

there's still a lot that goes on. When I was walking down the ward to M[]'s desk I glanced at a room for half a second and saw a male patient in the room (near M[]'s desk), but NO speech or interaction was made. Also, when I was walking towards the kitchen and I also glanced at a room and also saw a male patient for half a second glance, again, NO speech or interaction was made. The patient near M[]'s desk was in bed and the patient near the kitchen was sat on his chair. Like I said I only interacted with two FEMALE patients.

14 Feb 2023, 13:54
See security details

Hi [RHP], this is everything now. On Thursday, opposite room 21 and 22 or 20 and 21. 1 saw the back of a FEMALE patient and I asked P[] (domestic cleaner) why she was dabbling her arm with a tissue as she had a little bit of blood on it. P[] said it's because of the treatment she's had. Regarding the accusations I don't know what else to say other than I didn't speak to any male patient, there was no interaction, I didn't go into a room with a male patient in it. I didn't serve drinks and biscuits. I certainly didn't do what I've been accused of. The room I went in was room 21 and 22 or 20 and 21, with two FEMALES, one had purple hair. I was leaning against the door whilst talking to them (females) and barely putting my feet in the room.

Date: Fri, 17 Feb 2023, 12-04
Subject: Re: Investigation
To: [RHP}

Hi [RHP] did you receive my previous email? It's quite important that we know the exact details.
Many thanks
[DWH]

On Wed, 15 Feb 2023, 18:55 [DWH] wrote:
Hi [RHP], my parents and I are trying to get a solicitor together incase the police need a
; statement from me as well as an interview. For all that can you name the accusations word for word or specifically so that we know exactly what they are so it helps prepare me with the solicitor."

96. DWH also provided contemporaneous Placement Visit Records. Multiple handwritten entries for 7 Febraury 2023 (from mentor, placement officer and learner) state that: "He is not so keen on going it to see the patients, even if the staff encourage him to do…", '[DWH} isn't very confident when speaking with paitnets and prefers not to as he is worried they will be made and tell him to go away" and "Not confident speaking to patients as unsure of their reaction".

Although he did not specifically rely on this in his witness statement or his counsel's submissions, the records provides some support for his account that he did not enter any male patient's room on 9 February 2023.

Evidence given to the Upper Tribunal

97. The contents of DWH's witness statement dated 10 October 2025 provided more detail and were adopted as his evidence in chief at the hearing. DWH stated relevantly as follows:

> "3.In September 2021 I began studying for my Level 3 Extended Diploma in Health and Social Care at [a] College ("the College"). As part of my placement, I volunteered with the [] Hospitals NHS Trust ("the Trust") at [a] Hospital ("the Hospital"). I started volunteering on 10 February 2022.
>
> 4. The placement provided that I attend the College 3 days a week and volunteer at [the] Hospital for the other 2 days.
>
> 5. I started my role as a volunteer with the Trust by providing a meet and greet service before moving to the Ear Nose and Throat Department. I then moved on to the Oncology Day Care Department and subsequently Ward [A] ("the Ward") which is an adult only ward.
>
> 6. At all times that I was volunteering with the Trust, I was supervised by [] RHP, the Voluntary Services Manager at the Hospital.
>
> 7. I enjoyed volunteering with the Trust and having the opportunity to work as a volunteer in the various different roles I was assigned to. My preferred work type was patient centred care work, and this was the role that I was fulfilling whilst working on the Ward.
>
> 8. When I turned up to volunteer on 9 February 2023, I made my way to the Ward. At that time, I had been assigned to work on the Ward for approximately 2 to 3 months. I arrived at the Ward just before 9am.
>
> 9. Before I entered the Ward I used the toilet just outside of the Ward entrance. After entering the Ward and before starting my jobs for the day, I made use of the toilet again. The second toilet I used is located on the Ward, just before reception on the left-hand side.
>
> 10. After using the toilet on the Ward, the first job I did was to check and restock the Danicentres. The Danicentres contain small, medium and large disposable gloves as well as disposable aprons and santry tissues. They are in frequent use and require regular checks and restocking.
>
> 11. The Housekeeper then asked me to put up some posters on the Ward's communal notice board near the reception. The posters were informative posters about Health and Social Care which I stuck to the board with Blu-Tack. This job took quite a while to complete.
>
> 12. I then helped the kitchen staff to place cutlery into plastic sleeves so that the cutlery could be handed out to the patients with their lunchtime meals.

13. After this I ended up standing outside one of the patient's rooms with 2 female patients and the Domestic Cleaner, engaging in general chit chat. I specifically recall doing so as I remember the Domestic Cleaner talking about cycling. Whilst I tend to talk less and listen more than others, I remember being engaged in this conversation.

14. Following this conversation, I was asked by the Housekeeper to take some used patient clothing to be cleaned. This involves taking used clothing that has been placed into plastic bags out of the Ward and putting them in the laundry trolleys.

15. It was whilst I was in the process of doing so, and before I had chance to leave the Ward, that I was approached by a senior nurse and asked to go to speak with RHP in her office.

16. I set the plastic bags of used clothes aside and proceed to RHP's office. Due to the manner in with the senior nurse spoke to me and because I was being asked to go to RHP's office during the middle of my shift, I immediately felt that something was wrong and became worried about why I had been asked to go to RHP's office to speak with her.

17. I did not have a very good impression of RHP and believed her to be a fiery and authoritative person. Having spoken to other volunteers about RHP, there was a general consensus that she was not a particularly pleasant person to speak with. I became more nervous the more I thought about having to speak with her in her office, especially as I had not been told why she wanted to speak with me.

18. When I went into RHP's office, her assistant was also in the room. RHP asked me to take off my face mask and sit down, which I did.

19. RHP informed me that an allegation of sexual assault had been made by a male patient. She asked if I had been in to any male patients' rooms that morning and I told her that I had not. She asked if I had spoken with any male patients that morning and I said that I had not.

20. RHP then asked me something along the lines of "so you didn't" whilst simultaneously making the gesture of lifting something up, which I assumed to be a bedsheet based on the male patient's allegation of sexual assault. I immediately told her that I had not done so.

21. Whilst RHP was vague about the allegation that the male patient had made and did not provide any specific details, the fact she had mentioned that a male patient had made an allegation of sexual assault as well as making the gesture of lifting something up, which I believed was a reference to lifting up bed sheets, did provide me with enough of an understanding of the general nature of the allegation that the patient had made. I found this allegation very shocking and was particularly concerned that RHP was asking me about the allegation in a way that suggested she thought that it was me that had done so.

22. After denying the allegations in their entirety, RHP then asked me to account for my movements that morning, which I did and I refer back to paragraphs 8 to 16 of this Witness Statement, above.

23. RHP told me that I was being sent home and asked that when I get home, I send her an email providing a written account of my movements at the Hospital that morning.

24. At this stage I was very shook up. RHP must have noticed that I (quite understandably) looked very upset and distressed about the whole ordeal I had just been put through. I think in order to try and comfort me, she told me that they were going to investigate the matter and that as part of their investigations they were sending everyone home, not just me.

25. I believe she must have only been referring to all of the volunteers (not all the hospital staff) and based on my knowledge of the matter now, I believe that this was probably a lie and that, for whatever reason, and without any evidence, she had already decided the allegation was true and that it was about me.

26. I cannot recall the entirety of the conversation that took place, but I believe that I was in RHP's office for approximately 10 minutes.

27. After my meeting with RHP I contacted my main course tutor at the College ("my Tutor"). Initially I sent my Tutor a message on Teams at 12.27pm and then telephoned and spoke with them at 12.28pm.

28. During my telephone call with my Tutor, I told them about the meeting I had had with RHP together with the allegation that had been made as I understood it from what RHP had said during the meeting. I told my Tutor that RHP thought it was me as, based on what she had said, that was what I believed at the time.

29. I told my Tutor that it wasn't me and asked what was going to happen, but my Tutor was not able to offer me with any assistance.

30. I subsequently messaged [JR](a safeguarding member of the College at the time) to ask for updates on what was happening with the investigation. I was told very little about what was happening but was informed that I was suspended from College and could only attend the College for my exams if I was accompanied by a chaperone.

31. Other than my initial meeting with RHP, I was not involved in any part of the Trust's investigation, and I was not invited to comment further on the allegations that had been made.

32. I was not invited to any disciplinary meetings and only became aware of what was happening when I received the Trust's letter, which provided the outcome of their investigation.."

98. DWH was cross examined by Mr Ryan and asked questions by the Tribunal panel. He maintained his account denying the alleged relevant conduct.

Findings of fact

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

> That on 9 February 2023 whilst volunteering on Ward [A] of the [] Centre of Oncology, DWH entered the room of a male patient and attempted to look at/make contact with the patient's genitals by unbuttoning his pyjama bottoms before being disturbed by a noise from outside of the patient's room.

100. The Appellant has not established any mistake of fact in relation to the DBS's finding on 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 or actual emotional harm to the patient). In coming to this conclusion we have had regard to the following evidence, facts and reasons.

101. We do not accept DWH's written or oral evidence that he did not enter any male patient's room on 9 February 2023 and did not attempt to unbutton a male patient's pyjamas in the manner alleged. We reject his key denial as being unreliable on the balance of probabilities. This is for the reasons set out below.

102. The most plausible and more likely explanation, as we find, is that contained in the LADO and Trust disciplinary findings and in DBS's finding of relevant conduct.

103. We reject DWH's account, as set out in his written and oral evidence to the Tribunal. We find it to be unreliable. We accept the DBS's case on the balance of probabilities in light of the evidence, facts and matters detailed below.

104. In essence, we agree with the DBS submission that there are four sources of evidence which support its finding of relevant conduct and establish that there was no mistake of fact contained therein.

Evidence relied on by DBS

105. It is necessary to identify and summarise the four sources of the material that was before the Respondent which it relied upn when it made its barring decision.

106. The most contemporary evidence is the notes of RHP from 9 February 2023 which are contained in Flag 4 – Young Health Champions Pastoral Support Report [104-105]. The first part of this report was undoubtedly written by RHP in the first person singular. She was the senior lead, and there is no dispute she interacted with DWH on the same day as the incident. We accept that much of the note is untested hearsay of what others are said to have said to JHP. Nonetheless, it is a contemporaneous note – the first part of the note appears to have been written on the same day – 'I received a phone call today..'. RHP, the author, was known to the Appellant as a result of their interactions that day and before while he had been volunteering as he accepts. She writes:

"Name of support in Trust: [RHP] Senior Lead

Name: DWH Area volunteer's: Ward [A] & Cancer Assessment Unit Date: 09.02.2023

Details of Concern and how it was raised:

I received a phone call today at 10:50am from HB (charge nurse ward [A]) to say that one of the OT assistants had been with a patient who had told her that a young man in a blue t-shirt had entered his room and opened his pyjamas and tried to touch his genitals. As the patient asked him what he was doing there was a noise outside of the room and the young man left in a hurry. I asked HB to send [DWH] to my office where I explained to him that I would have to send him home due to an incident that had taken place at the [ward], I asked [DWH] on four separate occasions if he had spoken to or seen any male patients on his voluntary shift, to which the volunteer said that he hadn't, I asked him to go home and send me an e-mail account of all duties that he had carried out on his voluntary shift and not to return to the Trust until advised to do so. I met Ward [A] charge nurse HB at 3.30pm and we went to speak to the patient...

The patient thanked me and said he hoped that the young man didn't get into any trouble but wasn't sure why he would want to look at his genitals, the patient had been spoken to on three separate occasions that day with regards to the same incident and on each occasion his version of events was the same. I stayed at the Trust until 20:30 to look at the CCTV with HB and the security team and the volunteer [DWH] did enter the patient's cubicle at 09:06am... [104]

…

Any other information...

- [DWH] has been e-mailing the Trust VSM [Volunteer Services Manager ie. RHP] for information on the incident, [DWH] had told the college what the incident was himself, but no one from the Trust had told him why he had been sent home?

...

 15 March 2023 VSM [ie. RHP] spoke to the volunteer [DWH] via telephone with regards to the allegations that had been made on the 9th of February, the first question that the volunteer asked VSM was is there any CCTV in the hospital and on the ward that I volunteer on VSM replied by saying yes there was CCTV in the hospital and on the ward that you volunteered on, volunteers reply was 'Oh Okay', ... The volunteer [DWH] then replied 'What? You're saying I cannot volunteer just because of that?',II asked him what he meant by that? [DWH] replied by saying you know the allegation made against me your suspending me just because of that. VSM went on to say are you aware of the allegations to which [DWH] replied that he was.

… [105]"

107. We find on the balance of probabilities that this evidence is reliable. This evidence of particular weight in that it describes RHP inspecting the CCTV, while with others, at 8.30pm on the same day as the incident, on 9 February 2023. It records RHP seeing DWH going into the male patient's room at 9.06am. It is precise and specific. DWH has flatly denied going into any male patient's room on that day both as RHP reports and as DWH has set out in his contemporaneous emails and evidence to the Tribunal.

108. In contrast DWH has given no explanation for what RHP records as seeing on the CCTV. Instead he has, perhaps understandably, complained that no one has seen the CCTV. However, that complaint does not attempt to address the evidence we do have. While it is a report, first hand hearsay, it is contemporaneous and on balance we accept it because the Appellant has not given any evidence which undermines the Report. He has not explicitly stated that RHP is mistaken in what she has identified or what she records (for example, she has mis-recognised him on the CCTV when it is another person) or is lying (making it up out of a grudge or some other motivation). DWH's witness statement and evidence to the Tribunal has simply not addressed the point that RHP records seeing him entering the male patient's room having watched the CCTV on the same day. The Appellant does state that he entered a toilet cubicle on the ward on that morning but has not suggested that this is what RHP may have seen on the CCTV. He was clear in his oral evidence that the toilet on the ward that he used was not connected to any patient's room.

109. These findings do not require us to rely on the second hand hearsay of what RHP records the patient as saying or nurse HB as saying.

110. The difficulty for the Appellant is that if we accept, which we do, that RHP's written record of what she saw on the CCTV that day is more likely than not to be reliable, then it means that DWH has not told the truth about entering the male patient's room when making his repeated denials. Thereafter, it also means that it is more likely than not that he not only entered the room but did what the patient described. There is no suggestion that the patient lacked capacity or has been confused and is referring to another volunteer or other member of staff. It is possible that another person entered the patient's room and did what is described by the patient or it is possible that the patient has misunderstood what has happened as an attempted assault when it was simply a carer adjusting his pyjamas. However, the Appellant does not positively assert these alternatives and they are less likely than not in light of the report of the CCTV which undermines his denials.

111. The next most contemporaneous evidence relied on by the DBS is from the LADO meeting - Flag 2- LADO – Allegation Meeting Record – 27 February 2023 [93-97]:

> "EMPLOYERS / AGENCY INFORMATION...

> RHP clarified that [DWH] had contacted the college on the day in question and informed them that there was an allegation, and an investigation was underway. He stated this was because he had gone into a patient's cubicle and placed his hand underneath the duvet and touched his penis.
>
> RHP is very clear that nobody had shared the allegation or concern with [DWH] at any point. RHP had only clarified with [DWH] as to whether he had had any contact with any male patients. [DWH] maintained for some time that he had not seen any male patients that day. He followed this up with an email later in the day. He has also stated that the allegation is embarrassing for him, however the trust have not shared what the allegation is...
>
> …
>
> It is recorded on the CCTV that [DWH] did enter [P's] room at 9.06am. [P] disclosed the incident to an occupational therapist.It is clear on the CCTV that an employee did pull an apron from the dispenser outside the room. It is believed this is the noise that was heard that disturbed [DWH].
>
> [DWH] has no role whatsoever in providing any clinical or intimate care to anyone... [95]
>
> CHAIR'S SUMMARY...
>
> The trust will now consider under what process they would complete an internal investigation. An investigation and outcome is necessary to inform the LADO conclusion and this must be recorded. It is also necessary as [DWH] must have the right to reply to the allegation. [96]"

112. There is a dispute of fact here. DWH says in his witness statement at paragraph 21 that while RHP was vague out the allegation she did make it obvious what the general nature of the allegation was. This in contrast to RHP who is recorded as saying that neither she nor anyone else did tell DWH the nature of the allegation involving the patient. Therefore she and the DBS relies upon this as being incriminating in that DWH is reported as having been able to describe to the college the nature of the allegation. We do not go so far as to rely on this against DWH as it relies on second hearsay of what the college purportedly told RHP about their conversation with DWH. What is clear is that DWH's contemporaneous emails from February 2023, like his emails, suggest he did not know the precise nature of the allegations against him (hence his request on 15/17 February 2023 for specificity). Nonetheless we are prepared to accept DWH's evidence that during his conversation with RHP on the day she had made a gesture from which he could reasonably infer a sexual allegation involving lifting up sheets. We do not therefore rely on him being able to describe the general nature of the allegations against him as being incriminating.

113. The next contemporaneous evidence is from Flag 3- the LADO – Final Meeting Record – 16 May 2023 [98-103] which states as relevant:

"SUMMARY / REMINDER OF INITIAL ALLEGATION...

It is alleged that [DWH] entered [P's] single bed cubicle and lifted the sheet and said he just needed to have a quick check, then proceeded to start to undo the buttons (press studs) on [P's] pyjama bottoms. [P] challenged the reason and at that point a noise was heard near the cubicle door and [DWH] fled the room. [DWH] only touched the outside of the pyjama but the (sic) was disturbed by the noise.

[P] is fully aware and has capacity and reported the incident to an occupational therapist on [Ward A] who alerted the Senior Sister. [P] gave a description that matched DWH including colour of uniform.

[DWH] confirmed to ER College tutor that a SG referral had been placed against him and went onto describe the incident despite not been told about it... [99]

EMPLOYERS / AGENCY INFORMATION...

AL shared that the investigation is now concluded, and RHP has held meetings with staff members of the ward and witnesses present at the time. The outcome is that they believe that although there is no tangible evidence, they do believe that there is a probability of the allegation of happening. The thing that stands out is that [DWH] had shared all the details of the allegation without anybody sharing this directly with [DWH]. How would [DWH] know the details of the allegation unless the allegation was true...

[RHP] found it strange that during a schedule phone conversation he did not say hello or anything else other than "is there CCTV in the hospital, is there CCTV on ward [A] and have you seen any footage of me on ward [A] at the hospital" all which RHP replied yes to. RHP stated he went quiet, RHP stated to [DWH] that a sexual allegation was made about him in the organisation which they need to investigate, and he responded by saying "so you have suspended me for that" RHP has always spoken to [DWH] with another member of staff present to ensure they are witness to the discussions.

We do know that [DWH] had shared the allegation with numerous individuals at the college before he was made aware of the allegation. the information he shared at that time was a near perfect description of the allegation that [P] had made. This could be viewed as an unintentional admission of what happened in the room. Excerpts from these discussions are below:

JD -"I spoke with [DWH] on Friday the 24th of February as he wanted to chat with someone about what was going on. He spoke about the incident and how it made him feel- like he was being blamed for something he hadn't done. He then kept saying things like "unless I forgot about it or have dementia or something". Even though he has not been told about the allegations, he seemed to know what the allegations were. He said there were 3 allegations. He kept making hand gestures depicting masturbation."

JR-13/02/23- I contacted [DWH] via telephone to advise him of the arrangements for accessing college during his exams and that he is not to be on site alone until the investigation is complete. [DWH] repeatedly asked what the Police will do and when/how they will contact him. [DWH] asked me if there were any details regarding the investigation/allegation that he should know about when questioned. [DWH] stated that he had told the NHS placement what had happened, describing going behind the curtain and lifting a sheet, and wasn't sure why the Police needed to be involved also.

SN- A male patient at the hospital has made an allegation that [DWH] put his hand under his duvet, opened the poppers on his pyjamas and tried to touch his genitals. RHP says that [DWH] has not been informed about the nature of the allegation but has been asked to account for his whereabouts and if he had any interaction with any male patients. Apparently [DWH] has strongly stated on multiple occasions that he had no interaction with any male patients on that day. When the CCTV was checked it showed [DWH] going into the male patients cubicle. RHP has confirmed that [DWH] has not been made aware of the nature of the allegation, however [DWH] has told his tutor that he has been suspended for lifting a duvet and undressing a patient, and for being in the bathroom with a patient...

RHP shared that...All the way through [P] has maintained his version of events and was consistent throughout but he did say he did not want to get the "lad in trouble."

RHP shared that since the incident happened sadly [P] has passed away. [P's] son has stated that they do not to pursue this for obvious reasons... [100-101]

POLICE INFORMATION...

The Officer in charge previously spoke with [P] regards to the allegation. [P] was stating that he was unsure as to whether he wanted to make a police complaint as he was happy for the trust to investigate the matter.

The police then filed this matter given it was not supported by the victim. [P] was more concerned that this could have happened to someone before, and he did not want this to happen again.... [101]

ONGOING / FUTURE SUITABILITY TO WORK / VOLUNTEER WITH CHILDREN:

The trust will not allow [DWH] to return to volunteer given the allegations and the concerns that [DWH] was dishonest initially stating he did not enter the room where was staying.

It was agreed by all that all the concerns around the allegation and the events left us to feel that [DWH] would not be suitable to work or volunteer in a setting whereas (sic) he may come into contact with children. WE also agreed that the concerns are so great that a DBS referral would be necessary for them to decide his suitability with both children and vulnerable adults [102]

CHAIR'S SUMMARY

> After reviewing the trusts investigation which include numerous witness statements and CCTV footage, professionals felt that based on the balance of probability we believed that there is enough evidence to substantiate the allegation that [DWH] did enter room and something untoward had taken place. We have no concerns about the credibility of [P's] allegation which he was consistent about throughout with various individuals and the police.
>
> We do know that [DWH] had shared the details of the allegation with numerous individuals from [ER] College before he was made aware of the allegation and indeed any details of the allegation. The information he shared at that time was a near perfect description of the allegation that had made. This could be viewed as an unintentional admission of what happened in the room given the full details he had shared. This also contributes [to] the decision of a substantiated outcome as saying this has fully confirmed what [P] had shared had happened. [102]"

114. We have already accepted above that we will not rely upon, as being incriminating or an unintentional admission, the reports of others that suggest DWH knew of the nature of the allegation before being told of it. Nonetheless, this evidence includes two matters we do consider to reliable and find as fact on the balance of probabilities. First, there is first hand hearsay that the patient had capacity when making his report of the incident and there is no suggestion or credible reason for considering that he deliberately made it up or was confused or mistaken in stating what had occurred. Secondly, there is RHP's account of a telephone call with DWH in which he asked unprompted about whether CCTV existed on the ward and whether RHP had seen it and then went quiet when RHP told him it existed and she had viewed it. DWH has said nothing about this telephone conversation with RHP – he has not disputed it in his witness statement nor oral evidence nor suggested RHP was mistaken or lying about the contents of the telephone call.

115. The final relatively contemporary evidence is from Flag 1- the DBS referral dated 23 June 2023 [84-92]:

> "Whilst volunteering [DWH] has undertaken the following training modules:-...
>
> Safeguarding Adults Level 1
>
> Safeguarding Children and Young People Level 1... [85]
>
> It is alleged that on the 9th of February 2023 [DWH] entered a single bedded cubicle on ward [A] whilst Volunteering, and lifted the sheet of a male patient and said he just needed to have a quick check, then proceeded to start to undo the buttons (press studs) on the patient's pyjama bottoms. The patient challenged him and asked the reason for what he was doing, at that point a noise was heard near the cubicle door and he fled the room. He touched the outside of the pyjama bottoms of the patient but was disturbed by a noise outside of the cubicle.
>
> The patient was fully aware and had capacity and reported the incident to an occupational therapist on [Ward A] who alerted the Senior Sister.

> The patient gave a description that matched that of [DWH] and included the colour of uniform he was wearing.
>
> [DWH] confirmed to his [ER] College tutor that an incident had taken place whilst on his voluntary shift and went onto describe the incident despite not been told about it when he was asked to leave the Trust by the voluntary service manager.
>
> After concluding a trust investigation which includes numerous witness statements and CCTV footage, professionals felt that based on the balance of probability we believed that there is enough evidence to substantiate the allegation that [DWH] did enter a male patient's room and something untoward did take place. We have no concerns about the credibility of the patient's allegations which he was consistent about throughout with various individuals and the police.... [87]"

116. We place some, but not a great amount of, weight on the evidence that the patient identified the colour of top that DWH was wearing on the day. In the original report by RHP on 9 February 2023 she reports the patient stating the man was wearing a blue t-shirt. In his evidence DWH he accepted he was wearing a blue top – a polo shirt with collars but it was light blue. While he stated there were other members of staff on the ward that day, such as nurses who would be wearing standard blue nurses uniforms, they did not have collars. DWH at no point has actively suggested that it might have been a nurse - or any other person such as another visitor or staff member – who entered the patient's room. We do not accept Ms Agyekum's submission that the patient must have identified a different person based on the difference in the tops described. It is simply is not clear one way or the other.We are aware of the risks of misidentification by a patient or any person that they have not seen before and only for a short passage or time and we would have been cautious about placing much weight on this. However, the fact that DWH was wearing a blue polo shirt top and the patient identified the perpretator as wearing a blue t-shirt is some corroboration of the more probative evidence that RHP saw DWH entering the patient's room on CCTV.

117. For all these reasons, we have come to the conclusion that the Respondent did not make a mistake of fact in its finding which did amount to one on relevant conduct. In short we find on the balance of probabilities that DWH committed the conduct the DBS found because:

    (i) The patient ("P"), who was fully aware and had capacity, contemporaneously reported the incident to an occupational therapist, spoke to a number of other staff including RHP and was prepared to speak to the police about it. Thereafter the patient gave accounts to others that were consistent with his initial report. We are not satisfied that P was mistaken or lying about the nature of the incident even though he did not wish to pursue a prosecution. P gave a description 'that matched that of DWH and included the colour of uniform he was wearing'. While it is not highly probative, and there is always a danger of mistakes in one-off identification, the description of clothing is consistent with DWH being the person.

(ii) Whereas the Appellant strongly denied on multiple occasions that he had any interaction with any male patient that day, RHP's report of the CCTV confirmed that the Applicant had entered P's cubicle at 9:06am that day. The Appellant had no role whatsoever in providing any clinical or intimate care to anyone. Beginning with DWH's email message dated 9 February 2023 in which he stated '...I did NOT interact with a male patient today...' he has continuously denied entering any male patient's room at all times. That is inconsistent with the CCTV footage which RHP reported as having viewed on the day of the incident. DWH has given no evidence or reason to undermine RHP's description of the CCTV as being reliable and we are not satisfied she is mistaken or lying in what she describes. We are not satisfied RHP had any reason to lie and her ability to recognise DWH was based on multiple contact such that the possibility of mistaken identification was reduced. Further, the CCTV footage is described as showing another employee pulling an apron from a dispenser outside P's cubicle, consistent with P's allegation that there was a noise near the cubicle door which caused the Applicant to flee the room.

(iii) The Appellant has provided no evidence in his witness statement or oral evidence or reason to undermine RHP's account of a telephone call with DWH on 15 March 2023 in which she records DWH asking about CCTV and going quiet when told that she had seen CCTV of the incident.

118. We do not rely upon the Trust's and DBS's reasoning against DWH that he unintendely admitted the allegation because prior to being informed by the Trust of the precise details of the allegation, the Appellant shared the allegation with numerous individuals at College, sharing information that was a near perfect description of P's allegation. Nonetheless, even if the DBS erred in relying upon this, it is not a material mistake of fact for all the reasons we have set out above.

119. Having regard to the evidence before the DBS, key passages of which are highlighted above, and taking into account all the evidence now before us such as the Appellant's evidence, we are satisfied the DBS did not make any mistake of fact which made material contribution to the finding of relevant conduct.

Discussion and Analysis

120. 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

121. 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 – the Respondent has failed to make any findings of fact with reference to any evidence, has not engaged with the burden of proof and has failed to provide adequate reasons

122. We reject this ground of appeal as not establishing a mistake of fact or law. The DBS made clear findings of fact with reference to the evidence - see the Final Decision Letter [111-112] and the Barring Decision Summary [117-121]. The latter document in particular provides adequate reasons for the DBS's finding of relevant conduct, part of which we quote below:

> "Nurse on [Ward A] at [the Hospital]). It was alleged by HB that one of the Occupational Therapist Assistants had been with a patient who told her that a young man in a blue t-shirt had entered his room, opened his pyjamas and attempted to touch his genitals. It is noted that the patient asked the young man what he was doing and at this point there was a noise from outside of the room they were in and the young man is said to have left in a hurry.
>
> As a result of the allegations which had been disclosed, RHP met with DWH and advised she would need to send him home due to an incident which was alleged to have taken place at the [the Hospital]. RHP stated she had asked DWH on 4 separate occasions whether he had spoken to or seen any male patients on his voluntary shift, to which DWH advised he had not. DWH was instructed to go home and asked to e-mail an account of all duties he had carried out on his voluntary shift and not to return to the Trust until he was advised to do so (Flag 4). RHP advised she met with [Ward A] Charge Nurse HB at 3.30pm and they went together to speak to the patient who at the time had his son visiting. RHP advised she began with how sorry she was that something of this nature had occurred and that the Trust would deal with matters accordingly. It is noted that the patient expressed his thanks and also stated that he hoped the young man did not get into trouble but he wasn't sure why he would want to look at his genitals. The patient is noted to have been spoken to on 3 separate occasions that day and his version of events was maintained throughout the conversations which took place. Additionally, RHP advised she and HB, along with the security team at the Trust, checked through the CCTV footage and noted that DWH was seen entering the room which the patient who made the allegation was in at 09:06am on the date in question (Flag 4).
>
> Additional information provided within the above document (Flag 4) advised that DWH was said to have disclosed information about the alleged incident to his college, however no one from the Trust had provided him with any details as to what the allegations were at this point in time.
>
> It is noted that contact was made with DWH on 15 March 2023 via telephone during which DWH is said to have led with questioning as to whether CCTV was present within the hospital and on the ward which he volunteered on. DWH is said to have been advised that CCTV was present and is noted to have responded by saying "oh okay". Moving on from this DWH asked why he had been suspended and he was advised it was the belief of the Trust that he had breached the terms of the voluntary policy of confidentiality and expected standards. DWH is noted to have responded to this information by saying "What? You're saying I can't volunteer just because of that?" DWH is said to have been probed as to what he was referring to? DWH is said to have stated "you know the allegation made against me". DWH was asked whether he was aware of the allegations to which he stated he was and he was then advised an allegation of sexual misconduct had been made against him. DWH is said to have asked if the CCTV footage had been reviewed and was informed it had and he asked

> what was going to happen to him. DWH was advised that until the investigations were complete they could not advise what would happen.
>
> [The] LADO have considered the information and allegations raised in respect of DWH (Flag 3) and have detailed that it was alleged that DWH told the patient that he just needed to have a quick check and he then proceeded to lift up the bed covers and started to undo buttons/press studs on the patients pyjama bottoms. The patient is said to have challenged the reasons for doing this and at that point a noise from outside of the room caused DWH to flee the room. The patient in this case is noted to have been fully aware of what occurred and is noted to have capacity. The description of the person provided by the patient matched that of DWH, including the colour of the uniform, according to the information provided. It is again noted that DWH had disclosed the allegations against him to his college prior to being informed by the Trust exactly what the allegations were.
>
> In considering the victim in this case has no known issues with regards to capacity and is said to have been fully aware of what occurred at the time of the incident, the DBS believes that his judgement was not impaired and his testimony can therefore be treated with some degree of credibility based on this. It is also acknowledged that the victim made it clear he did not wish for DWH to "get into trouble" as a result of the alleged conduct and the victim refused to support a police investigation in regards to the matter. This appears to show balance and further supports the credibility of the victim (Flag 3). It is also considered that DWH is noted to have disclosed to his college tutor details of the alleged incident prior to being informed of the details of the allegations by the Trust. This appears to indicate that there is substance to the allegations which were made as DWH appears to have disclosed them without any prior knowledge, other than if the allegations truly took place. Additionally, whilst there is nothing proved as such by the presence of the CCTV showing DWH going into the victims room, it is considered that he denied that he had been in contact with any male patients on the date in question which appears to be at odds with what is noted to have been captured on the CCTV footage. In considering all of the above factors, the DBS believe that the evidence indicates, on the balance of probabilities, that on 9 February 2023 whilst volunteering on [Ward A] of [the Hospital] of Oncology, DWH entered the room of a male patient and attempted to look at/make contact with the patient's genitals by unbuttoning his pyjama bottoms before being disturbed by a noise from outside of the patient's room."

123. Further, the DBS made express reference to the burden of proof (balance of probabilities) in its Minded to Bar Letter [78] and in its Barring Decision Summary [120].

<u>Ground 3- the Respondent has simply relied upon and adopted the information provided by the Trust which is fundamentally flawed</u>

124. We reject this ground as it does not establish a mistake of fact or law. The DBS was entitled to rely upon the information provided by the Trust and the LADO. Having considered the same, the Respondent found, as it was reasonably entitled to do, that it provided a sufficient basis to conclude that the central allegation wasproved. As to the averments to the effect that specific aspects of the Trust's evidence were flawed.

125. The DBS was entitled to rely on the descriptions given as to what the CCTV shows, even in the absence of having seen the CCTV itself. We understand the

Appellant's disquiet at the DBS not having seen the CCTV nor being able to see it himself. It is not ideal that the only evidence available to the DBS, the Appellant and Tribunal is a description. Nonetheless, while it would have been preferable for the DBS to seek to establish whether CCTV had been retained and if so, attempt to obtain and view it, on the facts of this case the DBS was not required to attempt to obtain the CCTV from the Trust, even if it existed at the time the referral was made to the DBS in June 2023 (some four months later).

126. The Appellant did attempt through his solicitors to obtain the CCTV footage and other primary material in March 2024 through a SAR. In addition he could at all times have sought to obtain a witness summons from the Trust to produce the CCTV, if it still existed, once it was brought to his attention. There is no evidence as to what happened to the CCTV footage and we do not know how long it was retained. All we do know is that a decision was made not to prosecute the Appellant which may have reduced the desire to retain evidence.

127. The description of the CCTV, which we find to be reliable, is of the following:

i. The Appellant entering P's cubicle at 9:06am (despite the Appellant claiming that he did not interact with any male patient that day).

ii. Another employee removing an apron from a dispenser, likely being the sound that prompted the Applicant to flee.

128. Even though some of the witnesses were anonymous, or were provided as second hand hearsay, their evidence was still of some weight. Further, RHP was providing only first hand hearsay of the conversations she had with DWH. There were a number of direct witnesses to:

i. What P said/alleged.

ii. What the Applicant said and did after the material incident.

c. As to P:

i. P's description of the perpetrator was said to "match" the Applicantand to "include" his uniform, i.e. it was not limited to the uniform.

ii. The Trust has unequivocally stated that its patient, P, had capacity.

iii. The Respondent was entitled to consider P to be more credible than the Appellant, not least given that the Appellant denied interacting with any male patients on the index date when the CCTV showed him entering P's room (Even if we find it not to be established that the Appellant had been able to describe what P alleged before the Trust informed the Applicant about the specifics of the allegation. RHP informed the Initial Multi Agency Allegation Meeting that she was "very clear that nobody had shared the allegation or concern with [the Applicant] atany point".)

d. No basis has been put forward to doubt RHP's credibility nor reliability nor to doubt the telephone conversation she had with DWH about CCTV.

129. All of the above is evidence the DBS was entitled to take into account, evaluate its weight and come to a conclusion as to its reliability.

Ground 4 – the Respondent has relied upon partial information, anonymous hearsay and speculation without further inquiry / evidence

130. This ground does not establish a mistake of fact or law.

131. The evidence that the Respondent had available to it and which it relied upon issummarised above. As above, we find that the Respondent had sufficient evidence to support the findings that it made on the balance of probabilities and it was entitled to give the weight that it did to each source of evidence.

132. As to an alleged lack of disciplinary process carried out by the NHS Trust:

a. The Appellant was a volunteer not an employee and the Trust's process has to be viewed through that prism.

b. In the Initial Multi-Agency Allegation Meeting on 27 February 2023 it was noted that it was necessary for the Appellant to have a 'right to reply'.

c. The Appellant was spoken to with regards to the allegations on 15 March 2023 (albeit the Respondent acknowledges that the Trust indicated that the Appellant would be invited to discuss the matter when investigations were concluded and it is unclear what came of that invitation). It is not ideal that he was not given a right of reply or any written identification of the allegation against him or hearing or meeting in which to address it. Nonetheless, the Appellant did provide his own contemporaneous emails setting out his account and had an opportunity to address the allegations with the DBS and did not make minded to bar representations. He had the full opportunity to address the allegations before us so any procedural deficiencies were not material.

d. By the time of the Muti-Agency Allegation Review Meeting on 16 May 2023, the Trust had completed its investigation.

e. P had died before the said meeting on 16 May 2023 and thus before the Respondent became involved on the referral on 23 June 2023.

f. By the time of the Initial Multi-Agency Allegation Meeting on 27 February 2023 the police had already resolved to 'file' the matter as a prosecution was not supported by P. As addresed below, it is difficult to understand why the Appellant failed to make at least initial representations to the Respondent.

Ground 5 – the Respondent's finding that the Applicant was subject to a disciplinary process and dismissed amounted to a material mistake of fact

133. We reject this ground. The fact that, as a volunteer, the Appellant may not technically have been "dismissed" pursuant to a disciplinary process is not material. The Trust ceased to allow the Applicant to volunteer from the date of the allegation and the Trust conducted an investigation which included speaking to the Appellant as regards the allegations as discussed above.

Ground 6 – it was an error of law for the Respondent to proceed without representations from the Applicant

134. We reject this ground. The Appellant was sent a Minded to Bar Letter dated 14 May 2024 that invited him to make representations and gave him 8 weeks to do so [80]. Track and trace confirms that the letter was signed for on 15 May 2024 [132]. Therefore the Appellant was given the opportunity to make representations prior to the barring decision and this accorded with the statutory obligation. As above, the police had decided to take no further action by 27 February 2023.

135. On 10 July 2024 the Applicant's solicitors asked the Respondent to delay its decision pending disclosure from the Trust (it had made a SAR in March 2024 seeking various information). It is unclear why the Appellant was unable to provide at least initial representations prior to seeing any further information that the Trust may hold. After all, the Appellant's position was and is that he simply did not interact with P (or any male) that day. In any event, the Respondent understood that this was the Appellant's position when it made its decision.

Ground 7 – the Respondent's finding regarding risk amounted to an error of fact and/or law as it was predicated upon primary errors of fact and/or law

136. We reject this ground as the DBS did not make an error of law and/or fact in relation to risk. We have already found that there was no mistake of fact in the finding of relevant conduct. The assessment of risk thereafter is primarily a matter for the DBS's expert evaluation rather than a matter of primary fact and one which we would only interfere with if it was made in error of law eg. it was irrational. The DBS set out a number of matters in its final decision letter as set out above which supported its risk assessment that there was a risk of DWH repeating his behaviour. All those matters were rational matters it was entitled to take into account: eg. deception of the victim, lack of empathy and insight etc. The fact that Appellant denied the relevant conduct consistently throughout to the Trust, DBS and to the Tribunal supports the finding as to his deception leading to the risk of future repetition.

137. When reaching its decision, the DBS relied on a risk assessment that DWH may repeat his behaviour if he were allowed to work with vulnerable adults again in the future in circumstances where he had not fully acknowledged his harmful behaviour.

138. 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.

139. 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."

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

141. Even leaving aside the fact that unless a decision of the DBS is legally or factually flawed, the assessment of (and, by extension, solicitude about) the risk presented by a person is a matter for the DBS (per Lewis LJ at [43] of *AB*), the DBS's analysis is unimpeachable in light of DWH's continued denial of what amounted to an attempted sexual assault upon a vulnerable adult. We have found his denial to be unreliable and have rejected his explanation as set out above. This means that the DBS made no mistake in finding there real risk of a repeat of the conduct.

142. Whilst the DBS's requirement to bar was engaged under paragraphs 3 and 9 of Schedule 3 of the 2006 Act irrespective of whether DWH was regarded as posing an ongoing risk, the DBS was entitled to conclude that someone who behaved as he did posed an ongoing risk, particularly once regard is had to DWH's continuing denial of his actions.

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

144. DWH'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.

<u>Ground 8 – the finding that the Applicant's role allowed him to gain access to children amounted to an error of fact</u>

145. The Applicant was included in the CBL on the basis of the Respondent's finding that the Applicant had "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" [111]. That finding was made in the context that "[a]s it is unclear what [the Applicant's] motivation was the DBS has been unable to identify the driving factors behind it and therefore cannot be confident [the Applicant] would not repeat [his] behaviour in the future in respect confident of children" [112].

146. We have accepted above this part of the DBS's reasoning in its decision letter that if DWH'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 DWH 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:

> "As it is unclear what your motivation was the DBS has been unable to identify the driving factors behind it and therefore cannot be confident you would not repeat your behaviour in the future in respect of children. The DBS has arrived at a conclusion that you have acted in an opportunistic and exploitative manner with the intention of gaining some form of self-gratification. The DBS is of the belief that the evidence provided supports a finding that you would likely repeat the behaviours, should you be given the opportunity, in respect of children due to your apparent exploitative and opportunistic behaviours. As such, the DBS is satisfied that it is appropriate to include you on the Children's Barred List."

147. We would also have found that it was proportionate to include him on the CBL – appropriateness is entirely a matter for the DBS.

148. However, it is important to distinguish these conclusions from the prior statutory requirement that in order for DWH 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. The DBS submit that, insofar as the Respondent's finding that "the role...would have allowed [the Applicant] to gain access to children" [112] amounted to an error of fact (which it did not admit), it was not a material one.

149. 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."

150. The DBS decision relied on the following reasons to believe that DWH had worked in regulated activity with children to include the Appellant on the CBL: "Whilst the behaviour was not carried out in respect of children, it is considered that the role which you held would have allowed you to gain access to children."

151. It is accepted that the Appellant had been given training in relation to safeguarding children but it was unclear and there was no evidence before us that patients below the age of 18 are treated at the Centre of Oncology, or that DWH had any access to such patients or that he engaged in regulated activity with them. Likewise, there was no positive evidence before the DBS or put by either party before us that patients below the age of 18 visited the Centre of Oncology or DWH had access to such visitors or that he engaged in regulated activity with them. Further, there was no evidence before the DBS or us to suggest that DWH might in the future work in regulated activity with children.

152. Following *A v DBS*, we are satisfied that there was a mistake of fact and law in including DWH on the CBL. This is because the test for regulated activity ("TRA") 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 DWH had previously or might in the future be engaged in regulated activity with children. The only matter the DBS relied upon in its decision letter and barring decision process summary were as follows:

"We understand you have volunteered in a role considered to be "regulated activity" in relation to children and adults. This is as a result of volunteering within the [] Centre for Oncology… it is considered that the role which you held would have allowed you to gain access to children…

TRA: Children Yes Hospital Volunteer."

153. We are satisfied that this was insufficient evidence from which the DBS could rationally have reason to believe that the Appellant had previously or might in the future work in regulated activity with children. There was no evidence of there being any children on the ward on which the Appellant volunteered and we accept the submission the role which DWH held would not have allowed him to engage in regulated activity with children currently or in the future.

154. We accept the submissions and evidence on behalf of the Appellant that the only evidence relied upon by the DBS was his volunteering in the Centre of Oncology. There was no evidence before the DBS at the time it made its decision, or before us on appeal, of DWH having engaged in any regulated activity with children or intending to do so in the future. 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 DWH from the CBL.

155. That is not to say that the public would not be protected if circumstances changed. If DWH 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 him 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

156. The decision of the Upper Tribunal is that the Appellant's appeal against the barring Decision of the DBS dated 22 July 2024 is dismissed in part and allowed in part. There was no mistake of fact or law in the decision to include him on the Adults' Barred List. The decision to include him on that list is confirmed. We find that there was a mistake of fact and law in DWH's inclusion on CBL and direct removal of him from that list.

Judge Rupert Jones
Judge of the Upper Tribunal

Authorised by the Judge for issue on 12 December 2025