



Appeal No. UA-2024-000043-V  
Neutral Citation Number: [2026] UKUT 26 (AAC)

**IN THE UPPER TRIBUNAL  
ADMINISTRATIVE APPEALS CHAMBER**

**Between:**

**SAK**

**Appellant**

**- v -**

**Disclosure and Barring Service**

**Respondent**

Pursuant to rule 14(1)(b) of the Tribunal Procedure (Upper Tribunal) Rules 2008, **THE UPPER TRIBUNAL ORDERS** that, without the permission of this Tribunal:

**No one shall publish or reveal:**

**the name or address of any of:**

- a. the Appellant in these proceedings, who is referred to by the cipher SAK;**
- b. the residents who are the subject of the allegations found proven by the DBS, who are referred to by one of the following ciphers: WR, EG, MS and DH;**
- c. members of staff employed by AA's former employer, who are referred to by one of the following ciphers: NK, KM, AC, RS, JS, C and MO,**
- d. other persons connected to SAK, who are referred to by one of the following ciphers: BM and LF,**

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

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

**Before: Upper Tribunal Judge Butler, Tribunal Member Heggie and  
Tribunal Member Hutchinson**

**Hearing date(s):** 29 October 2025  
**Mode of hearing:** Cloud Video Platform (CVP)

**Representation:**

**Appellant:** represented herself  
**Respondent:** Mr Ashley Serr (counsel)

*On appeal from:*

DBS registration number: 01013227919  
DBS Decision Date: 17 October 2023

**SUMMARY OF DECISION**

**Keywords: Finding of fact (65.9)**

*The DBS’s Barring Decision involved mistakes of fact on which the Barring Decision was based. The Upper Tribunal directed the DBS to remove the Appellant from the Adults’ Barred List.*

*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 to ALLOW the appeal and DIRECT that the Appellant be removed from the Adults’ Barred List.**

**The Disclosure and Barring Service’s decision of 17 October 2023 involved mistakes of fact on which the decision was based.**

**REASONS FOR DECISION**

**Introduction**

1. This appeal deals with whether the Disclosure and Barring Service (the “**DBS**”) based its decision made on 17 October 2023 under the Safeguarding Vulnerable Groups Act 2006 (“the “**SVGA 2006**”) to place the Appellant’s name on the Adults’ Barred List (the “**Barring Decision**”) on one or more mistakes of fact or errors of law.
2. We refer to the Appellant in the case reference by the initials “SAK”. We make a Rule 14 Order to protect her anonymity and privacy and confirm the Rule 14 Order previously made to protect his anonymity and privacy of others involved.

**A summary of the factual background**

3. SAK was employed by a Housing and Care provider company (called the “AH Group”) as a care assistant from 11 July 2022 until she resigned from her employment on 09 March 2023.

4. On 16 February 2023, SAK's employer suspended her with immediate effect until further notice. The AH Group carried out an investigation into the allegations the DBS later found proven against SAK. On 19 April 2023, the AH Group held a post-employment meeting in SAK's absence and decided that the allegations (sleeping on duty and failure to provide safe and appropriate care) were proven against her. The Home Manager who wrote this letter explained she had passed the findings to the AH Group's Internal Safeguarding Team, who might decide to refer SAK to the DBS. On 18 July 2023, the AH Group made a formal referral about SAK to the DBS.
5. On 15 August 2023, the DBS issued a Minded to Bar letter to SAK. SAK provided written representations in response on 02 October 2023.

### The Barring Decision

6. On 17 October 2023, the DBS decided to include SAK in the Adults' Barred List on the basis of the following findings of relevant conduct against her:

*On 16 February 2023, whilst working as a care assistant at ["M"] Care Home, you neglected your duty of care whilst on the waking night shift through: intentionally sleeping on duty, failing to complete adequate checks and attend to the continence needs of residents in care and failing to turn a falls sensor on.*

### Appeal grounds

7. On 22 January 2024, the Upper Tribunal received SAK's application for permission against the DBS's decision. On 16 April 2024, Upper Tribunal Judge Butler made directions admitting the application (which was five days late) and directing for an oral hearing to take place.
8. SAK's application was listed for an oral hearing on 09 October 2024 by remote Cloud Video Platform (CVP). Upper Tribunal Judge Butler adjourned that hearing because SAK explained she had not received a copy of the DBS bundle, nor a copy of the email the DBS stated had been sent to her. The Upper Tribunal sent out the bundle after the adjournment and SAK acknowledged she had received it by email the following day.
9. On 11 November 2024, Upper Tribunal Judge Butler heard SAK's application. Judge Butler granted SAK permission to appeal against the DBS's decision on the following grounds:
  - (a) Mistake of fact: SAK was willing to give evidence at an oral hearing and if she did and the Upper Tribunal panel found her evidence to be credible, it might indicate a mistake by fact of the DBS in terms of one or more of the findings of fact on which the Barring Decision was based;
  - (b) Error of law (1): The DBS may have made an error of law by failing to use its information gathering functions adequately in relation to the allegations it was

considering, including by seeking additional information from SAK in response to her written representations. SAK's written representations dated 02 October 2023 set out her position that the allegations had arisen from a workplace personal situation and stated: "*Evidence of this can be provided*". SAK also wrote that evidence could be provided of the unfair way in which she was dismissed. The DBS acknowledged SAK had made those representations and denied the allegations. It stated SAK lacked credibility in reporting this given her behaviour was reported by a senior member of staff and SAK also provided alternative context regarding her sleeping on duty, when questioned; and

- (c) Error of law (2): The DBS may have made an error of law in failing to take a rational approach to the evaluation of the evidence and / or failing to reconcile conflicting evidence in an adequate way. In its Barring Decision Summary, the DBS had acknowledged differences in the accounts given against SAK (by NJ and KM) but decided this did not detract from their credibility because it considered contextual details were corroborated. The DBS also acknowledged NJ's account was not fully corroborated. It appeared from the Barring Decision Summary reasoning that the DBS concluded SAK's account was not credible because her behaviour was reported by a senior member of staff and SAK provided alternative context about sleeping on duty when questioned. It was unclear what "alternative context" meant. It was also unclear whether the DBS preferred NJ's account to SAK's simply because she was more senior than SAK.
10. Upper Tribunal Judge Butler directed the DBS to obtain and disclose to SAK and the Upper Tribunal:
- (a) copies of all documents relating to the AH Group's investigation into SAK that had not already been disclosed. This was because SAK had disclosed some incomplete email correspondence with the AH Group to the Upper Tribunal about its investigation. This correspondence (including the missing emails) was not included in what the AH Group had disclosed to the DBS with its safeguarding referral; and
- (b) copies of the care plans for, and records of checks completed by care assistants in relation to the residents in rooms 22, 31, 32 and 39 at the relevant care home, for the period from 01 January 2023 to 28 February 2023 inclusive.
11. The Upper Tribunal also directed SAK to produce further documents, including a written account of what she said had happened, and some of the missing emails described at paragraph 10(a) above.
12. On 06 May 2025, the Upper Tribunal extended time for the DBS to provide the relevant documents and to provide its response to SAK's appeal. This was because SAK's former employer had given the DBS incomplete disclosure of documents.

13. The DBS provided the Upper Tribunal with 635 pages of additional documents in response to the directions at paragraph 10(b) above. These comprised the care plans for the relevant residents for longer periods of time than covered in Upper Tribunal Judge Butler's directions. When preparing for SAK's appeal, however, we found the documents covering the periods outside January and February 2023 were also relevant to what we needed to consider in determining the appeal grounds on which SAK had been given permission to appeal. We looked at all the records provided.
14. On 28 October 2025, via our clerk, we asked the DBS to provide documents mentioned in the DBS's updated index to its bundle, which were missing from the version of the bundle we and SAK had received. These were received the same day. At our request, our clerk also contacted SAK by email on 28 October 2025 to ask whether she had planned to send in the documents described at paragraph 11 above. Nothing was received.

### **The Upper Tribunal substantive oral hearing**

15. We held an oral hearing of SAK's appeal by CVP on 29 October 2025. SAK represented herself and Mr Ashley Serr of counsel represented the DBS. We were grateful to them both for the way in which they took part in the hearing and how they helped us address the matters we needed to decide.
16. At the hearing, Mr Serr confirmed that the various pages within the DBS bundle that contained more substantive redactions (relevant wording blocked out in black), related to residents in other rooms, for example, room 17 (page 606 of DBS bundle). Mr Serr confirmed these were unrelated to what we needed to consider in terms of the allegations the DBS found proved against SAK.

### **The legal framework for Barring Decisions**

17. The SVGA 2006 provides a person to be included in one or both of two Barred Lists, one for vulnerable adults and the other for children. Schedule 3 to the SVGA 2006 sets out provisions relating to adults (paragraphs 9 to 10). It sets out a number of ways in which the DBS may decide to include a person's name on a Barred List. In the present case the DBS relied upon the 'relevant conduct' gateway. This required the DBS to be 'satisfied' of three matters, namely:
  - (a) that SAK was at the relevant time, had in the past been, or might in future be, 'engaged' in, 'regulated activity' in relation to vulnerable adults (paragraph 9(3)(aa) of Schedule 3 to the SVGA 2006);
  - (b) that SAK had 'engaged' in "relevant conduct" (paragraph 9(3)(a) and paragraph 10 of Schedule 3); and
  - (c) that it was 'appropriate' to include SAK on the Adults' Barred List (paragraph 9(3)(b) of Schedule 3 to the SVGA 2006).

18. Where the DBS was satisfied of all three matters at paragraph 17 above, paragraph 9(3) of Schedule 3 to the SVGA 2006 required it to place a person's name on the Adults' Barred List.
19. It was agreed that SAK had worked as a care worker for vulnerable adults between July 2022 and February 2023. SAK therefore satisfied paragraph 17(a) above.
20. With regard to paragraph 17(b), SAK's case is that she had not engaged in the conduct alleged and that the DBS's decision that she did, involved the DBS making several mistakes of fact. SAK did not argue that if the alleged conduct were found to be proved, it would not amount to 'relevant conduct' for the purposes of the SVGA 2006.
21. In terms of paragraph 17(c) above, "appropriateness" is not a matter for the Upper Tribunal, unless the decision-making around the issue of appropriateness is irrational.
22. Section 4 of the SVGA 2006 sets out the circumstances in which an individual may appeal against the inclusion of their name in a Barred List. An appeal under section 4 may only be made with the permission of the Upper Tribunal (see section 4(4)).
23. An appeal may be made only on grounds that the DBS has made a mistake on any point of law or in any finding of fact which it has made and on which the barring decision was based (see section 4(1) and (2)). Section 4(3) provides that, for the purposes of section 4(2), whether or not it is 'appropriate' for an individual to be included in a barred list is "not a question of law or fact" and so, to that extent at least, is non-appealable.
24. Section 4(5) of the SVGA 2006 provides that unless the Upper Tribunal finds that the DBS has made a mistake of law or fact, it must confirm the DBS's decision. Section 4(6) of the SVGA 2006 sets out the outcomes available to the Upper Tribunal if it decides the DBS has made a mistake of law or fact. These are to either: (a) direct the DBS to remove the person from the barred list(s) or (b) to remit the matter to the DBS to make a new decision. Following **DBS v AB** [2021] EWCA Civ 1575, the usual order will be for the Upper Tribunal to remit a matter back to the DBS unless no decision other than removal is possible on the facts.
25. As explained at section 4(7) of the SVGA 2006, if the Upper Tribunal remits a matter to the DBS under section 4(6)(b), it may set out any findings of fact it has made on which the DBS must base its new decision. Furthermore, the person must be removed from the list until the DBS makes its new decision (unless the Upper Tribunal directs otherwise).
26. The Court of Appeal has made several recent decisions about the relevant principles to apply when considering how the Upper Tribunal can deal with the question of a mistake of fact in a DBS decision. See **DBS v JHB** [2023] EWCA Civ 982; **Kihembo v DBS** [2023] EWCA Civ 1547; and **DBS v RI** [2024] EWCA

- Civ 95. These Court of Appeal decisions are binding on the Upper Tribunal, and it must apply the relevant principles set out in them.
27. The decision of the presidential panel of the Upper Tribunal in **PF v DBS** [2020] UKUT 256 (AAC) is also relevant to the mistake of fact jurisdiction of the Upper Tribunal.
  28. Section 4(3) of the SVGA 2006 makes clear that the Upper Tribunal only has limited powers to intervene in relation to whether it is appropriate to include a person in a Barred List. The scope for challenge by way of an appeal is effectively limited to a challenge on proportionality or rationality grounds.
  29. At paragraph 43 of **DBS v AB**, the Court of Appeal stated:

“...unless the decision of the DBS is legally or factually flawed, the assessment of the risk presented by the person concerned, and the appropriateness of including him in a list barring him from regulated activity... is a matter for the DBS”.
  30. At paragraph 55 of **DBS v AB**, the Court of Appeal explained:

“[The Upper Tribunal] will need to distinguish carefully a finding of fact from value judgments or evaluations of the relevance or weight to be given to the fact in assessing appropriateness. The Upper Tribunal may do the former but not the latter...”.
  31. The decision of the Court of Appeal in **R (Iran) v Secretary of State for the Home Department** [2005] EWCA Civ 982 indicates that materiality and procedural fairness are essential features of an error of law. The SVGA 2006 does not contain any provisions to provide a basis for departing from that general principle. See **CD v DBS** [2020] UKUT 219 (AAC).

### SAK's oral evidence

32. DBS made its Barring Decision about SAK on the basis of documentary evidence, in the form of the referral form and related documents from the AH Group and SAK's written representations in response to the Minded to Bar letter.
33. As confirmed in paragraph 29 of **RI v DBS**, the Upper Tribunal is entitled to hear evidence from an appellant and assess it against the documentary evidence on which the DBS based its decision. Furthermore, the Upper Tribunal may view the oral and written evidence as a whole and make its own findings of fact (see paragraph 31 of **RI v DBS**).
34. The only witness in the appeal was SAK. The DBS did not call any witnesses. SAK had not provided a witness statement to describe what she was planning to say. SAK told us she did not realise she had been asked to send in any documents. In the hearings of her applications, SAK had previously explained that she struggles with written documents and some of the correspondence with her employer, and her representations to the DBS, had been written by her aunt.

35. With Mr Serr's helpful agreement, we heard evidence from SAK in the following way. The Upper Tribunal panel members asked SAK open questions about the layout and arrangements in place at M Care Home. We also explored with SAK the different types of care plan documents the DBS had obtained, with SAK explaining when and how these would be completed and where the care home would keep them. We agreed with Mr Serr that we would break early for lunch so that he had the opportunity to reflect on these parts of SAK's evidence before asking her questions in cross-examination. We also waited until Mr Serr had the opportunity to cross-examine SAK about the allegations, before asking our own questions about them.
36. SAK had a baby in December 2024, and we could hear the baby in the background at the start of the video hearing. When we asked, SAK explained she was supposed to have a babysitter, but they had let her down 10 minutes before the hearing and there was no one else available to look after the baby for her. As we explained to the parties at the time, we monitored the situation to make sure SAK was not distracted by having to attend to what her baby needed, and that there was no disruption to what Mr Serr and the Upper Tribunal panel also needed to address. After a few minutes, SAK's baby settled and was quiet throughout the hearing, including after the lunch break.
37. SAK told us there were two floors containing residents at M Care Home. There were 18 residents downstairs and around 19 or 20 upstairs (in rooms 19 to 39). There was a dining room upstairs in the middle of the building, with resident rooms on either side. There were two corridors going off from the dining room, one to the right and one to the left. There was a lounge area as well, further down the corridor, where room 31 was located, just to the side of it, facing that bedroom door.
38. SAK explained that after she started working at M Care Home in July 2022, she had always worked the night shift. These involved one care assistant working upstairs, one downstairs and a separate team leader. Her night shifts ran from 8pm to 8am.
39. SAK told us that during a night shift, the team leader would split their time between the downstairs and the upstairs areas or would base themselves in the downstairs office. SAK said that as team leader, NJ would come upstairs if needed but would not pop in to see how SAK was doing.
40. SAK explained that when her shift ended, she and the other care assistant would go to the team leader and tell them anything that needed to be said to the day staff. The team leader would then carry out the handover with the day staff. While this happened, the night staff had to wait until a day staff member came to take over physically from them.
41. SAK told us there were no set times for taking breaks during a night shift and the staff decided amongst themselves who went for a break and who covered while they did. SAK told us she used to take her 30-minute break as two 15-minute breaks, which was easier for her. If she was going to take a 15-minute break,

SAK would have to find the team leader to come and cover for her while SAK took her break. SA explained she would sometimes not take a break and continue through the night. The staff would take turns about who worked with the residents upstairs. Some staff preferred working upstairs but it was unfair on other staff to always have that pattern. SAK said she had more of a bond with the residents upstairs and therefore preferred working on that floor.

42. The DBS had decided that SAK failed to attend to the continence needs of WR (room 22), EG (room 32), MS (room 31), and DH (room 39). All their rooms were located upstairs. SAK had worked with WR, EG and DH since July 2022 and with MS from a few months later (when MS moved in).
43. SAK explained that when the night shift started, she would check the residents, then go round with their suppers. There would be two hourly checks to complete on all the residents. SAK would need to clean and set up the dining room, the hallways, do the laundry and help out other staff in any way she could.
44. SAK told us rooms 31, 32 and 39 were located on the left side of the Care Home and room 22 was located at the right. There were more rooms at the top end of the building, where room 22 was located. SAK was responsible for all the upstairs rooms when she carried out an upstairs shift. Her first job would be to go into a resident's room, check if they needed toileting and deal with this if they did. SAK would also ask the resident what they wanted for supper or if they wanted to go to bed instead. Supper would involve sandwiches, cakes and biscuits in the resident's room.
45. SAK said that one or two of the upstairs residents could sit in the dining room and walk around but did not do this very often. She explained the residents who lived on the first floor were not independent and tended to be a little bit more accepting of needing care. SAK would ask if they wanted to go to the toilet or if they needed anything. Some residents, such as WR, were difficult to move and tended to be dealt with in doubles (by two staff members moving the resident together). SAK said MS would always say if she needed a change or wanted to go to the toilet or have her pad changed. EG did not really talk, walk or do anything, and had to be checked physically rather than asked about what she needed. SAK would deal with EG in a double. SAK told us that she would go in and check DH; if she was a good mood and not fidgeting, SAK would change DH herself, but if she was not in a good mood, SAK would have to do her as a double.
46. SAK explained that WR was quite a big man and at times she would have to get a staff member from downstairs to help her move him around in the bed, to make sure the bed was dry and clean and to tuck him back in. The day staff used a hoist for WR, but the night staff did not because he was in bed and asleep by the time their shift started. SAK described giving WR pressure relief, which involved moving him to his side to avoid him developing pressure sores. SAK could change WR's pad by herself, but if his bedding needed changing, this would take two people. She said that the upstairs care assistant and team leader would normally team up to do the doubles upstairs.

47. Asked how often the checks would take place, SAK explained they were every two hours although MS's family had asked for her checks to be moved to 8pm. 2am and 8am. MS was getting annoyed when staff went in because the light in the corridor would wake her up when they opened the door.
48. SAK explained that when she did the checks, if the resident in a room was asleep, she would go over and gently wake them, telling the resident she was checking the pad. Most of the time, the resident would roll over and let SAK check it. Some residents loved having her come in at 2am to see them and would want to chat. As part of the checks, if the resident was awake, SAK would also ask them if they were ok. If the resident or their bed, was wet, SAK would clean this up.
49. SAK explained that the document marked "My daily record" for each resident would be completed every day with the following: whether the resident was asleep or awake when the staff member first checked on them, how they had been through the night, whether they had been given personal care or pressure relief and if there were any concerns. SAK said that if the resident was asleep all night, there was little the staff could write about them, so the day shift entries in the daily record were more detailed. SAK told us that what was written was a summary of everything done throughout the night or day shift. SAK confirmed that if a resident was behaving in a difficult way, this would be put on the daily record document, explaining what had happened. She would put her signature on the record. If another staff member had helped her, they would add their signature to the record as well.
50. SAK confirmed the separate document described as "My bath and shower record" would only be completed during the daytime, although if the resident was found soiled during the night and needed a bath, the night staff would probably fill this out. SAK had never had to bath WR during the night.
51. SAK confirmed there were specific documents for WR described as a "Hoist, Transfer aid and Sling Assessment" and "Wheelchair and scooter risk assessment for WR because he could not weight bear or transfer himself and had to be lifted using a hoist. SAK explained there was a Positional Chart to fill out for both WR and EG because they required pressure relief checks to be completed throughout the shift. SAK explained that even if the resident declined a pressure relief check, the care assistant would still have to write down what had happened. The AH Group would need proof that it was offered and declined in case a family member complained. SAK confirmed the medication records were filled out for residents by the day staff.
52. SAK explained the observation chart was different to the positional chart. She said that unusual behaviour, such as a resident pulling belongings out of a bedside cabinet or trying to pull themselves out of bed, would be recorded in the observation chart. SAK confirmed that some of WR, EG, MS and DH had an observation chart but not all of them.
53. SAK told us a resident's care plan would be kept downstairs in the main office. The documents kept upstairs were the daily record charts, observation and the positional charts, and any incident / accident records where the resident needed

to be monitored during a shift. SAK told us these documents would be kept upstairs in the dining room on the table nearest the door. All the daily records for the upstairs residents were kept in one folder, with 20 pages inside (one per resident).

54. SAK said she would fill out the records to explain whether personal care was needed (and given), what time she checked on them and whether the resident was ok – including if they were asleep or awake. SAK said that once she had completed her checks, she would go round and do the next set of checks and keep doing this throughout the night. She later confirmed that skin charts, fluid charts, eating charts, positional charts, observations and toileting charts were all in the upstairs folder.
55. Asked who would fill in these books on the upstairs floor, SAK explained that if she did the checks, she would complete the books. If a resident needed personal care and SAK asked the team leader to come and help while she delivered this, the team leader would put her own name against the checks she had completed. If SAK and another person were doing a double, both staff members would sign the record.
56. SAK told us some of the residents' rooms had fall sensors, also described as a falls mat. It would have a wire at the back and if someone stood on it, this would trigger an alert on the care assistants' pagers. Alternatively, there would be a button on the wall with something the resident or a carer could pull to summon help. These falls buttons were in all the rooms and in the corridors. Some of the residents also had alarms around their necks. These were the residents who were more independent with toileting and personal care and needed the alarm just in case they had a trip and fall.
57. SAK told us the pager was clipped to her pocket. If triggered, it would start beeping, the screen would go orange and it would indicate which room button or corridor button had been pressed. The care assistant would go straight to the room in question. To turn off an active alarm, SAK would have to go into the room (or to the relevant part of the corridor) and press the wall button. If a button was pressed or a falls mat sensor went off, the team leader would also receive an automatic notification.
58. SAK told us that WR did not have a falls mat but had a crash mat on the floor in case he rolled out of bed. EG (room 32) and DH (room 39) had falls mats in their rooms. These mats were located next to the bed and if the staff member stood on one of them while doing their checks, the sensor would go off. SAK said that a few times the falls mats had been broken for a while and the day staff would tell her in handover about this. For DH, in room 39, her falls mat had been broken for over a week, nearly two weeks. DH had a thing about pulling on the wires, meaning they broke faster and there were only so many mats available to use.
59. SAK confirmed there were also handover sheets completed when shifts changed from a night shift to a day shift (and day to night). The team leaders wrote those notes and they were put into a book downstairs.

60. SAK told us the nightshift in question started at 8pm on 15 February 2023. She was the upstairs care assistant, KM was the downstairs assistant, and NJ was the team leader. SAK said NJ and KM started working at the care home around the same time. SAK did not have an issue with NJ when she first started working with her, but after a few months, NJ was on her phone when she saw a picture of SAK and her cousin, BM. NJ said SAK's cousin was her friend and asked how SAK knew her. SAK explained they were related, and that her family did not have anything to do with her cousin because of things that were going on. SAK said NJ said she was seeing BM the next night. SAK said after this point, NJ's attitude towards her changed.
61. SAK said that for two or three months before February 2023, NJ had been quite funny with her and SAK was not comfortable working with her. NJ had been the team leader on her shift most of those times or had been the other care assistant. SAK said she was so uncomfortable with NJ's behaviour that she was looking around for another job. Unfortunately, SAK had told someone else at work that she was looking for a different job. Other staff said they didn't want to see SAK go, but NJ asked her directly if she was leaving. SAK replied she was, and she wasn't going to lie to NJ about it. Things got a lot worse after that – for example, NJ would nitpick about things SAK had done or complain about her to RS, the other team leader.
62. SAK said that she arrived early at work, at around 7.20 pm on 15 February 2023, because she had to take the bus to work and had to time her arrival with when the bus dropped her off. SAK said that during the nightshift on 15 to 16 February 2023, SAK was already in the office when NJ arrived, but NJ did not talk to her. NK and KM came in together, laughing and joking. Neither of them spoke to SAK and started talking to the day shift team leader instead. SAK said she was told she had to go upstairs for the shift even though it was her turn to go downstairs and she never really heard anything from NJ and KM after that. At one point they asked her to come down and keep an eye downstairs. SAK could not remember specifically when this was. She thought it was midway during her shift. NJ was downstairs in the office doing her courses online for her job. NJ said she was going to the shop or McDonalds and told SAK to keep an eye on downstairs. SAK said she was upset by this because she was being told to look after around 40 residents by herself and no one had asked if she wanted anything from outside.
63. SAK said she had already told NJ that she did not feel well at the start of the shift. She said she had also had a migraine a few nights before and had told NJ and RS about this. SAK said at that time, NJ had acted like they were best friends and she thought everything was ok. On the night of the shift on 15 February 2023, however, SAK felt she was singled out and pushed to the side, which triggered symptoms from her long-term anxiety.
64. SAK told us that when the shift finished, she clocked out and was standing at the main doors talking to the day staff. The manager, AC, was talking to one of the day staff and NJ had already left. AC asked SAK to go into her office and said it had been reported that SAK was sleeping on shift and had not done her checks, money had been found on the floor in WR's room and MS had a bruise on her face.

65. SAK told AC the only time she was sat down at all was when she sat down in the dining room with her head to one side and her eyes closed. The lights had affected her migraine and the tablets she was taking were not helping. SAK said she was told not to come into work the next day, and this was her second to last shift before she was supposed to go on holiday. AC also asked her if it might be her money on WR's floor. SAK confirmed it wasn't and that her money was in her bag in the downstairs office. SAK said she told AC that WR didn't have money in his room because he was not allowed to have it and his family held it.
66. SAK told us that AC said MS had a bruise on her face (gesturing to her cheek when giving this evidence). SAK said that when she had the handover on 15 February, the day staff had told her that MS had a red mark on her face, which they thought was from MS sleeping with her face on her bracelet buzzer. SAK said she went into MS's room during her shift and asked if it was painful or MS wanted cream. MS had said no, she was fine and said: "Silly me". SAK and MS had a giggle about it because of the way MS was sleeping. SAK told AC this.
67. SAK said that after she had carried out her checks during the night shift, she had completed the folders in the dining room, everyone was clean and asleep. She sat on one of the chairs with her head back, having turned off the light because it was affecting her head even more and she didn't want to go home sick and leave the shift one member short. SAK said she sat with her head and her eyes closed. Five minutes later NJ said her name and SAK answered her. NJ asked about checks and SAK said they were done. NJ then went back downstairs. SAK thought this was after midnight. SAK had taken two paracetamol and some ibuprofen around 1.5 to 2 hours before NJ came up. SAK said she had taken a migraine tablet before she went to work and that she can only take so many of them during the day. SAK told us she did not take any breaks during her shift because she wasn't feeling well and there was no point taking a break and having something to eat when she felt unwell. SAK said she carried on during the nightshift instead.
68. SAK said after she was suspended, the next time she went to the care home was on 27 February 2023. She tried to tell AC her side of the story and was sitting there visibly upset and crying but no one was listening to her. SAK said that she resigned on 09 March 2023 because she was told that if she went back to work, she would still have to work with NJ and she felt uncomfortable working with her. SAK's wanted to fight the disciplinary even if she was not going back to work at the care home. Then SAK's nan in Scotland had a health scare and SAK was not doing too great with her anxiety and the situation. SAK rushed up to Scotland to be with her nan because she had found a lump and SAK was told she might not have much time left. When SAK was sent details after that, she had completely forgotten about it and then received an email from AC saying she had not replied to the last email about the grievance.
69. In cross examination, SAK said NJ knew she was unwell because they had been on the same shift a couple of days before when she told NJ and that on 15 February 2023, when NJ arrived, the dayshift team leader asked SAK if she was ok in front of NJ and SAK said: "Yeah, I've just got a migraine".

70. SAK said NJ started working at M Care Home after her, late in 2022, but had been promoted to team leader because the care home asked if anyone wanted to apply for it. SAK said she was asked if she wanted to go for it and she said no, because she did not feel comfortable giving the residents medication because if anything went wrong, she wouldn't be able to live with herself. SAK said that because she struggles to read and write, she finds medication books harder to complete. SAK explained this was not NJ's first care job, so NJ knew what to do. SAK said the shifts with NJ were really good at first but as soon as NJ saw a picture of SAK and her cousin, NJ was really funny with her. SAK said her cousin had tried saying her family had done things they hadn't and that this had included her uncle and aunty. She said there was a whole family feud going on at the time.
71. In cross-examination, SAK said that there could not have been any money on WR's floor during the nightshift because he did not have money in his bedroom, and his legs did not work so he could not get out of bed and onto the floor to get to his possessions in his cabinet. SAK said she was not asleep when NJ called her name, and she answered NJ the first time that she spoke to her. SAK said that at this time, she was sitting in a chair and had her head back (in describing this she physically gestured it being slightly on one side). She was in this position for about 5 minutes. SAK said she was in the dining room after finishing her notes and was in the dark because the lights made her head worse. Pressed about how dark it was in the room, SAK said that the chair she sat on was near the door and it was not completely dark in the dining room because she could see the light coming in through the door. SAK said the hallway lights were on, and she could see NJ clearly because she was standing in the doorway with the door open. SAK said she then saw NJ go back to the lift to go downstairs. When asked, SAK said she did not see KM standing in the doorway with NJ.
72. When Mr Serr said KM might have been stood to the side or round the corner, SAK said it was possible. She told us in response to our subsequent questions that so far as she was aware, KM was not with NJ at that time because the door had glass in the middle and wood around the outside and she could see through it. SAK also said that after NJ left the doorway, SAK saw her go to the lift by herself and take it downstairs.
73. When asked which rooms were closest to the dining room door, SAK said they were rooms 19 or 22; the resident in room 19 did his own things and only needed someone to pop their head in at 2 am to make sure he was asleep and breathing. SAK said the position was the same for rooms 20 and 21. She said the first room after the dining room that would involve physically changing and checking a resident would be room 22, and the next rooms after this needing active care would be room 24 on the same side as 22, and 25 on the opposite side.
74. Mr Serr put the account from NJ at page 48 of the bundle to SAK. In response, SAK said that she answered NJ the first time she was spoken to and that NJ did not say anything to SAK about appearing to be asleep. NJ just asked if she had done the checks and SAK replied that she had.

75. Asked about the account from NJ about trying to speak with SAK during the night by radio and mobile phone, SAK said that half the time the radios were not charged and she would keep her phone in her pocket for this reason (to get through if the radio had died due to low battery). SAK said that when NJ rang her, she was with a resident in their bathroom (she thought it was room 33). She had undressed the resident and was trying to get her changed. SAK said she couldn't just get her phone out and answer it in those circumstances and she did not hear NJ on the radio because it was dead. SAK said she had the mobile phone in her pocket on silent and could hear it vibrating while giving personal care. SAK said that once she had finished delivering this, she went into the bedroom and called NJ back to see what she needed.
76. Asked about NJ's account that a woman had fallen, SAK said she remembered someone falling later on during the shift. SAK said it was DH, in room 39 and her floor sensor had not been working for ages. When she changed DH earlier in the shift, it did not cross her mind to check the falls mat because it had been broken for ages. SAK said she told AC it was her fault for not double-checking the mat but at that time it did not cross her mind because it had been broken for ages and she had not been told that it had been fixed or a new one provided.
77. Asked about KM's statement, SAK said that KM had written that she was found asleep at 4 am but this was when NJ said she was radioing through to SAK. SAK said, "*How could I be asleep when I had already been in a room sorting someone out while NJ was trying to call me?*". Mr Serr suggested KM might have been wrong about the timing, writing her statement the day after a long night shift when she might be fuzzy on the details, and what KM might have meant is 3am. SAK replied that at 4am, KM would know what she should be doing, which is going around the rooms and doing her checks of residents. SAK said she did not see how KM could have got that timing mixed up.
78. SAK confirmed she was not involved with the fall for DH recorded at 6.10am on 16 February 2023. SAK told us she heard the buzzer but was in the bathroom with a resident who was unsteady on their feet, so could not leave them and run as she didn't want to cause two falls to get to one. SAK said that when she went to room 39, NJ was there. NJ asked SAK if the falls sensor was on, and SAK explained it hadn't been working. DH was sat on the floor. SAK said that NJ asked her to help DH up and sit her in the chair so she could check her back. SAK said that she put DH into the chair and checked her over. NJ said she would go and record the fall on the paperwork. SAK confirmed this would have been the document NJ completed the document on page 690 in the bundle.
79. Asked about NJ's statement that she had reported SAK at other times for not checking or changing residents, SAK said no, this was the first time she had been reported for anything. SAK said this allegation came as a surprise to her.
80. In cross examination, Mr Serr asked SAK about the daily record entries and she explained they would reflect all checks made at the time. Mr Serr suggested that SAK's entries in the positional chart for WR on 15 February 2023 (page 310) contained very precise timings. He asked SAK whether she might have filled them out retrospectively. SAK said no, and that WR's room was always at the top so

his would be the first one she would go into when carrying out the two hourly checks. Mr Serr suggested that WR would likely wake up during personal care when changing his pad. In response, SAK said WR would stay asleep throughout the full night, and it would be the same for every staff member. SAK said she could change WR's pad by herself while he was asleep but if he was soaked and the bedding needed changing, it would need two staff to do it.

81. Asked by Mr Serr why her entries for all the residents seemed to use such similar wording, SAK said that most of the other staff members wrote very similar things for each resident because if the resident was asleep all night, there is nothing else they can really write compared to the day staff. If she changed a pad, this might need noting, and this is what the reference "personal care" meant in the notes.
82. SAK told us that if she went into a resident's room and saw them with a bruise, she would go and tell the team leader. SAK said that she was told at handover from the day shift staff member that MS had a mark on her face from the buzzer on her bracelet. SAK said that as it had already been passed on by the day staff, she did not pass it on to NJ as a new thing. SAK told us no one mentioned MS having a bruise on her arm and that she would not have noticed this because MS wore long sleeves and was already in bed when she went in to see her.
83. Asked whether NJ would need someone with her to count a resident's money, SAK said she believed they would all do the same thing and have someone there, because if the care assistants did anything and it came back, it would be the assistant's word against theirs (meaning the resident or family member). When asked about recording this, SAK said it would be recorded, and it should have been in the daily record sheet and also put into a handover from one team leader to the other. SAK said there were written handover notes, but she had never seen them and the handovers would be given verbally at the shift change. SAK said she did not understand why NJ would have called KM upstairs to help her check and change the residents because KM should be doing her downstairs checks and SAK was upstairs and able to check the upstairs residents.
84. We asked SAK why the situation with her cousin it was relevant to what had happened. SAK said BM had made a false allegation that SAK's uncle had beaten BM's wife (LF) on a night out. SAK referred to the email on page 133 of the bundle, which she said was from her uncle's solicitor. This confirmed SAK's uncle was cleared of the allegations and that the magistrate stated he simply did not believe BM or LF about them. SAK said this was long before the allegations about her work in February 2023.
85. SAK said BM had also claimed SAK stole money from LF's underwear drawer and had hit their 5-year-old son when she used to care for him. SAK said that after BM and LF had split up, she had seen LF and their son walking down the street and the son had come towards her and cuddled SAK, which he would not do if she had hit him.
86. NJ had referred in her email dated 16 February 2023 to undertaking spot checks upstairs. Asked if she saw where NJ went after she spoke to SAK in the dining

room, SAK said she saw NJ get in the lift just outside the dining room and go downstairs. Asked whether spot checks were a normal part of the shift, SAK said they were not, and this was the first time she had heard of them being done.

87. We asked SAK about whether she would have known, if NJ had gone to residents' rooms and carried out the checks and changes set out in her email on page 48 of the bundle. SAK said she would have been aware of it because NJ would have to turn off the sensor in room 31 (MS's room), otherwise SAK would be notified as soon as the door opened by a loud beeping noise and buzzing from the sensor inside. SAK also said that where she was sitting in the dining room, she would have seen people walking past to go and carry out the spot checks. Asked if the spot checks NJ said she carried out should have been recorded anywhere in the documents, SAK said that if they had been done and residents found wet, this should have been put in the night books in the dining room and, for WR and EG, also recorded as personal care in their positional charts.
88. Asked about her relationship with KM, SAK said that on the 15 February 2023, it was a little bit off and she didn't speak to SAK. SAK said that she thought it might be her feeling anxious and unwell but through the night it got worse, and she messaged a friend who used to work there, asking what she thought about it. SAK's friend said she did not know what KM's issue was, and the week before, KM was picking SAK up from home and dropping her off at work.
89. When asked, SAK said that what got worse was feeling singled out and not involved in anything. She said that when she went downstairs about the care plans, both NJ and KM walked out of the office to the laundry and did not speak to her. SAK said that normally, they would turn to her and explain they were going to the laundry and to let them know if anything and how to deal with an emergency. However, NJ and KM did not do any of this and simply toddled off without speaking to SAK at all.

### **Mr Serr's submissions on behalf of the DBS**

90. Mr Serr made submissions in four related areas about why the DBS considered it had not made a mistake of fact in finding the allegations proved against SAK. These were the following.

*(a) NJ's evidence was believable and should be relied on*

91. Mr Serr submitted we should consider NJ's written evidence to be believable and accurate. He argued the alleged history of animosity between SAK and NJ was convoluted without much to back it up. Mr Serr invited us to conclude it was far-fetched for NJ to concoct a story against SAK and involve another innocent party (KM) in it, just because of some history involving SAK and her family and cousin. Mr Serr submitted that leaving aside the issue of timings, SAK did not really dispute how NJ described seeing her in the dining room, sitting in a chair with her feet up and her head back and to one side. SAK also did not really dispute that she did not answer NJ on the radio - she said she did not hear it as the radio was dead. SAK did not dispute that she had not answered her mobile phone calls -

she said she was delivering personal care when they were made and could not answer the phone.

92. Mr Serr argued that if NJ was accurate in this evidence, could she really be said to have made up the other evidence? Mr Serr said that SAK did not really dispute NJ's evidence at pages 46 and 48 of the bundle. Mr Serr submitted that SAK could not say what state the residents were found in on 16 February 2023 because she was not with NJ when they were checked. All SAK could say was that in her case, when she attended to those residents at around 2am, they were fine. NJ said they were very much not fine and, coupled with finding SAK asleep, NJ put two and two together and it was clear that SAK neglected care users and left them to soil themselves.
93. Mr Serr acknowledged NK and KM had not recorded the checks they said they made and the state in which they said they found residents. Mr Serr said there were two possibilities for this. One was that it was made up and NJ and KM never delivered that care. Mr Serr submitted the alternative explanation was they did not record the care provided because it was not planned for, it was not a routine check, and NJ had focused on providing the care and not noting it. Mr Serr submitted that just because it was not minuted in the documents did not mean the care was not provided. He submitted that given how much of NJ's account SAK accepted to be true, the rest of what NJ had written was likely to be true.

*(b) NJ's evidence was corroborated by KM's evidence, which made both sets of evidence more reliable*

94. Mr Serr submitted that not only did we have NJ's evidence, it was also corroborated by KM's statement. He argued that there was no real history of animosity between KM and SAK. Mr Serr acknowledged KM's statement was "pretty thin" but argued this was due to SAK's employer not having a fully ventilated disciplinary process, which he said was due to SAK failing to engage. Mr Serr argued that the employer only really carried out an investigation saying there was a case to answer and had reached a brief conclusion.
95. Mr Serr acknowledged KM was not properly interviewed and neither she nor NJ were asked about the discrepancies in their statements. He submitted the reason for this was SAK herself; the disciplinary process was truncated because SAK did not engage in it. Mr Serr argued that the documents provided indicated there were quite a lot of opportunities given to SAK to take part; dates were moved, she was allowed to bring her aunt as a companion, and, generally speaking, SAK failed to turn up to meetings. Mr Serr argued SAK may have engaged throughout some points in the process, but when it came to key hearings, she did not attend. He challenged SAK's evidence that she did not receive the email of 11 April 2023 as something: "I am not sure I agree with", but, even if it was correct, Mr Serr suggested that it was for SAK to follow up by email, asking what had happened to the meeting she requested.

*(c) What SAK recorded in the residents' care plans could not be relied upon*

96. Mr Serr submitted that while there were entries in the care plan documents for the relevant residents indicating SAK had checked them during the night shift in question, these did not establish that she had actually done so. He submitted that some appeared to be entries for the whole night and others appeared to be more regular checks, but were suspicious because they were recorded on the hour and were very generic entries. Mr Serr argued the Upper Tribunal needed to ask itself whether it could rely on those documents to say that SAK did provide the care she recorded. He submitted the records were not comprehensive and questioned whether it was rational for SAK to say she was providing personal care while a resident was asleep.
97. We asked Mr Serr about the entries by other care assistants on pages 723, 725 and 727 of the DBS bundle. Some entries appeared to be general in a similar way to SAK's entries. Mr Serr said this showed that care assistants provide generic entries, but did not mean they all provided the stated care. He submitted he was not sure the totality of the care plan documents took the Upper Tribunal further one way, or the other. Mr Serr said he accepted it was probably a point against the DBS that the people said to have provided the care to residents when SAK failed to do so, did not record this. Mr Serr argued however that he was not sure the Upper Tribunal could look at an observations chart and see an entry that says a resident was: "*asleep, asleep, asleep, asleep*" and conclude from it that those checks had been undertaken, when the notes were so generic and potentially retrofitted.
98. We asked Mr Serr about the possible logical tension between: (a) his argument we should not rely on the lack of notes by NJ or KM as undermining their evidence about the alleged incidents and them delivering care, and (b) his argument we should not rely on the notes by SAK as corroborative evidence that she did carry out checks or deliver care. Mr Serr argued NJ was not responsible for looking after those residents that evening. He acknowledged NJ had not written on the relevant forms at 3am that the relevant resident was really wet and she had to give personal care. However, it was not like the records contained notes throughout the evening (e.g., at midnight and 8 am) and NJ missed including them at 3am. Mr Serr argued it might be said that NJ was simply a poor record keeper or did not need to record these matters when she did not usually administer care to the residents herself.
- (d) SAK's admission that she did not check the falls mat in room 39 and ought to have checked it*
99. Mr Serr submitted we had the admission from SAK in her evidence that she did not check the falls mat for DH in room 39 and that she accepted she was at fault for not checking it. Mr Serr argued that had SAK done so, she might have noticed the falls sensor was not working and it was not inevitable that she would not have noticed this.
100. Mr Serr submitted that in terms of a mistake of fact in one or more of the allegations the DBS had found proved, it had made discrete findings. These could be broken down into: (1) did SAK sleep intentionally while on duty, (2) did she fail to attend the continence needs of residents and (3) did she fail to turn a falls

sensor on? Mr Serr submitted that if the DBS made no mistakes of fact in finding those facts proved, SAK's appeal must fail. Mr Serr submitted that if the Upper Tribunal decided that the DBS made mistakes of fact in finding all those facts proved, the only decision properly open to the Upper Tribunal is to direct that SAK be removed from the Adults Barred List.

101. Mr Serr submitted that if the Upper Tribunal decided the DBS made mistakes of fact in finding some of those facts proved, but not others, the Upper Tribunal should remit the appeal back with findings of fact and to direct that SAK remained on the Barred List while the DBS made a new decision.
102. Asked what the DBS meant by "intentionally sleeping", Mr Serr submitted there is a range of behaviours that might constitute intentionally sleeping, from bringing in a sleeping bag with the intention of using it to sleep, to simply dozing off and somewhere in between. Mr Serr submitted that intentionally sleeping could include a person who, while working, goes to sleep and knows they are doing this. He argued that by putting her feet up with her head back and her eyes closed, SAK had created the conditions whereby she could not work and was likely to sleep. Mr Serr submitted this amounted to intentional sleeping even if for a brief period.

### **SAK's response to Mr Serr's submissions**

103. In response to Mr Serr, SAK said that NJ was the team leader, filling out paperwork had got NJ her job as team leader and she was always filling out forms in that role. SAK disputed that NJ would have done checks and delivered care that night without recording it, arguing NJ knew what to do, both as a team leader and as a care assistant. SAK said that if these events had happened, NJ should have written them down and handed over to the dayshift team leader about the bruise and the money. SAK argued that whether this is done at 3am or at 8am, the person must sit down and do it. SAK said she never fell asleep on the night shift, she doesn't sleep at night, and she never did at that job. SAK said she sat down and put her head back because her head felt like it was in a vice, which she had reported and that she was trying to do her job and not leave the residents at risk (rather than go home and leave the shift understaffed).

### **Our approach towards the mistake of fact appeal ground**

104. In *PF v DBS* [2020] UKUT 256 (AAC), the Upper Tribunal explained a mistake of fact may be in a primary fact, or in an inference, and it may consist of an incorrect finding, an incomplete one or an omission. The Upper Tribunal explained that one way to show a mistake of fact is to call further evidence to show that a different finding should have been made. The Upper Tribunal confirmed the mistake does not have to have been one on the evidence before the DBS and it is sufficient if the mistake appears in the light of further evidence or consideration.
105. We had the benefit of further evidence in deciding this appeal, in particular, the oral evidence from SAK during the hearing, together with the brief documents provided by SAK and the care plan documents provided by the AH Group (which were not before the DBS when it made its decision).

106. As explained in *RI v DBS*, where relevant evidence is adduced before the Upper Tribunal, the Tribunal may view the oral and written evidence as a whole and make its own findings of primary fact (Bean LJ at paragraph 31 of that decision).

### **Our assessment of the oral and written evidence as a whole**

107. Dealing first with SAK's oral evidence, we found her to be a credible witness in the evidence she gave during the hearing. There were a number of matters we found particularly relevant to SAK's credibility, which supported our assessment that her evidence could be relied upon:

- (a) SAK explained the different documents that made up the care plans for residents and why they must be completed. SAK knew what the documents were for and explained, in a straightforward and internally consistent way, when they were completed, and why. Relying on the expertise of the panel, we found SAK's explanation consistent with our own knowledge and experience of this type of documentation;
- (b) SAK's account of her actions during the nightshift on 15 February 2023 was consistent with the layout she provided for M Care Home, including where specific bedrooms were located upstairs. It made sense overall;
- (c) SAK's account of her actions during the shift on 15 February 2023 was generally consistent with what was recorded in the documentation in the DBS bundle. We drew those entries to SAK's attention during the hearing. SAK had made those entries in February 2023 and not seen them for over 2 years. We accepted she finds reading and writing documents difficult. Despite this, her account fitted with what they recorded. Her account was also consistent with the way other staff members completed their entries shown in the records;
- (d) SAK raised credible criticisms about the discrepancies in NJ and KM's written accounts. These highlighted inconsistencies that were relevant to whether they could be considered reliable. Furthermore, these points were often made in response to a question SAK had been asked rather than SAK pressing to make the point herself. This appeared to point away from SAK shaping the evidence deliberately simply to fit a narrative;
- (e) At times, SAK volunteered evidence that highlighted her own vulnerabilities rather than necessarily painting her in the most positive light. We considered this likely to indicate she was being truthful rather than saying something self-serving. For example:
  - (i) SAK told us she had been invited to apply for a team leader role but did not to apply because she didn't feel comfortable delivering the medication with her difficulties with reading and writing. We believed her explanation she did not apply for the role because if anything had gone wrong in it, she could not have lived with herself;

- (ii) SAK had produced emails showing she had pressed the AH Group to go ahead with the disciplinary meeting even though she had resigned, as form of grievance. SAK had contacted the AH Group about this several times. SAK's explanation that she chose to prioritise visiting her grandmother who might be dying, rather than follow up the meeting, admitted she effectively shut down her own grievance process; and
  - (iii) SAK said the falls mat in room 39 had been broken for around one or two weeks before the shift on 15 February 2023 and she had been told about this. No one had told her whether it was working on 15 February 2023. As a result, SAK did not double-check the sensor in room 39 during her shift. SAK told us that when her manager AC spoke to her about the shift, SAK apologised for not double-checking whether this falls mat was working; and
- (f) SAK provided a credible explanation of the noticeable change in NJ's behaviour towards her once NJ realised she was related to BM. SAK's description of how NJ and KM behaved towards her during the shift starting on 15 February 2023 was plausible. Some of the behaviours described at paragraph 62 above could be categorised as micro-aggressions. We believed SAK's evidence that she messaged her former colleague who knew everyone involved and asked if it was her anxiety or she was being given the cold shoulder. We decided what SAK described could be explained in the context of a family feud into which NJ had been drawn because BM was her friend.
108. We took into account, and placed some reliance upon, the Facebook screenshots SAK provided about NJ's connection to her cousin BM and the email to her uncle about the acquittal when prosecuted for assaulting LF. These documents are not substantial in terms of the evidence they contain. We relied on them to the extent that they showed NJ had a connection to BM, and SAK's uncle had been acquitted of an alleged assault involving LF with his solicitor recording the magistrate said they found BM and LF's evidence unreliable.
109. We took into account, and placed substantial reliance upon, the care plan documents provided to us about WR, EG, MS and DH during the night shift on 15 February 2023. We had the daily record, observation chart, and positional chart entries for WR during the relevant nightshift (pages 250, 310 and 331). We had the daily record entry for MS during the relevant nightshift (page 499 of bundle). We had the equivalent entry for EG on page 563. We had the observation chart and positional chart entries for DH during the night shift in question on pages 726 and 733. All the records included entries recorded by SAK about what had happened during the night shift. We had not been provided with the daily record for DH for the relevant night shift. However, we had other records for her during that shift completed by SAK. We also had, and took into account, the falls report completed about her by NJ on 16 February 2023.
110. To the extent it was relevant, we also took into account entries made in those documents at other times, including by other staff members. We used them to assess how records would, or might, be made generally. This was relevant to Mr Serr's argument that SAK's entries for her two hourly checks were not reliable

because of their timings and the fact they sounded very similar. As we pointed out to Mr Serr during the hearing, some other care assistants also recorded similar sounding (and timed) entries for the residents. See, for example:

- (a) the nightshift entry on 16 February 2023 on the daily record for DH on page 654 by care assistant “C”, which recorded: “*20.00 Pressure relief, 22.00 Personal care, 00.00 Pressure relief, 04.15 personal care*”;
  - (b) the post-fall continuation record for DH on page 654, recorded by C, which recorded: “*22.05 Asleep in bed, 00.00 Asleep in bed, 04.00 Asleep in bed. 06.00 Asleep in bed*”;
  - (c) the entries on 19 February 2023 by C that DH was “in bed” four times in a row (page 725);
  - (d) the entries on 22 February 2023 by MO that DH was: “*asleep*” at 00.00, 02.00, 06.00 and 07.40 and receiving “*personal car[e]*” at 04.00 (page 723 of bundle).
111. Set in this context, SAK’s entries for DH on 15 and 16 February 2023 of: “*2200 asleep, 0200 asleep, 0400 asleep, 0600 asleep, 0730 sat in chair*” appeared consistent with how other care assistants recorded checks at night. We accepted her explanation why they would be similar (i.e., little to record). We did not accept Mr Serr’s argument that the internal similarity of what SAK recorded in her two hourly checks, or the timing recorded for these, made them unreliable.
112. We took into account and assessed what was in the written accounts from NJ and KM. These were recorded in the email from NJ dated 16 February 2023, the note of the telephone discussion between AC and NJ dated 16 February 2023, and the handwritten statement from KM dated 16 February 2023. Having assessed those accounts, we did not find them to be reliable evidence of what happened during the night shift from 15 to 16 February 2023.
113. NJ provided a relatively detailed email on 16 February 2023, which she marked as a statement and which appeared to set out events in her own words. It was sent at 9.17am, about an hour after the relevant shift ended. The account given did not appear internally consistent. Putting on one side SAK’s evidence that it was unusual to carry out spot checks, if NJ did carry out spot checks and discovered residents needing changing, it did not make sense for her to call KM upstairs, forcing KM to leave her own 19 residents unsupervised. The more straightforward approach would be for NJ to find SAK, who was already on the first floor and was responsible for the residents needing assistance. Relying on our specialist expertise, we also took into account that spot checks would usually be carried out with the relevant care assistant present, to hold them accountable while the team leader pointed out to any failures to provide care.
114. NJ’s email appeared to provide a narrative of what happened in the order when she said it happened. If so, it is unusual that the email described events at 4am and 4.30am *before* events at 3am, which NJ categorised as: “On further checks”, implying they took place *later*. NJ wrote that the first two residents she checked

required full continence changes, one had an unreported black eye and the other had money left all over the floor. This implied things had gone very badly wrong on the first floor and residents were unsafe. If so, why did NJ delay her other spot checks to around an hour later, rather than go and check all the residents straight away? This delay did not make sense, especially since NJ wrote that after changing WR, she found SAK asleep in the dining room. This might imply SAK had not checked the residents at all, or not for some time.

115. Nor is NJ's account consistent with the brief notes of her interview with AC on 16 February 2023 (about half an hour earlier). The interview notes recorded NJ telling AC she checked rooms 31, 32, 22 and 39, and her spot checks were all done at 3am. By using that specific ordering of rooms, NJ appeared to be saying she checked room 32 before room 22, and that she checked all four rooms at around the same time. Both points are different from her statement.
116. The handwritten statement from KM is very short, as Mr Serr acknowledged. KM stated she and NJ found SAK asleep at 4am. This conflicted with the 3am timing NJ had used. We accepted SAK's argument about the importance of this timing; at 4am, KM should have been carrying out her own checks for residents downstairs. This timing was also inconsistent with NJ's account that she spoke to SAK at 4am about a buzzer going off. Mr Serr argued KM might have made a mistake about timings, but we accepted SAK's point that KM would have known the importance of what she was meant to be doing at 4am.
117. The order of events in KM's statement also did not explain why she was upstairs in the first place. To us, it presented as if KM and NJ happened to be upstairs together and came across SAK asleep. Finally, KM wrote: "*Due to this [SAK being found asleep] myself and [NJ] carried out the upstairs checks and found room 22 saturated.*". This is not consistent with the order in which NJ said things had happened; (1) that she found WR in room 22 with money on his floor, (2) she summoned KM upstairs to witness her counting the money on the floor and (3) that they later found SAK asleep in the dining room. In our assessment, these inconsistencies are important, rather than trivial. They relate to contemporaneous accounts rather than ones produced some time later.
118. Mr Serr acknowledged that KM's statement was very brief and that the investigation by the AH Group was "not fully ventilated". We would categorise it as inadequate. We do not agree with Mr Serr's suggestion the investigation was brief because SAK failed to engage with the disciplinary process. The AH Group had 11 days between suspending SAK (16 February 2023) and the Case Summary Report triggering disciplinary action (27 February 2023). It should have investigated the allegations properly during that time, including obtaining adequate statements and checking accounts with the care plan documentation. There is nothing in the Case Summary Report to suggest that SAK's employers took any of those steps. Nor does the documentation suggest the AH Group took those steps during March 2023, when SAK was pressing for a disciplinary hearing to take place.
119. There is nothing in the documentary evidence provided to indicate that AH Group carried out an adequate investigation before the meeting on 19 April 2023. Mr Serr's argument only relates to what happened after 11 April 2023. We do not

consider that SAK can be considered responsible for her employer's failures to carry out a proper investigatory and disciplinary process.

120. Having identified inconsistencies in NJ's evidence and KM's evidence, we assessed that different witnesses may perceive or remember the same events differently. Allowing, for this, however, both accounts are contradicted by the care plan documents for the four residents in question. This was important when evaluating NJ and KM's accounts, for the following reasons.
121. We accepted SAK's evidence that staff member must record they have changed a resident's pads and underwear and will describe this as "personal care". We accepted SAK's evidence that if WR had been half out of his bed, with money strewn across the floor, this should have been written down in his daily record and also in a handover note. We agreed with SAK that NJ should have recorded how much money was found and where it was put. We accepted SAK's evidence that unexplained bruises or injury are recorded in an incident report or skin monitoring chart. There are examples of these in the documents provided by the AH Group. See, for example, pages 681 and 702 (skin monitoring charts for DH about unexplained bruising on 21 and 22 February 2023).
122. Despite this, NJ recorded neither of the alleged incidents of WR (money) and MS (bruise) in the contemporaneous records provided to us. There is a record that MS had a visible bruise on her right eye and right arm on 16 February 2023 (page 659 of DBS bundle). NJ did not however, record this, which would be expected if she had discovered it for the first time as part of a spot check. Instead it was recorded by a day shift member in the next day shift. SAK told us the previous day shift staff had told her MS had a red mark on her face and therefore the night shift staff knew about that mark already.
123. None of the contemporaneous records provided to us document that WR, MS, EG or DH were found soaked in the middle of the night shift and had to be changed. This contradicts both NJ and KM's accounts. In relation to WR in particular, SAK's evidence (supported by the care plan documents) was that he needed lifting with a hoist. SAK told us it would take two members of staff to change him and his bedding if he was soaked. NJ and KM claimed WR was soaked when they discovered him. NJ also claimed he was doubly incontinent. The observation charts for WR and the positional charts for WR do not have any record of NJ and / or KM changing him or moving his position during the nightshift in question.
124. Mr Serr suggested NJ had not recorded the care she provided because it was not planned for, it was not a routine check, and NJ had focused on providing the care and not noting it. He also argued NJ and KM might think they did not need to complete records for upstairs residents (who were SAK's responsibility). However, it would be illogical not to record a spot check simply because it is not a routine check. Recording incidents, whether unexpected ones or simply giving personal care, provides continuity of care for vulnerable adults and transparent accountability for what is happening in the care home. Doing so protects the staff as well as the residents. In any event, given NJ was the team leader leading the

nightshift in M Care Home, *all* the residents were her responsibility, whether they were upstairs or downstairs.

125. NJ completed a falls report for DH in room 39 at 6.10am on 16 February 2023 (see page 690 of the DBS bundle). She also completed a skin monitoring chart for DH related to the fall in question (page 694). We note that NJ's statement states she called KM upstairs to witness her counting WR's money. In our assessment, these matters undermine Mr Serr's argument that NJ might think she did not need to record matters involving upstairs residents. They also undermine the alternative argument that NJ might have been a poor record keeper. While we do not have extensive records showing entries and signatures for NJ, the falls record for DH on page 689 confirms NJ recorded a two hourly check on 19 February 2023 (wrongly recorded as 2022), which she recorded and signed as: "*2010 Awake in bed, 2200 Awake in bed, 0010 Awake in bed, 0210 Awake in bed*". These entries, together with the falls report and the skin monitoring chart, contradict the suggestion NJ did not fill out forms for upstairs residents. They also demonstrate another staff member using similar wording for different night shift entries about a resident.
126. Given the seriousness of NJ's allegations about all four residents, and what KM claimed in respect of WR, we would have expected to see records of all those matters, both personal care and the more unusual discoveries (WR's money and MS's unexplained bruise). None of the care plan documents provided to us support the allegations made that SAK left residents soaked due to incontinence during the night shift in question. Nor do they suggest that NJ discovered WR in his room with money all over the floor or noticed for the first time that MS had a mark or bruise on her cheek.
127. In our assessment, the most likely explanation for NJ failing to record the alleged incidents in the relevant care plan documents is that she did not carry out spot checks during the night shift on 15 February 2023 and did not discover the four residents in a soaked state. The same applies to KM in respect of WR. For the same reason, we also consider it unlikely that NJ found money on the floor in WR's room or that MS having a bruise came as a surprise to those on the night shift rather than something day shift staff had previously told them about. In our view, these, together with the account of SAK not answering phone calls immediately, appear to form part of an incorrect narrative NJ presented that SAK slept on duty and for a substantial period of time, long enough for all the alleged events to occur.
128. SAK told us that after the meeting on 16 February 2023, WR's money and MS's bruise were not mentioned again. This is consistent with the second investigation meeting notes on 27 February 2023 and the Case Summary Report, which do not mention either. Nor does the outcome of disciplinary hearing document on page 52 of the bundle.
129. We note that the final part of NJ's statement dated 16 February 2023 also made non-specific allegations that she found residents hanging out of bed and floor sensors not on. This is separate to her account of the fall that appears to involve DH. These allegations are not mentioned anywhere in the investigation meeting

notes with NJ on 16 February 2023. We recognise those notes are brief and that the investigation meeting notes with SAK on the same date are clearly incomplete, given SAK told us AC asked her about WR's money and MS's bruise and SAK apologised about DH's floor sensor.

130. It is difficult to know what level of investigation the AH Group carried out about allegations of more than one floor sensor not being on. The investigation meeting notes dated 27 February 2023 state SAK was asked about floor sensors and said they were all working. This is not consistent with SAK's evidence that she apologised to AC for not double-checking DH's sensor, unless the note on 27 February 2023 was about NJ's wider claim that SAK had not switched on several sensors and several residents ended up out of bed as a result.
131. The AH Group did not make any finding about a specific allegation that SAK left floor sensors switched off, whether the single sensor in DH's room, or a wider range of sensors across several rooms. The outcome of disciplinary hearing document lists that the allegations found proven were that SAK failed to provide appropriate care to the residents in rooms 22, 31, 32 and 39 and slept on duty.
132. Again, we consider it likely that NJ made the non-specific allegations of a range of residents "*hanging out of bed and their floor sensors not on*" to support the overall picture she was painting of SAK failing to provide adequate care. There is nothing in the care plan documents provided to us to support that this occurred in the terms NJ alleged. If it did occur in that way, there is no plausible explanation for it to be missing from those documents.
133. We were not persuaded by Mr Serr's argument that the fact SAK agreed some of NJ's statement was correct makes it more likely the rest of it is truthful and accurate. The fact that NJ recorded accurately how SAK was sitting does not, of itself, mean that everything else in her statement is true, or more likely to be true. In our assessment, it does not outweigh the significance and reliability of the evidence that points the other way, including the documentary records the AH Group has now provided.
134. SAK does not have to provide a reason why NJ and KM might provide inaccurate accounts in order for us to decide on the balance of probabilities they are not reliable. SAK has, however, provided an explanation in her oral evidence, supported to an extent, by the documents she provided. We are satisfied that SAK and her family have experienced problems in their relationship with her cousin BM, which went as far as a failed prosecution before a magistrate and that BM and NJ were friends. We have also taken into account SAK's evidence that NJ's behaviour changed once she discovered SAK and BM were related and had the chance to speak to BM about this, as well as her evidence about how NJ and KM treated her throughout during the nightshift in question.

### Findings of fact

135. In line with the approach in *RI*, the Upper Tribunal, having viewed the oral and written evidence as a whole, may make its own findings of primary fact.

136. Having heard and evaluated the evidence, including SAK's oral evidence, we make the following findings of fact, on the balance of probabilities:
- (a) During her night shift on 15 and 16 February 2023, SAK was experiencing migraine symptoms;
  - (b) A couple of days before the nightshift in question, SAK had told NJ and RS during a shift that she was experiencing a migraine;
  - (c) Before her shift started on 15 February 2023, SAK told the day shift team leader in the office, in front of NJ, that she was experiencing migraine symptoms, when the team leader asked SAK if she was ok;
  - (d) SAK took a tablet to counter her migraine symptoms before starting her nightshift on 15 February 2023. She took over the counter painkillers for her symptoms during that shift;
  - (e) During the nightshift starting on 15 February 2023, SAK was working upstairs, looking after residents in rooms 19 to 39. KM was working downstairs, looking after residents in rooms 1 to 18;
  - (f) NJ was the team leader for the nightshift on 15 February 2023. During that shift, NJ based herself on the ground floor of the care home;
  - (g) At one point during the night shift on 15 February 2023, NJ told SAK she would also have to look after the residents on the ground floor while NJ went to buy herself food;
  - (h) At another point during that night shift, SAK went downstairs and found NJ and KM had gone to the laundry without telling her;
  - (i) SAK would generally have a 30-minute break during her 12-hour shift. She tended to take this as two 15-minute breaks;
  - (j) During the night shift starting on 15 February 2023, SAK did not take a formal break because she felt unwell and eating food would have made her feel worse;
  - (k) During the night shift starting on 15 February 2023, SAK completed two-hourly checks of the residents in rooms 22, 31, 32 and 39 and recorded them in the relevant care plan documents in the upstairs dining room;
  - (l) During the night shift starting on 15 February 2023, SAK checked and delivered personal care to, the residents in rooms 22, 31, 32 and 39 in accordance with the notes she made in their care plan documentation;
  - (m) During the night shift starting on 15 February 2023, the only personal care delivered to the residents in rooms 22, 31, 32 and 39 was that recorded by SAK;

- (n) Before her night shift started on 15 February 2023, at the point of handover, SAK was told by a day shift staff member that MS had a red mark on her cheek. During the nightshift, SAK spoke with MS about this, offering her cream for it, which MS declined and said she was fine. MS told SAK she thought she had got the bruise through sleeping with her cheek on the buzzer from an alarm bracelet;
- (o) NJ did not record MS having a bruise on her cheek during the night shift in question;
- (p) Having reached around the middle of the night shift in question and having recorded the latest two hourly checks she had carried out on the upstairs residents, SAK sat down in the upstairs dining room with the lights switched off, her feet off the ground and her head leaning back and slightly to the side. SAK sat like this in order to manage the symptoms of her migraine. She was in this position for about 5 minutes;
- (q) SAK did not fall asleep while in this position;
- (r) While SAK was in this position, NJ came upstairs and spoke to SAK through the open door of the dining room. SAK could see NJ because the light in the hallway was switched on;
- (s) At this time, NJ asked SAK if she had carried out her checks. SAK responded that she had;
- (t) NJ left the doorway to the dining room and took the lift back downstairs to the ground floor. At that time, KM was not present on the first floor;
- (u) SAK's radio ran out of battery during the night shift starting on 15 February 2023;
- (v) At around 4.30am during the night shift, NJ telephoned SAK a couple of times. SAK did not answer those calls because she was in the middle of delivering personal care to a resident who was undressed;
- (w) SAK telephoned NJ back once she had delivered personal care to the resident and confirmed she had completed her checks;
- (x) For a period of around one to two weeks before the night shift starting on 15 February 2023, the falls mat in DH's room (39) was not working. SAK knew this because was told about it during a day shift handover. SAK was not told whether this position had changed prior to the night shift starting on 15 February 2023;
- (y) Some residents in the home had fall mats in their rooms. However, all the residents' rooms had alarms on the walls that could be pulled or pressed if required. There were also alarms in the corridors in the care home;

- (z) At around 6.10am on 16 February 2023, DH experienced a fall in her room (39). The emergency buzzer went off, alerting staff. DH was found sitting on the floor next to her bed. At the time this buzzer went off, SAK was delivering personal care to another resident. Once she had completed that action, SAK went to DH's room and found DH on the floor and NJ present;
- (aa) NJ asked SAK if the falls sensor was on. SAK replied that she had not double-checked whether it was working. NJ completed a falls report for MS that day;
- (bb) At the end of the night shift, SAK's manager AC asked SAK to go into her office. AC told SAK it had been reported SAK was sleeping on shift and had not done her checks, that money was found on WR's floor and discovered that MS had a bruise;
- (cc) AC asked SAK about the money, and if it was WR's or hers. SAK explained it could not be WR's because he wasn't allowed money in his room and it was not hers, because her bag was downstairs during the shift. SAK also told AC that it had been reported to her by the day staff at handover that MS had a bruise on her face, and that this was due to the buzzer on her bracelet;
- (dd) The AH Group did not raise these matters again with SAK after the discussion on 16 February 2023;
- (ee) SAK volunteered to AC that she had not double-checked whether DH's floor sensor was working during the shift in question. She apologised for this;
- (ff) At the time of the night shift, SAK's cousin BM had been involved in a longstanding feud with SAK and her family. Within the context of this this feud, SAK's uncle had been acquitted by a magistrate of assaulting BM's wife LF;
- (gg) NJ knew, and was friends with, BM. She had been tagged with BM in Facebook photographs because she was present at a social event involving BM in July 2022; and
- (hh) NJ became aware that SAK and BM were related because she saw a photograph of them together and asked SAK how they knew each other. SAK explained they were related and did not have anything to do with each other. When she told SAK about this, NJ said she was due to see BM the following day. Although NJ and SAK had previously got on well, NJ's behaviour towards SAK changed after this discussion.

### **Our conclusions on the mistake of fact appeal ground**

137. It follows from our analysis of the evidence, including the further evidence made available to us, that we have made primary findings of fact confirming the DBS made a mistake of fact in finding proved the allegation that SAK failed to complete

adequate checks and attend to the continence needs of residents in M Care Home on 16 February 2023.

138. Our primary findings of fact also confirm the DBS made a mistake of fact in finding that SAK intentionally slept while on duty during the nightshift on 15 February 2023. This includes the necessary finding within that allegation that SAK was asleep. We have decided this was a mistake of fact because SAK was not asleep and was awake, while trying to manage the effects of a migraine she was experiencing. While her eyes were shut and her feet were up, SAK remained alert and answered NJ's question about checks. The finding that she intentionally slept on duty therefore involved a mistake of fact.
139. Based on the evidence before us and our findings of fact, we have decided the DBS also made a mistake of fact in finding that SAK failed to turn on a falls sensor. The DBS made a specific finding of fact that SAK failed to turn the sensor on. That is not the same as making a finding that SAK failed to check whether a falls sensor was on.
140. To be able to make and sustain the finding of fact that SAK failed to turn on a falls sensor, the DBS also needed to make findings of fact that the falls sensor was not switched on, and would have been capable of working if it had been.
141. As explained above, the AH Group did not find this specific allegation proved against SAK. The DBS Barring Decision Summary confirms that it found the allegation proved by relying on the part of NJ's written statement that stated:

*"Later that shift a lady had a fall, which if the floor sensor was on, I would have been alerted (alerted) within the time of this happening".*
142. NJ did not identify the person in question, either by name or by room number. It has never been confirmed that this statement relates to DH in room 39, although we accept it will relate to her. Apart from the wording in italics above, there is no documentary evidence before us to confirm the floor sensor in DH's room was switched on or off, or that it was working during the night shift starting on 15 February 2023.
143. The falls report NJ made on about DH on 16 February 2023 does not record the time she completed the report, although it lists the fall as occurring at 6.10am. NJ recorded: *"Emergency buzzer went off and DH was sat on floor, next to bed. Checked no injuries other than a red mark"*. By completing the falls report, NJ introduced an additional requirement for the two hourly checks on DH to be documented in the falls report for the next 72 hours, as well as in her other existing documentation.
144. SAK's evidence was that DH's falls sensor had not been working for about a week to two weeks, this often happened with DH, and SAK was not told during the handover for the shift on 15 February 2023 that her falls sensor was now working. SAK's told us NJ asked her if the falls sensor was on, SAK replied it had been broken, and she had not double-checked it. SAK later told AC it was her fault for not double-checking the falls mat in DH's room but at the time it did not cross her

mind because it had been broken for ages and she was not told it was fixed or that a new one had been provided.

145. We have uncontroverted evidence that an emergency buzzer went off in DH's room, which alerted both NJ and SAK. Although NJ asked SAK whether the falls sensor was on, we do not have any positive evidence that it was in fact working but switched off, apart from the inference from the wording within NJ's statement that if the floor sensor was on, she would have been alerted within the time of it (the fall) happening. There is also circumstantial evidence in that NJ asked SAK whether the sensor was switched on. In our assessment, however, NJ's claim the fall was left unnotified due to the floor sensor not being on is undermined by the contemporaneous record she wrote confirming that a buzzer sounded, alerting her that DH needed help.
146. NJ completed the contemporaneous falls record for DH. She: (a) recorded that an emergency buzzer went off, which might have been the buzzer from the falls sensor, and (b) did not record that DH's falls sensor was not switched on or that DH's fall had gone unmonitored for any particular reason. In our view, if the falls sensor had been working but switched off, the falls report would have been an obvious place to record this. It would have explained the circumstances in which DH fell. It would also remind any staff recording the 2-hour checks for the next 72 hours to check and make sure the falls sensor was switched on.
147. We take into account that we have found substantial portions of NJ's account to be unreliable. For the reasons set out above, we also consider what she wrote about the falls sensor (in room 39) was unreliable and that what she asked SAK about it is also unreliable. In those circumstances, there is no reliable positive evidence that during the nightshift, the falls sensor was switched off when it was capable of being switched on.
148. The Upper Tribunal confirmed in paragraph 39 of **PF** that there is no limit to the form a mistake of fact may take; it may consist of an incorrect finding, an incomplete finding, or an omission. In the context of the DBS's finding about the sensor, we have decided the DBS made a mistake of fact in terms of omission. It has omitted to make findings, including whether the floor sensor in question was switched on or off at the time when the relevant resident fell and whether it was capable of working at that time. Those factual findings were essential to the overall finding of fact the DBS made in finding the floor sensor allegation proved against SAK.
149. Alternatively, if it can be said the DBS made a finding of fact that the falls sensor was switched off, and was capable of being switched on, by inference from its finding that SAK failed to switch it on, there is insufficient evidence to support that finding. If the buzzer which sounded was the floor sensor, it must have been switched on. We accept SAK's evidence that the falls mat for room 39 had been broken for more than a week and this was known to both day shift and night shift staff. No one had told her it was repaired or replaced. In those circumstances, if the falls mat sensor did not sound, it might not have been working at all.

150. Mr Serr asked us to rely on SAK's admission that she failed to check whether the falls sensor was working. This is not, however, an admission that removes the difficulty described above. The allegation found proved against SAK was not that she *failed to check whether* a sensor was switched on or working, but that SAK did not switch it on. That allegation required other essential factual findings to be made, and the DBS has omitted to make them, which is a mistake of fact. Alternatively, if made by inference, those findings contain a mistake of fact.
151. In relation to all three allegations the DBS found proved, we have decided they contain mistakes of fact on which the Barring Decision was based, within the meaning of section 4(2)(a) of the SVGA 2006.

### **The error of law arguments**

152. Given what we have decided about mistake of fact above, it is not necessary to consider the appeal grounds about errors of law.

### **Conclusion**

153. Having considered evidence that was not before the DBS, which we found to be credible, we have found that the DBS made mistakes of fact on which the Barring Decision was based.
154. Where the Upper Tribunal finds that the DBS has made mistakes of fact on which the Barring Decision was based and / or material mistakes of law, the Upper Tribunal must either direct the DBS to remove the person from the list or remit the matter back to the DBS for a new decision.
155. We have found the DBS made mistakes of fact in relation to all the allegations it decided were proved against SAK. Given this, and applying the principles in **DBS v AB**, we are satisfied that no other decision than removal is possible on the facts. This approach is also consistent with the submission Mr Serr made at paragraph 100 above.
156. We therefore direct that SAK must be removed from the Adults' Barred List.

**Judith Butler**  
**Judge of the Upper Tribunal**

**Josephine Heggie**  
**Specialist Member of the Upper Tribunal**

**John Hutchinson**  
**Specialist Member of the Upper Tribunal**

Authorised by the Judge for issue on 19 January 2026