



Neutral citation number: [2026] UKUT 176 (AAC)

**Appeal No. UA-2021-001746-V**

**IN THE UPPER TRIBUNAL  
ADMINISTRATIVE APPEALS CHAMBER**

**Between:**

**AA**

Appellant

-v-

**Disclosure & Barring Service**

Respondent

**DECISION OF THE UPPER TRIBUNAL**

**Upper Tribunal Judge Mitchell  
Upper Tribunal Member Hutchinson  
Upper Tribunal Member Turner**

*Hearing:* Decided without holding a hearing

*Representation:*

Appellant: unrepresented

Respondent: Andrew Webster, of counsel, instructed by solicitor to  
DBS

*On appeal from:*

Decision-maker: Disclosure & Barring Service (DBS)

DBS reference: 00921205730

Decision date: 17 December 2020

## **SUMMARY OF DECISION**

### **65. Safeguarding Vulnerable Groups**

#### **65.26. Safeguarding Vulnerable Groups – Proportionality.**

Judicial summary

Barring interfered with the Appellant’s Article 8(1) rights in that it impeded her ability to develop, without outside interference, her personality in her relations with other human beings. However, it did not preclude all relations with other human beings, only work-related relations with children and vulnerable adults and those doing regulated activity relating to children and vulnerable adults. In the light of the evidence about risks posed by the Appellant, barring was a proportionate and necessary interference with the Appellant’s Article 8(1) rights.

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

## **DECISION**

**The decision of the Upper Tribunal is to DISMISS the appeal. The Upper Tribunal decides that DBS’ decisions involved neither a mistake on any point of law nor a mistake in any finding of fact, within the meaning of section 4(2) and (3) of the Safeguarding Vulnerable Groups Act 2006. Under section 4(5) of the 2006 Act, the Upper Tribunal CONFIRMS the barring decisions made in respect of the Appellant by DBS.**

## **REASONS FOR DECISION**

### **Introduction**

1. In these reasons:

- “2006 Act” means the Safeguarding Vulnerable Groups Act 2006;
- “DBS” means Disclosure and Barring Service.

## **Factual background**

### Evidence before DBS

2. On 18 (or 19) August 2019, [the Appellant] assaulted strangers in a public park, two women who were visiting the park with two children. While no criminal proceedings ensued, [the Appellant] does not dispute that the incident took place. Previously, [the Appellant] had been involved in two further incidents which led to her being convicted of two charges of common assault and one of using threatening behaviour.

3. DBS' decision letter stated that all of these incidents took place while [the Appellant] was experiencing psychotic episodes. It is clear, from the evidence, that [the Appellant] has had mental health problems for some time. The medical evidence within the Upper Tribunal bundle includes clinical records dating back to some 10 or so years before the 2019 incident. The evidence includes:

(a) 10 September 2008, letter from psychologist to psychiatrist: Appellant's confidence and self-esteem markedly improved after successful start to training course; after stopping Haloperidol (anti-psychotic medication), no longer had difficulties with getting-up and motivation;

(b) Care Programme Approach Care Plan dated 16 August 2012. The Care Programme Approach is a programme for the therapeutic management of patients with more severe mental health problems. The Appellant's Plan includes statements that:

- the appellant had a diagnosis of Schizoaffective Disorder;
- she would often become stressed if she overexerted herself with voluntary / work activities, and was then working 30 hours weekly;
- she occasionally heard derogatory voices but could recognise not real;
- she believed she could function without anti-psychotic medication but was aware of vulnerability to relapse (advised to discuss medication concerns with clinical team);
- she had been relatively well over 'past years' with no reported incidents of verbal aggression;

- she had presented minimal clinical risk over the previous year, and coped well with stressors;
  - “Previously...significant risk of dangerousness towards self/others, non-concordance with medication, becoming more sensitive to others around her and having strong emotional reactions, feeling very tired, struggling to get out of bed, hearing voices and feeling confused”. Currently, however, no active symptoms to indicate clinical risk;
  - crisis plan: psychiatrist to be notified immediately if any part of care plan not being implemented;
  - within ‘risk chronology’: “2010/2001 [*date typo?*] – [Appellant] has a history of non-compliance with her anti-psychotic medication”; “no previous or current history or risk to others” but overdoses in September 2007 and May 2009; “known to comply with treatment plans when well, but has a history of not completely complying with her medication when relapsing in her mental health or when mentally unwell”; “when mentally unwell, she may disengage from CMHT and others”; “mentally well since 2009 when she was discharged from [N] Centre for Mental Health. She has remained mentally well in spite of the stress of sorting out her welfare benefits as well as employment issues”;
- (c) 21 August 2013, psychiatry letter: Appellant continued to experience highly distressing, derogatory second and third-person auditory hallucinations; more irritable with very low frustration threshold; advised needs therapeutic dose of anti-psychotic medication for foreseeable future;
- (d) 1 October 2013, psychiatry review: significant improvement in Appellant’s mental state; psychotic symptoms fading, keen to discontinue Aripiprazole (anti-psychotic) which “unfortunate”, encouraged to take lower dosage instead;
- (e) 19 August 2015, Care Programme Approach assessment:
- discharged from psychiatric to GP care in 2013;
  - GP reported deteriorating mental health involving hearing voices;

- [Appellant] reported ongoing problems with voices but can cope 'without any problem', although two months ago a deterioration in mental state led to altercation with neighbour whom she thought made derogatory comments, and threw flowerpot at her;
- 25 February 2015: Appellant arrested after threatening a shop keeper whom she thought had been very rude to her; she threw a can at him;
- despite medication compliance, continued to hear voices; reported medication made her feel low and mentally unstable; requested medication review due to belief she was over-medicated and her side-effect concerns;
- never been keen on compliance with anti-psychotic medication but reported full compliance with anti-depressants;
- reported hearing sexually denigrating voices when mentally unwell; could cope with them but 'annoying';
- appeared to have good insight, complied with medication, seeks support from family and professionals. Happy to continue with medication, including Aripiprazole 2.5mg daily;
- within 'identified risk issues': hearing voices might result in further confrontation, challenging behaviour, and harm to others;
- mental illness involved paranoid ideation; functioning independently but not able to fulfil and exploit potential in community; despite good understanding of mental health, reluctant to 'capitalise' on professionals' views and recommendations; would benefit from regular compliance with prescribed psychiatric medication;

(f) 2 September 2015, psychology referral by mental health nurse: hospital admission following fire in Appellant's flat; reported increase in voices over past year following discharge from CMHT to GP care; constant sexually derogatory voices and increased paranoia; admission history: 2008, six months following attempted hanging; 2010, three months but unable to recall reason. Taking daily 40 mg Citalopram (anti-depressant), and 5 mg Aripiprazole (anti-psychotic) but reluctant to increase dosage due to perceived side-effects;

(g) 16 September 2015, CMHT letter to GP: last 4-5 months, heard voices more frequently: daily sexual insults but no command hallucinations; was starting to get angry at voices and 'lash out' at members of public; mostly able to recognise voices not real but sometimes difficult, which made her angry and upset; reported stopped Aripiprizole last week (recent dosage increase from 2.5 to 5 mg. daily caused anxiety); maintained not currently psychotic since not feel as she did on last hospital admission; remained reluctant to take anti-psychotic medication; clinical view: currently lacked insight; agreed to take Olanzapine (anti-psychotic) 5 mg daily, as alternative to Amipriprizole;

(h) 29 September 2015, HTT (home treatment team) discharge summary: regular home visits 17 to 28 September 2015; reported stopped taking anti-psychotic medication before confrontation with neighbour because she thought psychotic symptoms resolving; "insight remains poor – says she plans to discontinue medication once supply from GP has run out"; discharged to care of CMHT;

(i) 25 November 2015, CMHT letter to GP: reported Olanzapine helping symptoms; still heard derogatory voices but less bothered; keen to join gardening group; "clinical opinion: still hearing voices but not bothered by, and does not react to, them"; good insight – happy to continue to engage with services and take medication; reluctant to increase Olanzapine dosage, which might help her since voices persist; maintain current dosage, review next appointment;

(j) 15 June 2016, CMHT letter to GP: six months of psychology sessions were very effective; reduction in voices; reported 'negative commentary' on public transport and tended to cycle instead; while voices reduced, anxiety increased; dealt with anxiety by cycling or gardening; happy with current medication; risk to others assessed as low;

(k) 1 July 2016, CMHT letter to [Appellant] about psychological therapy: [Appellant] reported difficulty managing intrusive voices; therapy helped her to accept critical voices and 'let them go'; reported increased confidence in ability to cope with voices and demonstrated determination to manage them;

(l) 6 January 2017, criminal justice mental health report connected to an incident in Tesco: reported full compliance with medication but experienced auditory hallucinations;

(m) 15 February 2017, CMHT letter to GP: voices becoming more difficult, same frequency but increasingly derogatory; assaulted Tesco staff member (thought called her “bitch”); had found psychological coping strategies useful but not on this occasion; reports hearing voices from TV and radio, which now avoids; reluctant to go out due to voices; symptoms worsened since August 2016 despite reported medication compliance; Olanzapine increased to 10 mg daily;

(n) 3 April 2017, witness statement of Dr S of CMHT: regarding risks posed, [Appellant] was vulnerable in community due to auditory hallucinations and their attribution to others;

(o) 17 May 2017, CMHT letter to GP: reported less bothered by voices after increased dosage of Olanzapine; using psychological strategies effectively; currently no risk to others;

(p) 23 October 2018, CMHT letter to GP: failed to attend medical reviews in January and June 2018; continued to experience derogatory auditory hallucinations; recently requested that GP refer her back to CMHT care; continues to comply with medication and no reported side-effects; very good insight into illness and able to access support if needed; no evidence poses significant risk of harm to others.

4. We now describe the medical evidence for the period immediately preceding and following the August 2019 park incident which, unless indicated otherwise, are taken from the Appellant’s case notes:

(a) 7 January 2019, CMHT records: [Appellant] not attend appointment; advised if no contact in three weeks, CMHT would assume services no longer wanted and discharge her;

(b) 19 August 2019, case notes: removed to hospital (place of safety) by police under section 136 of the Mental Health Act 1983 following park incident; [Appellant] admitted mental health deterioration in recent weeks; “history of non-compliance with medication/services”; partial insight; had developed some strategies to deal with voices but lost insight at times and misattributed voices, “can lash out aggressively”; compulsory admission under section 2 of the 1983 Act recommended due to risk to self and others;

(c) 19 August 2019, criminal justice screening/assessment: rudimentary understanding of allegations against her; initially calm but became distressed, irritable and angry; clear paranoid ideation; disclosed command hallucinations; reported more intense symptoms in past few weeks; did not think she required hospital admission; during park incident, thought a jogger called her a prostitute, intended to attack him with bike lock but could not find him and came across family group (mother, grandmother, two children), watched for a while; thought they were talking about her, tried to hit mother with bike lock before punching grandmother, arrested at scene; assessed as posing an on-going risk due to inability to “restrain on acting out against the voices to harm others”;

(d) 19 August 2019, Mental Health Act assessment: had been using CBT techniques to manage symptoms, but increased stress associated with anger and ‘lashing out’; said “she could not control her behaviour at that time [in the park] as...tormented by the auditory hallucinations”; admitted stopping taking medication previously; realised mental health deteriorated recently; accepted required hospital admission, in particular for medication review since current medication may no longer be effective;

(e) 20 August 2019: compulsory admission to hospital for assessment under section 2, Mental Health Act 1983: notes previously discharged from CMHT due to non-engagement; unclear if compliant with medication; presented risk to others ‘in context of hallucinations of a derogatory nature’;

(f) 23 August 2019: granted leave of absence from hospital (to Appellant’s home); reported compliant with anti-depressant medication but only takes when ‘things get really bad’; anti-psychotics made her feel “like a vegetable” but agreed they improved ‘the voices’; previously, last took anti-psychotics in June 2018; tends to take for two weeks until feels a bit better; reluctant to switch to less sedating anti-psychotic but agreed reduction in Olanzapine dosage from 10 to 5 mg daily;

(g) 25 August 2019, post-leave progress report: reported feelings of persecution; willing to engage with HTT and treatment plan; can “lash out”;

(h) 27 August 2019, post-leave progress report: voices still troubling her but not as bad as on admission; no thoughts of harm to self or others; in park incident, felt rage and anger at things believed said about her; Olanzapine stopped, replaced with different anti-psychotic medication, Amisulfaride;

(i) 4 September 2019, discharge (from HTT) liaison form completed by psychiatrist: partial insight; “self-medicating her Olanzapine [for about a year] by using it for 2-3 weeks when she felt that her voices were becoming more prominent”; on ward, 10 mg Olanzapine daily quickly improved mental state; reported Amisulpride decreased voices with fewer side-effects; currently 50mg Amisulpride morning, 100 mg night; no thoughts of harming others; assessed as posing low risk; strongly encouraged to continue taking Amisulpride;

(j) 5 September 2019, HTT visit: presented well; content to continue medication and no reported side effects. Numerous similar entries in notes for September 2019;

(k) 6 September 2019, detailed review of mental state: [Appellant] reported deterioration in mental state linked to family stressors; not take Olanzapine for six months, had felt well and it sedated her; reported recent reduction in voices, which attributed to Amisulpride but not wish to increase dose; denied persecutory beliefs; reported feeling bit low due to isolation; had tried to engage in activities to avoid depression; reported many years’ compliance with anti-depressant Citalopram; expressed desire to do voluntary work preferably in care sector in which had experience; said work would make life meaningful; presented well; showed some insight: accepted stopping Olanzapine had contributed to her relapse;

(l) 16 September 2019, HTT Multi-Disciplinary Team meeting notes: mental state stable, compliant with and happy about medication; denied abnormal thoughts and thoughts to harm self or others; “motivated to engage in community activities/work”; plan: discharge to outpatient clinic;

(m) 22 September 2019, discharge appointment: presented well and “mentally stable”; medication helpful, no side effects; “voices have drastically reduced; no compulsion to harm self or others in the community”; reminded to contact GP for repeat prescription;

(n) 3 October 2019, discharge plan: no risk concerns on discharge from HTT;

(o) 9 October 2019, psychiatry consultation: presented well; “hears voices occasionally” but “no delusion”; “happy with her medication for keeping her better in mental state and having no side effects”;

(p) 6 December 2019, consultant psychiatrist to GP: “lacked capacity at the time [of park incident] and I believe that her aggressive action was influenced by the relapse of her psychiatric disorder”;

(q) 26 February 2020, psychiatry consultation: looked ‘quite well’ since starting Amisulpride; “no longer hears the voices and was well presented”;

(r) 2 April 2020, GP to psychiatrist: still looked ‘quite well’ since starting Amisulpride (anti-psychotic medication); plan to reduce dosage;

(s) 18 May 2020, psychiatry consultation: reluctant to start Aripiprazole (different anti-psychotic medication) but would let psychiatrist know her decision in two weeks’ time;

(t) 7 October 2020, CMHT to GP: since 2019 hospital admission, maintained on “fairly low dose of antipsychotics”; doing very well for past year, doing volunteer work; taking active steps to reintegrate into society; presented well; showed “very good insight”.

5. The Appellant supplied, with her pre-barring written representations to the DBS, supporting letters from: a person for whom she had previously worked as a nanny; a long-standing personal friend who holds a doctorate; an Employment Specialist at Working Well Trust, a mental health charity, who described her commitment to obtaining new qualifications and stated that, over the last year, no one working with her expressed any concern for their safety, and described her optimism and motivation about ‘stepping back’ into society as a healthy and stable individual.”

#### DBS’ barring decisions

6. On 17 December 2020, DBS decided to include the Appellant on both the list of persons barred from working with children and the list of persons barred from working with vulnerable adults.

7. DBS’ decision letter included the following findings and related judgements:

(a) “significant concerns remain in relation to your irresponsible and reckless behaviour”;

(b) the ‘changes’ made by the Appellant following discharge from hospital in September 2019 were “acknowledged”. She had accepted: her diagnosis of

Schizophrenia (we note that most of the medical evidence refers to a diagnosis of Schizoaffective disorder); the need to take anti-psychotic medication; that “more therapeutic methods” of coping with her symptoms are insufficient, that her actions during the park incident were ‘completely wrong’. The Appellant had also demonstrated “credible remorse”;

(c) “It is accepted that you have continued to take your anti-psychotic medication during this time, are dedicated to your recovery and wish to contribute to society”, and “you are engaged in all of the support and services that have been offered to you”;

(d) “the medication you are currently on has stopped the voices and you have reported no side-effects”;

(e) “only a relatively short space of time has elapsed, approximately 15 months, since you were released from hospital”. Despite the Appellant’s “vast improvement”, she had “previously demonstrated significant periods of improvement and stability, then later relapsed and caused harm to others, both physical and emotional...previously, you have repeatedly chosen to disregard professional recommendations when it came to your medication and instead sought alternative options which you felt were more beneficial...struggled to accept your mental health diagnosis and the steps that needed to be taken to manage these issues”;

(f) despite a medical history of professional intervention and support, the Appellant had “chosen to stop taking your medication, disengaged with professionals and subsequently relapsed”, there was “no assurance that similar behaviour would not be repeated in the future” and the history showed disengagement and a preference for her own therapeutic methods over those recommended by professionals;

(g) “a more significant period of time is required to sufficiently evidence that you are able to manage your mental health conditions, which includes taking your medication and engaging with support services”;

(h) there was no assurance that, in the face of known stress factors, the Appellant would not experience a deterioration in her mental health and fail to recognise the need for anti-psychotic medication and professional support. The Appellant’s posed an unacceptable risk to children and vulnerable adults;

(i) regarding the Appellant's article 8 rights, these were referred to by DBS but "any impact on the individual must be weighed against the necessity to protect vulnerable groups from harm" and "you represent an unacceptable future risk to both children and vulnerable adults, therefore, it is also proportionate to include your name in the Children's Barred List and the Adults' Barred List".

8. DBS' decision was based on the analysis contained within a 'structured decision-making' document. Many of the document's findings were repeated in the DBS decision letter but, in addition, the document included findings that:

(a) at the time of the shopkeeper incident, the Appellant had stopped taking anti-psychotic medication because she believed she was not psychotic, and her lack of support from mental health services was due to her own disengagement;

(b) following discharge from hospital after the 2019 park incident, the Appellant's doctor reported that she had only partial insight and a poor history of compliance with medication and engaging with mental health services;

(c) Tower Hamlets mental health team reported that, following the 2019 hospital discharge, the Appellant was medication compliant and doing well;

(d) "it does not appear that she can demonstrate significant change long term and this is evidenced with a series of mental health crisis over a period of time and a breakdown in her ability to manage these without her anti-psychotic medication which she has repeatedly chosen to cease", "the DBS have no confidence that she is able to sustain her anti-psychotic medication" and "the future risk is too serious for a reasonable person to ignore and there is a potential for escalation in her behaviours, therefore 'critical concerns' have been raised..";

(e) "DBS consider that [recent progress] is relatively short in duration, with multiple previous incidents of positive engagement, to then later disengage" and "it was not just her Schizophrenia and mental health symptoms that contributed to her having a mental health episode, but also external factors such as financial, family and work pressures".

### **Ground of appeal**

9. The Upper Tribunal granted the Appellant permission to appeal on a single ground, described as follows in its permission determination:

“22. [The Appellant’s] Article 8 [of the European Convention on Human Rights] arguments are not structured in the way one would have expected had they been formulated with the benefit of specialist legal expertise. But that should not be fatal to her case given her documented mental health history and the generally recognised difficulties currently faced by anyone in accessing free legal advice. The essence of [the Appellant’s] case is that, in determining whether the interference with her Article 8(1) rights, occasioned by barring, were justified under Article 8(2), the DBS failed to take into account the therapeutic importance to her of work and the particular way in which she wished to participate in the life of the community. Arguably, these are recognised aspects of the right to respect for private life protected by Article 8(1) of the European Convention on Human Rights.

23. I grant [the Appellant] permission to appeal on the ground that DBS arguably erred in law in its Article 8 analysis by failing to consider whether barring would (1) through precluding [the Appellant] from working in her chosen field, arguably prejudice her continued recovery and (2) arguably impair her ability to participate as she wished in the life of the community through doing voluntary work (arguably, the reference to ‘hobbies and pastimes’ in the barring process document was not a recognition that barring would impair [the Appellant’s] ability to participate in her preferred type of community-related voluntary work). In terms of the materiality of the DBS’ arguable error, I am not prepared at this stage to find that, were the matters described above accepted and taken into account, barring would have remained a proportionate response. It is also arguable that, had these matters been considered, the DBS would have revisited its conclusion that further medical evidence was unnecessary and might instead have concluded that proper respect for [the Appellant’s] Article 8(1) rights called for an expert opinion on what was arguably the key issue in this case namely whether it was more likely than not that she would remain compliant with anti-psychotic medication, and other treatment recommendations, for the foreseeable future.”

10. The Upper Tribunal’s permission determination concluding with the following words:

“I would strongly suggest that [the Appellant] seeks legal help in dealing with her appeal. She may find it easier to obtain free legal assistance now that she has been granted permission to appeal. [The Appellant] might wish to consider

contacting MIND's Legal Line on [...] (and supplying MIND's Legal Team with a copy of this grant of permission to appeal). Her appeal raises an issue that may be of interest to MIND namely the relationship between rehabilitation from mental illness and DBS decisions to bar an individual from working with children and/or vulnerable adults. If MIND cannot provide legal assistance directly, they may be able to direct [the Appellant] towards a legal adviser who can."

## Legal framework

### Safeguarding Vulnerable Groups Act 2006

11. A person included in a barred list maintained under the 2006 Act may appeal to the Upper Tribunal against the DBS' barring decision (section 4(1) of the 2006 Act). An appeal may only be made on the grounds that the DBS made a mistake on any point of law, or in any finding of fact on which the barring decision was based (section 4(2)). Section 4(3) provides that "the decision whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact". In other words, there is no right of appeal against the DBS' decision that it is appropriate for a person to be included in a barred list.

12. While the 2006 Act provides for no right of appeal against a DBS decision that it is appropriate to include a person in a barred list, that does not exclude a right of appeal on the ground that barring a particular person is disproportionate. However, in assessing proportionality the Upper Tribunal must accord appropriate weight to the decision of the barring authority "as the body particularly equipped to make safeguarding decisions" (*B v Independent Safeguarding Authority* [2013] 1 WLR 308).

13. In *Disclosure & Barring Service v AB* [2021] EWCA Civ 1575, the Court of Appeal held, at [43], that, absent a legal or factual flaw in a barring decision, "the assessment of the risk presented by the person concerned, and the appropriateness of including him in a list...is a matter for the DBS". This was echoed in the Court of Appeal's decision in *Disclosure & Barring Service v JHB* [2023] EWCA Civ 982 where it said, at [93], "there is a distinction between the assessment of the evidential material on which a finding of fact is or might be based, and an assessment or value judgment, such as an assessment of risk, which is based on findings of fact which have already been made".

14. In *PF v DBS* [2020] UKUT 256 (AAC) a Presidential Panel of the Upper Tribunal said, at [43], that, on appeal, the Upper Tribunal could hear evidence that was not before DBS. If the Upper Tribunal heard no new evidence, the DBS' decision "might well be the starting point" [49]. If the Upper Tribunal heard significant new evidence, DBS' evaluation of the evidence would probably be 'overtaken', so that "the only appropriate approach for the UT would be to start afresh" [49]. *PF* was applied by the Court of Appeal in *JHB* in which it held, at [90] that, in a case where the Upper Tribunal heard "very limited evidence" so that the DBS' decision was the 'starting point', the Tribunal was not free to make its own assessment of the written evidence unless and until it found an error of fact or law.

15. In *JHB*, the Court of Appeal also said:

"95...the UT understood the DBS's reliance on paragraph 2 of *Volpi v Volpi* [[2022] EWCA Civ 464] as a submission that, in order to show that there has been 'a mistake of fact' it is necessary to show that there was no evidence to support that finding, or that it was irrational. I agree with the UT that if that were the position, section 4(2)(b) would be redundant. But, in my judgment, that is not the position on an appeal such as this, for two reasons. First, a finding may be 'wrong' for this purpose, even if there was some evidence to support it, or it was not irrational...Second, a finding may also be 'wrong' for the purposes of section 4(2)(b) if it is a finding about which the UT has heard evidence which was not before the DBS, and that new evidence shows that a finding by the DBS was wrong, as the UT itself explained in *PF*..."

16. In *Disclosure & Barring Service v RI* [2024] EWCA Civ 95, the Court of Appeal was of the view that the *ratio* of *JHB* was "difficult to discern". Bean LJ said:

"33...I venture to suggest that it [*JHB*] may be authority for the proposition that if the UT has exactly the same material before it as was before the DBS, then the tribunal should not overturn the findings of the DBS unless they were irrational or there was simply no evidence to justify the decision. The same rule may apply where, as in the *JHB* case itself, oral evidence is given but not on matters relevant to the decision to place the appellant on one or both of the Lists."

Human Rights Act 1998

17. Section 6(1) of the Human Rights Act 1998 provides that it “is unlawful for a public authority to act in a way which is incompatible with a Convention right”.

18. The Convention Rights include Article 8 of the European Convention on Human Rights, which provides:

“1. Everyone has the right to respect for his private and family life...

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

19. In *Botta v Italy* (21439/93) (1998) 26 241 E.H.H.R., the European Court of Human Rights said, at [32], that “the guarantee afforded by Article 8 of the Convention is primarily intended to ensure the development, without outside interference, of the personality of each individual in his relations with other human beings.”. We doubt it would be seriously disputed that, in most cases, barring interferes with an individual’s right to respect for their private life, as that concept was explained in *Botta*.

**Proceedings before the Upper Tribunal**

20. This case has taken a long time to come to fruition. In November 2022, the Upper Tribunal granted the Appellant permission to appeal against DBS’ barring decisions. Case management directions required DBS to provide a written response within one month of the date on which the permission determination was issued, which they did. The directions also provided for DBS’ response to be issued to the Appellant and required her written reply within one month.

21. Due to an oversight, DBS’ response was not sent to the Appellant by the Upper Tribunal until June 2023. The Appellant’s written reply should have been received at the Upper Tribunal by 1 July 2023. Despite reminders from Upper Tribunal staff, no reply was forthcoming and on 26 May 2024, the Upper Tribunal warned the Appellant that, if no reply was received within one month, her appeal was liable to be struck out. In response, the Appellant informed the Upper Tribunal that she did not have access

to DBS' written response. Arrangements were made for a copy of the response to be sent to the Appellant, and she was given a further month to reply.

22. Arrangements had been made for a hearing of this appeal, but the Appellant informed the Upper Tribunal that she no longer requested a hearing of her appeal, and was content for it to be decided on the papers. DBS did not object.

## **Arguments**

### Appellant

23. The Appellant submits that, since she started taking Amisulpride in 2019, she has remained compliant, and "I have had no incidents...no voice delusions and my mental state is normal". Since 2020, she has worked full-time as a gardener.

24. The Appellant supplied a letter from a consultant at her Community Mental Health Team. Dated 11 January 2024, the letter states that the risk posed by the Appellant is 'low'. While the letter does not state expressly whether the Appellant is compliant with her anti-psychotic medication, it expresses no concern about compliance (most of the letter is about the Appellant's wish to have IVF fertility treatment). A subsequent letter dated June 2025 states "currently no psychopathology or risk identifiable and no particular action is needed". This letter expresses no concern about the Appellant's medication compliance. Had there been such a concern, we are sure that one or other of the consultant's letters would have mentioned it.

25. The Appellant describes in some detail how, over recent years, she has successfully pursued a career in horticulture (we note how impressed and pleased we were to read the Appellant's description of positive developments in her life). However, the Appellant argues that being placed on both barred lists impedes her further progress in her chosen occupation.

26. The Appellant takes issue with DBS' finding that she chose to disregard and disengage from medical professionals, and instead favoured her own methods to deal with her mental health. What DBS described as disengagement was in fact a family crisis in connection with which she needed to travel to another country. DBS also fail to acknowledge that the Appellant has the right to disagree with medical professionals. In any case, the Appellant submits, she did not ignore medical advice and tried to implement coping strategies she had been taught during the incident in a supermarket

referred to in DBS' decision letter. The Appellant also argues that this incident was not fairly assessed because staff at the supermarket ganged up on her and ensured that their versions of events fit together.

## DBS

27. DBS draw the Upper Tribunal's attention to a leading case law authority about the assessment of whether a measure that interferes with Article 8(1) rights is proportionate. In *R (Quila) v Secretary of State for the Home Department* [2011] 3 WLR 836, Lord Wilson said:

"45... in such a context four questions generally arise, namely: (a) is the legislative object sufficiently important to justify limiting a fundamental right?; (b) are the measures which have been designed to meet it rationally connected to it?; (c) are they no more than are necessary to accomplish it?; and (d) do they strike a fair balance between the rights of the individual and the interests of the community?"

28. DBS argue that their barring decisions were proportionate, and this appeal should be dismissed:

(a) DBS expressly applied their mind to Article 8 and proportionality. The decision letter noted that barring might affect the Appellant's earning potential and other aspects of her life, including 'hobbies and pastimes' which, in the context of this case, extended to volunteering;

(b) there is some evidence that working and/or volunteering might be beneficial to the Appellant, but not that this needs to be in the form of regulated activity. The key factor that emerges from the available evidence is that medication compliance is the critical factor, not volunteering or working. And it cannot be ignored that, previously, the Appellant had worked with children and vulnerable adults yet still experienced a relapse in her mental health;

(c) as mandated by the authorities, DBS were required to weigh the Appellant's rights against the wider interests of the community. For the purposes of that exercise, the evidence disclosed: (i) the Appellant was at risk of relapsing; (ii) a pattern of the Appellant having extended periods of stability followed by unpredictable relapse; (iii) a pattern of medication compliance and engagement with support services followed by

a failure to comply or engage; (iv) when unwell, the Appellant has been assessed as posing a risk to herself and others; (v) that risk has manifested itself on multiple occasions; (vi) barring does not prevent the Appellant from engaging in all forms of work or volunteering. These considerations clearly emerge from the evidence. Even if DBS' proportionality assessment was flawed, a properly conducted assessment would have arrived at the same conclusion.

29. DBS also submit that it was not necessary to commission additional specialist medical assessment evidence. The conclusions of any such assessment would necessarily have been speculative based on a history already known to DBS. A risk would have been identified (of relapse, non-compliance and further harm to others) but that would not have "added anything that was materially new".

### **Analysis**

30. It is unfortunate that the Appellant was unable to secure legal assistance, as suggested by the Upper Tribunal when granting her permission to appeal. The single ground of appeal raised a legal issue that could not be considered simple or straightforward. However, the Upper Tribunal is satisfied that it did all that it reasonably could to assist the Appellant to obtain legal representation, including providing contact details for an organisation that offers legal help to people with mental health problems. We must now decide this appeal on the material before us.

31. We remind ourselves that the authorities require the Upper Tribunal, in assessing proportionality, to accord appropriate weight to the decision of the barring authority "as the body particularly equipped to make safeguarding decisions" (*B v Independent Safeguarding Authority* [2013] 1 WLR 308).

32. In our judgment, and taking into account the requirement to accord appropriate weight to DBS' analysis of proportionality, we are satisfied that, as matters stood when DBS made their decisions in 2021, barring the Appellant from working with children and vulnerable adults was a proportionate response to the risk that the Appellant had been assessed to pose. As DBS submit, at that date of their decisions, the evidence disclosed a discernible pattern of compliance and relapse, in relation to medication and engagement with support services. The incident which precipitated DBS' consideration of barring was, on any view, a serious, and random, one which reportedly involved use of a weapon against two members of a family group at leisure in a public park. The Appellant's actions were preceded by a period of non-compliance with anti-psychotic

medication. Despite evidence that, by the end of 2019, the Appellant's condition had stabilised, was medication compliant and not considered by her clinicians to pose a risk, we are satisfied that barring was a proportionate response given the severity of the park incident, the Appellant's compliance history and the relatively short period of time that had elapsed since the incident. Barring interfered with the Appellant's Article 8(1) rights in that it impeded her ability to develop, without outside interference, her personality in her relations with other human beings. However, it did not preclude all relations with other human beings, only work-related relations with children and vulnerable adults and those involved in regulated activity relating to children and vulnerable adults. This was in our judgment a proportionate and necessary interference with the Appellant's Article 8(1) rights.

33. The thrust of the Appellant's submissions is that, since the park incident, she has maintained her recovery and continued to be medication compliant. Her new medical evidence certainly seems to us to support that. However, that evidence, being produced in 2024, obviously was not before DBS. It seems to us that what the Appellant might consider doing is making a request to DBS to exercise their discretionary power to review a person's continued inclusion on a barred list, and supporting any such request with up-to-date medical evidence.

**Authorised for issue by Upper Tribunal Judge Mitchell,  
on 23 April 2026.**

Section 4 of the Safeguarding  
Vulnerable Groups Act 2006.