Neutral Citation Number: [2026] UKUT 208 (AAC)
Appeal no. UA-2025-000976-V

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

TT

Appellant

and

The Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Johnston, Suzanna Jacoby and Rachael Smith
Decided on 1 June 2026 following an oral hearing in Manchester on 15 May 2026

Representation:
Appellant: The appellant represented herself.
DBS: Mr Serr of counsel

On appeal from a decision of the Disclosure and Barring Service

ANONYMITY ORDER

1. On 2 September 2025 the Upper Tribunal made an order as follows:

> "(5) Pursuant to rule 14(1) of the Tribunal Procedure (Upper Tribunal) Rules 2008[2], the
> Upper Tribunal prohibits the disclosure or publication of—
>
> (a) the name of each of the following in relation to these proceedings—
> (i) MEK - Manager
> (ii) ANP – Advanced Nursing Practitioner
> (iii) MKC – Manager
> (iv) JB – Vulnerable Adult
> (v) CF – Vulnerable Adult
> (vi) EJ – Vulnerable Adult
> (vii) AZ – Staff member
> (viii) DM – son of Vulnerable Adult
> (ix) LB – daughter of Vulnerable Adult
> (x) AR – Vulnerable Adult
> (xi) ML - Manager
> (xii) MJS - Manager

(xiii) MJW - Manager
(xiv) MIT - Manager
(xv) JC – Vulnerable Adult
(xvi) AM – Vulnerable Adult
(xvii) MLR – Regional Manager
(xviii) MCV – Manager
(xix) LW – Staff member
(xx) LA – Staff member
(xxi) the Care Home

(b) any matter likely to lead members of the public to identify any of the persons mentioned at subparagraph (a) above.

Breach
6. Any breach of the order at paragraphs 5 above is liable to be treated as a contempt of court and punished accordingly (see section 25 of the Tribunals, Courts and Enforcement Act 2007). Punishment can be imprisonment for up to two years, or a fine, or both."

2. The Upper Tribunal varied the anonymity order to add MW, one of the two witnesses for the appellant today to the list of anonymised names. The same prohibition on disclosure and publication of her name or any matter likely to lead members of the public to identify her applies, along with the consequences set out above.

SUMMARY:
Safeguarding vulnerable groups: 65.2: 65.5: 65.9 (1)
Mistake of fact: The DBS made mistakes of facts in their final decision that the appellant failed in her safeguarding duties to the service users at the care home where she worked.
[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

1. The appeal is allowed and the DBS is directed to remove the appellant from the adults' barred list, following an oral hearing on 15 May 2026.

2. The hearing was held in Manchester. The appellant represented herself. The DBS was represented by Mr Serr. We are grateful to both for their submissions and representation.

REASONS FOR DECISION

A. Introduction

3. The appellant appeals to the Upper Tribunal against the DBS's decision under reference 01041226779 communicated in the Final Decision letter dated 7 April 2025 (pages 185-191 of the bundle) to include her in the adults' barred list.

B. Procedural Background

4. Permission to appeal was given by Upper Tribunal Judge Johnston on 28 August 2025. Permission was given on the grounds of mistakes of fact in respect to the allegations

of facts found proved by the DBS, if mistakes of fact were found on whether the decision to bar was disproportionate and therefore a mistake of law.

5. The DBS through Mr Serr relied on the facts alleged against three service users for the decision to bar the appellant. These facts found by the DBS are as follows:

> (1) On an unspecified date prior to 10 April 2024, you dismissed concerns over the welfare of [EJ], a vulnerable adult in your care, failed to escalate your request for pain medication for her and failed to document your actions in relation to obtaining this pain medication.
>
> (2) On an unspecified date prior to 10 April 2024, you failed to provide or ensure adequate monitoring and care for [JB], (a vulnerable adults in your care) diabetes.
>
> (3) On an unspecified date prior to 10 April 2024, you "tormented" [CF], a vulnerable adult in your care, with a cigarette lighter by repeatedly telling [CF] it was not [CF's] and was yours which caused [CF] emotional distress.

C. The Law

6. The relevant legislation is in the Safeguarding Vulnerable Groups Act 2006 (the Act).

7. Section 2 of the Act requires the DBS to maintain an adults' barred list. By virtue of section 2, Schedule 3 to the Act applies for the purpose of determining whether an individual is included in the list. Regulated activity is determined in accordance with section 5 and Schedule 4 to the Act.

8. Section 3 provides that a person is barred from regulated activity relating to vulnerable adults if the person is included in the adults' barred lists. Regulated activity is determined in accordance with section 5 of, and Schedule 4 to, the 2006 Act. Schedule 3 to the Act provides for inclusion by reference to, among other things, "relevant conduct" by the person included in the lists. Relevant conduct is what the DBS relied on in this case. The appellant must have been engaged in relevant conduct, and the regulated activity test must be met. That is, that the person has at any time engaged in relevant conduct and is, or has been or might in future be, engaged in regulated activity relating to vulnerable adults (Paragraph 9(1)(a)(i) and (ii) of Schedule 3).

9. Relevant conduct is defined in the Act as, among other things, conduct which endangers or is likely to endanger a vulnerable adult, and conduct which, if repeated against or in relation to a vulnerable adult, would endanger that adult or would be likely to endanger him (paragraph 10(1)(a) and (b) of Schedule 3). A person's conduct endangers a vulnerable adult if he harms a vulnerable adult, causes a vulnerable adult to be harmed, puts a vulnerable adult at risk of harm, attempts to harm a vulnerable adult or incites another to harm a vulnerable adult (paragraph 10(2)(a)-(e)).

10. Schedule 3 paragraph 16(1) and (3) of Act provides-

> 16(1) A person who is, by virtue of any provision of this Schedule, given an opportunity to make representations must have the opportunity to make representations in relation

> to all of the information on which DBS intends to rely in taking a decision under this Schedule. …

11. Section 4 of the Act governs appeals. It provides that an appeal may be made to the Upper Tribunal against a DBS decision only on the grounds that the DBS has made a mistake on any point of law or in any finding of fact which the DBS has made and on which the decision was based. Subsection (3) of section 4 provides that, whether or not it is appropriate for an individual to be included in a barred list is not a question of law or fact (our emphasis).

12. In DBS v RI [2024] EWCA Civ 95 Bean LJ said this:

> "31. It seems to me plain that the Presidential Panel in PF were saying that where relevant oral evidence is adduced before the UT in an appeal under s 4(2)(b) of the 2006 Act the Tribunal may view the oral and written evidence as a whole and make its own findings of primary fact. I would add that whether or not A stole money from B cannot be considered a matter of "specialist judgment relating to the risk to the public" engaging the DBS's expertise. I reject Ms Patry's submission that the Upper Tribunal is in effect bound to ignore an appellant's oral evidence unless it contains something entirely new. Such an approach would be anomalous and unfair. It would be anomalous because, as Males LJ pointed out during oral argument, an appellant who attended the Upper Tribunal hearing and stated that she was innocent but was not cross-examined, would be liable to have her appeal dismissed because no item of fresh evidence had been put forward, whereas if she was cross-examined, and in the course of that cross-examination mentioned a new fact, that would confer on the UT a wider jurisdiction to allow the appeal on mistake of fact grounds. Usually courts and tribunals (and juries) think more highly of parties who have maintained a consistent account than those who come up with a new point for the first time in the witness box.
>
> …
>
> 35. Such a technical approach would also, in my view, be clearly unjust. The DBS has draconian powers under the 2006 Act. A decision to place an individual on either or both of the Barred Lists is likely to bring their career to an end, possibly indefinitely. Parliament has given such a person the right of appeal to an independent and impartial tribunal which can hear oral evidence. It is in my view open to an appellant to give evidence that she did not do the act complained of and for the UT, if it accepts that case on the balance of probabilities, to overturn the decision."

13. If the DBS has made an error of law or fact, the Upper Tribunal determines whether to remit or direct removal of the person's name from the list (section 4(6) of the Act). In Disclosure and Barring Service v AB [2021] EWCA Civ 1575, at paragraph 73 Lewis LJ says as follows:

> "For those reasons, I would interpret section 4(6) of the Act as permitting the Upper Tribunal to direct removal of the name of a person from a barred list where that is the only decision that the DBS could lawfully reach in the light of the law and the facts as found by the Upper Tribunal."

D. Factual background

14. The appellant was employed as a senior care assistant at the Care Home (the home) at the time of the allegations. She worked there from 12 April 2022 initially being hired as a care worker. She was promoted to being a Senior Care Worker in about June 2023. She worked in this position for about a year before she was dismissed on 09 May 2024. The DBS referral was made on 20 June 2024 by the regional manager of the home. The

appellant's witnesses MEK and MW also worked at the home. MEK was in the same position as the appellant but worked on a different floor of the home.

15. The allegations accepted by the DBS are set out in paragraph 5 above. The appellant was dismissed by letter dated 09 May 2024. She appealed the decision but was not successful. Neither the DBS or the Upper Tribunal had access to that appeal or the decision that followed. We did however have access to the notes of the investigation meetings and the dismissal letter.

16. The DBS sent the Minded to Bar letter on 26 February 2025 giving the appellant the opportunity to make representations which she did in an undated letter at page 149 of the bundle. The DBS decision letter barring the appellant was sent to her on 07 April 2025.

E. The hearing

17. The appellant told us that working for the care home was her first experience of working in care. She was employed as a care assistant in 2022 and was promoted to Senior Care Assistant sometime in 2023. Before she started as a care assistant, she shadowed a carer and learnt how to change pads, washing and repositioning residents and other tasks to do with day-to-day care.

18. On the days she was on shift she was responsible for 24 residents and usually had a permanent care worker and an agency staff member working with her. During her time at the care home, she had at least three managers. She said she got on well with the staff and managers.

19. Mr Serr asked the appellant questions around the care plan for EJ. This was updated in October 2025 so may not have been in place at the time of the allegations. The appellant could not remember if it was the same. This care plan has paracetamol prescribed on a PRN basis (pp 302 of the bundle) so in this respect at least it was different at the time of the allegation. There was also information about what to do if CF became aggressive. The appellant told us that she was never aggressive when she worked with her.

20. The appellant told us that medication was given as set out in the MAR chart. That would have the medication listed with dates and times for it to be given. The care workers would put notes of how the resident presented on an app twice a day.

21. As to the allegation that the appellant did not escalate the concerns reported to her about EJ being in pain she said she did. She had been told by the night staff about this. She said she may not have documented this but assumed the night staff would have done this. She said she was not told this by day staff. She had seen EJ herself as well but may not have documented this. She discussed the pain check carried out by day staff for every resident and it was not raised with her. The appellant said she called 111 who advised her to speak to the GP. The care staff had to ask the ANP (a nurse with the ability to prescribe medication) before they called the GP. She did this and the ANP told her that doctors don't like prescribing paracetamol and don't give it. She refused to prescribe it. She also spoke to the ANP a couple of times when she was on site. If the ANP said she would not prescribe the medication calling the GP would make no difference as all the GP said was talk to the ANP. As all medication had to be prescribed, she could not give EJ paracetamol without a prescription.

22. In the dismissal letter at page 131 of the bundle, the manager dismissing her says that "I do not accept your mitigation and note you agreed that you could have done more to support this resident's discomfort." The appellant said she did not agree with this. She had called 111 and spoken to the ANP and any call to the GP would have been pointless as they would refer her back to the ANP. She could not remember whether she documented her steps.

23. MEK gave evidence that she worked upstairs but had left about six weeks after the appellant was dismissed. She was aware of EJ. When she used to try and get medication from the ANP it was impossible. The managers at the home told the care staff not to contact the GP but to contact the ANP. She said speaking to a manager would "never get you anywhere". In relation to EJ the night staff had not managed to get medication through the ANP either. She had put in numerous complaints that were not pursued and nothing changed.

24. MW also gave evidence. She worked at the care home. She told us that she made numerous complaints to managers and the medication was terrible – it was always in a mess. Nothing was ever done about it. She said she looked after EJ who never mentioned pain. She told us that the side effects of her other medication made her restless. She told us that she could not get the ANP to prescribe medication. She said that she had seen the appellant with residents and that she thought she was brilliant. She would adapt to everybody, and her caring was to a high standard. In terms of AZ who made the allegations about EJ being in pain and the appellant not doing anything about it she said AZ always made herself look busy when she was not.

25. MEK said that the appellant could speak rudely to staff on occasions and she spoke to her about this, but this was just how she was. She was blunt but not callous or racist as she was accused of being. However, the appellant would never speak in this way to residents. Whenever she came down to the appellant's floor one of the residents would always be in the office talking to the appellant. She did say in her interview during the investigation on 10 April 2024 that she would now go to management if she thought the appellant was rude to staff (pp 112) but said to us that that was just an answer then and she was facing her own problems at the time. She had been accused of racism but was cleared by the investigation.

26. As to the allegations about JB that the appellant failed to provide or ensure adequate monitoring and care for his diabetes, she said that the carers would use a scanner which goes over his arm if they needed to. She had not been told he was hypoglycaemic by the staff. Staff changed his catheter bag every two hours and if they had noted he was not well they should have told her. When the district nurses arrived she spoke to them, and AZ said to her and the nurses that he had been like that for a while. The appellant said she had not been told and that she was "disgusted" by this. AZ should have told her. It is alleged that she did not escalate this to senior management and the reason was that AZ did not like to be challenged and there was no point as management never did anything. She accepted that she probably did say that she cannot force him to eat because she couldn't. It was very difficult to get him to eat and even his family could not get him to eat. His blood sugar in the morning was perfect. She provided text messages between herself and JB's family. There is a text message dated 19 March 2024 which said:

> "need to sort somet this morn with [JB}. None seems to know who should be doing what or when x
>
> I mean with the medical side [appellant] not your place or staff x"

27. In what is presumably an email copied another unnamed family member reported that JB was still in hospital and they did not want him to go back to the care home. They said when they met MIT, they were given assurances that JB's needs could be met. They complained about the "senior staff" but did not name anyone. (page 115 of the bundle) It is impossible to know who they were complaining about. At page 116 of the bundle there is a longer document which is unsigned and undated presumably from a family member which said as follows with regards to encouraging [JB] to eat:

> "…when we started to question this, we were met with the blunt response "we can't force him to eat", true, but a bit of effort with an old man is all that is needed. All of these were discussed with [MIT] prior to us taking a complete leap of trust to move him into a [care] home. I have communicated with sisters and the names that we know are [the appellant], and another chap (bald head), not sure of his name … along with another Asian chap - but don't have any other info than that. Of course, [MIT] failed us all with initially promising of care/service that could not be delivered, certainly not with the current staff."

28. The investigation report at page 128 of the bundle said this:

> "Allegation 1b:- (JB) Safeguarding report raised by district nurses regarding failure to monitor blood sugar levels of resident JB and subsequent failure to provide the necessary corrective support. When challenged on this by DN's, TT stated we can't force him to eat, however there was no evidence of any encouragement. Failure to ensure JB was correctly cared for have resulted in hospitalisation of this resident. (See appendices 2, 6, 12, 13, 14)."

29. The care plan regarding diabetes is at page 326 of the bundle. It is probably the care plan that was in place for JB at the time as it was last updated on 22 March 2024. It does not give any specific information about timelines for when JB should be monitored. It said as follows:

> "Staff need to monitor [JB] for signs and symptoms of hypoglycaemia (low blood sugar) or hyperglycaemia (high blood sugar) and if they suspect JB has either to contact the emergency services and follow advice".
>
> …
>
> "[JB] needs monitoring for hypoglycaemia or hyperglycaemia. [JB] has a Freestyle Libre to monitor his blood glucose levels. The user manual is in scanned documents. The District Nurses are responsible for applying the sensors and monitoring his blood sugars levels. <u>If instructed</u> Senior Care staff can use the reader to provide the District Nurses with a reading." - our emphasis.

30. The appellant told us that had she been told by AZ about JB appearing unwell there were things she could have done about this. She had sweet snacks for him to raise his blood sugar she could have given him. She said that JB was one of her favourite residents. It was difficult to get him to eat as he did not like the food. She did not accept she could have done more to encourage JB. She asked carers to go to his room, and he told them to leave; she said his family said, "you could put a steak dinner in front of him and he wouldn't eat".

31. The appellant explained that the tool for monitoring JB's diabetes was used during the night shift as that was when he was prone to have "hypos". The district nurses had responsibility for monitoring JB's diabetes in the daytime. She attended every day with the district nurses. On the day when he was admitted to hospital she did tell MKC the manager about AZ but he did not say anything or write it in the notes. She did not write notes as he was doing this.

32. MEK told us that although she was not responsible for JB as he was not her resident, she knew about him and she told us he should never have been at the care home as his needs were too complex.

33. As to the allegations about CF that the appellant tormented her over a lighter, she denied this. She said she knew CF's family and CF was always coming into her office for a chat or to get cigarettes and her lighter as her cigarettes and lighter were held for her in a box. Annexed to her representations to the DBS is a message from the MW. It says "I've come home with [CF's) lighter…"

34. CF's care plan was updated on 14 September 2025 well after the appellant was dismissed. It is impossible to know what the care plan said at the time of the allegation. The current care plan says among other things to avoid arguing or contradicting: and if CF becomes increasingly aggressive or unmanageable the next steps to be taken. The appellant said that CF was nothing like this when she was working and was always calm. She knew who the appellant was and she came into the office every 5-10 minutes during the day. The time when the appellant told CF that the lighter was hers not CF's was when it was. The text message confirms that it was missing at some stage as MW had mistakenly taken it home. In any event the relationship between the appellant meant that they could have that conversation and that no distress was caused. They talked all through the day.

35. MEK told us that the appellant did walk the floor and talk to a lot of residents. The person who made this allegation always wanted her own way and was angry. She told us that CF has recently moved to a new care home where she is working and has been moved to supported living because she is quite able. She said that the appellant could be blunt to staff but never to residents.

36. MW also said that the appellant was "brilliant" with residents and she would often hear the appellant and residents laughing.

F. Oral submissions from the parties

37. Mr Serr said the DBS relied on the allegations about the three residents set out at paragraph 5 above. He said that although the buck did not entirely stop with the appellant as she was not a doctor or a nurse, as a senior carer she had extensive responsibilities. The real concerns were with EJ and JB. JB ended up in A&E and there is extensive information in the care plan. There were serious incidents from family, staff and the district nurses. When asked about trying to have him eat, the appellant said, "we tried but we can't force him."

38. As to the allegations of EJ, there is a commonality in the two allegations in that the appellant did not adequately document what was happening. The evidence shows she seemed to be content with the first answer but that was not good enough, JB was in hospital

and EJ in pain. The ANP refused pain medication, but the appellant could have asked her to see EJ and the appellant did not see her either. She did not take ownership.

39. Ultimately the tribunal needs to decide whether there has been a mistake of fact. The decision letter said she did not escalate pain medication, she did ask the nurse but not the GP and did fail to document. Therefore, there was no mistake of fact. As to JB she failed to provide adequate care. She accepted that he had diabetes and the care plan has instructions for what to do. He ended up in hospital as he was not adequately monitored. If there was a serious problem with him eating, she should have acted first. As to CF she accepted she had not spoken appropriately in the investigation meeting and was a "bit silly".

40. The appellant submitted that she did not repeatedly say to CF that this was not her lighter. As to JB she was not trained in diabetes, but she had set up a tool for the night staff to monitor his blood sugar. During the day it was the District Nurses' responsibility. She had 24 residents to look after and relied on the support of the carers. For EJ she said she tried to get medication but once the ANP had said she would not prescribe paracetamol there was nothing more she could do. The GP would have said go and speak to the ANP if she had called them.

G. Analysis of the grounds of appeal on which permission was granted.

41. **Mistake of fact**

42. The first allegation to address is as follows:

> "On an unspecified date prior to 10 April 2024 you dismissed concerns over the welfare of [EJ], a vulnerable adult in your care, failed to escalate your request for pain medication for her and failed to document your actions in relation to obtaining this pain medication."

43. The evidence from the care home in the bundle that the appellant did dismiss concerns over EJ's pain medication came from the referral to the DBS (page 67 in the bundle), an undated and unsigned document which may be the copy of an email at page 96 of the bundle, the investigation report at 128 of the bundle and her answer to questions in the investigatory meeting at page 142 – 143 of the bundle. The appellant made representations to the DBS on this allegation at page 149 and 150 of the bundle.

44. We accept the evidence of the appellant that the night staff had informed her they thought EJ was in pain and that is why she attempted to get paracetamol prescribed. She called 111 and was advised to contact the GP. After that call she asked the ANP for a prescription of medication as it was the ANP who prescribed this medication. She had asked the ANP more than once. She knew that if she called the GP, she would be told to ask the ANP which we accept she did on at least a few occasions. Mr Serr submitted that the appellant did not escalate the request for pain medication. We find she did in that she requested the prescription from the ANP on at least a few occasions. We do accept that she did not call the GP but also accept her evidence that the practice was that there would be no point – she would be sent back to the ANP. MEK supported this evidence when she told us that the managers at the home told the care staff not to contact the GP but to contact the ANP. She said speaking to a manager would "never get you anywhere". In relation to EJ, she was aware that the night staff had not managed to get medication through the ANP either. She had put in numerous complaints that were not pursued and nothing changed.

45. We find the appellant did ask for pain medication by calling 111 and asking the ANP. She knew that she could not contact the GP because staff were told that they should ask the ANP and even if she had called the GP would have referred her back to the ANP. We accept that this is what happened in this particular care home and GP's practice.

46. MEK said that staff were told not to contact the GP. We find the appellant did all she could in the environment in which she worked. We acknowledge that there is no evidence that this was documented at the time but there were few staff for 24 residents. The failure to document the actions whilst not helpful to the appellant does not detract from the fact that the appellant did try and obtain medication. We found her and MEK credible on this point. All possible avenues had been explored by the appellant and, according to MEK, the night staff. MW's evidence is also supportive in that she said it was impossible to get the ANP to prescribe medication. MW told us she reported the care home to the CQC, but we had no evidence of that report or any outcome. What is clear to us though is that the processes in the care home were not robust. There should have been an ability for care staff to go to the GP if the ANP refused but they were told not to do this. We therefore find the DBS made a mistake of fact in finding the allegation proved.

47. The second allegation to address is as follows:

> "On an unspecified date prior to 10 April 2024 you failed to provide or ensure adequate monitoring and care for [JB], (a vulnerable adults in your care) diabetes."

48. We heard from the appellant today that she was not aware that JB was not well. She told us that JB was stable in the morning and his blood sugar results were perfect. She relied on staff to report any concerns, and she had measures she could take if any concerns were reported. Her evidence was that he was more unstable at night and so she had prepared a tool for the night staff to monitor him but in the day the monitoring in place was that the staff would report any concerns to her and it was the district nurses who were responsible. The care plan which is likely to have been in place when JB was a resident in the care home says as follows:

> "Staff need to monitor [JB] for signs and symptoms of hypoglycaemia (low blood sugar) or hyperglycaemia (high blood sugar) and if they suspect JB has either to contact the emergency services and follow advice".
>
> …
>
> "[JB] needs monitoring for hypoglycaemia or hyperglycaemia. [JB] has a Freestyle Libre to monitor his blood glucose levels. The user manual is in scanned documents. The District Nurses are responsible for applying the sensors and monitoring his blood sugars levels. <u>If instructed</u> Senior Care staff can use the reader to provide the District Nurses with a reading." - our emphasis.

49. The care plan sets out that the Freestyle Libre could be used to monitor his blood sugar levels, but the appellant could only use the device if instructed by the district nurses as set out in the care plan. She had not had any concerns reported to her by the staff, who were specifically tasked with monitoring him in the care plan and who were aware of these concerns. His blood sugars were perfect in the morning. She had taken steps to have him eat by asking staff to encourage him but realised the limitations of this as carers were told to leave his room when they tried to do this. It is clear to us the staff member who had

noticed he was unwell failed to report the concerns to her and so she did not take the steps at her disposal. In the bundle there was no evidence of any reports on the app which the carers were meant to fill in. The appellant provided a text message from family saying that the "medical side" did not know who should be doing what or when, and that the family member who sent that message did not lay blame at her feet in that message.

50. MEK who was not responsible for JB's care but knew of him was clear that he should never have been at the care home as his needs were too complex. It was not a nursing home. It seems that he came to be there as the family were reassured by MIT, a manager who left, that the care home could manage his diabetes and this was not true. We accept MEK's evidence that JB should not have been in the care home and needed a more specialist service. The appellant said that the District Nurse team had said JB's needs were far too complex for a care home and that he should have been in a nursing home.

51. The evidence from the family is difficult to rely on as it is not clear in one statement who they were complaining about. The second statement does name the appellant in terms of not encouraging him to eat but they were not there and it is the blunt response from the appellant they were complaining about. We accept she did ask carers to encourage him to eat and this encouragement was rebuffed. The central complaint in this statement was against MIT who reassured the family that JB could be looked after in the care home.

52. Although the District Nurses also complained about the blunt response, they were responsible for monitoring JB during the day. Had specific instructions been given it is likely that the appellant would have followed them but there were not. She was not instructed by them to use the Freestyle Libre to take readings for them. One might have expected there to be a checklist of instructions which included how often JB needed to be checked, whether his blood sugars were to be checked by the staff and how, what actions to take or food to be given to him in the event there was a problem, instructions about when to call the District Nurses but the instructions/advice in the care plan is very general. What we do have is that his blood sugars were perfect in the morning and the staff member failed to alert the appellant that he was not well. We have no evidence that there was any note made on the app by the carer who was monitoring him.

53. As Mr Serr accepted, the appellant was not medically trained. Her abilities to care for JB were limited by this. Had she been told he was poorly earlier by staff who knew, she would have been able to act. Had she been instructed by the District Nurses in a clear way she would have been able to act. In the evidence before us the instructions were not clear. Despite this the appellant knew the morning blood sugar results were perfect and was reasonably relying on the staff to tell her if anything was wrong and the District Nurses to monitor JB.

54. We therefore find that the appellant did not fail to provide or ensure adequate monitoring and care for JB. She was ill advised to be so blunt but was failed by the care staff, the care home and was not instructed by the District Nurses clearly. It may be that other evidence exists from the District Nursing team, but it is not before us today nor in the evidence submitted by the DBS to us.

55. The third allegation to address is as follows:

> "On an unspecified date prior to 10 April 2024 you "tormented" [CF], a vulnerable adult in your care, with a cigarette lighter by repeatedly telling [CF] it was not [CF's] and was yours which caused [CF] emotional distress."

56. Although the care plan was relied on by Mr Serr, he accepted that we did not know what care plan was in place at the time of the allegation. It therefore takes us no further. He also submitted that the real concerns relied upon were the two previous allegations.

57. The appellant accepts that the conversation with CF occurred. She said it was her lighter because it was. She provided evidence that the night care staff had mistakenly taken CF's lighter home although we do not know whether this was at the time of the allegation as we have no date for when the allegations occurred. We know the message was sent on 7 March 2024 which is a date prior to 10 April 2024. We accept the appellant had a good relationship with CF and spoke to her often during the day. The DBS recognise there is no direct evidence "in regards to [the appellant] "tormenting" [CF]" (page 196 of the bundle) or that she was distressed. They rely on the employers finding that this allegation was proved. We do not have the direct evidence to the employer either. The DBS find that the appellant made contradictory statements that the lighter was hers, but we cannot find the contradictions. In her representations and at page 83, the investigation interview by the employer she said the same thing, that her lighter was hers.

58. We accept that the appellant had a good relationship with CF, that she was joking and there is no reliable evidence of tormenting her or CF being distressed. We do have direct evidence from the appellant that CF was not distressed, which we accept. We therefore find that the DBS made a mistake of fact.

59. **Mistake of law**

60. As we have found the DBS made mistakes of fact on all the substantive allegations on which the DBS relied, we do not need to consider proportionality.

H. Conclusion

61. As we have identified mistakes of fact, and we must apply section 4(6) of the SGVA to direct the DBS to either remove the person from the list or remit the matter to the DBS for a new decision. In this case, given our findings of fact, the only decision the DBS could lawfully reach would be to remove the appellant from the adults' barred list. We therefore direct the appellant is removed from the adults' barred list.

Upper Tribunal Judge Sarah Johnston
Suzanna Jacoby
Rachael Smith
01 June 2026
Corrected on 16 June 2026 to remove witness names