Neutral Citation Number: [2026] UKUT 337 (AAC)
Appeal No. UA-2025-001559-V

IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Between:

LC (anonymity order in place)

Appellant

- v -

THE DISCLOSURE AND BARRING SERVICE

Respondent

On 10 December 2025 a Registrar of the Upper Tribunal made an Order pursuant to rule 14(1)(b) of the Tribunal Procedure (Upper Tribunal) Rules 2008, that, without the permission of this Tribunal, no one shall publish or reveal the name of the appellant in these proceedings or any matter likely to lead members of the public to identify her.

That Order remains in place. Any breach of that Order is liable to be treated as a contempt of court and punished accordingly (see 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, or both.

Before:	Upper Tribunal Judge Church Tribunal Member Graham Tribunal Member Hutchinson
Hearing date:	25 June 2026
Mode of hearing:	Remote video hearing (CVP)

Representation:	
Appellant:	Ms Rao of counsel, instructed by The Royal College of Nursing
Respondent:	Mr Ryan of counsel, instructed by DLA Piper UK LLP

On appeal from:	The Disclosure and Barring Service
Case No:	01044252314
Decision Date:	24 June 2025

SUMMARY OF DECISION

SAFEGUARDING VULNERABLE GROUPS (65)

This appeal is against the DBS's decision to place LC's name on both the children's and adults' barred lists. That decision was based on its findings as to LC's conduct while working at a children's mental health unit which involved her locking a vulnerable child (Patient A) in her room for prolonged periods during two successive night shifts in 2022.

While the appellant accepted the core finding that she locked Patient A in her room and that this was not in accordance with her employer's seclusion policy, she argued that the decision to bar her was based on various mistakes of fact.

The appellant also argued that the DBS erred in law in its decision making, including:

finding her conduct in relation to Patient A was "transferable" to vulnerable adults,

treating LC's mental ill-health as an "aggravating feature" justifying her name being placed on the barred lists.

The Upper Tribunal dismissed the appeal, finding that the DBS had made no material mistake of fact or law. It confirmed the DBS's decision.

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 dismiss the appeal.

REASONS FOR DECISION

Introduction: what this appeal is about

1. The Appellant was at the relevant time working as a nurse in a CAMHS unit for children with learning disabilities and suspected mental disorder for assessment.
2. The Appellant accepts that she locked Patient A, a 14-year-old learning disabled patient detained under section 3 of the Mental Health Act 1983, in her room on two successive night shifts in May 2022 and did not follow her employer's procedures with respect to placing patients in seclusion.
3. Following a serious incident report which determined that the Mental Health Act 1983 Code of Practice had been breached, the Nursing and Midwifery Council (**"NMC"**) initiated fitness to practice proceedings. Following a hearing on 4-18 March 2024 the NMC made findings of fact about the Appellant's conduct and suspended her registration as a nurse. The Appellant has since been struck off the register by consent.
4. A referral was made to the Disclosure and Barring Service (**"DBS"**), which made initial findings based on the findings of the NMC. The findings in relation to the Appellant's conduct on the night shift of 17-18 May 2022 (the **"first night shift"**) were that she:

a. did not document that she had locked the Patient in their room in Patient's Care Plan;

b. did not complete the restrictive intervention section of the Patient's notes;

c. did not complete a DATIX/Incident Form regarding the incident;

d. after locking the Patient in their room did not:

   i. call the on-call medic;

   ii. call the on-call manager.

e. did not document that she had locked the Patient in their room in the Handover Sheet; and

f. whilst conducting handover to day shift, did not inform one or more colleagues that she had locked the Patient in their room.

(together, **"Competent Body Finding 1"**)

5. The findings in relation to the Appellant's conduct on the night shift of 18-19 May 2022 (the **"second night shift"**) were that she:

   a. whilst on the night shift/disclosing Patient A's sleep pattern during handover, did not inform one or more colleagues that she had locked Patient A in their room on the last night shift;

   b. incorrectly informed agency staff that all patients on Ruby Lodge were 2:1.

   c. on one or more occasions locked Patient A in their room without any clinical justification.

   d. between 04:15-07:00am whilst Patient A was exhibiting distressing behaviour,

      i. restricted staff from going into the Patient's room to provide support.

      ii. used words to the effect of:

         1. "This is what boundaries are"

         2. "No she needs to learn to self-regulate"

         3. "She has always got her own way"

         4. "She needs to learn"

         5. "She's got away with it for too long"

   e. did not document that she had locked Patient A in their room in their Care Plan.

   f. did not complete the restrictive intervention section of Patient A's notes.

   g. did not complete a DATIX/Incident Form regarding the incident.

   h. after locking Patient A in their room, did not:

      i. call the on-call medic;

      ii. call the on-call manager.

   i. did not document that she had locked Patient A in their room in the Handover Sheet.

j. whilst conducting handover to day shift, did not inform one or more colleagues that she had locked Patient A in their room.

k. on an unknown date after Colleague Y disclosed details about an unknown patient's attachment disorder, shouted at Colleague Y using words to the effect of: "no she hasn't she's just spoiled".

(together, **"Competent Body Finding 2"**).

6. The DBS made an additional finding based on its own assessment of the documentary evidence before it, that having become aware of a safeguarding concern during the first night shift when a colleague suggested she was administering medication in excess of Patient A's prescription ("filling the syringe all the way to the top"), the Appellant delayed reporting that safeguarding concern until 22 May 2022 (DBS's **"Additional Finding"**).

7. The DBS sent the Appellant a "Minded to Bar" letter setting out its initial findings and informing her that it was minded to place her name on both barred lists. It invited her to make representations against barring, which her representative (the Royal College of Nursing) duly did on her behalf.

8. Having considered the documentary evidence and the Appellant's representations, the DBS adopted Competent Body Finding 1 and Competent Body Finding 2 and, based on those findings and its own Additional Finding, DBS decided on 24 June 2025 to place the Appellant's name on both the children's barred list and the adults' barred list on the basis that:

a. the Appellant had engaged in regulated activity by reason of her long career as a nurse;

b. competent Body Finding 1, Competent Body Finding 2 and the Additional Finding amounted to "relevant conduct" in relation to both children and vulnerable adults; and

c. it was appropriate and proportionate to do so,

(the **"Barring Decision"**).

Grounds of appeal

9. The Appellant appeals the Barring Decision. She argues that the Barring Decision is based on several mistakes of fact, namely:

a. that she deliberately withheld information about the incidents of the first night shift and the second night shift;

b. that all staff involved with Patient A's care on the first and second night shifts were spoken to as part of the employer's investigation into the incidents;

c. that she did not accept responsibility for locking Patient A in her room;

d. that she failed to report a safeguarding concern from the first night shift; and

e. that there was no clinical justification for the Appellant locking Patient A in her room on the second night shift.

10. The Appellant also argued that the DBS erred in law in:

a. concluding that her conduct as found by the DBS amounted to "relevant conduct" in relation to vulnerable adults for the purposes of Schedule 4 Part

2 paragraph 9(3)(a) of the Safeguarding Vulnerable Groups Act 2006 (the **"2006 Act"**);

b. treating her accepted mental ill-health as an "aggravating feature" justifying her name being placed on the barred lists;

c. finding that her lack of supervision upon her return from an extended period of sick leave was not relevant to LC's behaviour;

d. failing to have regard to the full decision of the Nursing and Midwifery Council Fitness to Practice Panel (including those exculpatory of LC); and

e. failing to find that she had demonstrated insight and remediation such that a repetition of the incidents was unlikely.

The Legal Framework

The statutory scheme

11. There are multiple gateways under Schedule 3 to the 2006 Act to a person's name being included on a barred list. The Barring Decision relied upon the "relevant conduct" gateway, which is explained further below.

The 'relevant conduct' gateway

12. The provisions relating to the "relevant conduct" gateway under the 2006 Act require the DBS to be 'satisfied' of three things:

    a. that LC was at the relevant time, had in the past been, or might in future be "engaged" in, "regulated activity" in relation to children and/or vulnerable adults (see paragraphs 3(3)(aa) (in relation to children) and 9(3)(aa) (in relation to vulnerable adults) of Schedule 3 to the 2006 Act);

    b. that LC had "engaged" in (see paragraphs 3(3)(a) (in relation to children) and 9(3)(a) (in relation to vulnerable adults) of Schedule 3 to the 2006 Act) "relevant conduct" (defined in paragraph 4 (in relation to children) and paragraph 10 (in relation to vulnerable adults) of Schedule 3 to the 2006 Act); and

    c. that it was "appropriate" (and proportionate) to include LC on the barred list(s) (see paragraph 3(3)(b) (in relation to children) and 9(3)(b) (in relation to vulnerable adults) of Schedule 3 to the 2006 Act).

13. If the DBS was satisfied of all three matters above, it was required to place LC's name on both barred lists.

14. LC does not dispute that the "regulated activity" requirement is met in this case by reason of her past work as a nurse, so item a. in paragraph [12] above was not in issue in this appeal.

The Upper Tribunal's jurisdiction under the 2006 Act

15. Section 4 of the 2006 Act sets out the circumstances in which an individual may appeal against the inclusion of their name in the barred lists or either of them. 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 made (see section 4(1) and (2) of the 2006 Act).

16. An appeal under section 4 of the 2006 Act may only be made with the permission of the Upper Tribunal (see section 4(4) of the 2006 Act).

17. Unless the Upper Tribunal finds that the DBS has made a mistake of law or fact it *must* confirm the decision of the DBS (see section 4(5) of the 2006 Act). If the Upper Tribunal finds that the DBS has made such a mistake it must either direct the DBS to remove the person from the list or remit the matter to DBS for a new decision.

18. If the Upper Tribunal remits a matter to DBS under section 4(6)(b) of the 2006 Act the Upper Tribunal may set out any findings of fact which it has made (and on which the DBS must base its new decision) and the person must be removed from the list until the DBS makes its new decision, unless the Upper Tribunal directs otherwise.

19. Section 4(3) of the 2006 Act provides that, for the purposes of section 4(2) of the 2006 Act, whether or not it is "appropriate" for an individual to be included in a barred list is "not a question of law or fact".

The relevant authorities

20. An appeal under section 4 of the 2006 Act is not a full merits appeal permitting the Upper Tribunal to substitute its own judgment on the question of appropriateness. An appeal can succeed only if the appellant can demonstrate an error in a material finding of fact or in the approach taken by the DBS as a matter of law.

21. In relation to whether it is "appropriate" to include a person in a barred list, the tribunal has only limited powers to intervene. This is clear from section 4(3) of the 2006 Act and relevant case law. In particular, the judgment as to appropriateness (described by Wyn Williams J in ***R (RCN) v SSHD & ISA*** [2010] EWHC 2761 (Admin) as *"the ultimate question"*) may only be challenged on the grounds that it is irrational, disproportionate or otherwise unlawful (see §104 and see also ***DBS v AB*** [2021] EWCA Civ 1575 (***"AB"***)). The DBS is well-equipped to make safeguarding decisions of this kind (see ***AB*** at §§43-44, 55 and 66-75)).

22. When it comes to mistakes of fact, the "starting point" for the tribunal's consideration will be the DBS decision: ***PF v DBS*** [2020] UKUT 256 (***"PF"),*** §51(g). Notwithstanding that, the tribunal will not defer to the DBS on factual matters, but the amount of weight given to the DBS's findings of fact will depend on all the circumstances: ***PF*** at §§49 and 51(f). The evaluation of evidence is not a mistake of fact and therefore, if an appellant does not produce evidence on appeal which was not available to the DBS, then the tribunal may only find that there has been a mistake of fact if it concludes that there is no evidence to support that finding of fact or that it was irrational: ***DBS v JHB*** [2023] EWCA Civ 982 (***"JHB"***) at §§93-95.

23. If the tribunal hears evidence which was not before the DBS, it may be entitled to reach the view that, having heard that evidence, a factual finding of the DBS was wrong: ***JHB***, §95; ***DBS v RI*** [2024] EWHC Civ 95 (***"RI"***), §§28-29. Any mistake of fact must be material in the sense of making a material contribution to the overall decision, to warrant the setting aside of a barring decision: ***PF***, §51(b).

24. Where it is submitted that a decision to include a person on the Adults' Barred List or Children's Barred List amounts to a disproportionate interference with that person's rights under the European Convention on Human Rights (**"ECHR"**), the tribunal must accord "appropriate" weight to the conclusions reached by the DBS on this matter, noting its particular expertise in these matters: ***B v ISA*** [2013] 1 WLR 308. If the tribunal finds that the DBS has exercised its power rationally and in accordance with the purpose of the 2006 Act, *"it would require very unusual facts for it to amount to a disproportionate restriction on Convention rights"*: ***Belfast City Council v Miss Behavin' Ltd*** [2007] 1 WLR 1420.

25. The appeal is against the decision made by the DBS, not simply the contents of the decision letter: see ***XY v ISA*** [2011] UKUT 289 (AAC) (***"XY v ISA"***) at §40. The DBS's decision must *"be read fairly and as a whole"*: ***AB***, §46.

26. At §55 of ***AB***, the Court cautioned*: "[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…"*. At §[43], the Court 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".*

27. In the subsequent Upper Tribunal case, ***AB v DBS*** [2022] UKUT 134 (AAC), the Upper Tribunal decided (albeit in the context of a case that was based on the "risk of harm" rather than the "relevant conduct" gateway) that ***AB*** meant that the Upper Tribunal could consider, on appeal under the 2006 Act, a finding of fact by DBS that an individual poses "a risk" of harm but not a DBS assessment of the "level of the risk posed" (see §§49-52 and 64).

28. When considering appeals of this nature, the tribunal "must focus on the substance, not the form, and the appeal is against the decision as a whole and not the decision letter, let alone one paragraph…taken in isolation": ***XY v ISA*** at §40).

29. When considering a barring decision, the tribunal may need to consider both the Final Decision Letter and the document headed 'Barring Decision Summary' that is generated by DBS in the course of its decision-making process. The two together, in effect, set out the overall substantive decision and reasons (see ***AB v DBS*** [2016] UKUT 386 (AAC) at [35] and ***Khakh v ISA*** [2013] EWCA Civ 1341 at §§6, 20 and 22).

30. The statement of law 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 and there is nothing in the 2006 Act which provides a basis for departing from that general principle (see ***CD v DBS*** [2020] UKUT 219 (AAC)).

31. The DBS is not a court of law. Reasons need only be sufficient/adequate. The DBS does not need to engage with every potential issue raised. There are limits, too, as to how far the DBS needs to go in terms of any duty to "investigate" matters or to gather further information for itself, but it must carry out its role in a way that is procedurally fair.

32. If the Upper Tribunal finds that the DBS made a material mistake of fact or law under section 4(2) of the 2006 Act, it is required under section 4(6) either (i) to direct that DBS removes the person from the relevant list(s) or (ii) to remit the matter to DBS for a new decision. Following ***AB***, the usual order will be remission back to DBS unless no decision other than removal is possible on the facts.

The permission stage

33. In her application for permission to appeal LC raised various mistakes of fact and law.

34. Judge Church granted LC permission to appeal to the Upper Tribunal on the papers. The judge was persuaded that since LC disputed key factual findings and since LC proposed to give evidence at an oral hearing at which her evidence could be tested under cross-examination, there was a realistic prospect of LC establishing that the DBS had based its Barring Decision on material mistakes of fact. Judge Church's

permission was unrestricted. He made Case Management Directions and directed an oral hearing of the substantive appeal.

The oral hearing before the Upper Tribunal

35. The remote oral hearing of the substantive appeal took place on 26 June 2026.

LC's evidence

36. LC attended the hearing. She adopted what she said in her witness statement dated 4 June 2026, which she confirmed to be accurate, and she gave fresh evidence in response to questioning from Mr Ryan, the panel and Ms Rao.

37. That evidence included:

    a. LC was a nurse for 18 years until she was struck off the nursing register in 2025 by consent following the fitness to practice proceedings. Prior to becoming a nurse LC had worked as a support worker in a healthcare environment;

    b. At the time relevant to the allegations against her LC was employed by an NHS trust (the **"Trust"**) as a nurse working at an in-patient CAMHS assessment unit for young people with learning disabilities and mental health problems;

    c. LC has a longstanding diagnosis of depression (since about 1994), for which she was prescribed Fluoxetine by her GP, and a more recent diagnosis of post-traumatic stress disorder for which she has received psychotherapy and eye-movement desensitisation and reprocessing therapy since August 2022 and for which she is awaiting further treatment;

    d. LC experienced a traumatic incident in 2020 when she was assaulted close to the Trust's premises. During the assault she lost consciousness and believes she was raped. She reported the incident to her GP, the police and her manager, but no action was taken despite her manager telling her that she would make a safeguarding report;

    e. LC has required several periods of sick leave while employed by the Trust, and in 2015 she was suspended by the Trust for a period on physical health grounds;

    f. In 2019 LC was referred to the Trust's occupational health team due to concerns for her mental health. The occupational health team recommended reasonable adjustments be made, including the provision of greater support from LC's managers, but these were not fully implemented;

    g. In 2021 LC was again referred to the Trust's occupational health team due to concerns about her physical and mental wellbeing. A stress risk assessment was undertaken but no action plan was produced following the assessment;

    h. LC suffered a traumatic bereavement in July 2021 when her sister died in Norway in very distressing circumstances;

    i. LC went on sick leave due to her mental health between 1 January 2022 and 6 February 2022 and upon her return was referred to occupational health but did not receive an appointment with them until June 2022 (after the incidents the subject of the allegations against LC).

Culture of the ward

38. LC described the environment at Ruby Lodge.

    a. There was a practice, of which management was aware, of using the locked parts of corridors to seclude patients in a way inconsistent with the Trust's seclusion policy (LC referred to this as being "put up the corridor").

    b. Although LC had received MAYBO restraint training, she was required to undertake regular refresher training and by May 2022 her training was substantially out of date due to Covid, sick leave and being asked by managers to prioritise clinical work over training.

    c. LC was supposed to have management supervision and clinical supervision monthly, but had not received any management supervision since early 2021 and no clinical supervision since 2019.

    d. Ruby Lodge was often understaffed.

39. *Night shift of 17-18 May 2022*

    a. The night shift of 17-18 May 2022 was LC's first shift following a period of about two weeks' sickness absence.

    b. The Trust's policy was to hold a return-to-work interview, but no return-to-work interview was held with LC.

    c. LC did not feel well enough to work the shift but due to her history of sickness absences she was unable to self-certify any further sickness absence and was unable to get a sick note from her GP.

    d. Prior to the shift LC told her line manager and another manager that she did not feel well enough to do a restraint and was told that she wouldn't have to do one.

    e. There were about 5 members of staff on duty, including LC, but one of those 5 staff members went off duty at 10pm.

    f. LC was nurse in charge on the shift.

    g. Two of the staff members on duty at Ruby Lodge with LC were appropriately trained in using restraint, while Patient A required 5-6 members of staff to restrain her effectively given her size and strength.

    h. LC was told by a colleague that on the previous night shift Patient A had gone into another patient's room and got into bed with them, causing the other patient distress, and Patient A had exhibited challenging behaviour that resulted in her being restrained.

    i. LC was told by colleagues that staff had suffered injuries including cracked ribs and bloodied faces during interactions with Patient A and was shown a photograph of a former colleague with a bloodied face and this information was "in her head" as she started the shift.

40. *Night shift of 18-19 May 2022.*

    a. For most of the shift LC worked with 3 support workers and 1 nurse.

    b. Concerned about the risk that Patient A would go into another patient's bedroom or would seriously injure another patient, LC locked her in her room again.

c. LC went into Patient A's room a few times during the shift to check that she was OK, during which visits the door was locked from the outside by a colleague outside the room.

41. LC denied that she had said the precise words attributed to her by the DBS ("This is what boundaries are"; "No she needs to learn to self-regulate"; "She has always got her own way"; "She needs to learn"; and "She's got away with it for too long") she said she might have said something on the lines of "she needs a boundary to keep patients safe".

42. LC accepted that she locked Patient A's room during the night shifts of 17-18 May 2022 and 18-19 May 2022 and accepted that she made serious mistakes on those shifts, namely:

    a. she should have made clear notes about what happened on the shifts or (if not practicable during the shifts) as soon as possible after the shifts;

    b. she should have contacted a senior colleague to escalate her seclusion of Patient A;

    c. she should have been clear in handover about what happened on the shifts; and

    d. she should have given more consideration to the emotional harm that she accepts was caused by locking Patient A in her room and spent more time balancing it against the distress that restraint would cause.

43. Under cross-examination she accepted that she should have called the on-call medic and the on-call manager in accordance with the Trust's seclusion policy, but she did not.

44. She accepted that some time before June 2021 her colleague "EB" had told her that another colleague, "PA", had told her that she had administered a full syringe of medication, which would have been more than the prescribed dose. She discussed with colleague EB how dangerous it would be and believed that colleague EB was going to report the safeguarding concern, but she did not. LC accepts that she should have checked whether colleague EB did in fact report the concern and, if she did not, should have reported the concern to management herself. LC said colleague PA told her on 17 May 2022 in the context of a discussion about the behavioural issues on the ward that she was going to fill the syringe all the way to the top. LC says that she reported this when she met with her manager on 21 May 2022 to discuss the events of the night shifts of 17-18 and 18-19 May 2022.

Analysis

Mistake of fact grounds

45. The Upper Tribunal heard fresh evidence from LC. We found that LC was significantly unwell in May 2022. She was too unwell to return to work in such a challenging role and while she raised concerns with her managers about her ability to cope with the full range of her duties, her concerns were dismissed. We find that LC was badly let down by her employer.

46. The panel is persuaded by LC's evidence that the DBS's finding that all witnesses were spoken to in relation to the first and second night shifts was mistaken. This mistake of fact was not material, though, because the core facts relied upon by the DBS are not significantly in dispute: LC accepts she locked Patient A in her room on

both the first and second night shifts, she accepts that she failed to call either the on-call medic or the on-call manager, she accepts she failed to make proper records or to give appropriate handover to the day shift, and she accepts that being locked in her room caused Patient A significant emotional harm. Given these undisputed facts, the DBS was clearly entitled to find that LC had engaged in "relevant conduct" in relation to children. Given that LC accepts these matters, we do not consider that the outcome would have been any different had the DBS not made that mistake of fact.

47. It was also argued on LC's behalf that the DBS made a mistake of fact when it found that LC had waited 4 months to report a safeguarding concern about a colleague having made a comment during the first night shift about "filling the syringe all the way to the top" (i.e. inappropriately over-medicating a patient). The DBS made a finding that there had been a deliberate withholding of this information, which it found to amount to relevant conduct in relation to children. The evidence on this matter is somewhat confused, but even if the DBS was mistaken in its findings as to the failure to report this matter promptly, such mistake would not have been material because of the gravity of the findings about LC's own failings during the first and second night shifts. In the light of the seriousness of those findings (and LC's admissions) it is highly unlikely that the DBS would have reached a different decision on barring had it not made the Additional Finding.

48. The panel has considerable sympathy for LC given her poor health and the lack of support provided to her by her employer. While the panel does not accept LC's evidence that a manager (now deceased) tore up a sick note provided by LC's GP in the past (considering that had this been the case LC would have raised it earlier than she did), it does accept that LC's managers were unsupportive and that they prioritised covering shifts over staff welfare. There also appears to have been a culture of poor practice on the ward.

49. However, we accept the DBS's characterisation of LC's conduct during both the first and second night shifts as irresponsible and demonstrating poor problem-solving and coping skills and a lack of empathy for a very vulnerable patient in her care. Even though the NMC found there to be some clinical justification for Patient A's seclusion during the first night shift, her failure to call the on-call medic or the on-call manager on that shift represents a serious failing that resulted in Patient A being denied important safeguards. Similarly, the failure to make a proper record in relation to Patient A's seclusion was a serious failing. Like the NMC and the DBS, the panel is not persuaded that there was a clinical justification for Patient A being locked in her room on the second night shift. Having heard LC's evidence, the panel finds that Patient A was locked in her room as a pre-emptive measure to ensure that the second night shift went calmly, rather than in response to any imminent risk to patients or staff.

50. Ms Rao argued that the DBS was mistaken to find that LC "deliberately withheld" information about the incidents of the first and second night shifts, making a distinction between a "deliberate withholding" and a mere omission to record. We are not persuaded that this is a material distinction in the circumstances of this case. It must be remembered that the scheme under the 2006 Act is not punitive but instead protective. What is important is that LC did not follow the Trust's policies and did not complete the relevant paperwork or alert the on-call medic and on-call manager of Patient A being locked in her room. This was significant from a safeguarding

perspective because it prevented colleagues from knowing what occurred during the shift and prevented Patient A from receiving appropriate medical attention.

Mistake of law grounds

Transferability

51. While the conduct relied upon by the DBS was conduct in relation to a child, "relevant conduct" in relation to a vulnerable adult for the purposes of paragraph 9 of Part 2 of Schedule 3 to the 2006 Act is defined in paragraph 10(1)(b) to include "conduct which, if repeated against or in relation to a vulnerable adult, would endanger that adult or would be likely to endanger him". This is what the DBS refers to as "transferability".

52. Ms Rao, on behalf of LC, argued that the DBS erred in law by failing adequately to explain how it arrived at its finding that LC's conduct in relation to Patient A, a child, was "transferable" to adults, especially given that LC's name had been removed from the nursing register and she had no intention of working in nursing again. She said the DBS's reasoning proceeded on the basis that she would be a nurse with keys who would be in a position to lock people in.

53. In its Final Decision Letter the DBS provided an explanation of its decision making in this regard: "As our concerns regarding your irresponsibility, poor problem solving/coping skills and lack of empathy are not specific to the age of those in your care, the DBS is equally satisfied that if you were to work or volunteer in regulated activity with vulnerable adults going forward, you may respond to challenging behaviour by acting in a manner that you know to be outside of policy and procedure and to pose a risk of harm to a vulnerable adult in your care. Due to your behaviour on the second night shift, the DBS is satisfied that you may choose to act in a manner than places a vulnerable adult in your care at risk of harm, when there is no clinical justification, without regard for the harm you may cause. In addition, the DBS is satisfied that you may deliberately withhold information relating to the safe care of vulnerable adults in order to avoid the potential negative consequences of your actions. Due to this, we also have concerns that you may fail to report or escalate, should you become aware of others acting in a manner that poses a safeguarding risk. Overall, therefore, the DBS is satisfied that you pose a significant safeguarding risk to vulnerable adults, and that it is appropriate to include you in the Adults' Barred List."

54. That reasoning is not predicated on LC continuing to practice as a nurse. Rather, it proceeds on the basis that the DBS has reason to believe that LC might work in regulated activity with vulnerable adults. Given LC's experience and skills, which would equip her to work in a non-nursing role such as a healthcare assistant, this is by no means an unreasonable basis to proceed. The DBS's concern is not confined to circumstances where a vulnerable adult may be locked in a room. Rather, the DBS explains that in the light of LC's conduct towards Patient A, it is concerned that if presented with challenging behaviour LC might not comply with policies relevant to safeguarding. The panel is satisfied that the DBS has explained with adequate clarity why it considered your conduct with children to be transferable to vulnerable adults and did not err in law in this regard.

Treating mental health as an "aggravating feature"

55. Ms Rao argued that the DBS erred in law by treating LC's mental health difficulties not as mitigation for her conduct, but as an "aggravating feature". This ground is misconceived because it fails to acknowledge the protective nature of the DBS's role under the 2006 Act. LC's mental health was clearly relevant to her conduct. As such

the DBS was required to take it into account when carrying out its assessment of the risk that LC might in the future engage in relevant conduct in relation to children and/or vulnerable adults should she be permitted to continue to work in regulated activity. The DBS did not treat LC's mental health difficulties as an "aggravating feature", but rather as a matter relevant to the assessment of future risk. It did not err in this regard.

Finding lack of supervision on return to work not to be relevant to LC's conduct

56. While it is argued on LC's behalf that the DBS erred in law in finding that LC's lack of adequate supervision upon her return to work following sick leave was not relevant to the conduct it found her to have engaged in, that is not what the DBS found. Instead, it said the lack of adequate supervision "was not considered to explain why [LC] acted in the manner [she] did" (see first paragraph on page 6 of the Final Decision Letter at page 375 of the Upper Tribunal bundle). The DBS considered that as an experienced nurse LC should have been aware of the potential for her actions causing Patient A harm and should have called the on-call medic and on-call manager in accordance with the Trust's seclusion policy. This aspect of the DBS's decision making discloses no error of law.

Failure to have regard to full decision of NMC Fitness to Practice Panel

57. Ms Rao argued that the DBS cherry-picked those passages of the NMC's decisions which tended to support the decision to bar her while ignoring those passages which are exculpatory, and that this was in error of law.

58. The DBS accepted the factual findings of the NMC, as it was entitled to do, but it carried out its own assessment of the risk that LC might engage in relevant conduct in relation to children and/or vulnerable adults in the future. It was the DBS's statutory duty to carry out that assessment for itself. The DBS's assessment was a different assessment from that carried out by the NMC (which was limited to consideration of LC's fitness to practice as a nurse). The DBS's approach was consistent with the approach set out by the Court of Appeal in ***XYZ v Disclosure and Barring Service*** [2025] EWCA Civ 191. The DBS did not err in law in this regard.

Failure to find that LC had demonstrated insight and remediation

59. The DBS expressly acknowledged and addressed the points made in LC's reflective statement (which accompanied her solicitors' representations in response to the Minded to Bar letter) in its Barring Decision Process document (see pages 754 and 760 of the Upper Tribunal bundle). The DBS explained why it found LC to have only "very limited" insight into the harm caused by her actions. While LC demonstrated a somewhat greater understanding of the impact of her actions by the time she gave her evidence before the Upper Tribunal, the DBS's assessment was open to it on the evidence before it and its finding of lack of "very limited" insight involved no error of law.

Proportionality

60. Ms Rao argues that the Barring Decision was disproportionate, especially given the fact that LC has no intention to practice as a nurse again, was at the time of the Barring Decision suspended from practice as a nurse, and has now had her name removed from the nursing register.

61. The proper approach to assessing proportionality in safeguarding cases is the four-fold test set out in ***Bank Mellat*** [2013] UKSC 39, as explained in ***KS v DBS*** [2025] UKUT 045. Applying that test:

a. the objective of the measure (the protection of children and vulnerable adults from being caused harm by those entrusted with their care in regulated activity) is plainly sufficiently important to justify interference with a protected right to respect for LC's private and family life.

b. the measure (placing LC's name on the adults' and children's barred lists) is rationally connected to that objective.

c. there is no less intrusive measure available that would achieve the objective (the 2006 Act is binary: the DBS can either include an individual's name on a barred list or not. There is no option of imposing conditions, or including an individual's name on a barred list for a limited time.

d. the infringement of LC's rights is not disproportionate to the likely benefit of the measure.

62. LC's conduct involved serious safeguarding failings which caused serious emotional harm to Patient A and the DBS has assessed there to be a significant risk of repetition should LC be permitted to work in regulated activity. In those circumstances the panel is not persuaded that the Barring Decision is disproportionate.

Conclusion

63. The Barring Decision was not based on any material mistake of fact, and it involved no material mistake of law. It is confirmed.

Thomas Church
Judge of the Upper Tribunal

Roger Graham
Tribunal Member

John Hutchinson
Tribunal Member

Authorised by the Judge for issue on 27 August 2026