IN THE UPPER TRIBUNAL ***Appeal No. UA-2022-000111-V***
ADMINISTRATIVE APPEALS CHAMBER **[2024] UKUT 160 (AAC**)

Between:

PM

Appellant

- v –

Disclosure and Barring Service

Respondent

Before: Upper Tribunal Judge Citron, Mr Hutchinson and Ms Smith

Decided following an oral hearing at Manchester Civil Justice Centre on 15 April 2024

Representation:

Appellant: by himself
Respondent: by Ashley Serr of counsel, instructed by DBS Legal Team

DECISION

The decision of the Upper Tribunal is to dismiss the appeal. The decision of the Respondent made on 22 July 2021 (reference DBS6191 00934380818) to include the Appellant in the children's and adults' barred lists is confirmed.

REASONS FOR DECISION

This appeal

1. This is an appeal against the decision ("**DBS's decision**") of the Respondent ("**DBS**") dated 22 July 2021 to include the Appellant ("**PM**") in the children's and adults' barred lists.

The decision

2. The decision was made under paragraphs 3 and 9 of Schedule 3 to the Safeguarding Vulnerable Groups Act 2006 (the "**Act**"). These provide (in very similar terms as regards both children and vulnerable adults) that DBS must include a person in the relevant barred list if

a. it is satisfied that the person has engaged in relevant conduct,

b. it has reason to believe that the person is, or has been, or might in the future be, engaged in regulated activity relating to children/vulnerable adults, and

c. it is satisfied that it is appropriate to include the person in the list.

3. Under paragraphs 4 and 10, "relevant conduct" includes, amongst other things, conduct which endangers a child/vulnerable adult or is likely to endanger a child/vulnerable adult, or which, if repeated against or in relation to a child/vulnerable adult, would endanger them or would be likely to endanger them; and a person's conduct "endangers" a child/vulnerable adult if he (amongst other things)

a. harms them or

b. causes them to be harmed or

c. puts them at risk of harm.

4. The letter conveying the decision (the "**decision letter**"):

a. stated that DBS was satisfied that PM had engaged in relevant conduct in relation to vulnerable adults, specifically conduct which endangered a vulnerable adult or was likely to endanger a vulnerable adult;

b. stated that DBS was also satisfied that PM had engaged in relevant conduct in relation to children, specifically conduct which, if repeated against or in relation to a child, would endanger that child or would be likely to endanger them;

c. stated that DBS had taken the following into account:

(i) on 18 April 1995 PM accepted a caution for indecent assault of a female aged 16 or over; and on 25 September 1995 PM was convicted of destroying property by Wirral Magistrates Court; we shall refer to these as the "**1995 caution and conviction**";

(ii) it had been found by the Nursing and Midwifery Council ("**NMC**") that, whilst PM was employed as a registered nurse at a hospital in 2013-2016:

a. on or around 22 November 2016 PM behaved in an inappropriate manner in that he spoke to a patient aggressively; left the patient's water out of her reach; and intimidated the patient;

b. in or around November 2016 PM behaved in an inappropriate manner towards another patient in that he intimidated her;

c. in or around September 2013 PM said to a female colleague words to the effect of "women are only good for cooking and making beds so get to it";

d. in or around September 2013 PM said to that female colleague that he liked her top as you could see down it;

e. between September 2013 and December 2014 PM sent one or more inappropriate message to that female colleague on Facebook;

f. between September 2013 and November 2014 PM slapped that female colleague's bottom; on one or more occasions tried to hug her and/or grab her from behind;

g. in or around November 2014, PM grabbed that female colleague and kissed her;

h. PM's conduct at e, f and g above was sexually motivated;

(we shall refer to the above as the "**NMC findings about 2013-2016**")

d. found the following, all of which arose when PM worked as a senior carer at a care home between April and July 2020 (PM's employment there was terminated on 12 July 2020, at the end of the probationary period), proved on the balance of probabilities:

(i) during his first two weeks (between 20 April and 4 May 2020) PM

1. continued to shave a resident without their consent;

2. assisted a resident with feeding who did not need assistance, causing the resident to retch between mouthfuls;

3. transferred a resident alone when specified two staff were required;

4. continued to listen to music on his mobile phone after being asked by a resident to stop;

5. continually failed to wear a PPE face mask correctly;

(ii) during the next fortnight (between 4 and 21 May 2020) PM verbally falsified the frequency of his meeting the needs of residents;

(iii) in his second month (21 May to 19 June 2020) PM

1. failed to complete MAR (medication administration record) charts accurately;

2. did not check prescription labels;

3. did not keep a clean work area;

4. was neglectful of the environment residents were left in;

5. delivered a level of care lower than required;

(iv) during first week of July 2020 PM said "watch it, do you want to go down in the lift or down them stairs" to a resident who was in a wheelchair;

(v) prior to 10 June 2020 PM told a dementia resident that she was responsible for the death of Frank Sinatra by running him over in her car;

(vi) during the first week in July 2020 PM

1. told a resident that when she died they would have to hire a crane to lift her out of the building and into her coffin;

2. played drums on the resident's belly;

3. said when she was in the lift, the lift could break;

4. said to the resident: "it isn't rocket science, what do you want?", putting soup in front of the resident, "have that"

(we shall refer to findings (i) to (vi) above as DBS's "**2020 probationary period findings**");

e. stated that a pattern of sexually motivated behaviour towards female colleagues (on the part of PM) "began to grow" from the NMC findings about 2013-2016, when added to the 1995 conviction and caution. The decision letter said that PM's representations (to DBS) followed the "same" pattern of no awareness and no remorse, as was shown in relation to the event that led to the 1995 conviction and caution (the 1995 caution was for indecent assault of a 22 year old female colleague:

slapping her on the bottom and "throwing her on a bed jumping on top of her and writhing"; the 1995 conviction was for throwing a milk bottle through the window of an ex-girlfriend's house);

f. stated that PM had, in working with vulnerable adults (in 2020), continued to upset residents, cause distress and neglected to care for them, placing them at risk of harm. It said that PM remained unaware of the harm he had caused and showed no credible remorse.

5. DBS's "barring decision process" document stated that DBS had "some" concerns under the headings "excessive/obsessive interest in sex" and "irresponsible and reckless"; DBS had "definite" concerns under the headings "attitude endorsing harmful behaviour" and "callousness/lack of empathy"

6. In the first of these categories where there were "definite" concerns, the DBS document stated that PM had displayed behaviour for many years that suggested that he had an "attitude" that his actions were justifiable. It said that PM made open verbal comments at the expense of residents because he considered it to be a joke. It said that PM had not listened to advice and guidance and continued to behave in ways he wanted rather than should, such as continually not wearing his PPE mask correctly. It said that the evidence suggested that PM's "attitude" at work had been towards both colleagues and residents and had persisted for years.

7. In the second of those categories where there were "definite" concerns, the DBS document said that PM had continually failed to appreciate the impact of his behaviours on his "victim". His behaviour had caused distress and alarm to his "victims" and PM has brushed it off by stating that he was only joking or that he denied any involvement. It said that PM's lack of awareness and remorse had been a concern for the NMC and again in the newer information received by DBS the evidence suggested a lack of awareness, remorse and an inability to consider the impact of his behaviour on those around him.

Jurisdiction of the Upper Tribunal

8. Section 4(2) of the Act confers a right of appeal to the Upper Tribunal against a decision by DBS under paragraphs 3 and 9 of Schedule 3 (amongst other provisions) only on grounds that DBS has made a mistake

   a. on any point of law; or

   b. in any finding of fact on which the decision was based.

9. The Act says 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" (section 4(3)).

Grant of permission to appeal

10. Permission to appeal was given by the Upper Tribunal in a decision issued on 17 July 2023 on the ground that it was reasonably arguable that DBS made mistakes in its 2020 probationary period findings, and that these are findings of fact on which DBS's decision was based. This was the only ground on which permission to appeal was given.

11. In that decision, Judge Citron said as follows under the heading *Why I have found it reasonably arguable that DBS made a mistake in certain findings of fact on which the decision was based*:

> "18. In my view it is not realistically arguable that DBS made a mistake in making the factual findings [in the NMC findings about 2013-2016], given the detailed and even-handed process (a 6 day NMC hearing) from which they emerged, and the passage of time since 2013-2016 when the events in question took place. It is fanciful in my view to argue that PM's oral evidence at this stage would be sufficient to overturn those findings, on the balance of probabilities.
>
> 19. Turning to [DBS's 2020 probationary period findings], these are in large part based on the minutes of "monthly probation review meetings" attended by [FB, a deputy manager], and PM. I note the following:
>
> a. the minutes contain some positive statements about PM's performance (e.g. "you have a lovely way with people with dementia" – see page 127 of the bundle) – but these do not make their way into the factual findings made by DBS;
>
> b. the meetings were attended by FB, who appears later to have tried to distance herself from the proceedings and come to PM's "defence";
>
> c. the minutes of the final such meeting – on 12 July 2020, which, as things turned out, was the last day of PM's employment – also has a contemporaneous record of PM's denial of the allegations made against him.
>
> It seems to me that the above aspects of the contemporaneous documentary evidence supporting [DBS's 2020 probationary period findings] make it reasonably arguable that evidence produced by PM at a substantive hearing would show, on the balance of probabilities, that some of [DBS's 2020 probationary period findings] were mistaken.
>
> The sort of evidence PM could produce would be, most obviously, his own oral evidence and the contemporaneous written evidence in the monthly meeting minutes that provides contextual evidence and/or corroborates PM's oral evidence; in addition, if PM were to produce FB herself as a "live" witness at the hearing, providing oral evidence in support of her letter on page 195 in the hearing bundle, that, too, would give PM's arguments for a mistake on the part of DBS a "more than fanciful" prospect of success.
>
> 20. I note that in respect of a number of [DBS's 2020 probationary period findings], PM accepts the bare facts as found, but objects to the lack of context e.g. PM accepts that he
>
> a. made the remarks at [paragraph 4d(iv) above],
>
> b. tapped the patient's stomach as at [paragraph 4d(vi) 2 above],
>
> c. transferred a patient alone (when he was new to the job at the care home) and
>
> d. did not wear a face mask, both as at [paragraph 4d(i) 3 and 5 above] –
>
> but he says that important context is missing from these findings. In my view it is reasonably arguable that omission of relevant context is a mistake in a finding of fact.

> 21. I have considered whether mistakes in [DBS's 2020 probationary period findings] above would be "material" in the context of the decision as whole, given that the [1995 caution and conviction] are not challenged, and, in my view, a challenge to [NMC findings about 2013-2016] is fanciful. In my view, in the light of the fact that DBS's "barring decision process" document found "definite concerns" in the areas supported by [DBS's' 2020 probationary period findings] (PM's "attitude" and "callousness/lack of empathy"), and only "some concerns" in one area supported by the 1995 caution and conviction and the NMC findings about 2013-2016] ("interest in sex"), it is reasonably arguable that mistakes in [DBS's 2020 probationary period findings] were, in themselves, "material" to the decision as a whole.
>
> 22. I see no reasonable argument that DBS made a mistake on any point of law in the decision; in particular, it does not seem to me arguable that the decision is disproportionate, given the factual findings on which it is based."

Documentary evidence before the Upper Tribunal

12. In addition to the decision letter and DBS's "barring decision process" document, evidence in the bundle of 255 pages included:

    a. the 37-page report of the NMC, following a hearing on 23-27 April and 9 May 2018 (the decision of the NMC panel was to strike PM off the register)

    b. PM's training record

    c. a reference for PM dated 17 April 2020

    d. monthly probation review meeting forms relating to meetings on 4 May, 21 May,19 June and 12 July 2020 (all attended, and signed, by PM and by "HR", his line manager; FB (shown as "DM" – deputy manager) also attended all but the first)

    e. witness statements and emails from FB, and two of PM's colleagues at the home, "DT" and "DG", dated 10 July 2020

    f. "outcome of probationary meeting" letter dated 12 July 2020 (signed by HR)

    g. PM's representations to DBS, including four character references

    h. an (undated) later letter from FB to PM

    i. PM's letter to DBS of 6 January 2022 in connection with a request for a review of its decision, including eight reference letters

    j. documents relating to PM's work as a door supervisor: qualifications and references.

The Upper Tribunal hearing

13. PM attended the hearing, presented both arguments and evidence, and was cross examined on the latter by Mr Serr, who also made submissions on behalf of DBS. No other witnesses gave evidence at the hearing.

Summary of PM's main arguments and evidence

14. PM gave an overview of his career, including putting the NMC findings, in particular, in context, from his perspective. He said he felt that some of the staff at the care home he worked at in 2020 were against him (as he had the job that

one of them had wanted); he said he felt isolated and ostracised there, and "set up for a fall". He gave us his view of the various incidents on which DBS had made factual findings (and we will refer to these in the discussion that follows); in broad terms, he said he was aware of his somewhat distinctive "manner" and "sense of humour" but said that he had not, in practice, upset vulnerable adults he was caring for.

Summary of DBS's case

15. DBS adduced no new evidence at the hearing and submitted, in high-level summary, that there was no material mistake of fact or law in DBS's decision.

Why we have decided that DBS did not make a material mistake in its 2020 probationary period findings

16. The (only) issue before us is whether there were material factual mistakes in DBS's 2020 probationary period findings.

17. We had quite a lot of contemporaneous documentary evidence before us, in particular the notes of the four (signed) probationary review meetings, and emails and statement from the time; on the other hand, the only "live" witness evidence, from someone who could comment on those documents, was that of PM. Our overall approach to the evidence – documentary and oral – was to review it critically and realistically. We tended to give evidence more credence to the extent it was corroborated, closer in time to the events it described and/or objectively plausible. This applies equally to PM's oral evidence: much of it was credible and reliable; but not all of it. We explain in the discussion which follows, where (and why) we have not been persuaded by PM's oral evidence, on significant points.

18. We would comment on two pieces of documentary evidence in particular:

Character references

19. There were a number of reference letters and emails about PM and his character in the bundle – and some were potentially more relevant than others, as they came from nursing colleagues and family of patients. However, none of these individuals were called by PM to give oral evidence (and so be questioned on their statements); and none of them were first hand witnesses to the events underlying DBS's 2020 probationary period findings. As a result, we could not place any significant weight on these references, as regards our task of deciding if there were material factual mistakes in DBS's 2020 probationary period findings.

The later letter from FB

20. There was an undated, typed letter to PM, signed off "Good luck Fi", which PM said was from FB. It read as follows:

> "Dear Paul
>
> I am compiling this letter to you which I should off done a long time ago to apologise for my involvement in your removal from [the care home]
>
> I've heard the outcome of the dbs and I think it's unfair for you to be punished for the things you were reported for t that I've known to be untrue
>
> I was asked to put in writing about the client being pushed down the stairs and I know it was said by you it would be quicker to go down the stairs than wait for

> the lift which takes forever I was asked to word the complaint to show you in a bad light
>
> The complaint about you upsetting a client over running over Frank Sinatra I know that was fabricated in the way to as it was reported to me that you weren't even in the room when it was said
>
> I can say there was no medication mistakes when I did the checks were done
>
> As for playing drums on a patient's stomach I know you have done that before and fully explained the reasons for trying to find bowel sounds especially on a patient who suffers from constipation
>
> You were set up to fail but you already knew that but to your credit you never tried to blame anyone else or argue that that's because of your professionalism and you know that it was certain people trying to get rid of someone who they seen as a threat
>
> I'm sorry Paul x"

21. In our view, little evidential weight can be put on this letter to the extent it runs counter to more contemporaneous documentary evidence from FB, given that (i) there was nothing to vouchsafe the authenticity of the letter (other than PM's putting it before us), given that it did not bear a signature or a date; and (ii) PM did not call FB as a witness at the hearing (despite this being raised as a possibility in the decision giving permission to appeal), such that she could be questioned on those discrepancies in her evidence.

22. We now turn to discussing the question of factual mistakes in DBS's 2020 probationary period findings.

A pattern of insensitivity/inappropriateness

23. Most of DBS's 2020 probationary period findings are about incidents which, by all accounts (including PM's), did occur – the factual dispute is about whether DBS misrepresented the incidents by stating, or implying, that PM, in the incident, was being insensitive or inappropriate in his dealings with a vulnerable person. This applies to the incidents where DBS found that PM

    - "continued to shave a resident without their consent"
    - "assisted a resident with feeding who did not need assistance, causing the resident to retch between mouthfuls"
    - "played drums" on a resident's belly
    - "joked" with the in-wheelchair resident about going down the stairs
    - told a resident that a crane would be required to take her out when she died, and that the lift could break with he in it
    - said "have that" when putting soup before a resident.

24. In our view, DBS did not make a mistake in finding that, on these occasions, PM's style of interacting with the vulnerable adults he was caring for was insensitive, inappropriate and/or misjudged (in terms of how it would make the vulnerable adult feel). We rely on the contemporaneous documentary evidence (which indicates that the care home viewed the incidents in this way), and also on our own intuition, expertise and common sense, in preference to PM's oral evidence

(to the effect that he made sure that none of these interactions caused upset). We accept – and DBS did not find otherwise – that PM was not *always* inappropriate or insensitive, in his dealings with vulnerable adults; rather, it was an aspect of PM's style that recurred in these various incidents. We also fully accept (and, again, DBS not find otherwise) that PM did not *mean to* upset or discomfort the vulnerable adults in question; we fully accept that PM did not have "bad" intentions as regards the vulnerable adults he worked with in 2020.

25. We have considered whether it was a mistake on DBS's part not to "contextualise" these findings (rather as we have done in the preceding paragraph), and make findings as to the "positives" of PM's style with vulnerable adults he was caring for. In our view, omitting to make such findings was not a *material* mistake, in the sense of one that affected the outcome (DBS's decision to bar): it is clear enough that DBS found there to be a pattern in PM's "insensitive/inappropriate" interaction with vulnerable adults, but DBS's decision did not rest on this being his invariable way of treating such adults, or on his "style" not having other, more positive aspects.

26. We now turn to specific other elements of DBS's 2020 probationary period findings.

Failed to wear PPE face mask correctly (during first two weeks of probation period)

27. This finding was based on statements in the probation review meeting on 4 May 2020. PM essentially accepts the finding that he failed to wear a PPE face mask on a number of occasions – but says there were *good reasons* (our words, not his) for his not wearing a PPE face mask. In the documentary evidence, the reason given was that PM was speaking to someone hard of hearing; at the hearing, PM told us that he had "long covid" and was told by his doctor that he had immunity. We are not persuaded that DBS made a mistake in not making a finding as to these "reasons" for PM not wearing a PPE face mask: in our eyes, they lack credibility (there was no corroborating evidence as to what PM said about his doctor) and, in any event, it is clear from the probation review meeting notes that the care home did not accept that PM did not have to wear a PPE face mask (and those notes indicate no attempt by PM to persuade them otherwise).

Continued to listen to music on his mobile phone after being asked by a resident to stop (during first two weeks of probation period)

28. This finding was also based on statements in the 4 May 2020 probation review meeting. PM told us the finding was mistaken, as he did not have, or listen to, music on his phone. His response in the notes of the review meeting is recorded as: "I haven't played music on my phone, I have had my phone out". In our view, there is no *material* mistake in this factual finding: the essence of the finding, in our view, is that PM was absorbed in his phone (whether for music or for

something else); that the resident asked him to stop paying attention to his phone; and that PM refused.

Standard of care below that expected of senior carer (first two months of probation period)

29. We consider here the findings relating to sub-standard provision of care by PM: that he

- moved a patient by himself when two carers were required
- verbally falsified the frequency of his meeting the needs of residents
- failed to complete MAR charts accurately;
- did not check prescription labels;
- did not keep a clean work area;
- was neglectful of the environment residents were left in.

30. These findings were based on the probation review meeting notes from 4 May, 21 May and 19 June 2020. PM, broadly, did not agree with them, but, given they were documented contemporaneously (in documents PM signed), we do not find that DBS made a mistake in these findings. We note that, as regards moving the patient by himself when two were required, the meeting notes from 4 May record that PM said that "staff" had told him to do it this way; his line manager is recorded as expressing scepticism that this would have been said, but said she would investigate; however, we see no mistake here by DBS in finding that two were "required", given that, from the line manager's recorded response, it would have been clear that two persons were needed to move the patient, regardless of what colleagues may or may not have said to PM at the time.

31. We note that the probation review meetings also note certain of PM's professional strengths (e.g. in completing paperwork) and improvements (e.g. 19 June meeting note says "medications are now being administered at a better time"): however, we do not consider DBS to have made a material mistake in not making findings on these more positive aspects, as, fairly clearly in the overall context, doing so would not have affected the outcome.

Told a dementia resident that she was responsible for the death of Frank Sinatra by running him over in her car

32. Our impression both from PM's written representations in the bundle, and from his presentation at the hearing, was that this was a finding that PM particularly wished to challenge: his evidence was that he had made great efforts with the resident in question, and would not have done such a thing, as he knew it would upset her.

33. The evidence relied on by DBS here is an email from a colleague, "DT", to HR (PM's line manager), at 16:02 on 10 July 2020; the incident was also discussed at the probation review meeting on 12 July 2020: after being told that it had been

reported that he told a woman with dementia that she ran over Frank Sinatra with her car, PM is recorded as responding:

> "PM: I said, Irene said a woman from Fulham kissed him?
>
> Denies that he said she pushed him under a car.
>
> Does not even know Irene could drive.
>
> A woman from Fulham kissed him."

34. At the hearing, PM told us that *someone else* had told the service user in question that she had run over Frank Sinatra.

35. We accept that PM had no intention to upset the patient in question. We note that in the 12 July 2020 meeting, PM referred to something else – a "woman from Fulham" kissing "him" (presumably, Frank Sinatra). The evidence is thus somewhat confused. It seems to us probable that something was said by PM to the dementia patient, in a humorous or lightly teasing vein (from his point of view), involving Frank Sinatra (who, PM tells us, the patient in question was a great fan of), and, for whatever reason, it "landed badly". Whatever was said (by PM) may not have been, specifically, about the patient "running over" Frank Sinatra – but, whatever it was, it upset the patient. Accordingly, in our view, there is no *material* factual mistake here as, even if DBS had made a finding in line with what we have just said is, probably, what happened here, it would not have affected the outcome (as it would have been a further example of PM's insensitivity/inappropriateness with vulnerable adults, albeit not malicious, and generally well-meaning).

Conclusion

36. The sole ground on which permission to appeal was given was that DBS's made mistakes in its 2020 probationary period findings, and those mistaken factual findings were material to its decision to include PM in the barred lists. That ground has not been made out, either because there were no mistakes, or the mistakes made were not material. DBS's decision is accordingly confirmed.

Zachary Citron
Judge of the Upper Tribunal

John Hutchinson
Rachael Smith
Members of the Upper Tribunal

Approved for release on 3 June 2024