THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

UPPER TRIBUNAL CASE NO: UA-2023-001738-V
[2024] UKUT 413 (AAC)
AG V DISCLOSURE AND BARRING SERVICE

THE UPPER TRIBUNAL ORDERS that, without the permission of this Tribunal:

No one shall publish or reveal the name or address of any of the following:

(a) AG, who is the Appellant in these proceedings;

(b) any of the service users or members of staff mentioned in the documents or during the hearing;

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

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

Decided following an oral hearing on 25 November 2024

Representatives

Appellant	Michael Polak of counsel, instructed by Spencer West LLP
Disclosure and Barring Service	Ashley Serr of counsel, instructed by DBS Legal Services

DECISION OF THE UPPER TRIBUNAL

On appeal from the Disclosure and Barring Service (DBS from now on)

DBS Reference: 00999112250
Decision letter: 6 September 2023

This decision is given under section 4 of the Safeguarding Vulnerable Groups Act 2006 (SVGA from now on):

As DBS made a mistake in the findings of fact on which its decision was based, the Upper Tribunal, pursuant to section 4(6)(b) and (7)(a) and (b) of SVGA:

makes findings of fact and remits the matter to DBS for a new decision; and

directs that the appellant remain in the list until DBS makes its new decision.

REASONS FOR DECISION

A. History and background

1. On 6 September 2023, DBS decided to include AG in the adults' barred list on the basis of the following findings of fact:

- During your employment you were aware that residents were being given high risk foods in contravention of the SALT guidelines. You failed to check and monitor the meals which were given to residents nor did you direct staff to ensure the food given was in line with SALT guidelines. This resulted in one resident TA being given a high risk food which caused her to choke and be admitted into hospital where she later died.
- You failed to monitor and maintain quality assurance of food diaries as such staff continued to complete the food diaries to a low standard where it was unclear what residents had actually consumed.

SALT stands for Speech and Language Therapy.

2. AG applied to the Upper Tribunal for permission to appeal against the decision. Upper Tribunal Judge Brunner KC gave her permission to appeal. She directed a hearing of the appeal, which took place before us on 25 November 2024.

B. The legislation

The barring provisions

3. These are the relevant provisions of Schedule 3 SVGA on which DBS relied. Just to avoid any misunderstanding, we have set out the legislation in full, but not every part of these paragraphs was relevant to AG.

Behaviour

Paragraph 9

(1) This paragraph applies to a person if–

(a) it appears to DBS that the person—

(i) has (at any time) engaged in relevant conduct, and

(ii) is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, and

(b) DBS proposes to include him in the adults' barred list.

(2) DBS must give the person the opportunity to make representations as to why he should not be included in the adults' barred list.

(3) DBS must include the person in the adults' barred list if–

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

(aa) it has reason to believe that the person is or has been, or might in future be, engaged in regulated activity relating to vulnerable adults, and

(b) it is satisfied that it is appropriate to include the person in the list.

Paragraph 10

(1) For the purposes of paragraph 9 relevant conduct is–

(a) conduct which endangers a vulnerable adult or is likely to endanger a vulnerable adult;

(b) conduct which, if repeated against or in relation to a vulnerable adult, would endanger that adult or would be likely to endanger him;

(c) conduct involving sexual material relating to children (including possession of such material);

(d) conduct involving sexually explicit images depicting violence against human beings (including possession of such images), if it appears to DBS that the conduct is inappropriate;

(e) conduct of a sexual nature involving a vulnerable adult, if it appears to DBS that the conduct is inappropriate.

(2) A person's conduct endangers a vulnerable adult if he–

(a) harms a vulnerable adult,

(b) causes a vulnerable adult to be harmed,

(c) puts a vulnerable adult at risk of harm,

(d) attempts to harm a vulnerable adult, or

(e) incites another to harm a vulnerable adult.

(3) 'Sexual material relating to children' means–

(a) indecent images of children, or

(b) material (in whatever form) which portrays children involved in sexual activity and which is produced for the purposes of giving sexual gratification.

(4) 'Image' means an image produced by any means, whether of a real or imaginary subject.

(5) A person does not engage in relevant conduct merely by committing an offence prescribed for the purposes of this sub-paragraph.

(6) For the purposes of sub-paragraph (1)(d) and (e), DBS must have regard to guidance issued by the Secretary of State as to conduct which is inappropriate.

The appeal provisions

4. Section 4 SVGA contains the Upper Tribunal's jurisdiction and powers.

> **4 Appeals**
>
> (1) An individual who is included in a barred list may appeal to the Upper Tribunal against–
>
> …
>
> (b) a decision under paragraph 2, 3, 5, 8, 9 or 11 of Schedule 3 to include him in the list;
>
> (c) a decision under paragraph 17, 18 or 18A of that Schedule not to remove him from the list.
>
> (2) An appeal under subsection (1) may be made only on the grounds that DBS has made a mistake–
>
> (a) on any point of law;
>
> (b) in any finding of fact which it has made and on which the decision mentioned in that subsection was based.
>
> (3) For the purposes of subsection (2), 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.
>
> (4) An appeal under subsection (1) may be made only with the permission of the Upper Tribunal.
>
> (5) Unless the Upper Tribunal finds that DBS has made a mistake of law or fact, it must confirm the decision of DBS.
>
> (6) If the Upper Tribunal finds that DBS has made such a mistake it must–
>
> (a) direct DBS to remove the person from the list, or
>
> (b) remit the matter to DBS for a new decision.
>
> (7) If the Upper Tribunal remits a matter to DBS under subsection (6)(b)–
>
> (a) the Upper Tribunal may set out any findings of fact which it has made (on which DBS must base its new decision); and
>
> (b) the person must be removed from the list until DBS makes its new decision, unless the Upper Tribunal directs otherwise.
>
> …

C. Our findings of fact

Our approach

5. We approached the case in accordance with the decision of the Court of Appeal in *RI v Disclosure and Barring Service* [2024] 1 WLR 4033. By that, we mean that we heard evidence, made our own assessment of it, and made findings based on that assessment. In addition to the evidence in the papers, we had a written statement from AG dated 21 November 2024 with attachments. She answered questions from Mr Polak, was cross examined by Mr Serr, and answered questions from the panel.

6. In questioning AG, assessing the evidence and making our decision, we have had the benefit of the practical knowledge and experience that the specialist members bring to this jurisdiction. We refer to what the Upper Tribunal said about their qualifications for appointment in *CM v Disclosure and Barring Service* [2015] UKUT 707 (AAC) at [59] to [64].

AG's career

7. AG was the registered manager of a Home that provided supported living for residents with learning difficulties. Their cases were complex and they lacked capacity. The Home was owned by a charity, which operated nationwide. The Home consisted of two houses on the same site. There were typically five residents in each house. Staffing was always a problem and AG had no say in recruitment policies. There were also related issues about pay and conditions for staff.

8. AG worked for the charity from 2006, beginning as a support worker. She progressed in her career until she became a registered manager in 2012. Later that year, she was transferred to the Home, where she worked until she resigned in September 2022. The Home was always rated as Good by the Care Quality Commission.

TA

9. TA moved into the Home in 2003. She had autism. Her poor posture and weak neck and throat muscles put her at risk of choking. Sadly, she died in hospital on 15 June 2022 at the age of 59 following a choking incident at the Home on 13 June. This was not her first choking incident; there had been an earlier one in 2020.

10. On 2 February 2015, KW (a speech and language therapist) provided Eating and Drinking Information to be part of TA's care plan. It was reviewed on 14 August 2020 by LJ (another speech and language therapist). The entry for food read:

> **TA needs an IDDSI Level 6 Soft and Bite sized diet. This texture is:**
>
> Soft, tender and moist, but with no thin liquid leaking/dripping from the food
>
> Ability to 'bite off' a piece of food is not required
>
> Ability to chew 'bite-sized' pieces so that they are safe to swallow is required
>
> 'Bite-sized' pieces no bigger than 1.5cm x 1.5cm in size
>
> Food can be mashed/broken down with pressure from fork
>
> **Please see additional information sheets regarding this texture.**

IDDSI stands for International Dysphagia Diet Standardisation Initiative.

11. This chart was also provided:

HIGH RISK FOODS

Stringy, fibrous textures e.g. pineapple, runner beans, celery, lettuce
Vegetable and fruit skins including all types of bean, grapes, peas and sweetcorn
Mixed consistency foods e.g. cereals which do not blend with milk, e.g. muesli, mince with thin gravy, soup with lumps, juicy foods such as melon where fluid separates off in mouth
Crunchy foods e.g. toast, dry biscuits, crisps, crackers, breadsticks
Crumbly items e.g. bread crusts, pie crusts, crumble, flaky pastry, dry cake
Hard foods e.g. boiled sweet, nuts and seeds, raw apply, raw carrot
Tough, chewy foods e.g. toffee, steak, pork, bacon
Sticky foods e.g. cheap white bread, peanut butter, some cheeses, marshmallow
Round or long shaped foods e.g. sausages, grapes

Taken from National Descriptors for Texture Modification in Adults written by the Royal College of Speech and Language Therapists and the British Dietetic Association (2002)

12. The **Supporting TA Guidance Notes** contain this instruction:

> Staff to ensure all of TA's food is mashed with a fork and it is to be moistened if necessary with sauces, gravy or custard whichever is appropriate for the food she is eating. This is to help TA with swallowing food successfully and to help prevent choking on food which it too large for her to swallow comfortably.

13. The food was not to be liquidised, as a fluid diet would have led to further loss of muscle function and of the related ability to chew and swallow.

14. AG carried out a risk assessment of TA on 10 December 2021; she was rated at moderate risk for choking and dysphagia. AG wrote:

> TA has deteriorating muscle tone in her neck which means when she is tired or not having a good day she finds holding her head and neck upright more problematic. This means she also finds swallowing more restricted so staff have to be attentive at all times when TA is eating and drinking.

AG recorded the following as measures currently in place to prevent risk of injury:

> Staff to prepare TA's food as advised by the SALT. See the attached advice sheet on the back of this risk assessment.
>
> TA's food must be cut up into small pieces and must be moist. Staff must sit with her when she eats anything or drinks. Staff must encourage TA to eat/drink slowly as directed by SALT.
>
> If TA has any serious choking incidents she must be seen by the medical services urgently and the SALT notified.

> Annual eating and drinking assessments are completed and in support plans.

Later, she wrote:

> For staff to identify any foreign object which TA may pick up and put in her mouth to eat. TA needs to drink regularly to maintain her hydration levels and good health. TA has 1:1 support 24 hours every day to keep her safe. Staff are to be vigilant in removing foreign objects which TA may be able to ingest which may lead to her choking. There is regular input from Speech and Language Therapists who advise how to support TA as safely as possible. It has been made clear that it is in the best interest of TA to carry out this risk assessment in order to minimise the risk of TA choking.
>
> TA`s 1:1 staff to watch her at all times and to stop her from putting foreign objects into her mouth which she may ingest and choke on. This risk assessment covers all activities related to TA eating and swallowing food. Her food is cut into 1 cm by 1 cm cubes and portions served individually on her plate. Her food should be moistened with gravy, sauces or custard where necessary. TA must use a teaspoon to eat so as not to put too much into her mouth in one go. She must be prompted verbally to slow down whilst eating and to stop and have a drink in between mouthfuls. TA`s 1:1 staff to offer TA a variety of drinks regularly and to record these on her daily record sheet within the Duty Pack. TA`s 1:1 staff support MUST support TA whilst she is drinking as she can drink very quickly which can lead to coughing. As per KW's (SALT) recommendations (attached to this risk assessment dated 2.2.15), TA should take no more that 2 sips in succession before pausing to swallow and breathe. Staff should use verbal and physical (hand over hand) prompting as necessary to achieve this and supported on a 1:1 basis for all drinking tasks.

13 June 2022

15. On 13 June 2022, AG choked and collapsed while she was being fed. She was taken to hospital, where she died on 15 June 2022. The immediate cause of her death was aspiration pneumonia. This resulted from food or liquid being taken down her airways or into her lungs while she was being fed in the Home on 13 June.

16. YW, the senior support worker, was feeding TA her lunch when she choked. She wrote a report on 14 June 2022, in which she described TA's meal and what followed. There is no need to record the distressing details. AG attached a copy of the report to her witness statement.

Food diaries

17. This is a convenient point to deal with food diaries. Staff were required to complete a food diary for each resident to show what each had eaten and drunk during the day. As far as we can tell, they did so. The standard to which they did so is another matter.

18. TA's diary for 13 June read:

Breakfast:	3 x Weetabix
Lunch:	Small amount salad + squash

There is no mention of any fluid with the breakfast. TA surely had some milk with the Weetabix, which is high risk as it does not blend with milk. Coming to lunch, there is no detail of what the salad contained. If it contained lettuce, that was high risk. YW's report says she prepared salad, quiche, beetroot and boiled egg 'for all'. If TA ate any of the quiche, that was high risk as it would have a crust. YW says she fed TA beetroot, but that is high risk unless it can be squashed down with a fork. So, the diary for that day was unparticularised (the salad) and incomplete (the beetroot). It is only a slight exaggeration to say that all TA's food diaries that we have seen were unparticularised. The evidence does not show how often they were incomplete. The one thing that the diaries do show is that TA was consistently fed high risk foods.

19. Before the incident occurred, the Home's deputy manager had identified problems with the standard to which these diaries were completed.

The coroner's inquest

20. The coroner held an inquest into TA's death. According to a newspaper report, provided by AG, the coroner said:

> Staff were not aware of the requirements of TA's care due to failings in management leadership. This was also a care home regularly running at less than 50% requirement.

We understand the second sentence to refer to staffing levels. The first sentence must refer to AG.

D. AG's responsibilities

AG's contractual duties

21. DBS's findings refer in part to things that AG had failed to do. A failure assumes a duty, which naturally leads to her job description. Part of the **Main purpose of the Role** included:

> The Registered Manager role has overall responsibility for all aspects of the operational day to day leadership and management of the Home which include Registration as the manager with the relevant regulator (CQC) and compliance with all legislation and external and internal standards and is accountable to the Regional Director.

Part of the **Core Accountabilities or Responsibilities and Success Definitions** was:

> **Deliver services to the required regulatory and internal standards**
>
> …
>
> - Ensure that the necessary risk assessments for the people we support and your team are in place at all times, and implemented to a high standard.

22. AG told us that she did not carry out spot checks on the food diaries. She said that this was not covered by the bullet point entry we have quoted. Whether that is right or not, it overlooks the statement that she 'has overall responsibility for all aspects of the operational day to day leadership and management of the Home'.

With the benefit of the knowledge and experience of the specialist members, we find that checking the food diaries was within her 'overall responsibility'.

23. This accords with other evidence that AG gave. She told us that a deputy manager was appointed from early 2022 and they had split her duties between them. The deputy identified that the diaries contained insufficient details about what residents were eating. So checking the diaries was part of the deputy's duties and, by definition, had been part of AG's duties. We also notice that in her witness statement, AG wrote:

> 17. As the Manager of the … site, I was responsible for:
>
> a) running the site;
>
> b) ensuring all policies and procedures were implemented;
>
> c) ensuring compliance in all specified areas;
>
> d) ensuring all staff were trained; and
>
> e) ensuring support was given in accordance to each individual's support plan.

Paragraph 17(e) contradicts her assertion about the scope of her duties. In their Gross Misconduct letter of 21 October 2022, AG's employers said:

> … it was your responsibility to ensure guidance and support plans were implemented thoroughly …

24. AG's attitude and understanding of the scope of her duties was the underlying cause of the problems that led to TA's choking on her meal. AG said at the hearing that she was not saying that she bore no responsibility. When asked what responsibility she did accept, she struggled to give an answer and finally mentioned staffing. She still does not understand what was lacking in her management of the Home.

The range of AG's duties

25. AG told us that she was busy discharging her duties. We accept that the full range of her duties kept her busy. We also accept that being understaffed increased the burden on her. However, the demands on her time do not help to define her duties or absolve her from responsibility if they were not carried out. However busy she was, she had time to monitor the food diaries. This task could have been undertaken in those spare moments that are always available, even to busy managers. There were only five residents in each of the houses for which she was Registered Manager. It would have taken only a few minutes each week or month to flick through the food diaries. Had she done so, she could not have missed that:

- The entries for TA contained insufficient detail of what TA had been fed to show that her diet was appropriate. What, for example, was in the 'salad' that she was eating on 13 June? We also know that it contained beetroot, but only because YW, the senior support worker who fed her on 13 June 2022, has said so.
- For the last three months of her life, TA was regularly, almost routinely, being fed items that were high risk.

AG's ill-health

26. AG told us that she was affected by ill-health from at least the beginning of 2022. AG was not on site on 13 June 2022. She had been feeling unwell for some months, but put off consulting her GP until 8 April 2022. She was referred to hospital for a biopsy, as a result of which she was diagnosed with endometrial cancer. She went on sick leave from 13 June 2022 and underwent emergency surgery on 16 June 2022.

27. We accept that AG was affected by ill-health, but that does not absolve her from responsibility. Moreover, the problems that led ultimately to TA's death did not begin with AG's ill-health. AG's attitude to her role and responsibilities was long-standing.

28. AG also told us that she was still recuperating during the period when her employer was investigating her conduct. We accept that that is possible and have relied on her evidence only to the extent that it could not have been affected.

Support staff

29. AG told us that the staff knew what TA was and was not allowed to eat. She trusted them and relied on them, especially YW the senior support worker. Taking YW first, she had only recently been promoted. AG told us that this had taken some time to achieve because YW had her own ways of doing things that prevented her progressing faster than she did through the process. Given that background, AG should not have relied on her to the extent that she did. She told us that YW had admitted in her report that she knew she was feeding TA high risk food. That is not what it says.

30. As to the staff generally, the food diaries show the extent to which they fed TA contrary to her dietary requirements. We do not accept that so many staff would be so lax given the seriousness of choking for TA. The best explanation is that they did not know what the requirements were and we so find. Which means that AG did not communicate them effectively.

Communications with staff

31. We made the finding on failure to communicate effectively despite AG's evidence.

32. AG told us that the information was held with TA's support plan, which all staff signed to say they had read. The limited evidence was that the information was not held on file. Even assuming that it was available to staff, AG was relying on a procedure without monitoring whether it was being carried out. On the evidence of the food diaries, the support staff had either not read or not complied with the information that AG said was available to them. Checking the diaries or walking around at a meal time would have revealed what was happening.

33. AG also told us that eating and drinking was discussed at team meetings. We do not accept that. There was no mention of this in the minutes for 2022, despite their quality and the mention of other health needs. We find that the omission of eating and drinking is significant, given the nature and contents of the minutes generally. We find that this topic was not discussed.

34. AG told us that she had put a sheet of high risk foods on display in the kitchen. This was during lockdown when there was much more cleaning take place than normal. She accepted that it could have become displaced. This evidence is too qualified to allow us to find that the sheet was ever on display sufficiently to communicate its message to staff.

35. Finally, AG told us that, despite TA's diet, there had been no previous incident. Leaving the 2020 incident aside, that is correct. But it is beside the point. The choking incident on 13 June 2022 and its consequences were an accident that was waiting to happen.

E. Conclusions

36. We now set out our conclusions on each of DBS's findings.

During your employment you were aware that residents were being given high risk foods in contravention of the SALT guidelines.

37. AG told us that she was not aware of what the residents were being fed. That is surprising, as she told us that she was generally aware of what was happening either from her office or as she walked through the house. She also told us that she worked shifts with the residents and had fed TA. We cannot, though, accept that she would have allowed the practice to continue if she had known what was happening. We find that DBS made a mistake in making this finding. This is in AG's favour in that it removes any suggestion of a callous disregard for the residents. On the other hand, it emphasises that her approach to her duties failed to identify what had become close to routine behaviour for the support workers.

You failed to check and monitor the meals which were given to residents nor did you direct staff to ensure the food given was in line with SALT guidelines.

38. AG accepts that she did not check or monitor the residents' meals. She could not say otherwise given her denial of any knowledge of what they were eating.

This resulted in one resident TA being given a high risk food which caused her to choke and be admitted into hospital where she later died.

39. This is about causation.

40. The food TA was fed for her lunch on 13 June 2022 was high risk. The employer's regional head of care and support told the coroner that:

> The food served to TA that day was not consistent with the requirements for her.

YW's detailed description of what happened to TA while she was eating shows that the food led to her collapse and admission to hospital. DBS did not find that the choking incident led to TA's death, but that is what the coroner found.

You failed to monitor and maintain quality assurance of food diaries as such staff continued to complete the food diaries to a low standard where it was unclear what residents had actually consumed.

41. AG admitted that she did not monitor the food diaries. We have food diaries for TA, but not for any of the other residents. We see no reason for TA's diaries to be completed differently from anyone else's. The handwriting shows that they were

completed by different staff over the period from April to June 2022. Accordingly, we find that DBS was entitled to generalise this finding.

42. As to the standard of recording, it is sufficient to refer to what we have said about the entry for TA's lunch on 13 June. All the diaries lacked sufficient particulars and at least the one for 13 June was incomplete.

F. Disposal

43. We have found that DBS made one mistake in its findings of fact. This relates to AG's actual knowledge of what was happening. That is a significant change. Although it is not necessarily decisive, it is sufficient to justify making a new judgment on proportionality. That is why we have remitted the case to DBS to make a new decision.

44. Proportionality was discussed briefly at the hearing. We find no mistake of law in DBS's conclusion that it was proportionate to include AG in the list, given the finding that she knew what was happening. We consider that the preferable course in this case is to allow DBS to make another assessment now that finding has been removed.

Authorised for issue
on 10 December 2024

Edward Jacobs
Upper Tribunal Judge
Roger Graham
Matthew Turner
Members