Parliamentary and Health Service Ombudsman

An investigation into the Charity Commission: Miss A's complaint

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Our decision

1. Miss A told us the Commission failed to give an appropriate regulatory response to concerns she raised about a charity. She said the Commission also failed to manage its relationship and communication with her sensitively and with respect for her vulnerability as a victim survivor of sexual abuse and a whistleblower.

2. We found failings in the way in which the Commission communicated with Miss A. It did not follow guidance it publicly gave the expectation it would, and failed to recognise it needed to explain its change in thinking about the regulatory action it was going to take, leaving Miss A in an extremely confused and vulnerable state.

3. We found failings by the Commission because the evidence it has given us about its decision making, does not account for the decisions it has made. We have not seen sufficient evidence from any source to demonstrate the Commission has adequately followed its risk assessment guidance or that it has balanced the relevant factors it said it had balanced about the risk of harm to beneficiaries, the Charity, and charity in general, to reach its decisions.

   We have been unable to obtain evidence that provides adequate account for the Commission's decision that the case was low risk at its closure. We found that in relation to this case that impacted on the objective of the Commission to enhance public trust and increase accountability in the sector.

4. During our investigation the Commission has said it is concerned we are attempting to usurp its role and replace its decision. We reviewed this feedback carefully but we are not commenting on the appropriateness of the regulatory decision made by the Commission. We are identifying maladministration in the way the decision was made.

   We respect the Commission's discretion and appreciate that the Commission might operate without maladministration by considering relevant factors in accordance with its guidance and what it says it will do, demonstrating they have done so, and still reach precisely the same conclusions.

5. The failings by the Commission caused Miss AA a significant and serious exacerbation of her vulnerabilities and emotional ill health. We uphold the complaint.

6. We recommend the Commission:

- apologises to Miss A
- arranges an independent review of its handling of its communications with Miss A in conjunction with a recognised safeguarding specialist organisation
- conducts a review of its handling of this case
- review its internal guidance on the assessment of risk
- pay Miss A financial compensation.

The complaint

7. Miss A complains she was institutionally betrayed by the Charity Commission when it investigated her complaint about her sexual exploitation by a Trustee of a UK charity.

8. She says the Charity Commission failed to carry out an investigation that was fit and proper in accordance with its role as a Regulator or deliver an outcome commensurate with the failings and omissions of the Charity and the Trustee.

9. She says the Charity Commission also failed to ensure her welfare, specifically given her vulnerabilities arising from the fact she was a victim of sexual exploitation, sexual abuse and was experiencing retaliatory actions from the Charity because she was a whistleblower.

10. Miss A told us her complaint about the Commission's investigation and communication were dismissed without due consideration.

Background

11. In July 2019 a charitable safeguarding organisation raised concerns with the Commission on behalf of Miss A. The concerns were about the actions of a Trustee (the former Chair) of a charity (the Charity) of which Miss A was a beneficiary and volunteer. The complaint was that the former Chair had entered into an inappropriate relationship with Miss A, one which she described as abusive and had reported to the police. The complaint also concerned financial irregularities, in particular payments to the former Chair and his family and travel expenses.

12. The Commission opened a Regulatory Compliance case into the Charity. Over the next year and a half it corresponded with the Charity in respect of its regulatory concerns. The key events during that time were:

- in August 2019 the Commission contacted the Charity and described the allegations made to it as 'extremely serious'
- on 17 April 2020 the Commission issued an Action Plan to the Charity.

The Commission's records show it had an internal case discussion on 22 April 2020. It says it discussed the 'case exit strategy'. It shows the potential regulatory outcomes the Commission was considering at that time were:

- Official Warning
- disqualification of one or more Trustees
- wind up of the Charity.

The Commission's records show a further case strategy meeting held on 21 May 2020. The records of that say:

'Agreed that we should be working towards an Official Warning as a minimum with a possibility of disqualification if we find evidence of wrongdoing by individual Trustee(s).'

On 10 August 2020 the Commission received what it referred to as an 'extremely worrying safeguarding review' by an independent provider in respect of the Trustees response to the safeguarding incident raised by Miss A. By this time, it's case management records also show it was dissatisfied with the Trustee responses to the other safeguarding issues.

On 24 August 2020 the Commission spoke to the Trustees about the safeguarding review and questioned whether the Charity should consider winding up, but the Charity refused.

On 1 September 2020 the Trustees advised the Commission of their intention to wind up the Charity. They asked for six months to wind up.

The Commission later decided it did not have sufficient evidence to disqualify any of the Trustees or the former Chair. It issued an Official Warning, which was published on the Commission's website. The Commission told us it only followed up on some issues (the safeguarding issues) in the Warning because the Charity was planning on winding up.

By April 2021, the Charity had not wound up as it had said it would. It had also not complied with some requirements of the Commission's Action Plan issued in April 2020, or the Official Warning, specifically in respect of safeguarding and conflicts of interest.

On 26 April 2021 the Commission considered whether to open a statutory inquiry (which it had considered at a number of points before). At this point it recorded that it could not open a statutory inquiry on the basis the Charity had not complied with the Official Warning because the Commission had only been pursuing compliance from the Charity in respect of the safeguarding matters. The Commission recorded the 'desired regulatory outcome' was the wind up of the Charity and said this was still likely to happen without a Statutory Inquiry.

However, in May (and again in June) 2021, the Charity informed the Commission it no longer intended to wind up.

Following this, the Commission sought to visit the Charity, eventually doing so in October 2021. The record of that meeting shows the Commission said it still had concerns about the engagement of the Trustees with the issues it had raised, on which it said it would provide further written advice.

On 22 May 2022 the Commission then closed their case. In its closing letter to the Charity the Commission said there had been a pattern of behaviour by the Trustees which raised concerns about the Trustees ability and/or willingness to cooperate with the Regulator. It went through actions not done by the Trustees including in relation to the appointment of a safeguarding specialist and conflicts of interest with the former Chair and his family:

'We acknowledge that steps have been taken by the Trustees to address some of the actions, there are still some areas that need to be addressed. In particular, we are concerned that the Trustees are failing to act in the best interests of the charity in making balanced and adequately informed decisions and avoiding or managing conflicts of interest, including personal benefit'.

13. Miss A subsequently complained about the Commission's handling of its communications with her and the regulatory outcome of the Commission's investigation of the Charity.

14. During the complaint process, the Commission acknowledged it should have warned Miss A there was no certainty the Charity would wind up. It did not acknowledge any other errors or failings in its actions.

Evidence

15. We have considered extensive evidence from Miss A and from the Commission's records. We have spoken to Miss A and to the Commission at length to understand the facts on which we rely in this report.

16. We use relevant law, policy, guidance and standards to inform our thinking. This allows us to consider what should have happened. We have referred to the following standards:

- The Charities Act 2011 (specifically schedule 3)
- The Charities Act 2006 (Principal Regulators of Exempt Charities) Regulations 2011
- our 'Principles of Good Administration', February 2009
- Office for Product Safety and Standards, 'The Regulators Code', 2014
- The Charity Commission, 'Risk and Regulatory framework', February 2018
- The Charity Commission, 'Safeguarding duties for charity trustees', 2017
- The Charity Commission, 'Conflicts of interest: a guide for charity trustees', May 2014
- The Charity Commission, 'Strategy for dealing with safeguarding issues in charities', 2017
- The Charity Commission, 'Report serious wrongdoing at a charity as a worker or volunteer', 2018
- Department for Business, Energy & Industrial Strategy (DBEIS), 'Whistleblowing: prescribed person's guidance', 2017
- The Commission's operational guidance on Official Warnings, Considering Cases in a Regulatory Framework, Assessing Evidence, Disqualification, and Opening a Statutory Inquiry.

Findings

17. Miss A told the Commission about an inappropriate relationship the former Chair of the Charity had with her while she was a beneficiary and volunteer at the Charity. The Commission acknowledged this was a safeguarding matter.

18. Safeguarding is generally accepted to be the responsibility of all organisations that work with or for children and adults at risk to prevent and protect them from harm, abuse or exploitation. An adult at risk includes people with a care or support need, people with physical or mental ill health, with addiction problems, and people who are otherwise unable to keep themselves safe from neglect or abuse. This latter point can include where there is a power imbalance within a professional or charitable relationship.

19. Miss A could have been considered an adult at risk at the time the former Chair had a relationship with her and when a safeguarding charity approached the Commission on her behalf. This is because of her lived experience of human trafficking and sexual abuse, her mental health problems (which she self-disclosed to the former Chair and to the Commission) and her experience with the former Chair and the Charity.

20. The Commission's guidance for charities, which was issued in 2018, says safeguarding should be a governance priority for charities and they should act to protect people from harm. 'People' in the Commission's guidance includes beneficiaries, staff and volunteers, and other people who come into contact with a charity.

21. We have not seen any operational guidance for Commission staff about safeguarding people who came into contact with the Commission from the time of these events. However, the Commission had policies regarding how it would handle safeguarding concerns raised with it. We would assume the Commission's guidance to charities, that safeguarding was a priority and the sector should act to protect people from harm, was a standard the Commission also applied to its work and inherent in its approach.

22. The paragraphs above are a small piece of the safeguarding context within which all public bodies, including the Commission, operated at the time of the events we are looking at here. They demonstrate the importance such issues were (and are) being treated on a national scale.

Complaint one: the Charity Commission failed to carry out an investigation in accordance with its role as a regulator

23. We have looked thoroughly at all the actions the Commission took during its investigation into the charity Miss A complained about (the Charity). Many of

these, particularly its early actions, were in accordance with its operational guidance and policy, and general principles of good administration.

24. We have found some areas where we do not think the Commission has acted in accordance with its guidance in respect of its assessments of risk. Assessment of risk is how the Commission decides on the priority of a case and the proportionate regulatory action. We have also found the Commission cannot therefore account for its decisions about the prioritisation of the case or the regulatory action it pursued.

The Commission's prioritisation of the case

25. The Commission describes itself as a risk led regulator. It applies a risk framework to direct its resources most efficiently and proportionately. It uses risk to determine how to investigate concerns about charities. It uses risk when deciding the regulatory outcome it pursues or achieves in a particular case.

26. The Commission's Risk and Regulatory Framework and safeguarding risk guidance say the Commission will assess the risk of a case throughout its consideration of it. It says it will assess both the impact and likelihood of the risk associated with the concerns that have been raised with it. It says it assesses the actual harm of an incident if it has already occurred and the risk of future harm.

27. The Commission told us it had no requirement for its staff to make a record of the risk assessments it does. It told us the level of risk of a case at a given time could be inferred from the actions being taken on the case, as recorded in its case management records.

28. The Commission's internal operational guidance about its assessment of risk in respect of safeguarding concerns, which was in place in 2018, says factors which suggest a safeguarding case was high risk include:

- live risk to beneficiaries
- the perpetrator (or alleged perpetrator) is still associated with the charity
- the police and or other agencies have a current investigation (or have not yet been informed)
- the trustees are not dealing with the matter.

29. In July 2019 when a charity approached the Commission with Miss A's concerns, the Commission did a risk assessment. The Commission told us it no longer holds that risk assessment. However, it appears from the documents we have seen that the Commission identified a 'live risk' and immediately assigned the case to a senior specialist case worker.

30. The Commission told us a ‘live risk’ specifically refers to cases where there is an urgent or unfolding risk requiring immediate intervention. The Commission’s Safeguarding Business Rules document says that when the Commission assesses the risk of a safeguarding case it has received, and identifies a live risk, staff should take the following actions:

- escalate the matter internally
- contact the relevant authorities immediately
- establish whether the trustees are dealing with the matter appropriately.

31. The Commission told us it took the following actions after its receipt of Miss A’s case and deciding it had a live risk:

- sought information from the Police in the UK and the relevant foreign country
- referred the concerns to the relevant Local Authority Designated Officer (LADO)
- requested urgent intelligence checks
- consulted the Commission’s Safeguarding Lead for advice and arranged for liaison with the National Crime Agency (due to international nature of allegation)
- made contact with, and sought further information from the charity who raised the concern with them
- contacted the relevant foreign country’s charities regulator.

32. It told us as a result it had information that:

- the alleged perpetrator had resigned as a trustee ‘due to an extramarital relationship with a volunteer’
- the Trustees had been made aware of the allegation
- Miss A was not in the care of the Charity, or in receipt of other regulated activities
- Miss A was no longer in direct contact with (or in the same country as) the Charity
- all of the relevant safeguarding and crime investigation authorities had been made aware of the allegations.

33. The Commission took the actions above in July and August 2019. Those actions appear to be in accordance with the Commission’s guidance as set out in paragraph 28.

34. The Commission told us the information it obtained in paragraph 30 led it to consider the case was still high risk, but that there was a less immediate risk (we assume this means no live risk). The Commission said it did not do another risk assessment at this point because there was no need to.

35. Miss A told us she was concerned there was a delay in allocating the case at this point. A regulatory compliance team (a team that conducts non-statutory investigations) caseworker was assigned to it at the end of November 2019. She said she was concerned that delay (between August and the end of November) showed the Commission had not attached appropriate priority to her concerns. Miss A told us she was also concerned the Commission's caseworker wrote to her in March 2020 to say the case was almost concluded. She is concerned the caseworker had determined there was no or low risk at that point.

36. The delay in allocating Miss A's case or its allocation to regulatory compliance teams rather than statutory inquiry teams is not in itself indicative of the priority the Commission afforded it. At a macro level, wider resource considerations determine what work the Commission can do in what teams and at what speed. The Commission confirmed to us the allocation of an individual case is dependent on its risk assessment. At the point the Commission allocated the case to a caseworker it said it considered the case high risk, but no longer a live risk. It says it did not do another risk assessment because it did not have to.

37. As in paragraph 24, in assessing the risk, the Commission's Risk and Regulatory Framework says it will revisit the assessment of risk throughout a case. While the Commission says it was not necessary to reassess the risk at this point, it did reassess the risk, reducing the risk from a live risk. This was relevant to how it went on to handle the case. The Risk and Regulatory Framework says the Commission will assess the risk of the impact and likelihood of the concern, and the risk of future harm when assessing risk. The Commission's safeguarding risk assessment guidance (paragraph 26), which provides specific advice to caseworkers about risk factors in safeguarding cases, says that things such as the following are relevant to the assessment of that risk:

- live risk to beneficiaries
- the perpetrator (or alleged perpetrator) is still associated with the charity
- the police and or other agencies have a current investigation
- the trustees are not dealing with the matter.

38. The Commission's account about why it no longer thought the case had a live risk in paragraph 30 and 32 place weight on the resignation of the former Chair and Miss A's current safety when deciding the risk was less immediate.

These are factors that are relevant to an assessment of future harm as required in the Risk and Regulatory Framework.

However, the Commission's records and comments to us do not show it also then took account of, or balanced, the fact the former Chair appeared to be closely connected to the Charity by undertaking work for it and by being married to the chair that replaced him. The Commission's records and explanations do not show it took account of or balanced the possibility and risk of the Chair being in contact with other beneficiaries. It does not show it took account of or balanced whether the Trustees were dealing with the matter.

39. Because the Commission says it was not necessary to complete a new risk assessment at this point, and it has no evidence of its initial one, there is no evidence what assessment it made of these factors that were relevant to its assessment of risk according to its guidance. All we have is the Commission's retrospective confirmation that the case remained high risk.

    We can infer from that retrospective statement the Commission took some of the factors in the guidance into account to some extent, otherwise the case would be unlikely to be high risk. However, the Commission cannot account for its assessment of the impact and likelihood of these factors as required by its guidance. The actions it then took in allocating the case do not allow anyone to infer its risk assessment, and do not necessarily support its retrospective comment the case was high risk.

40. The specific nature of the factors the Commission takes into account in an assessment of risk are also important to understanding how the Commission decides to handle a case. For example, the Commission's guidance in paragraph 26 says that where the case is assessed as high risk and there are concerns that Trustees are not dealing with the matter appropriately the Commission should consider referral for a statutory inquiry, or, issue an Action Plan, closely monitor progress and maintain contact with relevant safeguarding authorities. It is clear the action by Trustees is relevant to the regulatory outcome.

41. From the evidence we have seen, we can see the caseworker decided to issue an Action Plan to the Charity in early 2020 with a visit to be arranged for an inspection when possible. No other regulatory action appears to have been suggested. That may fit the guidance above and might infer the case was high risk and the Commission took account of the Trustees' inaction, but we can see that after Miss A contacted her MP about the imminent closing of the case, the Commission determined in a case review the potential regulatory outcomes of the case would be Official Warning, disqualifications or wind up of the Charity. Miss A believes this was a change of approach by the Commission and it had not taken the case seriously initially.

42. The Commission says it does not record risk assessments. However, where a regulatory action was being selected its guidance says those decisions are made on the basis of risk. The Commission said we should be able to infer its risk assessments from the case management records.

43. However, without a contemporaneous recorded assessment of risk done in accordance with the Commission's guidance, or other evidence of what that assessment involved and the factors that were balanced, we are not able to say what the Commission's view of the risk, or the risk factors, were at either the point the Commission apparently intended to close the case with an Action Plan, or when it then determined possible regulatory outcomes could include disqualifications and wind up.

    It is not possible to say whether it took a different view of the risks after the involvement of the MP or why. It is not possible to know what risk factors the Commission were taking into account or how they were balanced. While issuing an Action Plan, seeking an Official Warning, disqualification or wind up may all be regulatory actions proportionate to a high-risk case (as described in the Commission's safeguarding business rules), which the Commission says this case was, they are also proportionate to lower risk cases and infer very different assessments of the risk and risk factors.

44. In summary, for the reasons above, the evidence we have seen does not show the Commission can show it took all relevant factors into account that its Safeguarding Risk Indicators and Risk and Regulatory Framework guidance said it would take account of in its risk assessments. Risk assessments are how it determines how to handle a case.

45. Our Principles say organisations should be able to account for decisions. The Commission cannot do this in respect of its decisions about the allocation of the case and the proportionality of the regulatory action taken and proposed.

The Commission's regulatory action

46. Miss A also complained about the regulatory outcome of the Commission's investigation.

47. The Commission's guidance says its general regulatory outcomes when investigating concerns about a charity are to obtain compliance with Trustee duties and Charity law, and to increase public confidence in the charity and charities more generally. The Commission's Safeguarding guidance says its safeguarding specific regulatory outcomes are:

    - the charity and its trustees operate according to their governing document, the law and commission guidance
    - charity has proper and adequate safeguarding policies and procedures in place (for example child protection and safeguarding policies and vetting procedures to check trustees, staff and volunteers)

- the Commission is satisfied that the charity trustees are handling suspicions, allegations or actual instances of abuse properly, responsibly and appropriately
- issues are appropriately referred to other relevant agencies (for example LADO, Police, Care Quality Commission).

48. As such, the Commission's guidance sets out what the Commission is aiming to do and that frames the information it gathers. We have seen the Commission sought information in accordance with these aims.

49. However, in accordance with the Commission's Risk and Regulatory Framework, the regulatory action taken by the Commission to bring about those aims should be commensurate with the risk. We have therefore looked at the risk assessments the Commission made. To do this we spoke with the Commission about how it assessed risk. It said that it assessed risk in accordance with its guidance and that the assessment of risk was not recorded but could be inferred from its case management records.

50. The Commission says it treated the case as high risk throughout. Given the lack of records showing how the Commission assessed the risk, we have to assume the features of the case that made it high risk initially were as set out in the Commission's letter to the Charity, dated November 2019, expressing its serious regulatory concerns. It described these as 'an allegation that former Trustee [the former Chair] has misused charity money and is currently under investigation by the [foreign country] police for sexual, physical and mental abuse of former beneficiary and volunteer'.

51. The Commission's records show in the following months the Commission had significant ongoing concerns commensurate with the concerns in that November 2019 letter. Of particular relevance here, these included the adequacy of safeguarding policies and procedures and the Trustees' ability to manage safeguarding issues within the Charity.

52. The Commission's case management records include repeated and similar records of concern about:

    - the connectedness of the former Chair to the Charity
    - conflicts of interest
    - the Trustees' inability to manage issues to do with the safeguarding incident.

53. For example:

    - the Commission's case management records dated March 2020 and 21 May 2020 which specifically say it has concerns about the connectivity of the former Chair to the Charity

- the Commission's regulatory actions, particularly the immediate actions it said the Charity needed to take as set out within its Action Plan dated 17 April 2020 (the Action Plan) which were:
    - revising its safeguarding policy
    - putting in place a safeguarding officer
    - implementing DBS checks for all those in contact with beneficiaries
    - reviewing the incident which led to this concern, including informing the LADO (for safeguarding) and commissioning an independent review
    - ceasing any inappropriate contact with the victim
    - ceasing any contact with the former Chair and removing his ability to use Charity social media and email accounts
    - addressing conflict of interest – trustees should avoid putting themselves in a position where their personal interests conflict with the best interests of the charity.
- the Commission's case management records dated 22 April 2020 and 21 May 2020, in which it said its intended regulatory outcomes were an Official Warning as a 'minimum', but could potentially also include disqualification of one or more Trustees and wind up of the Charity
- on 22 June 2020 the Commission wrote to the Trustees and said it had serious concerns. It said the Trustees' response to the very serious allegations 'has been and continues to be woefully inadequate'
- on 9 July 2020 and on 17 August 2020 the Commission's case management records show it discussed opening a statutory inquiry, on the basis of the Trustee's poor response (by 17 August the Commission had also received a very worrying independent safeguarding report)
- on 24 August 2020 the Commission spoke to the Trustees about the safeguarding review and questioned whether the Charity should consider winding up
- on 26 August 2020, the Commission's compliance, legal and statutory inquiry teams met. The record of that meeting says: 'Discussed options. We do not believe that we have the individual evidence to disqualify [the former Chair] but we will review this when putting together Official Warning to charity… Likely direction is Official Warning with remedial Action Plan with a short follow-up date'
- on 1 September 2020 the Trustees advised the Commission of their intention to wind up the Charity. The Commission's case management records show

its concerns about safeguarding and the connectedness of the former Chair to the Charity did not abate with the decision of the Charity on 1 September 2020 to wind up. For example:

- the Commission's rapid response to the Charity's use of its social media platform to discredit Miss A (and defend the former Chair) on 4 December 2020, inferring this was evidence of a conflict of interest and an inappropriate use of Charity resources
- the issue of the Official Warning
- the Official Warning reiterated actions from the April 2020 Action Plan that the Charity needed to comply with
- the Commission's rationale for the Official Warning:

  The charity have been provided with the opportunity to improve their safeguarding processes and procedures, however all correspondence from them has been vague and inadequate and from this we have not gained the assurance that the Trustees fully understand their duties in relation to safeguarding and concerns remain regarding risk to beneficiaries.

  Although the charity has provided us with a copy of a safeguarding policy, we have not received assurances as to how this will be implemented in practice and despite giving the charity every opportunity to resolve the issues and move away from [the former Chair], he continues to remain connected to the charity and his wife remains a Trustee.

55. By April 2021, the Commission's records show it was concerned the Charity had not wound up as it had said it would. In June 2021 the Charity told the Commission it was not going to.

56. The Commission's case management records show it did not think the Trustees had met with the requirements of the Official Warning in June 2021. The records show the Commission still had significant concerns about safeguarding at the Charity in respect of the safeguarding and conflict of interest issues it had already raised. They show the Commission repeatedly had these concerns over the following months. For example:

- case management records from 26 April 2021 about the Commission's discussions about opening a statutory inquiry because of the Charity's non-compliance with the Official Warning. Those say the desired regulatory outcome was the winding up of the Charity
- case management records about the Commission's contact with the police (to establish whether there was a criminal case or likely conviction that

would help inform decisions about the regulatory action (disqualification) the Commission could take)

- the Commission's decision to visit the Charity after it decided not to wind up, which is in accordance with Commission policy on escalating cases that have not complied with Official Warnings

- the Commission's case conference record dated 5 November 2021 in which the Commission expressed concerns about the connectivity of the former Chair to the Charity and the Trustees, as well as the Trustee's handling of (and conflict of interest in) a civil litigation instigated by Miss A.

57. At the point of closing the case and giving regulatory advice and guidance to the Charity in March 2022, the Commission's records suggest it still was not assured all its concerns about safeguarding, and particularly conflicts of interest arising from the former Chair's continuing connectedness to the Charity, had been resolved. For example:

- the Commission specifically set out in the closure letter to the Charity that the Official Warning had not been complied with in respect of the part of the warning which said, 'The Trustees have failed to act in the best interests of the charity in making balanced and adequately informed decisions and avoiding or managing conflicts of interest…'. It said a specialist safeguarding lead had not been appointed

- during our investigation the Commission told us it had continuing safeguarding concerns in respect of connectivity of the former Chair to the Charity in respect of the conflict of interest of the Trustees.

58. Despite the evidence in its case management files, as detailed in paragraphs 51 to 55, suggesting that the safeguarding issues listed in paragraph 50 were of serious concern and potentially of some risk, during this investigation the Commission told us that at the end of the case it determined the case was low risk. There is no contemporaneous risk assessment or record of the factors the Commission now says it took into account at the time it decided the case was low risk.

59. The Commission has pointed us to the closing letter to the Charity as the record of its decision. That highlights the Charity's non-compliance with the Commission's regulatory actions throughout the case but acknowledges some progress. In respect of how the Commission reached its decision about the regulatory action it would take, the letter says:

    'In determining the most proportionate action, we have balanced the progress that the Trustees have made in addressing the failings which led to the Official Warning with the ongoing risk to the charity, its beneficiaries, and the wider charitable sector. We are satisfied that the Trustees have demonstrated a willingness to address the failings and have made progress

towards improving the governance of the charity. It is for these reasons that the Commission has decided at this time to take no further regulatory action'

60. The closing letter to the Charity does not specify what risk factors to the charity, its beneficiaries, and the wider sector the Commission balanced in making its decision. We spoke to the Commission's casework team about this. In conversations with them and in a written response to us, it said it determined the case was low risk at this point for the following reasons:

- it had a face-to-face meeting with the Trustees in October 2021, which had given the Commission greater confidence in the Trustees' ability to implement the new safeguarding policies it now had. The Commission told us it became clear in the meeting the Trustees' first languages were not English. The Commission considered this explained some of the difficulties in corresponding in the past
- the Charity had appointed a new Trustee and the Commission expected that Trustee to hold the other Trustees to account in terms of conflicts of interest surrounding the former Chair and his personal relationship to the Trustees
- the Charity had recently appointed a well-known firm of solicitors to advise them. The Commission said it attached weight to the fact it had responses to most of its more recent queries from the solicitors and those met most of the requirements of the Official Warning
- the Charity no longer operated overseas, which was relevant to the incident leading to the resignation of the former Chair
- the Commission considered the connectedness of the former Chair to the Charity to be low risk because he was no longer a Trustee and there had been no obvious damage to the Charity's reputation as a result of his connection with the Charity
- it would not have been proportionate to take any other action because no other action would help sever the link between the former Chair and the Charity (for example, disqualification of the former Chair from being a Trustee would not stop him from volunteering/acting on behalf of the Charity, or any other)
- it had decided disqualification of the former Chair or any of the other Trustees was inappropriate because while some of the individual criteria may have been met, the Commission did not identify any wider risk to public trust and confidence in charity more generally and said it was unable to connect the other Trustees to any specific mismanagement.

61. Since receiving a copy of our provisional view, the Commission further clarified why the case was determined to be low risk for regulatory purposes. It said the fact there was no criminal prosecution of the former Chair meant

it did not think his connection to the Charity was of significant risk. It also said it had ‘robust’ evidence safeguarding procedures and practices at the Charity had improved. It did not define that robust evidence and therefore we have inferred this was the reasons it previously gave us, as described above in paragraph 57. We have also seen from the case management records, the Charity introduced DBS checks for volunteers and staff.

62. We have looked at whether the Commission took account of relevant factors and balanced the evidence, which would be in accordance with our Principles of Good Administration, when determining the case was low risk for each of the reasons the Commission has given us.

63. Firstly, whether or not there has been a criminal conviction is clearly a relevant factor in the Commission’s assessment of risk in any safeguarding case. However, in this case the Commission’s records show that, regardless of the criminal cases between Miss A and the former Chair in respect of alleged sexual assault and rape, it accepted the relationship the former Chair had with Miss A was an abuse or breach of trust and/or power. It was this, and the Charity’s handling of it, the Commission was taking regulatory action about. Those records say:

- 9 July 2020: the Commission recorded the indicators for opening an inquiry in future. It said these would include evidence of an abuse of position of trust by the former Chair. The note further said the Commission ‘already had evidence’ of an abuse of position by the former Chair
- 12 March 2021: the Commission’s records say, ‘[The former Trustee was] … a Trustee and CEO of the Charity and she was a beneficiary and/or a volunteer. [He] should have known that, in fulfilling [his] Trustee duties, [he was] obliged to take reasonable steps to protect individuals from harm. Instead [he] admitted [he] engaged in a sexual relationship with her. That was a clear failure of … duty of care as a Trustee and this would also seem to me to have constituted an abuse of a position of power’.

64. It is therefore difficult to understand how the Commission’s assessment of risk, in respect of the breach of trust and the Charity’s handling of it, could be dependent on the criminal conviction (or lack of) of the former Chair for sexual assault and rape.

65. Secondly, we have looked at the robust evidence the Commission says it had of improved safeguarding at the Charity (as described by it in paragraph 57).

66. In its closing letter to the Charity the Commission said it had balanced risks to the Charity and beneficiaries against the progress made by the Charity. In accordance with the Commission’s safeguarding guidance, relevant factors in the risks to beneficiaries and charity include safeguarding specific risks (such as whether the Charity can put and is putting safeguarding into practice and

the proximity of the perpetrator). The Risk and Regulatory Framework says the risk of future harm should be assessed when doing a risk assessment.

67. We can see from the Commission's case management records the progress the Charity said it took and the actions the Commission said it still had to take in respect of the concerns the Commission had. Of relevance to this report, those included actions in respect of conflicts of interest and specialist safeguarding expertise. Nevertheless, we acknowledge that some progress by the Charity might lower the risk.

68. However, we have seen no articulation of the remaining risks of harm and future harm to the Charity, its beneficiaries or the charitable sector that the Commission considered, or the weight it gave to those risks.

69. The only contemporaneous evidence we have is summarised in paragraphs 50 to 55, which suggests serious safeguarding concerns around conflicts of interest and the connectedness of the former Chair and, on the other hand, the documents submitted by the Charity and the closing letter to the Charity which implies the Commission thought the Charity were willing to improve, but noted its long non-compliance.

70. We also have the reasons the Commission gave in paragraph 57 for its decision the case was low risk. However, within those reasons we have seen no evidence the Commission took into account relevant facts to an assessment of risk, as described in its guidance.

71. We have set out below examples of the facts the Commission's guidance, case records and final decision would suggest were relevant to the assessment of risk to the Charity, beneficiaries and the sector in this case, but which are not apparent in its contemporaneous records or the reasoning the Commission has now provided. The Commission has said that it would clearly have knowledge of these facts and taken them into account, and it cannot be expected to record everything. However, as we set out below we have not been able to gather an account from the case records, the final decision of the Commission, or during this investigation that demonstrates those facts were assessed and balanced in the Commission's assessment of risk, which is what the Commission says it will do and, in this case, said it did:

    - the Commission said the face-to-face meeting with the Trustees explained some of the communication difficulties in corresponding with the Charity in the past. In saying this it appears the Commission had determined the actions of the Trustees in engaging with the Commission was relevant to an assessment of risk. That would be in accordance with its Risk and Regulatory Framework and safeguarding guidance (paragraphs 24 to 26). However, the conclusion that the Trustees were willing to address the issues the Commission raised with it around conflicts of interest concerning the former Chair is not the one that could be inferred from the Commission's case

management records and the ongoing concerns in paragraphs 50 to 55. Its closing letter to the Charity could also be inferred as saying the Commission felt the lack of engagement from Trustees and their conflict of interest with the former Chair was an ongoing risk. The Commission told us in this investigation it took a discretionary decision not to attach weight to other reasons for the Trustee's lack of engagement in its assessment of risk. We have seen no evidence of that weighting or how that discretionary decision was made. We cannot infer it from the Commission's records or from what it has now told us. We do not think the Commission has been able to demonstrate it took other reasons for the Trustee's lack of engagement into account or that it balanced them. It cannot therefore demonstrate it took factors its guidance suggests are relevant to an assessment of harm or future harm into account, and which its closing letter said it did balance. It therefore cannot account for its decision here

- in saying the Charity appointing a new Trustee was robust evidence of change in the Charity, there is no evidence the Commission considered the relevant fact the new Trustee was a former business partner of the former Chair when assessing the risks to beneficiaries. We raised this with the Commission. It told us Trustees in small charities commonly have personal relationships with one another and that would not be a reason to be concerned. While we have no disagreement with this general statement, the statement the Commission made in this case - that the new Trustee would be able to hold other Trustees to account in respect of the conflict of interest in respect of the former Chair - does not seem consistent with the circumstances in this case. When we raised this with the Commission, it told us this was not material to its assessment of risk because the conflict of interest with the former Chair was low risk anyway given the lack of criminal conviction. However, see our findings in paragraphs 58 to 62 regarding the relevance of that consideration

- in saying the Charity no longer operated overseas – which was where the safeguarding incident with Miss A took place - the Commission has provided no evidence it assessed the risks of future harm associated with the Charity's operations still being with vulnerable beneficiaries/adults at risk in the UK, such as homeless people. When we raised this with the Commission it said it was fully aware of the Charity's UK operations and took those into account, but did not place significant weight on that. We have not seen evidence of the Commission's weighting of the risk of the safeguarding concerns it had as set out in paragraphs 50 to 55 in respect of the vulnerability of UK beneficiaries. We have not seen evidence of any assessment of risk that would explain that weighting, or how that discretionary decision was made. We do not think the Commission can demonstrate it took this factor into account. The vulnerability of beneficiaries is a factor its guidance suggests is relevant and one which its closing letter said it did balance. The absence of evidence from any source about this means the Commission cannot account for its decision here

- we note information from other people regarding the Charity and former Chair would be relevant to any assessment of risk. The Commission told us Miss A had sent it evidence from other people about the Charity and the former Chair. It said the information did not carry weight in its decision making. It said none of the testimonies alleged sexual abuse (note: Miss A disagrees and says they did). It said the testimonies were 'unsubstantiated opinion' which it would not have been proportionate to look into further. It said it archived that evidence and has destroyed it in line with its case work procedures. It is not clear why that evidence was separated from the rest of the case records, but we have not considered that issue specifically. However, in destroying that information we do not think the Commission has been able to demonstrate it took factors its guidance (risk of future harm) suggests are relevant into account. It therefore cannot account for its decision here
- in saying the connectedness of the former Chair was low risk because he was no longer a Trustee does not demonstrate the Commission was acting in accordance with its safeguarding risk assessment guidance, which says connectedness is a risk factor regardless of Trusteeship. The Commission may have had other reasons why the connectedness was low risk but, other than that described in paragraphs 58 to 62 (which appear to us not to be relevant to the question of the management of a breach of trust), we have not seen evidence of what those were. We do not think the Commission has therefore been able demonstrate it took factors its guidance suggests are relevant into account and balanced them, which its closing letter said it did. It therefore cannot account for its decision here
- the Commission said the Charity's reputation was not damaged by the connectedness of the former Chair. It said the former Chair's actions did not cause a wider loss of confidence in charity. We have seen no evidence in the case management records about the Commission taking any steps to assess this. We have only seen the Commission were aware of reporting about the incident in national newspapers and on social media. There is no evidence the Commission took a view on how that impacted the reputation of the charity sector more widely. We do not think the Commission has been able to demonstrate it assessed the impact of the incident and risk of future harm/reputational risk in this respect. It cannot therefore demonstrate it acted in accordance with the Risk and Regulatory Framework. It therefore cannot account for its decision here.

72. Miss A told us she was upset and disturbed about the Commission's final decision that the case was low risk and to give regulatory advice and guidance to the Charity. She said she could not understand why the Commission had chosen that action.

73. The Commission has said there were no other proportionate regulatory actions it could take against the Charity that would have had any effect on

the clear conflict of interests it had found in respect of the former Chair's ongoing connectedness to the Charity.

74. During this investigation the Commission also told us it rarely used its powers to, for example, disqualify Trustees or seek the wind up of a charity. However, this would appear to us to be a resource consideration.

75. The two descriptions of proportionality, in paragraphs 73 and 74, are different. In the first case, the Commission is suggesting the action would not be proportionate to the risk. In the second the Commission is suggesting it is constrained as a matter of resource. Limited resource would understandably mean only the highest risk cases would be acted on. That is not a matter for us.

76. However, for the reasons we have already explained, we have not seen evidence of how the Commission took account of the relevant factors it now says it did or how it balanced them. It cannot account for its decision making. It is therefore also unclear why regulatory advice and guidance was a proportionate regulatory action for it to take.

77. Further, the Commission's Official Warning guidance says decisions not to escalate regulatory action if a charity does not comply with an Official Warning should be explained to preserve public trust and confidence. There is no contemporaneous explanation from the Commission about its decision not to escalate its regulatory action following the Official Warning in the light of at least one of its safeguarding regulatory outcomes not being met.

78. Increasing public trust and confidence in charity is one of the Commission's general regulatory outcomes. The failures in the Commission's decision making at this point and its apparent failure to meet the requirements of its own Official Warning and risk guidance would appear to fail to meet two of the Commission's statutory objectives – to increase public trust and confidence in charity, and to enhance the accountability of charities to their beneficiaries and the public. The failures to meet the standards set out in the Commission's own guidance to account for its decision and thereby increase public trust and confidence amount to maladministration.

Complaint two: the Charity Commission failed to ensure Miss A's welfare

79. Miss A told the Commission she was a victim and survivor of sexual abuse and a whistleblower.

80. The Commission's publicly available information about whistleblowing, 'Report serious wrongdoing at a charity as a worker or volunteer' issued in October 2018 says it may speak to whistleblowers to understand their concerns and again at the conclusion of the case but will not generally update

them. The Commission also submits reports on its whistleblowing activities. Its report for the 2018/2019 business year says it follows DBEIS guidance on whistleblowing. It says:

'We classify charity workers and volunteers who raise serious concerns with us about their charity as whistleblowers, as their role within a charity can mean they are well placed to identify serious problems.

'…During the reporting period, we completed our review of all aspects of our approach to whistleblowing and developed a new service which we are now piloting. Parts of this new service were put in place during the reporting period. We completed the rest of the implementation in June 2019.

'Our aim has been to put in place a more structured, supportive and personal approach which is appropriate to the needs of whistleblowers who can face risk and challenge when they speak out.

'…during the year we began to treat charity volunteers as well as charity workers as whistleblowers, where appropriate.

'It's a significant change that extends our ability to identify serious concerns that we need to act on. Whilst volunteers do not have any statutory protections if they report serious concerns to us (unlike workers), we recognise that in other respects they face many of the personal challenges and risks experienced by workers and therefore need the same sort of engagement from us.'

81. During this investigation, the Commission told us that whistleblowing legislation affords protections only to employees. It said it had chosen to recognise that charity volunteers could also be whistleblowers. Despite this, it told us that it did not follow the DBEIS guidance in respect of whistleblowing for volunteers, only employees. It said its standard communication policies applied to volunteers. It said employees are afforded protection in law that it is not legally required to do for volunteers.

82. However, the Commission's comments to us appear to be in contradiction to the commitment in the contemporaneous documents about its whistleblowing activities and commitments. Further, the DBEIS guidance for prescribed persons (the Commission is a prescribed person) has a section about what to do with a whistleblowing allegation and another on how to manage the expectations of whistleblowers. These are not legal protections. Among other things, the DBEIS guidance says:

- it can be a difficult decision for a whistleblower to make a disclosure, and the prescribed person should be sensitive to this. The prescribed person will manage the initial contact with the whistleblower to clarify and understand the nature of their disclosure and then take a decision about what action they will take

- it is important for prescribed persons to realise that they will often be hearing from anxious and distressed individuals. The two main barriers whistleblowers face are a fear of reprisal as a result of making a disclosure and the perception that no action will be taken if they do make the decision to ‘blow the whistle’
- a clear explanation of the statutory powers and remit of the prescribed person will give the whistleblower a more realistic expectation and they will be less likely to feel that their disclosure has been ignored
- all disclosures should be dealt with on a case-by-case basis and to a defined and published set of policies and procedures, ensuring a consistent approach. The policies and procedures will ensure that staff within prescribed bodies who deal with disclosures are confident in responding to whistleblowers and their concerns in a confidential manner
- feedback to the whistleblower is important
- where possible any feedback provided to the whistleblower will help to improve their confidence that the disclosure has been taken seriously and could prevent the whistleblower from feeling discouraged by their experience. However, in many cases only limited feedback will be possible.

83. The Commission’s stance in paragraph 76 is not clear from its publicly available information, other than the fact its website highlights volunteers may not have the same legal protections as employees. It also appears to us that to differentiate against volunteers in aspects of the DBEIS guidance that are not dictated for or restricted by legislation is contradicted by the Commissions publicly advertised guidance that volunteers too can be whistleblowers. This might produce unfair outcomes.

84. Our Principles say that where following policy, procedure or legislation produces an unfair outcome, organisations should consider taking an alternative approach. The Commission has done this in respect of addressing the significant role of volunteers in charity and in whistleblowing. But if the Commission does not intend to treat volunteers in the same way as other whistleblowers in respects not legislated for, it should be clear about that. Our Principles of Good Administration, ‘being customer focused’ says people should be clear about their entitlements. From looking at the website, Miss A would have had a reasonable expectation she was to be treated as a whistleblower and that the Commission would follow DBEIS guidance as far as possible.

85. It is also of note that Miss A was also a victim survivor of sexual abuse. The Commission’s safeguarding responsibilities, as for all organisations, were to ensure she did not come to harm through her contact with it. As explained above, we have not seen any single specific safeguarding policy in place at the Commission at the time in respect of the way in which the Commission

would manage people who approached them who are or may be victims of abuse or adults at risk. The Commission has shown us policies and documents it produced in August 2021 regarding people who say they have or are coming to harm through their engagement with the Commission.

86. We have seen the Commission made significant attempts to correspond with Miss A by email and conference call. We have seen they recognised she was vulnerable, engaged with advocacy groups supporting Miss A and provided her with a single point of contact. This is all in accordance with the Commission's 2021 guidance, as well as our Principles of Good Administration.

87. We have also heard that in a call on 23 April 2020 the Commission explained the role and remit of the Commission. The Commission said it would not prejudice its case by giving updates throughout its case, but that it would provide a further update at the conclusion of the case. This was in accordance with the whistleblowing guidance the Commission follows which advises whistleblowers should be allowed to provide their concerns, explain them verbally and receive information at the conclusion of any enquiries (as confidentiality will allow). This therefore is also in accordance with our Principles of Good Administration.

88. Miss A has, as we have looked at above, said there was a delay in contacting her and the Commission appeared to be closing the case without speaking with her. The Commission's usual processes do not expect it to engage with people who refer concerns, and its public information only says it may contact whistleblowers. We understand its practice in respect of speaking to all whistleblowers changed in the 2018/2019 business year and therefore this process was in its infancy. Nevertheless, Miss A had a reasonable expectation the Commission would engage with her, a fact the Commission has told us it accepts, and it is understandable she engaged an MP in spring 2020 because she had not been contacted.

89. Miss A also told us that the Commission 'institutionally betrayed' her later in the case. She told us it led her to expect that it would take action to remove the connectedness of the former Chair from the Charity. She said this was important to her as she was very concerned that the former Chair might use the Charity to repeat the events that happened to her with others. We set out below aspects of the calls we have heard or seen notes of to which she refers. These points do not constitute the entirety of any call. However, we have verified these were comments made by the Commission to Miss A during those calls. We note that many of the calls were long and discussed a number of issues. It is also of note we have set out in paragraph 82 the content of the call on 23 April 2020 in which the Commission set out its remit, and that Miss A would have been aware of that.

    9 November 2020:

- the Commission told Miss A it considered the former Chair's connectedness to the Charity was a continued risk
- the Commission told her the Charity would be winding up. Miss A asked the Commission if the Charity had just agreed to wind down. The Commission told her the engagement it had with the Charity brought about the wind up
- the Commission specifically said once the Charity was wound up none of the individuals involved in the events concerning Miss A could do the same things again and could not do them in the name of charity
- the Commission said the Charity would not be registered as a charity once it was wound up and could not rely on the uniqueness or the assurance that came with being a charity
- the Commission said it would do all it could to disable the former Chair from doing anything in future in the name of charity
- Miss A asked the Commission about 'public findings' because she said they would help her get closure. The Commission told her there would be a case report, and that the reports were 'usually' comprehensive. Miss A specified that she wanted people to know the former Chair was a de facto Trustee and know about the relationship with her as a beneficiary. The Commission agreed people would. It said the case report would give confidence to people like Miss A to come forward. The Commission confirmed the Trustees would be identified in the case report, it said Miss A could use the report to speak publicly.

8 December 2020:

- the Commission told Miss A that it was looking at how it could use its powers to compel the Charity to do what it said it was going to do. The Commission specified that those things were: wind up and stop fundraising
- the Commission said 'we abhor' the behaviour of the Charity in respect of a social media post it had made. The Commission said it could not do anything about the actions of the former Chair, only the Charity, but said they were not ignoring the fact he was still acting behind the Charity.

29 October 2021:

- the Commission recorded Miss A was concerned the former Chair had posted on social media that the Charity was to be exonerated
- it said it told Miss A the Commission had not yet made a decision.

2 November 2021:

- the Commission's files reference several calls from Miss A to its contact centre and the actions it took in response – to put in place a single contact and seek advice from its safeguarding specialist
- the record following this call says the Commission needed to manage Miss A's expectations by giving reasoning for its decisions. It said 'For example, if we are not intending to disqualify/remove one or more of the Trustees – what are our grounds for that decision? Similarly, if we are not going to take any action to enforce [the former Chair's] removal from the Charity, why not? I will need to have a separate discussion about how we deliver the outcome taking into account [Miss A]'s vulnerability but that will depend to a large extent on the outcome, so is for further down the line'.

16 November 2021:

- the Commission told Miss A the Charity was not going to wind up and the Commission was not pursuing this as an outcome
- the Commission told Miss A the Charity could not wind up because of the civil action she had pursued. It said things were 'increasingly not going [her] way'. Later in the call the Commission clarified that what it thought Miss A wanted was exoneration or direct criticism of individuals
- Miss A indicated she was still concerned with the connectedness of the former Chair to the Charity given the current governance structure of the Charity. The Commission only responded that it could not regulate individuals or keep the former Chair away from the Charity. It said it was not its role to do so
- the Commission said it had addressed the issues raised by Miss A in the Official Warning in February 2021. It said there were no new issues to address with the Charity
- the Commission told Miss A it was still engaging with the Charity to check the Trustees were acting to remedy the issues in the Official Warning and come into good governance.

November 2021:

- (we have not heard this call) we understand Miss A and her solicitor had a second call in November 2021 with the Commission regarding the way in which the Charity were conducting the civil action Miss A was taking. The Commission said it told Miss A the case report would not be comprehensive in this call. Miss A says this call simply contained regulatory advice about her civil case against the Charity.

90. In summary, the calls reflect the Commission's early concerns about the connectedness of the former Chair to the Charity and the serious concerns it had about this. The calls reflect the Commission also understood this was a

key concern for Miss A. The call of 9 November 2020, whether intended or not, inferred the Commission had brought about the wind up of the Charity, and that this was positive and desirable for the Commission, as was preventing the former Chair from operating within the Charity. The call of 8 December 2020 reinforced the impression the Commission was seeking to use powers to compel the Charity to wind up.

91. During our investigation, the Commission told us the winding up of the Charity was 'absolutely not' a desired regulatory outcome it would have considered using its powers to achieve. It told us the wind up was only a desirable regulatory outcome because the Charity had indicated it would do this. It told us it was pursuing compliance with the law and Trustee duties. This position is not clear in the call with Miss A on 9 November 2020 or 8 December 2020 and, in fact, it is very possible to infer the opposite.

92. In contrast to the calls in November and December 2020, in the call of 16 November 2021 the Commission appears to have been much more circumspect about the extent to which preventing the former Chair from being associated with the Charity was achievable or desirable. While this was reflective of the Commission's position at this point, the Commission did not appear to recognise during the call, even though its records of the earlier calls on 29 October and 2 November did recognise, the stark difference to its position and comments in the call a year earlier, which was the only information Miss A would have been aware of.

93. It is of note that when the Commission told Miss A things were 'not going [her] way', Miss A remonstrated that she did not want a specific outcome and she would accept any outcome that resolved the issue of conflict of interest and the connectedness of the former Chair to the Charity. There is no evidence she wanted 'exoneration'. This was consistent with comments she had made in the first call with the Commission on 23 April 2020 when she said the regulatory outcome she thought was appropriate was the removal of the Trustees of the Charity because she could not see any other way of ensuring the former Chair did not stay involved with the Charity. She said she did not think there was a 'halfway house' to achieving that. In other calls she suggested other outcomes, the focus of all were clearly ensuring the former Chair did not stay in contact with the Charity. As such, there is no evidence Miss A herself was specifically seeking the wind up of the Charity or actions it was not in the power of the Commission to take, and discussions about the desirability of winding up the charity would appear to have begun with the Commission.

94. The Commission told us of the difficulty of communicating with Miss A and explained that some things were said in the moment to try and alleviate her obvious distress. This is understandable. We also appreciate these comments were made in the context of a long correspondence and often lengthy calls. However, the comments made to Miss A that we have set out above, while

clearly made with the best of intentions to alleviate Miss A's distress at that time, would not be in accordance with the DBEIS guidance above insofar as they did not help to set clear expectations for Miss A. She spent more than a year believing the Charity would be wound up and that the Commission wanted this and may use its powers to achieve it.

95. We have also not heard in any call evidence that the Commission provided Miss A with an explanation that made clear why it had apparently changed its position so completely, or why it was not proportionate for it to take any other regulatory action such as those it set out in its records of the call on 2 November 2021.

96. In response to the provisional view report, the Commission told us it did not give reasons 'why' and its published guidance on reporting concerns to the Commission says that. We note that guidance says:

'Depending on circumstances the Commission may decide not to take further action. If it does not take action it will tell you why and keep a record of your report.

The Commission will inform you if it takes up a serious concern but it will not give you details of how it handles its casework. It will notify you of the outcome when it has finished its case.'

97. The guidance here clearly provides a wide scope for the Commission to engage and provide the information it sees fit in any specific case. For example, we note that the Commission's guidance on Official Warnings says that where an Official Warning has not been complied with and the Commission does not intend to escalate the case, it should for the purposes of public confidence, explain why in detail.

98. The Commission's explanations to Miss A about its apparent change of position do not appear to us to be in accordance with the DBEIS whistleblowing guidance in respect of feedback, which the Commission says it follows. The quality of the feedback provided by the Commission did not achieve confidence that Miss A's disclosure had been treated seriously and the feedback would be unlikely to have prevented any whistleblower from being discouraged. This is not simply a reflection of Miss A's subjective experience or needs and wants. This is because the Commission had created a significant expectation for Miss A and had provided a great deal of information about what it might do. In the light of that, the caseworker recognised (as per the record on 2 November 2021), that Miss A would need to be provided with reasons as to why those actions were not followed through. The quality of the feedback and explanations and the change in tone in the calls with Miss A would not meet the standards set out in the DBEIS guidance, the Commission's Official Warning guidance or our Principles of Good Administration.

99. The Commission's lack of a single internal policy for staff, as recommended in the DBEIS guidance is likely to have meant staff dealing with Miss A were not as prepared as they could have been for their conversations with her. We note the Commission did introduce new policies around people claiming to be experiencing harm in August 2021. This was therefore at the very end of this case. We can see that the actions the Commission took on 2 November were in accordance with that guidance in respect of providing a single contact and seeking advice from the in-house safeguarding specialists. However, the nature of the subsequent conversations the Commission had with Miss A were still not in accordance with the DBEIS guidance, or her vulnerability which the Commission had recognised on 2 November 2021. Our Principles say organisations should provide effective services with appropriately trained staff. We have not seen evidence to show the staff talking to Miss A had sufficient training or support from the Commission in respect of their telephone contact with Miss A.

100. The communication with Miss A was not good enough and did not meet the standards of being customer focused in our Principles of Good Administration. Specifically:

- the Commission failed to keep to its early commitments and inferred commitments or explain why it could not keep to those
- the change in the Commission's tone and the comments it made in the call of 16 November 2021 did not communicate the change in the Commission's position to Miss A in such a way that was sensitive to her needs as a whistleblower and a vulnerable person
- not all the information was accurate (for example, information provided around the content of the case report).

The Commission's communication did not follow basic principles of good communication. It did not adhere to the principle of giving feedback in the whistleblowing guidance. That was maladministration.

Complaint three: the Commission's complaint handling

101. Miss A told us that despite submitting a detailed complaint about the Commission's investigation and offering additional evidence, she was not contacted by the complaint investigator for her evidence.

102. She said she thought the Commission recognised it had prejudiced its own case by telling her the Charity was going to wind up and that this was desirable without it being a managed regulatory outcome. She said it had no intention of considering her complaint.

103. Miss A also told us the rapidity with which the case report was issued after her complaint was rejected left her with the impression the Commission never had any intention of properly reviewing her case.

104. We have seen the Commission's complaint response identified one issue arising from its handling of the investigation. It recognised it should have advised Miss A the wind up of the Charity was not a certain conclusion. It apologised for that error but did not identify any specific injustice to Miss A as a result of that.

105. The Commission did not respond to Miss A's detailed comments that she believed she had been significantly misled by the Commission. It did not respond to her concerns it had prejudiced its own investigation by telling her the wind up of the Charity was desirable. That was despite her saying she suffered severe mental health consequences and was left suicidal as a result of the change in tone from the Commission.

106. We have not seen any specific evidence to show the Commission's complaint handlers were under pressure to specifically discard Miss A's complaint. We do not think the issue of the case report so soon after her complaint was rejected can alone show the Commission had no intention of looking at her case. This is because, as someone who brought a concern to the Commission, Miss A did not have a right of response or challenge of the Commission's decisions. As such, it is reasonable that her complaint was handled separately to the ongoing regulatory action.

107. Nevertheless, the outcome of the complaint may have had an impact on the Commission's regulatory action, if it was upheld or found the investigation or assessment of risk was flawed. The Commission's complaint procedure says:

   'It is important that the officer considering the case understands what the customer's specific complaint is. If this is unclear, or not explicitly set out, the officer can add to the email/letter to clarify the customer's concerns or take any other proportionate steps that are necessary to understand the complaint. Often a telephone call can assist in developing understanding about the nature of the complaint and in creating a positive engagement with the complainant.'

108. The guidance also says when writing to the complainant with the outcome, the Commission aims to:

- show that we have fully understood the complaint
- show that we have fully understood the circumstances
- demonstrate that they have reviewed the case impartially and thoroughly (and without a preconceived idea that they would defend the Commission's position).

109. The fact the complaint handlers did not respond to Miss A's offer of additional evidence would not appear to be in accordance with the Commission's guidance or the Principles of Good Complaint Handling. Those say public bodies should keep the complainant regularly informed about progress, the reasons for any delays, and provide a point of contact throughout the course of the complaint. They say organisations should listen to and consider the complainant's views, to make sure they understand clearly what the complaint is about and the outcome the complainant wants.

110. The Commission's complaint responses also did not appear to engage with the complaint Miss A was making. Her complaint involved what she was led to believe by the Commission, but also the failure of the Commission to pursue the actions it initially appeared to see as desirable. It concerned the possible prejudice of the case.

111. The complaint responses from the Commission focussed on the Commission's inability to take any action against the former Chair in respect of the interpersonal assault described by Miss A. However, Miss A made it quite clear throughout her correspondence with the Commission that she was pursuing a police complaint about that. She had demonstrated she understood the remit of the Commission and the regulatory powers it had over charities and trustees. The Commission appeared not to engage with her complaint about how it had used its own powers or explain why it had not prejudiced its own case, if it had not. It did not get its complaint handling right in accordance with our Principles because it does not appear to have understood the essence of the complaint, the injustice caused to Miss A, the outcome she was seeking, or give reasons for its decision.

112. The Commission also did not identify any of the issues with the Commission's investigation such as we have identified in this report. We would not necessarily expect the Commission to reach the same conclusions as us. However, it failed to identify it had not given reasons as to why the regulatory actions it had given the impression it was going to take were no longer appropriate (as described by the Commission to Miss A in the call on 16 November 2021, and the cause of her complaint). Providing those explanations would have been in accordance with the relevant whistleblowing guidance and a key part of the relationship with Miss A and communicating with her sensitively and in a way that recognised her needs.

113. The Commission's complaint response appears to lack openness and transparency. We do not think the Commission explained its decisions in accordance with the Principles of Complaint Handling which say organisations give clear, evidence-based explanations, and reasons for their decisions. It is also of note the Commission took far longer than its published 30 days to respond to Miss A's complaint. We do not think the complaint response recognised or demonstrated the Commission understood the nature of Miss A's complaint. That was maladministration.

Injustice

114. Miss A was vulnerable. She had poor mental health and was a victim survivor before she even volunteered for the Charity. After her involvement with the Charity, she told us her situation was worse and she was at her most vulnerable when she contacted the Commission.

115. Miss A has given us a powerful account of how her contact with the Commission kept the negative experiences she had experienced in the past at the forefront of her thoughts. She experienced the contact as having to relive experiences she wanted to move on from. She said her ongoing contact with and about the Commission has meant that life events she was hoping to enjoy again after the matter was closed, have all been coloured grey.

116. While we recognise, as Miss A does, that she is likely to be suffering the consequences of events other than those caused by the Commission, she has explained that the Commission's failings have exacerbated her suffering.

117. Specifically, Miss A told us she experienced the news that the Commission was no longer working towards the wind up of the Charity and was intending on giving advice and guidance to address the conflicts of interest arising from the connectedness of the former Chair to the Charity, as trauma. She said the suddenness of the change of tone and action was extremely triggering in respect of her past abuse and left her suicidal, for which she needed hospital care. She told us she felt institutionally betrayed by the Commission.

118. Miss A also told us that her mental ill health was compounded by the fact she felt ignored and dismissed through the Commission's complaint process because it failed to engage with her or demonstrate it understood the seriousness of her complaint.

119. Miss A has provided us with information and evidence about her mental ill health from the medical professionals who help her. This specifically includes information and evidence that the Commission's actions have impacted on her wellbeing and contributed to a longer recovery for her. It demonstrates that medical professionals had concerns about those impacts at the time the Commission was looking at the Charity. We accept the accounts show that Miss A's experience of the Commission's actions was one of deep distress and an exacerbation of her mental ill health.

120. Miss A also told us her experience of the Commission meant she lost faith in its ability to be independent and carry out its strategic objective of increasing public confidence in charity. She says it led her to the view the Commission was acting in response to external pressure on behalf of the former Chair. The failings we have found in the Commission being able to account for its decision means the Commission have undoubtedly left a void

of understanding for its actions, which could be given any number of explanations.

121. The Commission says it has explained and accounted for its decisions in its explanations to us. However, as we have described above, we have not seen sufficient evidence even in those explanations that the Commission can account for its decisions in accordance with our Principles of Good Administration. There is insufficient evidence the Commission took account of and balanced factors it had identified in its guidance and in its decision letter to the Charity were relevant to its assessment of risk. We therefore cannot give Miss A any greater understanding about why the Commission made the decision it did.

122. As a whistleblower and a victim, Miss A had a right to expect to come away from her interaction with the Commission with confidence her disclosure had been taken seriously. It is a significant injustice to her that she has not had that experience and has had the need to complain further about the Commission to be taken seriously. It is a significant injustice this process is still unable to provide the reassurance she is seeking regarding the risks associated with the issues she raised and the Commission's ability to deal with them.

Recommendations

123. We recommend:

- the Commission apologises to Miss A
- the Commission arranges an independent review of its handling of its communications with Miss A in conjunction with a recognised safeguarding specialist organisation. The Commission should write to Miss A and to us to share the findings of that review and explain if and how it intends to implement any recommendations arising from it
- the Commission conducts a review of its handling of this case, in particular its assessment of risk, and the audit trail of and how it accounts for its decision making following its issue of an Official Warning. The review should be completed by someone from the Commission not originally involved in the case
- following from the two reviews above, the Commission should review its guidance on its assessment of risk and proportionality. The Commission should consider whether its internal and external guidance is fit for purpose given its clear view about what it needs to record and that resource constraints inform what it is proportionate for it to do.

124. Miss A has told us she did not make this complaint to receive financial compensation. However, she believes compensation would present a tangible recognition of what she has suffered. Miss A has said:

   '… I have never made this complaint for financial reasons and this is a point I have made unequivocally clear in the past. However, financial compensation represents a tangible measure of the harm caused and would ameliorate some of the suffering experienced'.

125. When looking at financial remedy we have to take a view on the injustice caused to an individual, regardless of the extent or gravity of the maladministration.

126. To decide on a level of financial remedy, we review similar cases where the person has experienced similar injustice, alongside our severity of injustice scale.

127. Miss A has suffered the injustices we have set out in paragraphs 114 to 122. In summary, Miss A's ability to live a normal life day-to-day was impacted by the actions of the Commission over at least a year (after it appeared to change its

regulatory aims in November 2021) with the repercussions continuing to the present day because she has to engage with this investigation.

128. We believe this means Miss A has suffered injustices in line with level four of our financial injustice scale, although we know she disagrees. Our guidance for level four says:

   ‘This level includes cases that have a significant and/or lasting impact on the person affected, such that it affects their ability to live a relatively normal life to some extent. Generally, the injustice will go beyond ‘ordinary’ distress or inconvenience, except in cases where it is very prolonged; the injustice will often be such that, even after the poor service ends, the failure could be expected to have some lasting impact on the person affected. The matter may ‘take over’ the affected person’s life to some extent.’

129. We believe Miss A has suffered multiple types of injustice at this level, which are defined in our guidance as:

- significant distress, lasting over three months, or which is ongoing
- material: significant hardship or other adverse impact on quality of life, lasting in excess of six months
- physiological: loss of opportunity for better clinical outcome in cases of moderately serious illness (in this case the exacerbation of her mental health illness) where there is no reduction in life expectancy.

130. We recognise that Miss A believes the injustice and distress she has suffered is a higher level of severity. It is difficult for us to accurately assess the full impact in any case of maladministration. However, what we can say on the basis of the evidence we have, is that Miss A approached the Commission to undertake its statutory role. Their failures to manage its communication with her and to demonstrate they fulfilled their role has caused her at the very least the injustices above, which she will have experienced as all the more severe given they are an exacerbation and sit on top of her pre-existing vulnerabilities and poor mental health. It is useful here, however, to set out Miss A’s view in her own words:

   ‘[The compensation recommended] signals to the public how serious the PHSO regards the conduct complained of. …[it is] an important representation of the significant harm incurred and it therein sends an imperative message. The public aren’t going to sit around and read the minute details around why this isn’t a level 6 (if it isn’t) and would potentially just see anything less as a representation that the PHSO does not see this matter in the serious light in which it needs to be viewed.

   While I accept that the Commission did not cause my prior vulnerability, including my sexual assault and therefore are not causally liable for that, there is a causal nexus between their egregious actions and institutional

betrayal and the significant harm and detriment caused concomitant on that. Almost without exception I presume that anyone who goes to an institution for help has some kind of prior vulnerability or issue that is not caused by that institution but the PHSO's role is to examine whether the institution responded appropriately to that vulnerability. For example, a person with cancer who seeks help from an NHS doctor cannot argue that his cancer was caused by the doctor or the relevant NHS Trust, but if the doctors did not conduct appropriate checks to identify the cancer early enough or engaged in some other kind of clinical negligence, then perhaps the person's prognosis or experience will nevertheless be significantly impacted by those actions.

Moreover, I do not agree that prior vulnerability is a mitigating factor. The Commission were dealing with highly vulnerable people and this makes what they did more egregious not less. I see the prior vulnerability as an aggravating factor that entitles complainant(s) to a higher financial remedy because it increases the duty of care and it makes the actions done in this context more unconscionable. To see prior vulnerability as a mitigating factor leads to an illogical conclusion: this would mean that someone of ordinary and normal fortitude coming to the Commission (which is highly unlikely in any event because most people who come to them are probably pretty vulnerable) would be entitled to a higher financial remedy or scales of injustice. This would be an irrational premise and the inverse should be the case: the greater the vulnerability, the greater the financial remedy. It is also a highly ableist and discriminatory.'

131. Our legislation requires us to assess the impact of failings and we cannot go further than that. We do not disagree with Miss A's comments that the vulnerability of a person may increase the injustice they have experienced. That is why we believe the Commission's failings in her case have affected her day-to-day life, whereas we may not decide that in a person who was less vulnerable or had less emotional investment in their concern.

132. However, just as we cannot ignore that a person with cancer cannot always attribute their cancer or prognosis to a clinical failing, and we can only seek a remedy for the additional distress or time lost, we cannot ignore that the Commission's actions were clearly an exacerbation of Miss A's poor mental health rather than the sole cause of it.

133. Mental health is complex and multifactorial and we cannot be precise in attributing part of it to maladministration. We appreciate different judgements may be reached.

134. However, for all the reasons above, we consider a level 4 injustice is in accordance with our guidance. Miss A has asked for the exact sum to remain confidential.

135. It is of note that the Commission believes this amount represents an indication that its decisions were categorically wrong. Our recommendation

here is not about the regulatory action that was or was not taken. Even if no more robust regulatory actions are justifiable in respect of either the Charity or the former Chair, the Commission's failings and the link from those to the impact Miss A claims are the only relevant considerations for us. Had the Commission been able to account for its decisions, whatever those were, and there was no other maladministration, we would not be linking impact at all.

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