From the Ombudsman Rebecca Hilsenrath

Parliamentary and Health Service Ombudsman

Simon Hoare MP, Chair of the Public Administration and Constitutional Affairs Committee
Sent by email only: pacac@parliament.uk

26 March 2025

Dear Chair,

In light of our joint objective for a closer working relationship between your Committee and PHSO, I am writing to update you about the compliance process regarding two reports we concluded about the Charity Commission last year.

These cases concerned the Commission's handling of complaints about serious safeguarding issues at two charities. We concluded, after a lengthy process, that the Commission had not complied with all our recommendations and wrote to inform them of our decision to lay the reports before Parliament. My office has now received a threat of legal challenge in relation to this. To my knowledge, this has never occurred before and it seems important I make you aware of this somewhat novel situation.

By way of background, PHSO investigated two complaints about the Commission's handling of concerns Miss A and Mr U raised regarding serious safeguarding issues at two different charities. Both investigations uncovered several failings, including around the Commission's decision making. In particular, we found failings in how it accounted for its decisions and in its communication with vulnerable complainants.

We issued the final reports to the Commission in March 2024. The Commission told us throughout our investigations and afterwards that it did not fully agree with our findings. It says it believes the majority of them do not fall within our jurisdiction. We disagree with this Commission's position. Nevertheless, in the interests of avoiding two publicly funded bodies spending taxpayer's money on litigation, we entered into mediation with them. It was agreed during this process that the Commission would attempt to comply with our recommendations.

We have given careful consideration to the steps the Commission has taken to implement the recommendations. We decided that, notwithstanding those steps, there remains an unremedied injustice to both complainants. I attach a copy of the letter we sent to the Commission setting this out.
As you will be aware, in cases of non-compliance, s.10(3) of the Parliamentary Commissioner Act 1967 provides us with powers to lay a special report in both Houses of Parliament. We

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have no enforcement powers. As you are aware, when we undertake investigations, we are doing so on behalf of Parliament. We decided, given the circumstances of the complaints relating to safeguarding and the position of the Commission, that it was appropriate to lay a special report.

When we wrote to the Commission to advise of this decision, it responded with a pre-action letter ahead of seeking permission for judicial review on the basis that my decision (both our letter of the 14 March 2025 and the decision which it embodies) is unlawful. I have attached a copy of that letter for the Committee's reference.

The Commission has previously indicated that it would seek a possible injunctive remedy and therefore we have paused the laying timetable to enable us to respond to the legal challenge in line with the pre-action protocol for judicial review. We do not wish to use public money to defend an emergency application.

We will of course keep the Committee informed as to our progress. We would welcome the opportunity to discuss the case in more detail and the role that the Committee may wish to play in holding organisations to account for non-compliance. This is an example of where a closer relationship between my office and the Committee and open dialogue about specific cases could help to ensure that public bodies respond to failures appropriately. I look forward to discussing this with you during our meeting on 8 May 2025 .

Yours sincerely,

Rebecca Hilsenrath
Ombudsman and Chair
Parliamentary and Health Service Ombudsman

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Parliamentary and Health Service Ombudsman

In Confidence
Mr David Holdsworth
Chief Executive Officer
cc Nick Baker, Chief Operating Officer
Charity Commission

By email

14 March 2025

Dear Mr Holdsworth,

I write further to the PHSO's reports issued on 28 March 2024 concerning Miss A and Mr U ("the reports") and to the subsequent communications and discussions regarding the reports and the Commission's proposals for implementing the recommendations made in the reports.

I have given careful consideration to the steps that the Commission has taken to implement the recommendations made in the reports. I have decided that, notwithstanding those steps, there remains in both cases unremedied injustice, and therefore the Ombudsman has decided that it is appropriate to lay a special report before both Houses of Parliament, pursuant to s. 10(3) of the Parliamentary Commissioner Act 1967. In each case, the special report will comprise the already published report and an addendum summarising my conclusions as to why there remains unremedied injustice. The two Forewords to accompany our reports are attached to this letter.

Miss A

In the case of Miss A, the report recommended as follows:

(1) The Commission apologises to Miss A.
(2) The Commission arranges an independent review of its handling of its communications with Miss A. The Commission should write to Miss A and to PHSO to share the findings of that review and explain if and how it intends to implement any recommendations arising from it.
(3) 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.

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(4) 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.

As you will recall, following a mediation between the PHSO and the Commission, there were limited amendments made to the recommendations and agreement was reached as to how the Commission would seek to implement the recommendations.

The third recommendation listed above was intended to deal with the following finding in the PHSO's report:

> *'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. PHSO has 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.'*

I have concluded that there remains unremedied injustice in relation to this conclusion, notwithstanding the Commission's actions in seeking to implement the third recommendation. That is for two reasons.

First, the review conducted by the Commission of its handling of Miss A's case does not explain how and why the Commission originally reached its conclusion as to the degree of risk raised by Miss A's complaint, stating merely that relevant regulatory options were appropriately considered and that it was necessary to infer the level of risk apprehended by the Commission as this was not explicitly recorded in any single document (§§37-38). It is necessary to refer to the reviewer's "Decision Log" in order to ascertain what were the reviewer's reasons for considering that the Commission's conclusions as to risk (whatever they were) were appropriate.

An important aspect of the remedying of injustice to Miss A was the communication of the outcome of the review of the Commission's handling of her case – that was explicitly agreed by the Commission as part of the terms of reference of the review. Whilst the Commission did communicate to Miss A the conclusions of the review, that document omitted a critical aspect of the reviewer's reasoning for upholding the Commission's actions. PHSO and the

Commission discussed Miss A's vulnerability and the Commission's intention to employ a barrister with safeguarding experience to assist the reviewer in their review and communications with Miss A. However, Miss A's vulnerability does not excuse the failure to communicate to Miss A in any form the reviewer's central reasons for upholding the Commission's risk assessment (whatever that was) which he said he had inferred. Nor does it excuse his choice to include those reasons in a "Decision Log" rather than in the document setting out the conclusions of the review that was sent to Miss A. There has, accordingly, been a failure on the part of the Commission to be open and accountable with Miss A regarding its reasons for not taking regulatory action against the Chair or the Charity.

Second, the critical reasoning of the reviewer to which I refer is to be found in §§15-16 of the Decision Log:

> *'15. As the allegations of rape as against [the Chair] had been dismissed and no findings were made in a civil claim as against him about those allegations, it is not the role of the Commission to determine the same. Therefore, these allegations cannot be held against him by the Commission now that the criminal investigation closed [sic].Therefore it is not open to the Commission to conclude misconduct or mismanagement on the basis of these unproven criminal allegations.*
>
> *16. [The Chair] admitted that he had an extra marital affair with a charity volunteer which he was a trustee [sic]. This could amount to misconduct or mismanagement in certain circumstances. As set out in para 13 above, I have considered all the recordings and messages provided by both parties and the impression I got from that was of a consensual relationship between 2 private adults.'*

I do not accept that this reasoning is an adequate and appropriate basis for upholding the Commission's original decision not to proceed further with regulatory action against the Chair or the Charity and more generally to close Miss A's case. It is not the case that the s. 181A Charities Act 2011 disqualification or other powers are dependent upon a criminal conviction; nor is it the case that it is simply not open to the Commission to conclude misconduct or management on the basis of allegations which have not been proven to the criminal standard. Given the small number of such cases that are ever investigated let alone prosecuted in the criminal justice system, that would represent a serious and unwarranted limitation on the scope of the s. 181A power.

Further, it was not reasonable for the reviewer to uphold the Commission's previous actions on the basis of his impression from a small number of recordings of phone calls that the interaction between a vulnerable volunteer and the Chair of the charity was consensual. There are well-known issues with apparent consent where interactions feature power imbalances and known trauma, of which the reviewer appears to have been unaware. Even if

the situation had been, in any sense, a consensual relationship, it involved a serious breach of trust by the Chair, as the Commission had previously recognised. The reviewer's only apparent engagement with that previous conclusion is in line 106 of Annex A to the Decision Log, where the reviewer appears to justify this on the grounds that "*evidenced regulatory concerns related to failings in structure and governance of charity rather than [the Chair's] or any other individual's behaviour*". There is no attempt to explain or justify why the serious breach of trust by the Chair was not regarded as an evidenced regulatory concern.

Mr U

In the case of Mr U, the report recommended that the Commission should:

(1) Look again at its risk assessments and regulatory decisions in Mr U's case. In particular it should:
- Look at the reasoning for its decision and consider whether those adequately account for the decision. The Commission's review should be done by someone from the Commission independent of the original investigation and PHSO's investigation.
- Having done that the Commission should determine whether the outcome in Mr U's case would have been any different.
- Involve person independent of the original case to look at the Commission's actions in this case and specifically at whether there is any learning in respect of how it assesses the risk of safeguarding incidents at charities and how it engages with people who may have been a victim of abuse.
- Consider whether its internal and external guidance on the assessment of risk is sufficient and coherent. The Commission should identify and act on any changes that need to be made.

(2) The Commission should write to Mr U to explain the outcome of its review and explain its decision in his individual case.

(3) The Commission should apologise to Mr U for the distress caused by its poor communication and its failure to account for its decisions.

Again, following a mediation between the PHSO and the Commission, there were limited amendments made to the recommendations and agreement was reached as to how the Commission would seek to implement the recommendations.

I am satisfied that the Commission has largely implemented the recommendations in Mr U's case. However, there are two respects in which I consider that there remains unremedied injustice in his case also.

First, whilst the document recording the outcome of the review, which was communicated to Mr U, does substantially explain the essential reasons of the reviewer for upholding the Commission's original decision-making, there are two important aspects of the reviewer's reasoning, as apparent from the Decision Log, which do not appear in the outcome document. In §11 of the Decision Log, the reviewer states as follows:

> "I have also specifically considered whether the changing safeguarding guidance and reporting requirements since 1993 should be taken into account under this heading. I note that the investigation did consider the developments in reporting since 1993 in the letter dated 29 January 2019 in which the officer state [sic] '*alleged abuse was first reported to SOMMF 25 years ago and there have been many developments in respect of reporting incidents since*'. I have also taken the changing guidance into account but in my assessment trustees are expected always to act in the charity and beneficiaries best interest, whether expressly required by law or not and should have been reported in 1993 and the obligation was a continuing one. The fact that it was not done at the time could amount to misconduct or mismanagement if established."

The reviewer here identified a serious error in the approach which the Commission had adopted to Mr U's complaint. It was at the heart of that complaint that the Charity had failed to report sexual abuse to the police or the Commission over a period of 25 years (whilst during the same period taking other actions which indicated a failure to take that abuse seriously). The reviewer has concluded that the Commission's central reasoning for not upholding Mr U's complaint regarding the non-reporting of abuse was erroneous. Yet that conclusion does not appear in his report. Rather, and somewhat misleadingly, the reviewer states in §25 that the case records "*show an assessment made within its discretion that further regulatory action was not necessary and appropriate in response to the apparent past failings of the Charity to communicate effectively and comply with relevant standards and duties*". The document recording the outcome of the review also fails to mention that the reviewer was critical of the Commission for not investigating the conduct of the Charity in holding a requiem mass for the abuser in 2011, long after it had become aware of his crimes. This was a potentially very serious instance of misconduct which was simply not investigated or taken into account by the Commission in its decision to close Mr U's case.

Both of these criticisms should have been reported to Mr U in proper discharge of the Commission's agreement to communicate the outcome of the review and explain its decision in his case.

Second, there is in my view further unremedied injustice in that the review has not properly grappled with the implications of the various errors which the Commission made when investigating Mr U's complaint. The outcome of that investigation, which was the closure of Mr U's case, is explained and justified as being "*reasonable and proportionate and within the*

Commission's discretion, based on all the relevant information available" (§20). The reviewer concludes (§31) that the Commission's decision to close the case was "*reasonable and proportionate, with evidence to show the most significant factors had been considered*". It is difficult to understand how the most significant factors had been considered in circumstances where the Commission had (according to the reviewer) erred in its assessment of the Charity's failure to report abuse and had erred in failing to consider the conduct of Charity in holding a requiem mass for the perpetrator. It also appears from §22 of the review outcome document that the Commission's reasoning in closing the case had failed to give sufficient weight to the interests of victims and beneficiaries.

Moreover, the reviewer was at certain points asking himself the wrong question, namely whether it would be proportionate to re-open an investigation into the Charity now, as opposed to whether the Commission's reasoning at the time of the case closure adequately accounted for its decision (see, for example, §22 of the decision log addressing the requiem mass issue).

In all the circumstances, I am not persuaded that the review has reached a reasonable conclusion on the question of whether the Commission's contemporaneous reasoning adequately accounted for its decision to close Mr U's case. Nor am I persuaded that the review has satisfactorily addressed the question of whether the outcome in Mr U's case would have been any different if the mistakes made by the Commission had not been made. There is no detailed analysis of, or consideration given to how the issues of proportionality should have appeared to the Commission if it had correctly directed itself on other important matters (including the failure to report, the requiem mass issue and the Commission's inappropriate focus on the reputation of the Charity). There are bare and somewhat opaque conclusions that further consideration of certain factors would not have "significantly" changed the outcome (§28), and further consideration of other factors would not have "materially" changed the outcome (§29). These conclusions are supported by a general endorsement of the proportionality of the Commission's decision (in §27) which again does not grapple with the mistakes made by the Commission in the assessment of proportionality which it apparently adopted when closing the case. I do not consider the reviewer's approach to be a robust and straightforward reckoning with the implications of the Commission's various failures for its contemporaneous reasoning in Mr U's case, as was in my view required if the recommendations in Mr U's case were to be properly implemented.

We intend to lay the special reports before Parliament week commencing the 24 March 2025.

Regards,

Karl Banister

Deputy Ombudsman and Director of Operations, Legal and Clinical