CHARITY COMMISSION
FOR ENGLAND AND WALES

Charity Inquiry

The Royal National Institute of Blind People

and

RNIB Charity

Chair’s foreword

There can be few more important roles for charities on our register than using expertise and professionalism to care for vulnerable people on behalf of the rest of society.

When charities provide such services for the State we expect these to be delivered with a degree of compassion, selflessness and empathy that private provision or the public sector cannot easily match.

It is precisely for this reason that such charities need to show they are making decisions for the right reasons, and with the right results. They must be motivated solely by their purpose and carefully consider the best interests of beneficiaries. Particularly as their operations expand and become more complex, they should be certain that whatever they do enhances the lives of those in their care.

No charity is more important than its purpose or the people it cares for. The following report should be read with this in mind.

The Rt Hon Baroness Stowell of Beeston MBE
Chair, Charity Commission for England and Wales

CHARITY COMMISSION
FOR ENGLAND AND WALES

A statement of the results of a class inquiry into:

The Royal National Institute of Blind People

Registered charity number 226227

and

RNIB Charity

Registered charity number 1156629

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Overview of the charities

1. The Royal National Institute of Blind People ("RNIB") was founded in 1868[1]. It registered with the Commission on 21 March 1963 and is governed by a Royal Charter dated 14 April 1949.

2. RNIB is one of the UK's leading sight loss charities. Its charitable objects, as set out in its Royal Charter, are *"to promote the better education, training, employment and welfare of blind and partially sighted people and generally to watch over and protect the interests of blind and partially sighted people and to prevent blindness."*

3. It undertakes its services and activities through a complex corporate group structure of charities and commercial trading companies ('the Group') which are 'subsidiary' to and subject to the overall control of RNIB.

4. At the time the statutory class inquiry opened in March 2018, 3 of the 'subsidiary' charities were principally responsible for delivering the charitable activities of the Group: RNIB Charity; Cardiff Institute for Blind People; and Bucks Vision. In addition, there was a related charity, RNIB Specialist Learning Trust which operated an academy.

5. The Group also includes 2 wholly owned trading subsidiaries; 2 inactive trading subsidiaries; 2 subsidiaries for its lotteries and raffles; 6 charities or special trusts holding permanent endowment and numerous shell charities.

6. RNIB's entry on the register of charities, and previous annual reports for RNIB and the Group can be found on the register of charities.

7. One of the subsidiary charities within the Group is known as RNIB Charity ("the subsidiary charity"). It was incorporated on 1 April 2014 and was registered as a charity on 10 April 2014. It is governed by memorandum and articles of association dated 1 April 2014.

8. Following a restructure of RNIB in 2014, the subsidiary charity was established in order to, among other things, take on the management of RNIB's regulated[2] services. There was a further restructure in April 2017 and it was intended that RNIB Charity would be wound up, and its functions transferred to RNIB. As a result, the board of RNIB Charity was reduced to 3 trustees, all of whom were also trustees of RNIB. At all times since incorporation, RNIB has been the only member of RNIB Charity. In practice RNIB was the ultimate controlling body of the subsidiary charity.

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[1] It was founded on 16 October 1868 as the British and Foreign Society for Improving the Embossed Literature of the Blind.

[2] In this report, "regulated services", "regulated establishments" and "regulated activities" refers to services, establishments and/or activities which are regulated by the Care Quality Commission, the Office for Standards in Education, Children's Services and Skills and/or the Care Inspectorate as the case may be.

9. In March 2018 RNIB through its group structure and the subsidiary charity operated a total of 18 regulated services in England and Scotland. These services included 2 schools, 1 sponsored academy, 1 college, 1 children's home, 5 care homes, 2 supported housing services, 3 supported living services, 2 day support and assessment centres, and 1 holiday scheme. These services were collectively regulated by the Care Quality Commission (CQC), the Office for Standards in Education, Children's Services and Skills (Ofsted) and the Care Inspectorate.

10. The RNIB group structure as at March 2018 is depicted below:

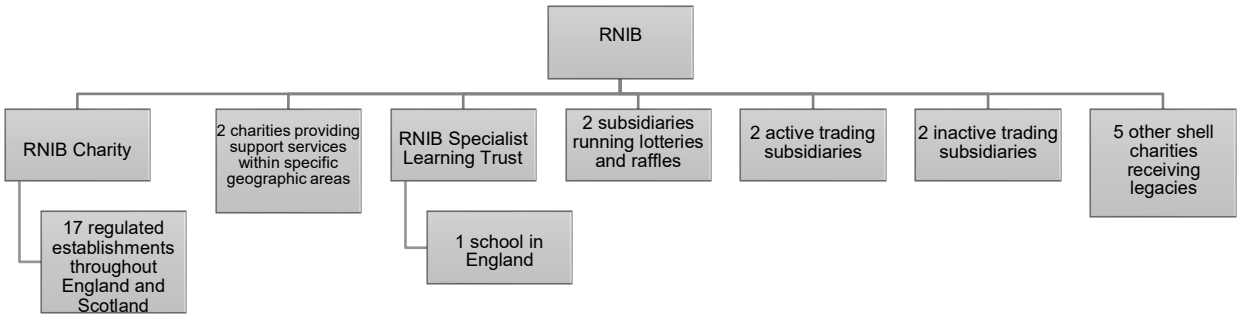

Figure 1: Depiction of RNIB group structure in March 2018.

11. The subsidiary charity's entry can be found on the register of charities.

12. RNIB and the subsidiary charity are also collectively referred to in this report as 'the charities'.

The RNIB Pears Centre for Specialist Learning

13. The RNIB Pears Centre for Specialist Learning ("RNIB Pears Centre") comprised of a school and children's home, replacing the RNIB Rushton School and Children's Home that was located nearby. It was able to accommodate 30 residential and 10 day students. In March 2018, when this inquiry opened, it catered for 17 residential and 8 day students. The school and children's home were registered with Ofsted. In addition, the RNIB Pears Centre also provided accommodation for children with highly complex healthcare needs on site, at bungalow 5. Bungalow 5 was registered with both Ofsted and the CQC.

14. Work on replacing the RNIB Rushton School and Children's Home began in 2004. In March 2006, the RNIB Board agreed to proceed with the development of what became the RNIB Pears Centre. It opened in November 2011 and closed on 7 November 2018.

15. During its lifetime, the RNIB Pears Centre provided care and education to a total of 57 visually impaired children and young persons with complex learning and physical needs, the majority of whom were residents of the RNIB Pears Centre.

Background to the opening of the statutory class inquiry

16. The opening of the class inquiry was subsequent to two reports of serious incidents ("RSI") submitted to the Commission by the subsidiary charity:

    a. an RSI dated 2 March 2018 relating to a safeguarding incident which took place on 20 February 2018 at the RNIB Pears Centre; and

    b. an RSI dated 16 March 2018 in which the Commission was informed that Ofsted had issued a notice of intention to cancel the registration of the RNIB Pears Centre children's home facility.

17. Ofsted's 9 March 2018 letter to RNIB outlined a series of incidents and repeated regulatory breaches relating to, among other things, medication errors and deficient safeguarding practices dating back to 2015. This is covered in further detail in the Findings section of the inquiry report under "RNIB Pears Centre", at paragraph 47.

18. The Commission received no correspondence or RSIs from the charities in relation to these matters prior to March 2018.

19. The Commission immediately contacted RNIB on receipt of these RSIs and requested further information. It also met with the Chair and Deputy CEO of RNIB on 27 March 2018.

20. The information supplied by the charities raised regulatory concerns about systemic failures in the governance and oversight of safeguarding matters in RNIB and the RNIB group. In summary the Commission's regulatory concerns at that time fell into 3 main areas:

    a. The risk to beneficiaries arising from the oversight and management of safeguarding arrangements at the RNIB Pears Centre.
    b. RNIB's governance and oversight of safeguarding in particular in respect of regulated activities.
    c. The reporting of serious safeguarding incidents by the charities to the Commission and other relevant agencies.

21. As a result of these regulatory concerns the Commission opened a statutory class inquiry into the charities under section 46 of the Charities Act 2011 on 29 March 2018.

22. Around the time of the opening of the inquiry, RNIB's then CEO stepped aside from the role. Following the opening of the inquiry, several RNIB Group trustees also subsequently stepped down. The inquiry closed with the publication of this report.

Issues under Investigation

23. In order to address the regulatory concerns identified above the scope of the class inquiry was originally set out as follows:

    a. The extent to which the trustees of the charities have taken and are taking reasonable steps to protect beneficiaries at the RNIB Pears Centre from harm.

    b. The sufficiency of the governance, oversight and management of the charities' safeguarding arrangements, including liaison with and reporting to relevant statutory agencies, and in particular in respect of the RNIB Pears Centre and with regard to the provision of regulated activities to vulnerable or high-risk beneficiaries.

    c. The extent to which all relevant safeguarding incidents since 1 January 2015 have been reported to the Commission in accordance with its serious incident reporting criteria applicable from time to time.

24. The trustees of the charities were advised at the opening of the inquiry that the scope could be extended or varied if additional regulatory issues emerged.

25. Following the closure of the RNIB Pears Centre, the inquiry's scope was expanded on 16 November 2018 to include, in respect of the RNIB Pears Centre, an assessment of:

    a. The likely or actual extent of any losses which will be incurred by the charities;

    b. The impact on the charities' finances; and

    c. The trustees' financial management and decision making and the extent to which they discharged their legal duties under charity law.

26. Material obtained during the course of the inquiry, including the emerging findings from an independent review conducted by Hugh Davies QC (see next section for further details) raised additional regulatory concerns in relation to RNIB's broader governance, board assurance and board decision making. As a result, following a meeting with RNIB on 12 March 2019, the Commission

formally notified RNIB's chair on 22 March 2019 of a further variation to the scope of the inquiry which was extended to consider:

"The sufficiency of the current governance and oversight of RNIB, in particular trustee decision making, safeguarding, risk management, assurance, and regulatory and legal compliance."

The conduct of the inquiry

27. Shortly before the opening of the statutory inquiry, RNIB had decided to commission a review into safeguarding arrangements at RNIB and in particular the RNIB Pears Centre.

28. Following the opening of the inquiry the Commission engaged with RNIB to enable the inquiry to directly supervise the review process and to ensure its independence from the charity. As a result, the Commission required that it had approval over:

    a. The scope and the terms of reference of the independent review;
    b. The selection of a suitably qualified reviewer; and
    c. The methodology of the review

29. The appointment of Hugh Davies QC to lead an independent review ("the Independent Review") was approved by the inquiry in June 2018. The Independent Review considered the following matters:

    a. The suitability of RNIB's processes for reporting safeguarding issues.

    b. The suitability of processes for monitoring safeguarding and other regulatory compliance within its regulated services and centrally.

    c. The culture around compliance within RNIB's regulated services.

    d. The extent to which remediation plans were adequate and delivered effectively.

    e. The adequacy of the speed at which serious issues were appropriately escalated.

    f. In relation to the RNIB Pears Centre,

        i. The adequacy of leadership, oversight and governance actions.

        ii. The appropriateness of the response to regulators and the manner and timeliness of such responses.

iii. The information and facts known and understood by key staff and trustees, how this was formally reported and escalated and whether appropriate mechanisms were used.

iv. Whether further and better information could reasonably have been obtained and the factors that prevented this from happening.

30. The Commission regularly engaged with the Chair of the Independent Review from its inception to its conclusion in April 2019.

31. The findings from the Independent Review resulted in the Commission expanding the scope of its statutory inquiry. In order to address further concerns arising from the Independent Review report, RNIB subsequently appointed Campbell Tickell and Girling Hughes Associates to, respectively, review RNIB's Governance systems ("the Governance Review"), and review and investigate safeguarding shortfalls and concerns ("the Safeguarding Review") that have come to light during the Independent Review.

32. The Commission approved the appointments of Campbell Tickell and Girling Hughes Associates, the terms of reference of the reviews and the review methodologies. The Commission engaged independently with the reviewers throughout.

33. The Governance Review examined the following areas:

    a. Overall governance structure

    b. Board composition

    c. Membership

    d. Board effectiveness

    e. Whether the Charity's governance arrangements were in accordance with the Charity Governance Code and the NCVO's ethical principles.

34. The Safeguarding Review's terms of reference included:

    a. To review:

        i. All safeguarding concerns, cases and disciplinary investigations at the RNIB Pears Centre from 2012 – 2019, ensuring that the appropriate referrals were made to regulators.

        ii. Safeguarding practices and risk management and all safeguarding concerns, cases and disciplinary investigations at two other RNIB

regulated establishments from 2015 – 2019, ensuring that the appropriate referrals were made to regulators.

iii. Safeguarding practices and risk management at a further two RNIB regulated establishments.

iv. All safeguarding complaints that have arisen during the Independent Review.

b. To provide the Commission with assurances about RNIB's prevailing recruitment processes and the implementation of RNIB's Safeguarding Improvement Plan relating to recruitment to RNIB's regulated services.

35. Although the Commission is not bound by the findings of these reviews, it has taken into account their findings and recommendations.

36. The regulatory difficulties at the RNIB Pears Centre, including the proposals by Ofsted to cancel the establishment's registration, led to two of RNIB's institutional creditors to consider that events of default had taken place. These technical events of default enabled the creditors to declare all amounts outstanding, some £21 million, immediately due and payable[3]. RNIB was not in a position to immediately repay that amount and would have been forced to take emergency refinancing measures had the debts been called in. Following a period of negotiation, the creditors sought additional security from RNIB in November 2018 in order that their rights in respect of the events of default be waived. As a result, in accordance with legal advice received, RNIB made an application on 13 November 2018 to the Commission seeking an order under section 124 of the Charities Act 2011 ("Section 124 Order") to approve the placing of charges on RNIB's premises at Judd Street, London, in favour of the creditors.

37. Given the severity of the financial impact of the regulatory difficulties at the RNIB Pears Centre, on 16 November 2018, the Commission expanded the scope of the inquiry to include an examination of the trustees' financial management and decision making, and the financial impact of the RNIB Pears Centre on the charities, as outlined above at paragraph 25.

38. Given the circumstances, the Commission immediately engaged with RNIB to consider its application and, on 19 November 2018, issued a section 124 Order, allowing additional security to be provided in favour of the creditors for the duration of the creditors' respective loans. As a result, on 18 December 2018, both creditors waived their rights in respect of the events of default.

[3] One of the technical events of default related to a loan facility which had not been drawn upon.

39. Concurrent with the conduct of the Governance Review and the Safeguarding Review, in response to the findings of the Hugh Davies QC Review and the Commission's own investigation into the trustees' financial management and decision making in respect of the RNIB Pears Centre, and the financial impact of the RNIB Pears Centre on the charities, the Commission issued an Official Warning to RNIB on 5 August 2019 ("the Official Warning") on the grounds that:

    a. RNIB failed to ensure adequate and effective governance, leadership, oversight and scrutiny, placing the Charity's assets and beneficiaries at undue risk.

    b. Between 2015 and 2018, in respect of the RNIB Pears Centre, RNIB repeatedly breached the regulations set out in The Children's Homes (England) Regulations 2015 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

    c. RNIB failed to ensure suitable processes were in place for monitoring safeguarding and other regulatory compliance.

    d. RNIB failed to ensure that RNIB's regulated establishments had appropriate systems in place for recording, reporting and escalating serious incidents, including complaints.

    e. RNIB failed to ensure that the RNIB Pears Centre had in place effective local leadership, governance and oversight.

    f. RNIB failed, with respect to the RNIB Pears Centre, to ensure effective responses to regulatory interventions by Ofsted and the CQC, in particular between 2015 and 2018.

40. On the same day, the Commission issued an order to RNIB under section 84 of the Charities Act 2011 ("the Section 84 Order") mandating that RNIB produce an action plan ("the Action Plan") addressing the recommendations and issues arising from the Independent Review, the Governance Review and the Safeguarding Review. Between August and October 2019, the Commission met with the Chair and Interim CEO of RNIB several times to discuss and provide feedback on the drafting of the Action Plan. On 10 October 2019, the Action Plan was approved by the Commission. The Commission took the decision to defer publication of the Official Warning until after the conclusion of the inquiry. This deferment:

    a. Enabled RNIB to develop proposals for the orderly transfer of RNIB's care homes, schools and colleges to new specialist providers.

b. Allowed RNIB to prepare a communications plan for staff, beneficiaries and other stakeholders, helping to ensure the ongoing stability of the services.

c. Helped ensure a stable transition for staff and beneficiaries.

41. Further, following the conclusion of the Independent Review, serious regulatory concerns had arisen about the governance of RNIB, in particular that the board suffered from a skills deficit in relation to, among other things, safeguarding. The Commission required RNIB to take immediate steps to strengthen its trustee board. RNIB undertook a recruitment exercise to recruit trustees with the relevant skill sets and experience. Of the 4 prospective trustees selected through an open recruitment process, only 1 was visually impaired. RNIB was prevented by its constitution from appointing the 3 other prospective trustees onto the board since RNIB's governing document required that at least 75% of trustees must be blind or partially sighted, and their appointments would have breached that requirement.

42. In July 2019, RNIB therefore made an application to the Commission under section 105 of the Charities Act 2011, asking the Commission to authorise the appointments of the prospective trustees.

43. On 14 August 2019, in order to support RNIB in strengthening its governance and safeguarding capacity at a time of significant organisational change, the Commission exercised its powers under section 105 of the Charities Act 2011 to authorise the appointments of the 3 non visually impaired trustees for a period of 16 months.

44. The inquiry periodically met with RNIB to review its progress against the Action Plan and review work. In October 2019, in response to the emerging findings of the Safeguarding Review, the Commission engaged with Girling Hughes Associates and RNIB in order to ensure that RNIB took the necessary immediate actions to address shortfalls identified in areas such as agency staff recruitment, induction and training, improvements to RNIB's new case management systems and ongoing central supervision of regulated services. Actions, timelines and success measures were agreed, resulting in RNIB strengthening its regulated activity estate internal audit regime, and an expansion of Girling Hughes' independent review of RNIB's regulated activity estate.

45. RNIB publicly announced in November 2019 they were transferring their regulated older people's care homes and education establishments to other providers. RNIB explained at the time in a press release that this was so they could focus on supporting more people with sight loss. Prior to the announcement, the inquiry discussed with RNIB the transfer programme and its communications plan.

Findings

RNIB Pears Centre

46. The inquiry found that the charities' failure to address shortcomings identified in regulatory inspections dated back to at least 2015 and these failures led to the RNIB Pears Centre being placed in special measures by both Ofsted and the CQC between 2017 and 2018.

47. The charities' failures in this respect are set out in the Notices of Proposal (NOP) by Ofsted to cancel the RNIB Pears Centre children's home registration, dated 9 March 2018 and 26 July 2018 respectively, and CQC's May 2018 and August 2018 inspection reports. The failures identified by Ofsted included the following:

    a. Repeated failures to meet regulatory standards in relation to ensuring adequate and appropriately trained and qualified staff at the RNIB Pears Centre.

    b. Repeated failures in relation to the behaviour management of beneficiaries.

    c. Repeated failures to record incidents of physical restraint.

    d. Repeated failures to ensure effective safeguarding processes and procedures.

    e. Persistent serious medication errors.

    f. Repeated failures in relation to management oversight of staff and processes.

48. Ofsted found that these and other failures constituted breaches of the regulations set out in The Children's Homes (England) Regulations 2015.

49. The failures identified by CQC included the following:

    a. Failure to ensure staff were appropriately trained in safeguarding.

b. Failure to put in place systems for the safe usage of medical and care equipment.

c. Failure to ensure safeguarding concerns were consistently investigated and reported to the appropriate bodies.

d. Failure to ensure adequate and appropriately qualified staff to support children and young people's needs.

e. Failure to ensure appropriate processes and procedures surrounding obtaining and recording consent.

50. The CQC found that these and other failures constituted breaches of regulations 9, 10, 12, 13, 17, 18 and 20A of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and in consequence, on 5 April 2018, imposed conditions on the RNIB Pears Centre's CQC registration.

51. Following receipt of Ofsted's NOP, the inquiry found that RNIB directed considerable resources to address the shortcomings identified by the regulators, however this was insufficient to attain the required standards of care.

52. The Independent Review found that children at the RNIB Pears Centre had needs and disabilities so complex that in some cases, a placement at the RNIB Pears Centre was an alternative to a hospital stay. Delivery of the standard of care required at the RNIB Pears Centre required staff and management to be receptive to external input, strong management and regular independent superintendence of management. The Independent Review concluded these were deficient.

53. The Independent Review also found:

a. There was no adequate risk/audit inspection function that reported centrally within RNIB.

b. A culture that was too insular and dismissive of external criticism from Ofsted, CQC and parents, and was too focussed on narrow regulatory compliance.

c. The RNIB Pears Centre operated with too much autonomy from RNIB.

d. A restructuring in 2017 resulted in the loss of key clinical staff, eroded management capacity, and compromised the ability of RNIB to effectively respond to events.

e. There was a disproportionately high number of basic medication errors, despite repeated training provided to staff on the procedures.

f. Staff training was poor, including in relation to safeguarding, and local leadership was shown to have failed at every level.

g. The safeguarding and complaints case management systems to be unsuitable.

h. A lack of coordination, trust and respect between the teams at the RNIB Pears Centre school and the care home.

i. Local and board oversight was deficient; the RNIB board failed to react adequately to successive Ofsted reports until the first Ofsted NOP in March 2018.

54. The Independent Review concluded that as a result, poor practices became entrenched and standards of delivery declined. The Independent Review outlined that by March 2018, when Ofsted issued its first NOP, the RNIB Pears Centre *"had reached a level of dysfunction such that it is unlikely it could have taken effective steps to remediate"* and deliver the improvements needed to bring itself back into regulatory compliance resulting in RNIB closing the RNIB Pears Centre in November 2018.

55. The inquiry examined the impact of the closure of the RNIB Pears Centre on RNIB.

56. As outlined in more detail above at paragraph 36, the inquiry found that the regulatory difficulties at the RNIB Pears Centre led to RNIB placing a charge on its premises at Judd Street, London, in favour of its creditors.

57. The inquiry reviewed board meeting minutes and material relating to attempts by RNIB to dispose of the RNIB Pears Centre, and found that the RNIB Pears Centre's regulatory difficulties in 2017 and 2018 led to the cost of borrowing increasing by approximately £100,000 a year from May 2018 onwards, and the regulatory difficulties made the transfer of the RNIB Pears Centre as a going concern a less attractive proposition to potential buyers. The direct costs of closure amounted to £0.61 million. The RNIB Pears Centre was ultimately sold with vacant possession for approximately £10 million in December 2019.

58. The RNIB Pears Centre, largely funded by borrowing, cost £26.6 million to develop, including the cost of the land on which it sits.

59. During its lifetime, the RNIB Pears Centre had a cumulative operating deficit of approximately £13.5 million, including £8.4 million in loan interest.

60. After accounting for the direct costs of closure, the total cost of the RNIB Pears Centre to RNIB is therefore estimated to be £30.71 million[4].

61. During the course of the Independent Review, complaints were made by the families of 4 children who had been placed at the RNIB Pears Centre, all of whom had learning difficulties and could not easily communicate their needs verbally.

62. These complaints were referred to the Safeguarding Review, which was established to address some of the concerns raised by the Independent Review. The Safeguarding Review highlighted a selection of incidents in their report, and told the inquiry that, among other things:

    a. It considered that RNIB's investigation and initial actions in respect of a complaint by a family about marks on their child were flawed and inadequate, and the records the Safeguarding Review have seen demonstrated a non-compliance with expected procedures, including those set out in the Working Together to Safeguard Children Guidance[5], where a child has an unexplained injury whilst in the care of people in positions of trust.

    b. When a parent complained that the temperature of the bathwater for their child was too hot, at 41°C, they were told that this was normal practice. This was a safeguarding issue and the matter was taken up by the child's social worker. The child's pocket money was also used to purchase a thermometer. The Safeguarding Review concluded from records they have seen that the complaint was substantiated and the child's pocket money should not have been used to purchase a thermometer. The Safeguarding Review told the Commission it considers the child's care plans to demonstrate poor record keeping since the safeguarding review was unable to discern when specific changes to the care plans were made.

        In relation to the same child, on a separate occasion, another RNIB Pears Centre staff member told the parent that there was no record of any accidents against their child when the parent had complained during a visit about their child sustaining sunburn, despite the sunburn being recorded

[4] Made up of £26.6 million development cost, £13.5 million lifetime operating deficit (including loan interest), and £0.61 million direct closure costs, less £10 million sale price.
[5] This is statutory guidance on inter-agency working to safeguard and promote the welfare of children.

on the child's records just days before. The parent had previously not been told of the injury.

The Safeguarding review also told the inquiry that in their view there was a failure to adequately communicate with parents about difficulties in managing a surgically inserted medical apparatus and the continued viability of that apparatus.

c. There was a delay of at least 3 months in obtaining new boots for a child who sustained injuries caused by boots that were too small. The Safeguarding Review pointed to 17 body maps documenting injuries to the child's feet.

d. In relation to another child, a parent told the Safeguarding Review that a change in prescribed medication following a medical appointment resulted in the child suffering an increase in epileptic fits. The child's parent, who would normally have accompanied the child to medical appointments, had not been told of the appointment. Had the parent been present, they would have been able to tell the doctor the medication had previously been tried and had made their child's epilepsy worse. The Safeguarding Review concluded that this was a failure of process and partnership working with the parents.

Separately, the Safeguarding Review reported to the inquiry that the parent had told them their child's medication records appear to be unclear as to the correct dosage of medication to be administered in case of a medical emergency; this had to be clarified with the GP when the child had a prolonged bout of seizure. The Safeguarding review concluded that this was a process failure on a number of levels including poor communication, medicine management, interface with the GP, parents, school and home staff affecting children's care.

e. Children at the RNIB Pears Centre were at times under supervised as measured against their care plans and/or assessed needs, and thereby exposed to risk of harm. The Safeguarding Review told the inquiry that at least in relation to one child, a lack of resources may have led to a cycle of deteriorating behaviour, impacting on the child's welfare.

63. The Safeguarding Review concluded that, "…The interviews with parents and the review of the corresponding data highlighted a number of difficulties at all levels across the [RNIB] Pears Centre. Lack of oversight and interim management arrangements of staff and services allowed a working practice to develop that was not child centred. Staff appeared to work in isolation with

inadequate training, support or resources to fulfil the requirements of their role and importantly the requirements of the Care Plans for extremely vulnerable children with complex needs. Systems did not support practice, record keeping was poor, training inadequate and compounded by an over reliance upon temporary staff many of which were not trained to the required standard for residential childcare staff."

64. In a letter to the Commission in January 2020, RNIB is clear that they do not dispute "the strength of feelings of these families… and sincerely regrets and apologises for the distress caused".

65. RNIB also told the inquiry that they have sought to be supportive and transparent with the parents of children at the RNIB Pears Centre:

    a. When the first Ofsted NOP was issued, their then CEO telephoned and wrote to all parents about the matter and kept the parents updated about subsequent events.

    b. When the RNIB Pears Centre closed, RNIB worked with each family to ensure that individual transition needs were met.

    c. Shortly after the Safeguarding Review was concluded, the CEO of RNIB contacted the families who had come forward to engage with the Independent Review to update them about the inquiry; RNIB felt that it had to step back from communicating with the families during the Independent Review and the Safeguarding Review so as not to prejudice the reviews. .

66. RNIB told the inquiry that they were truly sorry for the previous failings at the RNIB Pears Centre, and RNIB will make contact with families affected by the events at the RNIB Pears Centre once this inquiry is concluded to apologise and offer support.

67. Following their investigation of the parental complaints, the Safeguarding Review recommended that RNIB ensured:

    a. Robust communication between RNIB and family members of beneficiaries, and consider adding communication between RNIB and family members to the Safeguarding Quality Assurance Framework, and

    b. Maintenance of training records.

68. The Safeguarding Review, corroborating much of the deficiencies highlighted by the Independent Review, concluded that overall, among other things:

a. Management oversight of care at the RNIB Pears Centre was inadequate, including in relation to incidents and concerns raised, allowing the development of working practices which were not child centred.

b. There was a lack of coordination between the school and care home.

c. Record keeping at the RNIB Pears Centre was poor.

d. The RNIB Pears Centre was not always able to meet the assessed needs of children.

e. Training for staff was inadequate, an issue compounded by an over reliance on agency staff. This was exacerbated by weaknesses in recruitment practices in relation to pre-employment checks.

f. Record keeping and the procedure for administration of medication was poor.

69. In light of the above, the inquiry found that, in relation to the RNIB Pears Centre:

a. Between 2015 and 2018, RNIB failed repeatedly to ensure the RNIB Pears Centre operated in compliance with the regulations set out in The Children's Homes (England) Regulations 2015 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

b. RNIB failed to ensure that the RNIB Pears Centre had in place effective local leadership, governance and oversight.

c. RNIB failed, with respect to the RNIB Pears Centre, to ensure effective responses to regulatory interventions by Ofsted and the CQC, in particular between 2015 and 2018.

70. The inquiry considers the failings outlined above to constitute evidence of misconduct and/or mismanagement.

Safeguarding management across the RNIB establishments

71. The Independent Review found that there was a high degree of autonomy given to the charities' regulated establishments. As a result, the Independent Review considered that RNIB had a difficult relationship with its regulated establishments reflected in difficulties accessing and obtaining data on and reports from its regulated establishments, and requests for information were not always complied with.

72. The Independent Review also considered that there was an over-dependence on regulatory inspections. The Independent Review found that insufficient central scrutiny was given to regulatory inspection reports beyond the headline ratings, and central supervision was too high-level.

73. The Independent Review found that there was no functioning centralised data management system used by the charities across their regulated activity estate to report and record safeguarding concerns.

74. The Independent Review told the inquiry that at least between 2009 and 2018, in relation to safeguarding and the charities' regulated establishments, there was a spine of responsibility as between *"[senior managers], the variously styled committees, responsible executive and the trustee board wherein no single person had direct qualifying experience"* of regulated establishments catering to children and/or adults with complex needs.

75. The Independent Review found that these deficiencies were not identified and concluded there were systemic failures in the charities' recruitment and training practices.

76. Further, the Independent Review outlined that during a restructure in April 2017 RNIB failed to properly manage its process for appointing staff into key roles across its regulated activity estate, resulting in unqualified staff being appointed to key roles.

77. The Independent Review concluded that the quality of service within the charities' regulated establishments was a product of local management rather than centrally directed.

78. RNIB has taken steps to improve its management of safeguarding, since its Safeguarding Improvement Plan was initiated in April 2018. These included:

    a. Recruiting a new interim Director of Care, Education and Safeguarding in June 2018.

    b. Creating and appointing into role a new Head of Safeguarding.

    c. Creating a new safeguarding team structure.

    d. Creating new Safeguarding Policy and Practice Guidance.

    e. Putting all staff through newly created mandatory safeguarding training.

    f. Putting all trustees through mandatory safeguarding training.

g. Implementing a new case management system, procured off the shelf, which has been subject to ongoing improvements and customisations to cater for RNIB's needs.

79. RNIB also reviewed and strengthened its internal reporting protocols, with monthly reporting of Safeguarding cases to the Head of Safeguarding who in turn provides monthly reporting to RNIB's Executive Leadership Team. The Regulated Services and Safeguarding Committee, the committee responsible for oversight of safeguarding, receives reports every two months, and the Board, every quarter.

80. The Independent Review examined some of RNIB's progress to improve its Safeguarding management, between April 2018 and February 2019.

81. The review told the inquiry that RNIB's new Safeguarding Policy and Practice Guidance is a good example of its type, and described the various improvements made to RNIB's safeguarding processes, including the creation of a "clearly defined" hierarchy of accountability for safeguarding concerns, a new centralised safeguarding function and a new case management group with independent expertise as welcome developments. The implementation of RNIB's new case management system, then unprocured, was seen by the Independent Review as central to the delivery of safeguarding improvements, as were appointing into role the various new safeguarding positions.

82. As outlined earlier in the report a Safeguarding Review was mobilised to follow up on some of the specific concerns about safeguarding management raised by the Independent Review.

83. The Safeguarding Review found in 2019 that improvements to safeguarding management had been made in RNIB's establishments. In 3 out of the 4 RNIB establishments visited the reviewers found strong safeguarding processes in place and a good understanding of how to keep children and adults at risk safe from harm. It also found that staff on those 3 sites worked closely with other professionals and engaged with a wide range of support from various sources as part of their safeguarding work. Overall the Safeguarding Review had confidence that RNIB and RNIB's newly appointed CEO will continue to prioritise safeguarding management appropriately. However, the Safeguarding Review found some fragility in aspects of RNIB's safeguarding arrangements. This included evidence that quality and consistency of safeguarding management was too dependent in some areas on local management, for instance:

a. There was no consistent use of the RNIB Professional Code of Behaviour and staff induction documentation across RNIB's regulated activity estate.

b. The Safeguarding Review found "significant gaps" in relation to safeguarding at the 4th establishment which it visited, in relation to, among other matters, record keeping, recruitment processes and use of agency staff.

84. The Safeguarding Review also reviewed a dip sample of recruitment records dated between 31 August 2018 and 31 August 2019. It found a high degree of compliance with safer recruitment practices and concluded that although safer recruitment practices were being used, accurate centrally held records were not being kept, and a reliance on local establishments to maintain records and comply with recruitment checklists placed RNIB at risk of having unsuitable staff within its services.

85. Additionally, the Safeguarding Review found that some policies supplied by RNIB centrally to be out of date.

86. As a result of the deficiencies identified by these visits, as outlined above at paragraph 44, the Commission engaged with RNIB in order that immediate actions were taken to address shortfalls identified and embed further safeguarding improvements within its regulated activity estate.

87. RNIB has also, in response to the emerging findings of the Safeguarding Review, strengthened its safeguarding audit regime in order that safeguarding improvements are more consistently embedded within its services.

88. A number of recommendations have been made by the Safeguarding Review to build on the work already undertaken by RNIB. These have been incorporated into the Action Plan being monitored by the Commission.

89. The inquiry found that at least between 2015 and April 2018 there were systemic shortcomings in safeguarding management across RNIB's regulated activity estate, which included but were not limited to:

a. Failing to ensure suitable processes were in place for supervising and monitoring the adequacy of safeguarding arrangements across the estate

b. Material shortcomings in RNIB's safeguarding related recruitment and training practices.

90. Further, the inquiry found that RNIB's April 2017 restructure exacerbated these systemic shortcomings within RNIB.

91. The inquiry considers these shortcomings, together with the governance shortcomings over the same period, placed some of RNIB's beneficiaries at undue risk. The inquiry considers that the failings identified above to constitute evidence of misconduct and/or mismanagement in the administration of a charity.

92. The inquiry acknowledges the improvements that RNIB has made to the management of its safeguarding arrangements since April 2018. Some further work remains to be done to address the recommendations from the Safeguarding Review and these will be monitored by the Commission following the conclusion of the inquiry.

Serious/Notifiable safeguarding incident reporting

93. RNIB's regulatory difficulties in respect of the RNIB Pears Centre, outlined earlier in this report, were not reported to the Charity Commission until 16 March 2018, after Ofsted issued the first NOP.

94. The regulatory difficulties at the RNIB Pears Centre, and the opening of the Commission's inquiry, prompted RNIB to conduct an internal audit of safeguarding incidents going back to 2017. This resulted in RNIB, in June 2018, reporting to the Commission 26 previously unreported serious safeguarding incidents across a number of its regulated services dating from April 2017 to May 2018.

95. The Safeguarding Review examined safeguarding, medical and complaint records at the RNIB Pears Centre up to its closure in 2018 and found that there were inconsistencies in the manner in which incidents were recorded and the quality of recording was poor. Overall, the Safeguarding Review found a lack of management oversight of the quality of record keeping. The Safeguarding Review concluded that this risked information being lost, particularly information pertaining to specific individuals, did not allow for themes to be identified and contributed to beneficiaries at the RNIB Pears Centre being placed at risk.

96. The Safeguarding Review also examined incident reporting at 2 of RNIB's other regulated establishments between 2015 and 2018. The Safeguarding Review told the inquiry it found a "significant number" of cases at the services which should be considered for referral to the various regulators including, at the RNIB Pears Centre, 28 cases to the Disclosure and Barring Service (DBS). RNIB subsequently reviewed these cases the outcome of which is set out at paragraph 103.

97. The Safeguarding Review told the inquiry that prior to the introduction of a centralised system of reporting in 2019 and the implementation of a new case management system, incident records were maintained locally, and due to the poor standard of record keeping, it has not been practical for the Safeguarding Review to align the charities' records against data obtained from the Charity Commission, Ofsted and CQC. They have therefore been unable to determine definitively how many cases had not been referred to the appropriate regulators.

98. The Safeguarding Review told the Commission that the current practice of collating incidents centrally before a decision is made on reporting to the various regulators is an improvement from the previous system.

99. The creation of a central function to collate and make decisions on next steps for all safeguarding concerns was also recognised by the Independent Review as good practice.

100. In light of the above, the inquiry found that between 2015 and 2018, RNIB failed to ensure that its regulated establishments had appropriate corporate systems in place for the recording, reporting, escalating and management of safeguarding incidents, allegations and/or complaints/concerns. It is the inquiry's view that these shortcomings are more likely than not to have resulted in failures to report notifiable incidents of concern to statutory bodies in accordance with statutory and good practice guidance. Furthermore, the inquiry considers that these systemic inadequacies raised a heightened risk that some incidents were not appropriately managed, which may have allowed some employees or ex-employees to cause further potential harm to RNIB's beneficiaries or others outside of the charity.

101. The inquiry considers these shortcomings, together with the other shortcomings in RNIB's safeguarding management and governance over the same period, placed some of RNIB's beneficiaries at undue risk of harm and that these failings constitute evidence of misconduct and/or mismanagement in the administration of a charity.

102. RNIB have reported to the inquiry that they appointed a safeguarding consultant in January 2020 who is a qualified social worker to review the historical safeguarding incidents identified by the Safeguarding Review as requiring further reconsideration, and work with third party agencies to make the necessary referrals, including DBS referrals.

103. RNIB told the inquiry that the safeguarding consultant has reviewed the 28 cases the Safeguarding Review identified for consideration of a DBS referral.

Of these cases, it has referred 5 cases to DBS. 2 further cases are still being reviewed at the time of writing of this report.

Governance and trustee oversight of safeguarding and regulated establishments

104. The inquiry found that RNIB's oversight of regulated establishments was delegated to second-tier governance bodies such as committees and steering groups chaired by or whose membership included RNIB Board members which has continually evolved over the past 10 or more years. The inquiry therefore focussed its scrutiny of governance arrangements from 2014 onwards.

105. The RNIB Places Board was responsible for oversight of safeguarding between July 2014 and April 2017. The Independent Review described the Places Board as wholly ineffective. It concluded that the Places Board lacked safeguarding expertise, a criticism it also levelled at the other second tier governance bodies.

106. The Independent Review found that the Places Board's scrutiny of regulated establishments was focussed on quantitative measures and on compliance, and this, together with the related corporate culture of reporting by exception to the board and the lack of expertise on the board, led to the Places Board having only "superficial" scrutiny over the establishments.

107. Between April 2017 and March 2018, the Services Steering Group (SSG) replaced the Places Board. During its tenure, it met only two times: on 14 September 2017 and on 1 February 2018.

108. Therefore, given the Places Board last met on 3 November 2016, for a period of 10 months, there was no second-tier governance meeting directed at the charities' services or regulated establishments. In the inquiry's view, this was wholly inadequate given the scale and complexity of RNIB's regulated activity estate.

109. The first meeting of the SSG was a "scene setting day", focussed around discussing the role of the SSG. A discussion about the RNIB Pears Centre is minuted at item 8.3, reproduced below in full:

"Concerns were raised at the downgraded Ofsted rating for Pears and reasons which may have impacted on Ofsted and possible resolutions were discussed."

110. For context, in August 2017, Ofsted undertook a full inspection of the RNIB Pears Centre children's home and had downgraded its ratings for the children's home across all categories: its overall rating changed from "good" to "requires improvement to be good", in relation to the impact and effectiveness of leaders and managers from "requires improvement to be good" to "inadequate", and in

relation to how well children and young people are helped and protected from "good" to "requires improvement to be good".

111. At the second meeting, on 1 February 2018, the minutes record a discussion about the RNIB Pears Centre. The SSG was updated that Ofsted had rated the RNIB Pears Centre school as inadequate and had in December 2017 issued a notice restricting the provision of accommodation to new young people, and CQC was undertaking an inspection of bungalow 5. The minutes record that the SSG asked questions in relation to whether parents have been informed and the number of medication incidents. The minutes record also that members of the SSG were offered one to one meetings and there was an agreement to share further details and specific action plans with members.

112. The Independent Review concluded overall that the SSG never gained traction, and throughout 2017, corporate interest and superintendence of regulated establishments was progressively declining.

113. The RSSC replaced the SSG from April 2018 onwards. The RSSC is responsible for overseeing all safeguarding matters. Between April 2018 and December 2018, the RSSC met 5 times. The Independent Review told the inquiry that the RSSC demonstrated "marked" improvements in independence, expertise and accountability over preceding second-tier governance arrangements; the terms of reference make the RSSC directly accountable to the trustee board and prescribes how that accountability is exercised, and the RSSC is authorised by the RNIB Board to request information and investigate any activity within its terms of reference. The terms of reference also, significantly, prescribe an independent chair and at least 2 RNIB Board members with "experience of regulated adult and children's services"[6], and makes provision for up to two external independent members.

114. The Independent Review told the inquiry that the RSSC "is working effectively and hard-edged decisions/actions are resulting from it".

115. At board level, the Independent Review found that up to 2018, trustees lacked expertise in regulated adult and children's services, and trustees received no dedicated training in this area, compromising effective oversight of safeguarding and regulated services. The Independent Review found that there was a culture where the executive only reported exceptional events to the Trustee board

116. RNIB told the inquiry that as of January 2020, all trustees receive safeguarding training and the last refresher training took place in November 2019. RNIB also, in 2019, recruited a safeguarding trustee onto its board.

[6] The terms of reference has evolved during the course of the inquiry. It now prescribes that the RSSC must comprise of at least 2 RNIB board members, one of whom is the designated Safeguarding Trustee.

117. The inquiry found that trustee oversight of safeguarding and its regulated activity estate between 2015 and April 2018 suffered from serious inadequacies given the scale and complexity of RNIB's regulated activity estate. The inquiry considers these shortcomings, together with the shortcomings in RNIB's safeguarding management over the same period, placed some of RNIB's beneficiaries at undue risk of harm and that these failings constitute evidence of misconduct and/or mismanagement in the administration of a charity.

RNIB's broader governance systems and practices

118. In addition to the inadequacies in RNIB's trustee oversight of safeguarding and its regulated activity estate, the Independent Review also found shortfalls in RNIB's broader governance systems and practices.

119. The Independent Review found that successive RNIB boards were too passive in identifying areas that were not strategic priorities and/or which areas of provision RNIB should withdraw from. The Independent Review told the inquiry it found no coherent strategy around RNIB's regulated activity estate until 2017. The Independent Review suggested that there was in RNIB a "cultural affection" for specialist schools which "discouraged" confronting whether RNIB should be directly delivering those services, up to 2017.

120. Further, the Independent Review found that between 2016 and 2017, trust had broken down between some of the executives and trustees, and there was a culture where strategy was too slow to be implemented. The Independent Review found a dysfunction in leadership and governance over many years, a point that was repeated to the inquiry by various parties previously involved with RNIB.

121. In relation to RNIB's governance systems and practices, the Independent Review made various recommendations, including that RNIB:

    a. Amends its byelaws to reduce the minimum proportion of elected trustees from 50% to 25% in order to allow RNIB sufficient flexibility in populating its board with appropriately qualified trustees.

    b. Consults internally as to whether the minimum proportion of blind or partially sighted trustees should be reduced from 75%[7].

    c. Review whether appointment of trustees to specialist roles is compromised by the roles being unremunerated.

[7] The Governance Review subsequently recommended that RNIB moves towards being skills-based and amend its bye-laws to reduce the proportion of blind or partially sighted members. This has been accepted by RNIB.

d. Review RNIB's governance arrangements and practices.

122. The Governance Review undertaken by Campbell Tickell examined RNIB's governance systems and practices.

123. It concluded that considerable structural and cultural change was needed stating the RNIB Board*: "…*never realised its role as the Board of a group structure, with appropriate attention to how it exercises oversight across its different activities, attends to the interdependency of risk and financial matters, and ensures the senior leadership reporting and company secretary adroitness required to keep the Board informed about performance and risk*."*

124. The Governance Review found limited documentation setting out the relationship between RNIB and its subsidiaries, and found in particular that there was no intragroup agreement defining the relationship and reporting arrangements between RNIB and its subsidiaries.

125. The Governance Review further found that there were issues with the maintenance of an accurate membership register, which along with other weaknesses in its governance systems and controls, raised risks of not operating in accordance with its Royal Charter and Bye-Laws.

126. The balance of skills on the board was found by the Governance Review to have hindered board effectiveness.

127. The Governance Review also assessed RNIB's governance against the Charity Governance Code and found that RNIB was not fully compliant. Although the code is not a legal requirement it represents a standard of good governance practice. Example areas identified by the Governance Review where compliance with the Governance Code could be improved included:

    a. Introducing more precise targets, identifiable milestones and KPIs linked to the organisational purposes of RNIB.

    b. Clarifying the respective roles of stakeholders and members and RNIB's accountability to each group.

    c. Introducing improvements to RNIB's committee and steering group terms of reference.

    d. Developing the depth and detail of the trustee (and staff) Professional Code of Behaviour.

128. The Governance Review made over 30 recommendations[8] including recommendations relating to

    a. Simplifying and clarifying RNIB's group structure and relationships, and assessing the arrangements against the Commission's guidance on connections with non-charitable bodies.

    b. Reducing the size of the RNIB Board, moving the Board towards being skills-based in composition and, following consultation, amending RNIB's bye-laws to reduce the required proportion of blind or partially sighted trustees.

    c. Rationalising RNIB's membership including the creation of a formal corporate membership register and a membership policy, and taking steps to ensure compliance with RNIB bye-laws.

    d. Identifying, refreshing and maintaining the skills required for RNIB's boards and committees, implementing processes to appraise and improve board effectiveness and support, and engagement between the board and the executive to shape strategy, risk and an assurance framework for the board.

    e. Ensuring compliance with the Charity Governance Code.

129. It is a cause for concern for the inquiry that the Independent Review, the Governance Review and the Safeguarding Review all found deficiencies in RNIB's document management systems and consequently had difficulties accessing or locating information.

130. The Independent Review recognised that RNIB had made "significant progress" by April 2019. The Independent Review highlighted to the inquiry, among other things, that the Head of Governance had been made a formal member of the Executive Leadership Team, there was a new strategy, business plan and budget, and advice had been sought from governance specialists and charity lawyers to review RNIB's governance processes and compliance with the Charity Governance Code. The latter became the broader Governance Review. The Independent Review also highlighted as positive that a trustee away day in April 2018 resulted in concrete outcomes aimed at formulating RNIB's strategy and improving governance support.

[8] The Section 84 Order mentioned above at paragraph 40 mandates that with respect to governance matters, the Governance Review recommendations have primacy over those of the Independent Review.

131. The inquiry acknowledges that concurrent with the work of the Independent Review and Governance Review, RNIB has made progress to improve its governance systems and practices. RNIB provided information to the inquiry that:

    a. Its financial transformation plan has, among other things, generated surpluses and resulted in significant debt repayment despite the financial challenges presented by the closure of the RNIB Pears Centre.

    b. There have been improvements in its financial control environment.

    c. Their wider risk and control environment has been strengthened by among other things, the appointment of a new Head of Compliance, Risk and Assurance, and new regulatory compliance reporting at all board meetings.

    d. Business planning and reporting has been improved.

132. RNIB also announced in November 2019 that it had commenced the process of transferring its regulated older people's care homes and educational establishments to other specialist providers.

133. RNIB further told the inquiry that it has undertaken work to build capability, including developing a new Senior Management Team, strengthening RNIB's Executive Leadership Team, an updated safer recruitment policy, and a new probation policy with clear mandatory training requirements.

134. In light of the findings of the Independent Review and the Governance Review, and the Commission's own scrutiny of charity records, the inquiry found that at least between 2015 and April 2018:

    a. RNIB failed to ensure its governance arrangements appropriately matched the complexity and scale, and associated risks, of its activities and structure.

    b. RNIB failed to ensure it had appropriate governance systems and policies in place which placed it at undue risk of not operating in accordance with its Royal Charter and Bye-Laws.

135. The inquiry considers the failures outlined above to constitute evidence of misconduct and/or mismanagement in the administration of a charity.

136. The inquiry acknowledges the improvements to RNIB's governance during 2018 and 2019. RNIB remains under the Commission's statutory supervision and the

Commission will continue to monitor the remaining actions to strengthen RNIB's corporate governance after the conclusion of the inquiry.

Conclusions

137. The opening of the Commission's inquiry into RNIB and RNIB Charity, and the urgent need for RNIB to tackle serious performance issues at RNIB Pears Centre in 2018, could be characterised as lifting a lid on a metaphorical can of worms into the charities' affairs. This would eventually reveal comprehensive failures in governance that placed the safety of young people in its care at risk and allowed harm or distress to be suffered by some.

138. The findings from the QC led Independent Review, instigated as a result of the crisis at the RNIB Pears Centre and the centre's subsequent closure, resulted in the Commission extending the inquiry's scope. Two further pieces of review work into RNIB's safeguarding management and broader corporate governance ensued in order to address additional regulatory concerns arising from the Independent Review.

139. As a result of the work of these 3 reviews and the findings from the inquiry's own investigations, the Commission concluded that there were systemic shortcomings at RNIB between 2015 and 2018, exacerbated by the 2017 charity reorganisation, in respect of:

    a. RNIB's capability to manage complex and specialist care needs at RNIB Pears Centre

    b. the safeguarding governance and management of RNIB's regulated activity estate of specialist care and educational centres

    c. RNIB's broader corporate governance, which did not adequately address the complexity, scale, nature and associated risks of the charity's activities and disparate group structure.

    There is evidence to show that some of these failings predated 2015.

140. These shortcomings were not simply academic or abstract in nature. It is the Commission's view that some of RNIB's beneficiaries at its regulated activity establishments were placed at undue risk of harm – in addition some beneficiaries suffered harm or distress and they and their families were badly let down by RNIB. The RNIB Board failed to understand the breadth and scale of the services that it was overseeing. The inquiry is of the view that the seriousness of these shortcomings, particularly at RNIB Pears Centre, was

exacerbated by many of the beneficiaries having learning and communication difficulties, and they and their families were consequently heavily reliant on RNIB ensuring they were able to consistently and safely meet the needs of beneficiaries in their care.

141. Furthermore, these failings have resulted in major financial impacts for RNIB, with significant costs arising from the attempts to unsuccessfully turn round the RNIB Pears Centre and its subsequent closure along with the substantial costs incurred in the charity's reconstruction. It has resulted in the charity using £5.5 million of its reserves to pay off the residual debt for the failed enterprise at the RNIB Pears Centre.

142. These failings led to the Commission issuing an Order directing RNIB to prepare an improvement plan for the Commission's approval, aimed at addressing the Commission's regulatory concerns. The Action Plan which ensued from this direction involves a 2 year reconstruction process which has also required the support of the Commission's statutory powers to assist the charity both in refinancing and in strengthening its governance.

143. At the time of writing of this report, RNIB is advertising for a new Chair. The current Chair is due to leave the board later in 2020.

144. The Commission recognises that RNIB has helped countless visually impaired beneficiaries and also recognises the commitment of those involved in RNIB, both past and present, to support the visually impaired community. Commitment to a cause alone however is insufficient to safely and effectively deliver a charity's purpose. The Commission considers elements of the failings identified by the inquiry, and the associated reviews, as constituting misconduct and collectively, as serious mismanagement in the administration of the charity. This also resulted in our view in a breach in RNIB's duty to take all reasonable steps to protect the charity's beneficiaries from coming to harm.

145. Ultimately it is the charity's trustees who carry the legal responsibility for the management and administration of the charity and these failings. However, the Commission's decision to issue an Official Warning to RNIB reflects the regulatory view that these failings were as a result of the combined failings of the collective corporate body rather than particular individuals or the trustee body alone.

146. RNIB has made good progress in completing the Action Plan agreed with the Commission and it is part way through the transfer of care homes, schools and college to new specialist providers. It also completed the disposal of the RNIB Pears Centre site to Warwickshire County Council in December 2019. Some

further work remains to enable RNIB to complete its reconstruction and the Commission will continue to carefully monitor its progress in completing this transition.

147. Charity represent the best of human characteristics – that is why the way charities do their work matters. Unfortunately, RNIB fell far short of these expectations in its corporate stewardship of vital services for children with complex needs.

148. The Commission urges charities to ensure they learn the lessons from these findings. There are two key considerations from this inquiry which are relevant to other charities, in particular large charities:

    a. Charity trustees must ensure that their corporate governance is fit for purpose to provide robust oversight of their charity's operations and structure, taking into account the complexity, scale, nature and associated risks of its activities.

    b. Keeping people safe is a core consideration for all charity trustees and they must ensure that their charity's safeguarding arrangements are appropriate and robust. Taking reasonable steps to prevent people, in particular children and adults at risk, from coming to harm is not an optional added extra.

Issues for the wider sector

149. Trustees are collectively responsible for their charity and ultimately accountable for everything done by the charity and those representing the charity. Trustees must actively understand the risks to their charity and make sure those risks are properly managed; the higher the risk, the greater the expectation and the more oversight is needed. In a large and complex charity, it is normal for the executive to have significant decision-making authority – but the trustees must still be willing and able to hold the executive to account.

150. Protecting people and safeguarding responsibilities should be a governance priority for all charities. As part of fulfilling their trustee duties, trustees must take reasonable steps to protect people who come into contact with their charity from harm. Protecting people from harm is not an overhead to be minimised, it is a fundamental and integral part of operating as a charity for the public benefit.

151. Effective trustee boards lead by example, setting and owning the charity's values, setting the standard and modelling behaviours that reflect those values, and requiring anyone representing the charity to reflect its values positively. An

effective culture of keeping people safe identifies, deters and tackles behaviours which minimise or ignore harm to people and cover up or downplay failures. Failures to protect people from harm should be identified and lessons learned and there should be full and frank disclosure, including to regulators. There should be clear consequences for anyone whose conduct falls short of what is required regardless of how senior they are.