CHARITY COMMISSION
FOR ENGLAND AND WALES

Inquiry Report: Summary Findings and Conclusions

Oxfam

Registered charity number 202918

Published on 11 June 2019

CHARITY COMMISSION
FOR ENGLAND AND WALES

Foreword from the Chair

What follows is the report of our statutory inquiry into Oxfam GB. It concludes an investigation of significant scale and complexity.

But it is important that the scrupulous detail of our investigatory findings does not distract from the heart of the matter, or the important lessons that all involved in charity must learn from it.

Everyone involved in charity, all volunteers, all staff, all trustees are custodians of what charity means in the eyes of the public. That understanding is bigger than any single, charitable purpose. Leadership of any size of charity means pursuing a charitable mission selflessly and putting that mission before anything else. Exercising common standards, good judgment and integrity must lie at the heart of charitable leadership, including listening when people raise concerns and responding in a respectful and appropriate way. It is the responsibility of everyone involved in charity to speak out if they see something that places people or their dignity at risk.

Injustices are not the exclusive preserve of the unjust; they can be presided over by people who are in all other respects well-meaning and decent. Being on the side of good is also no guarantee against leaders focussing on the wrong issues, prioritising the wrong things, or missing opportunities to put matters right. Sound processes and systems in charities are crucial to prevent this, but still more important are the people, the attitude and behaviours they display, and the culture they promote.

No charity is so large, nor is its mission so important that it can afford to put its own reputation ahead of the dignity and wellbeing of those it exists to protect. But the implications of this inquiry are not confined to the failings of a single, big charity, because no charity is too small to bear its own share of responsibility for upholding the wider good name of charity.

Ultimately being a charity is more than just about *what* you do, it is also about the way in which you do it. The Charity Commission is determined to reassure the public that it understands this fundamental point and will work with the sector it regulates to demonstrate that fact in the months and years ahead.

Tina Stowell

The Rt Hon Baroness Stowell of Beeston MBE

Chair

June 2019

Background

Oxfam GB is a charity registered with the Commission which forms part of what is known as the Oxfam Confederation, which is headed by Oxfam International, a separate organisation registered as a charity in the Netherlands. The Oxfam Confederation comprises of a global network of 19 other Oxfam non-governmental organisations, referred to in this report as the "Oxfam Affiliates".

Oxfam GB is governed by trustees who are responsible for the control and management of its affairs, known in Oxfam as "the Council". This Inquiry explores matters as far back as 2010 and, as is the nature of charities' governance, trustee boards change. The report refers to either the "current trustees", the "2011 trustees" (those in post at the time of the Oxfam GB internal investigation into misconduct in Haiti) or "the former trustees" (those trustees in post between 2011, in particular after the conclusion of the Oxfam GB internal investigation into misconduct in Haiti, up to the point of the opening of the Inquiry). Oxfam GB's day-to-day work is delegated to its Chief Executive Officer ("CEO") and the staff. The CEO at the time of the events in Haiti is referred to as the "2011 CEO" who left in February 2013. "The 2013 CEO" refers to the CEO in post between April 2013 and 7 January 2019. Other individuals of relevance are referred to by job roles.

Prior to this inquiry opening, in November 2017, the Commission formally engaged with Oxfam GB following concerns made public about numerous Oxfam investigations in 2017 about safeguarding allegations involving senior staff. That engagement resulted in Oxfam GB agreeing an action plan due to be completed by March 2018 to address weaknesses identified by the Commission in its safeguarding governance.

Events were overtaken when, in February 2018 very serious concerns surfaced publicly about events in Haiti in 2010. The allegations claimed that, in 2010, Oxfam staff had sex with prostitutes, some of whom may have been "underage"[1]. Additional allegations were made about Oxfam GB's Country Director in Haiti, including that he had been allowed to resign. Subsequently a different allegation arose about the conduct of Oxfam staff in the Philippines in 2013. This also alleged sexual misconduct.

As a result, on 12 February 2018 the Commission opened an Inquiry into the charity. The purpose of the Commission's Inquiry was to examine the charity's governance, including leadership and culture of safeguarding matters, and their management, policies and practices.

The Inquiry has been conducted in two parts. Part 1 covered Oxfam GB's handling in 2010/11 of the allegations about Oxfam staff in Haiti. Part 2 covered Oxfam GB's wider approach to safeguarding, historically and currently. To inform the work for Part 2, the Inquiry supervised an external review and assessment of Oxfam GB's approach to safeguarding and people protection matters.

This document contains the Inquiry's summary findings, overall regulatory conclusions and summary of required actions going forward.

[1] *Uses of the term 'underage prostitute' in this report are taken directly from reports at the time. Current understanding of the term means that any prostitutes that were under the age of consent should be considered as minors who were victims of sexual exploitation and abuse*

Summary Index

Part 1: Oxfam GB's handling of the allegations in Haiti in 2011

1. Early warnings and the extent of problem

The staffing incidents and problems in Haiti identified in 2011 were not one-off isolated incidents; there were clearly issues in Haiti. These warning signs were identifiable at various points over the previous year, as early as June 2010.

There were examples of incidents of poor conduct by Oxfam GB staff in Haiti that had taken place in 2010 and evidence of some underlying behavioural issues amongst Oxfam staff. For example, concerns about two of the individuals who would later come under investigation in the 2011 were known about by senior staff locally in Haiti in 2010.

At the time this was a critical and key humanitarian emergency relief work and regarded by Oxfam GB itself as a large programme. There were some clear warning signs about staffing issues in the 2010 internal audit report into the control framework over the Haiti programme. The report identified issues which included that high turnover of management and a stressful environment contributed to lack of unity in the teams. Addressing concerns about staff well-being amongst the 550 staff was assessed as a major ongoing challenge. The staffing risks were rated "medium" for the emergency relief programme. These included the risk that the staff morale issues had an impact on effective delivery to beneficiaries, the risk around the lack of leadership and operational staff due to high staff turnover and also the risk that incomplete HR records had an impact on effective HR decisions. The responsibility for monitoring the implementation of medium risk items was with the executive. The items were closed off in the audit report's action plan list as completed in November 2010.

Aside from the audit, there were other concerns surfacing at the time about the way in which staff felt unable to report concerns with confidence through the local HR or the Country Director. In particular, staff expressed concern about whether local HR and the Director had the objectivity or competence to deal with staffing matters that were raised.

In November 2010, HR were made aware of concerns that there was a lack of awareness amongst staff of protection against physical and sexual exploitation and abuse (PSEA). The limited steps that the Inquiry could identify were taken as a result came too late (in June 2011) and were, in any event (as subsequent events would show) not sufficient.

The warnings signs in 2010 should have alerted Oxfam GB to the fact that there were some serious problems with the culture, morale and behaviours generally of their staff in Haiti. Some of the warning signs in 2010 about staffing issues in Haiti should have been escalated by senior staff locally.

Later events would show that when the allegations which instigated the internal investigation into staff misconduct in Haiti were reported in July 2011, the limited actions taken to address the issues raised by these events were not sufficient. By that stage staff confidence in Oxfam GB to address the behaviour of some staff in Haiti had further eroded.

It is not possible for the inquiry to conclude that if different action had been taken by Oxfam GB in 2010 this would have prevented some or all of the incidents in 2011. However, in the Inquiry's view it is clear that there were warning signs of serious staffing issues and the charity missed opportunities to address the cultural and behavioural issues in Haiti at that time.

2. Handling of the 2011 allegations and Oxfam's Haiti investigation

Allegations were first raised orally in early July 2011 by a whistleblower with Oxfam GB's senior leadership during an International Programme Leadership team meeting held at Oxfam GB's HQ. These concerns were followed up in writing by the whistleblower on 12 July 2011. Oxfam GB's leadership acted to mobilise an internal investigation which commenced on 23 July with an investigation team being dispatched to Haiti. The internal investigation started examining allegations against, and the conduct of, three members of staff. By the time it concluded it had extended to investigating 10 members of staff and reportedly involved over 40 witnesses. The outcome of the investigations led to various individual disciplinary hearings. An overarching final investigation report for all cases was produced in August 2011. The final report also contained recommendations for wider action for Oxfam GB and identified learning for the future.

In summary, the Inquiry's finding is that it was proper for Oxfam GB's leadership to have instigated an urgent investigation into the concerns raised by the whistleblower. The Inquiry identified some issues about how the investigation was conducted. These include concerns about the resourcing, capacity and experience of the investigators in specifically dealing with PSEA and/or handling safeguarding allegations. The team's knowledge, experience and skills were mainly in financial related investigation expertise.

The Inquiry also identified some worrying reports about the manner in which some of the investigators conducted themselves during the investigation, including their conduct when interviewing some witnesses. The Inquiry noted some lapses in good investigation standards, in some instances of poor and/or inconsistent record-keeping, and report-writing practices. The fact that sensitive information in an individual investigation report was leaked by a member of staff during the investigation was of serious concern. This compromised the safety and confidentiality of a witness, and led to intimidation of witnesses. This in turn led to further charges of bullying and intimidation that were investigated.

3. Allegations of staff use of prostitutes and the involvement of minors

Unlike some other organisations at the time, Oxfam GB did have a code of conduct in place that made it clear that harassment, intimidation and exploitation was prohibited, as was *"transactional sex with beneficiaries, sexual activity with persons under 18 or vulnerable people".* Its PSEA policy was that if prostitution was illegal in the country then it was prohibited under the Code of Conduct. However, it also gave a degree of discretion to local management about whether they could go further and ban staff using prostitutes more generally when it did not involve beneficiaries and was not an illegal activity in country. In this case, the local management would be or include the Country Director.

The internal investigation identified by admission and/or evidence that four[2] staff under scrutiny either did or were suspected of using prostitutes, including on charity residential premises. The final report could not conclude whether minors were involved in some of the incidents investigated:

"None of the initial allegations concerning fraud, nepotism, or use of under-age prostitutes was substantiated during the investigation, <u>although it cannot be ruled out that any of the prostitutes were under-aged"</u> [Inquiry emphasis].

From its examination of the internal investigation records available, and information and evidence provided to the Inquiry through its own enquiries, the Inquiry's finding is that not all lines of enquiry about the use of prostitutes and/or minors' involvement were fully pursued in 2011.

In the Inquiry's view, the position on the legality and culpability of the parties for the various activities connected with prostitution was not clear until after the conclusion of the internal investigation. In any event,

[2] The Country Director and three other staff subject to internal investigation

the external legal advice sought was not received until 1 September 2011 after the investigation findings were made and the outcome report had been finalised.

In light of the seriousness of the allegations and concerns that some females may have been under age, the Inquiry's view is that the lines of enquiry about the nature and extent of what happened should have been pursued further.

Given the serious nature of the allegations and potential risk of harm the 2011 CEO and the Director of International Programmes should have ensured and obtained sufficient evidence that the enquiries were fully followed up. With hindsight, the 2011 CEO publicly accepted in 2018 that more should have been done to follow up whether minors were involved. This was particularly important in the Inquiry's view due to the significance and seriousness of the allegations.

Oxfam GB proceeded on the basis that the allegation that the prostitutes were minors was found not to be true including when considering what to communicate internally and externally. However, the outcome report result left open the possibility those involved were under age.

Separately, Oxfam GB's senior executive had to deal with the two emails dated 18 July 2011 and 20 August 2011. Both were said to be from a 13 year old about herself and a 12 year old girl and made different and further allegations of physical abuse and other misconduct involving Oxfam staff. The Inquiry was informed that it was suspected by Oxfam GB at the time, but not then proven[3], that they were not genuine. The Inquiry's finding is that taking into consideration the seriousness of the allegations made in those emails, as well as the clear risks to the safety and security of those minors if the allegations were true, Oxfam GB should have tried harder and taken more steps at the time to identify the source of the concerns and followed up the allegations and concerns, notwithstanding they suspected them to be false. This shortcoming has been acknowledged by Oxfam GB's current chair who has accepted that: *"Oxfam did not adequately investigate the allegations, received in an e-mail dated 18 July 2011, that minors were being sexually abused by Oxfam employees, nor did it report these allegations to the Commission or appropriate law enforcement agencies. This would not be the case now. Today, such a serious allegation would be dealt with very differently."*[4]

In May 2019, in response to the statement made by the current Chair of trustees, the 2011 CEO stated to the Inquiry that *"At the time we believed that we had adequately followed up on these emails. We had been given reassurances by our staff that they had been to the convent and that there was no trace of these girls. We also believed that having a full investigation which resulted in nine people leaving our employment was the best way of ensuring that any ongoing abuse was immediately curtailed. I was dismayed to find out during the course of this inquiry that our investigations were not as full as they could have been. If these emails had been genuine I would want to know that they had been followed up as extensively as possible in order to find these individuals and ensure that they were safe. I am therefore relieved to know that we* [now] *have evidence backing up our understanding at the time that these emails were not genuine".*

The Inquiry's view is that Oxfam GB should not have taken the risk with the safety of minors. It should have reported the possibility of two girls being at risk to the local law enforcement authorities. The matter was reported to law enforcement in the UK by both the Commission and Oxfam in 2018. The decisions about and handling of the matter at the time meant the charity exposed itself to undue risk, amounting to mismanagement in the administration of charity.

The Inquiry's view is the focus of the Oxfam GB investigation at the time became about getting enough evidence to ensure the individuals of concern were removed from Haiti and Oxfam GB. The risk to and impact on the victims appeared to take second place and was not taken seriously enough.

Given the period of time that has passed, it will not be possible to conclude with sufficient certainty whether minors were involved or at risk.

[3] The steps the 2011 CEO explained she had taken in 2018 and 2019 to trace the provenance of the emails are explained in the detailed findings in the main report

[4] Correspondence dated 12 February 2019

4. The Resignation of the Country Director

It was a prudent and responsible decision for the then senior executive to ensure concerns about possible breaches of the code of conduct by the Country Director, who was holding a position of significant authority and responsibility, were looked into urgently.

From examining the records including transcripts of the interviews, the follow-up letter from the individual, records confirming his resignation and Oxfam GB's related email correspondence between Oxfam GB staff and senior leadership about what happened, the Inquiry's finding is that this evidence indicates that Oxfam GB encouraged and facilitated the Country Director's resignation as a solution to his response to the allegations.

It appears that the then senior executive believed that facilitating resignation was the best way to deal with the conduct of the most senior member of staff involved, manage the reputational risk to the organisation and minimise the disruption to its humanitarian programmes which would result if alternatively he had been subject to formal disciplinary procedures. The then executive, including the 2011 CEO and Director of International Programmes who were copied into key emails, and the Haiti investigation team had already discussed between themselves resignation as an outcome option before they formally presented the results of their enquiries to date to the Country Director.

The Commission is prohibited from acting in the administration of a charity. It is therefore not for the Inquiry to make or replace the decision of Oxfam GB. The regulator's role is to scrutinise the basis for the trustees' and/or executive's decisions and hold the charity to account for the consequences of them. The consequences of the decisions on this issue meant there was not parity of treatment with other staff who were found to have committed or been suspected of the same or similar conduct.

Even if they did not appreciate it at the end of July 2011, by the time the final report was ready it was, or should have been, clear to Oxfam GB that the consequences of the outcome of a facilitated resignation would mean that there had been a lack of consistent application of the staffing policies and procedures. Oxfam GB accepted publicly in 2018 that, with hindsight, their decision was wrong.

In an email to the 2011 CEO from the Head of Internal Audit on 27 July 2011, the 2011 CEO was informed of the Country Director's resignation and that he was "*very keen to co-operate"* and wanted *"a dignified exit".* The final investigation outcome report recorded the resignation as having been accepted, and the term used to "allow him a phased and dignified exit", provided that he would fully co-operate with the rest of the investigation. The Inquiry's view is that it is also clear for Oxfam GB to see, with hindsight, how a recorded desire to secure a "phased and dignified exit" for the individual would appear insensitive and not an appropriate response the public would expect.

Given that there was a formal and serious investigation into the conduct of ten staff, it is particularly concerning that similar allegations against two other members of staff were investigated differently and treated as potential gross misconduct. The 2011 CEO and Director of International Programmes do not accept the allegations and conduct was similar nor that the conduct in question, the use of prostitutes, was a breach of the code of conduct. Ultimately, the result of the decisions and different approach led to unequal treatment of other staff and meant that Oxfam GB did not apply its disciplinary processes, policies and procedures consistently and there do not appear sufficient reasons for doing so. This was mismanagement in the administration of the charity.

In the Inquiry's view this action and approach also exposed the charity to the risk that its approach could be understood that more senior staff would be treated more leniently. This approach could have jeopardised the handling of other disciplinary cases both at the time and been seen as setting a precedent or problem for dealing with similar future incidents.

The current Chair of Oxfam GB apologised to the Inquiry in February 2019 for what happened and promised that Oxfam GB's policies and procedures today would not allow this to happen now.

5. Chad and knowledge of prior incidents

The Inquiry established that when employing the Country Director in 2006, Oxfam GB relied on a reference which had been provided by a recruitment agency. The recruitment agency no longer exists. This appears to be personal reference from the individual's former line manager at his previous employment. An employment reference from his previous employer could not be located. As a result, Oxfam GB did not appear to know about the individual's previous dismissal from employment in Liberia.

In the Inquiry's view, there were general concerns emerging about staff conduct and behaviours in Chad in 2007. Rumours were circulating in 2007 amongst staff in Chad about prostitutes and "inappropriate relationships" but nothing had been raised that senior managers could "…*act upon...*". Separately, concerns about breaches of Oxfam's code of conduct by staff connected with an overnight stay in Oxfam premises in Chad were also raised with local Chad management in Oxfam in 2007. They were discussed but not escalated past country level and, in the end, could not be substantiated.

During the 2011 Haiti investigation, one of the witnesses raised the possibility of the use of prostitutes by staff in the past in Chad but these leads were not followed up.

From records examined by the Inquiry, in early August 2011, at the request of the then 2011 CEO, the Oxfam GB HR team undertook research to establish what Oxfam GB operations all the individuals under investigation had previously worked on and when. The initial results identified that there had been some overlaps between three of the individuals in Chad and potential overlaps between the two of the same individuals in Indonesia.

At trustee level, the Trustee Audit and Finance Group ("TAFG") were aware that work had been commissioned to look into these links; it was raised at a meeting of TAFG in September 2011 where a December deadline for a report on whether similar behaviour had occurred in other postings by those managers, was noted. The Director of International Programmes told the Inquiry she reported back orally to the 2011 CEO.

The Inquiry was unable to verify to its satisfaction that this work was completed, or that the executive fully followed up the outcome and actions to it, and were held accountable for doing so.

The former Director of International Programmes resigned in February 2018, stating: *"I am deeply sad to announce that I have resigned … Over the last few days we have become aware that concerns were raised about the behaviour of staff in Chad as well as Haiti that we failed to adequately act upon. It is now clear that these allegations - involving the use of prostitutes and which related to behaviour of both the Country Director and members of his team in Chad - were raised before he moved to Haiti."*

The Director of International Programmes informed the Inquiry that she had made a number of confidential enquiries in relation to this matter with staff which had not been documented. The outcome of those enquiries was that she could not identify any issue of concern in Chad. As a result, the Inquiry was informed that the report had been an oral briefing to the 2011 CEO, not a written report. The Inquiry is not suggesting that that briefing did not take place, but it is critical of the executive and then trustees for not ensuring there was a proper audit trail to show a matter of such significant concern was properly followed through and concluded.

The Inquiry finds that Oxfam GB's handling of these matters exposed the charity to further risks, as evidenced in February 2018. Those risks included not being able to state with certainty whether there were concerns about staff conduct in Chad that were known about and, where appropriate, acted on. This meant the charity was not able to have or provide the necessary assurance that the risks had been managed. In the Inquiry's view this amounts to mismanagement.

6. Oxfam's handling of requests of staff references after the 2011 events

Oxfam GB's handling of references for the Country Director immediately after 2011 appeared to be affected by uncertainty about what could lawfully be said to third parties and prospective employers. The Inquiry's finding is that this was made more difficult for Oxfam GB because of the decisions Oxfam GB took about the outcome of the investigation, the circumstances leading up to the resignation and its handling of the individual's departure.

Oxfam GB was limited in its ability to mitigate the risks to other parts of Oxfam and other organisations because it agreed and facilitated the Country Director's resignation. Oxfam GB created difficulties for itself as a result, in particular, of not being clear about what Oxfam GB could or should disclose without creating other risks to the charity arising through the use of more informal mechanisms.

Oxfam GB's handling of reference requests about other staff involved in formal investigation and subsequent disciplinary processes was different. There was evidence that Oxfam GB had taken some reasonable steps to protect other Oxfam Affiliates from being exposed to the risks posed by the findings that were upheld. This included informing prospective employers factually of what happened when asked and recommending that any requests for references to Oxfam were provided by Oxfam GB centrally. Oxfam GB was clear they would not give references for these staff beyond factual dates of employment and this decision was recorded on their Oxfam wide systems to ensure a consistent and correct approach.

The Inquiry finds that the approach of the other charities' and aid agencies' handling of reference requests for some of these staff was not as good as Oxfam GB's, particularly in their assessment and due diligence on prospective employees. Other charities did not pay enough attention about whether a reference was a personal or a corporate one before relying on it. Some charities also appeared to accept personal references by former employees as if they were corporate or organisational references. This might have been by mistake or as a result of not taking enough care to identify what the nature of the relationship of the individual giving the reference was. The Inquiry found some of these personal references were from individuals who were themselves subject of the 2011 Haiti investigation.

Oxfam GB is not responsible for the actions or omissions of other charities and aid agencies in the use of references and/or the nature of their pre-employment due diligence carried out on former members of Oxfam GB's staff. Nor indeed are they responsible for the decisions subsequently taken by other charities and agencies to employ former Oxfam GB staff dismissed in Haiti.

As a result of what has happened, Oxfam GB has reviewed its current policy and practices when providing references to third parties on current and former Oxfam GB workers. The Inquiry has seen some cases where Oxfam GB has taken appropriate action, including where necessary disciplinary action, against individuals who have breached Oxfam's employment procedures. As a result Oxfam GB has introduced a new set of standards regarding corporate references which have been introduced to manage the risks arising from individuals whose conduct the charity has cause for concern over.

7. Disclosures and reporting to third parties

In 2011, Oxfam GB's focus when reporting incidents to donors, and to its regulator, was on financial issues; for example, frauds, misappropriation and/or bribery incidents.

Oxfam GB was not used to dealing with reports about staffing and safeguarding matters at that time. That said, Oxfam GB did act responsibly in alerting and in making reports about their internal investigation outcome in 2011 to the Haitian government, DFID, DEC and the Charity Commission. However, Oxfam GB did not make a report about possible criminality matters relating to the events in Haiti to the local police authorities.

In addition, the impression the Inquiry has is that Oxfam GB's handling of these matters was influenced by a desire to protect Oxfam GB's reputation, and to protect donor and stakeholder relationships. The Inquiry's assessment is there was a tension for the charity when making a report to donors or regulators, between providing sufficient details of the incident and complying with the requirements, and the difficulties Oxfam GB saw in also respecting confidentiality and not triggering a lack of donor confidence and/or funding withdrawal. The concerns were a funding withdrawal may affect Oxfam's operational capacity and/or their actions may result in regulatory enquiry or intervention.

The Inquiry found that the content and nature of the incident reports to donors and the regulator were similar. They were limited in detail and all confirmed categorically no fraud or beneficiaries were involved. In relation to DFID, there were three rounds of correspondence connected to reporting the events. These reported to DFID that the issues of concern related to alleged misconduct by staff and clearly stated that there was no impact associated with DFID funding. At no point did Oxfam GB report to DFID that the allegations included or referred to sexual misconduct.

More generally in relation to all the reports, the Inquiry's view is that some material facts were not disclosed or explained about the breadth and full nature of the breaches of the code of conduct and misconduct investigations. These included that:

- the misconduct being investigated involved the use of prostitutes
- that the allegations included minors – and subsequently that the involvement of minors had not been substantiated but could not be ruled out
- the incidents may have raised criminal matters that may have been reportable to the Haitian police authorities and/or they decided not to report matters to the police authorities
- the breaches of the code of conduct involving the use of prostitutes took place on Oxfam GB provided residence

In their reporting, Oxfam GB used a specific definition of what constituted a beneficiary. The reports stressed the misconduct did not involve beneficiaries. This was based on the term as Oxfam GB understood and used that term. It is the Inquiry's view that by stressing in the reports that the incidents did not involve beneficiaries, the concerns would be likely to be interpreted as matters internal to or between Oxfam staff, albeit serious enough in some cases to warrant dismissal. Whilst Oxfam GB maintain they acted honestly and in good faith with no intent to mislead the Commission or underplay the seriousness of the allegations, with hindsight, they now accept they used a definition of beneficiary which was not the same as the definition commonly used by the Commission under its regulatory regime.

As the Commission said publicly in February 2018, the report made no mention of any potential sexual crimes involving minors. Leaving aside the report about the main investigation, in addition, Oxfam GB was also in receipt of specific allegations regarding two Haitian females aged 13 and 12 years old, who had claimed to be physically abused by an Oxfam "boss" and used for prostitution. The Commission has made clear that its approach in responding in 2011 would have been different had the full details that have been reported been disclosed at the time.

The expectation of and onus on a charity is to decide and identify material facts to report and be open and frank with the regulator when reporting. The Inquiry has taken into account Oxfam GB's usually prompt and regular reporting on other types of incidents, including on frauds and financial matters.

The Inquiry's view is that the incidents did involve beneficiaries so the categorical statements that they did not, were mistaken. The meaning of beneficiary for the regulator was as generally and publicly used by the Commission and as explained in its RSI and other guidance. The Inquiry also finds that Oxfam GB should have been more explicit about the exact nature of the allegations and how serious they were and this was unsatisfactory.

The Inquiry found no record that there was a "cover up". However, the Inquiry concludes, and agrees with Oxfam GB's current leadership, that Oxfam GB should have been fuller and franker in its initial report to its donors and the regulator.

Oxfam GB have explained why this happened and have accepted the criticism and learning on this and were keen to stress they are satisfied that *"this was not the result of any intent to mislead the Commission, or underplay the seriousness of the allegations…"*

The Commission's RSI reporting requirements have changed since 2011 and the Commission's response to them is more proactive and robust. Safeguarding reporting requirements are no longer confined to "beneficiaries at risk" issues.

8. Oxfam's handling of the issues publicly

Oxfam were open publicly in media statements, released on their website at the time, that there were serious issues with staff in Haiti in 2011. However, the Inquiry's view is Oxfam GB were not as careful, or full and frank as they should have been in referring to and using the Country Director's resignation in the way they did.

On 28 July 2011 in an email to the 2011 trustees, the reason for the resignation was positioned by the 2011 CEO as due to *"his overall responsibility, not because of involvement in the activities of concern".* In their external communications Oxfam GB referred to Oxfam GB's Director resigning taking managerial responsibility for issues that occurred while heading the programme. However, the risk was there was a wider picture and context from which the resignation arose. In the Inquiry's view, Oxfam GB encouraged and facilitated resignation as a solution to the response to the allegations against him. The approach Oxfam GB took in referring to the resignation and reasons for it publicly gave the impression that there were no issues about the conduct of the individual in Haiti.

The actions and approach taken on handling exposed the charity to undue risk. Now that the wider context and circumstances leading up to the resignation have been scrutinised and are known, it is clear the approach Oxfam GB took exposed the charity to concerns that it did not disclose the full picture at the time and/or diverted attention away from material relevant information, namely that there were concerns about the conduct of the same member of staff who was stepping forward to take responsibility for others' conduct.

9. Trustee oversight, briefing and follow up on the a) the investigation and, b) third party reporting and handling

In a large charity in particular, reliance by trustees on delegation to the executive is inevitable and essential. In a charity as large and complex as Oxfam GB, its trustees could not, and would not be expected to, have a detailed oversight of or involvement in all aspects of the charity's day-to-day work and all decisions on front-line operations. There will need to be a heavy reliance on a competent executive, in particular the CEO and the senior executives.

However, that delegation by trustees means it is essential that they ensure there are effective oversight, assurance and accountability mechanisms in place. Specialist committees, internal audit, meaningful briefing and reporting by the executive and other assurance mechanisms are critical. In essence, trustees need to be confident that they have sufficient oversight over key matters and are able to identify and ensure action on issues of concern, holding the executive to account and in turn enabling the trustees to fulfil their legal duties and responsibilities.

In Oxfam GB's case, the 2011 trustees were naturally heavily reliant on the delegated authority they gave to the CEO and executive. This included reliance on ensuring that the charity's policies and internal assurance mechanisms were properly implemented in practice, and that the trustees were provided with sufficient and meaningful reporting information. In this context, a trustee board would not normally be expected to be involved in routine staffing matters including investigations into staff conduct issues. However, with more senior the staff, and the more serious or widespread the misconduct, as was the case

here, the more oversight and assurance scrutiny by them would be expected. In turn, the more detailed and regular reporting to them should be expected as these would be matters of corporate significance and risk for which they would be legally responsible and accountable.

The Inquiry finds that there was limited documented trustee briefing about and during the Haiti investigation in 2011. Oversight of the handling of the staff issues of concern, including the Country Director, was handled by the then senior executive. Some oral briefings were said to be provided to the 2011 trustees by the 2011 CEO. The email of 28 July 2011, from the 2011 CEO to the 2011 trustees, is the only written record the Inquiry could locate of a written report or briefing to the trustees on progress prior to the final report. It is in this email that the 2011 trustees were informed of the Haiti Country Director's resignation. The 2011 CEO wrote *"This resignation is on the basis of his overall responsibility, not because of involvement in the activities of concern".* However, the events leading to his resignation were triggered by presenting to him concerns about his own conduct in breach of the code of conduct. The Inquiry's finding is that Oxfam GB encouraged and facilitated his resignation.

Later, the results of the enquiries conducted into the Country Director's conduct is more fully noted in the final report, a summary of which was given to the trustee committee, TAFG and also emailed to the whole trustee body on 17 October 2011. This investigation outcome report was not completed until after 26 August 2011, by which stage the Country Director had already left Oxfam GB's employment. The Inquiry is critical of how this was handled by the then executive in this period.

The final report's section on lessons learnt allowed the 2011 and former trustees to consider the organisational risks arising from the internal investigation's results and to scrutinise and oversee how the executive proposed they be addressed. However, although this was the case, the Inquiry was unable to establish to its satisfaction how the former trustees held the executive to account for this or signed off its satisfactory completion formally. In the Inquiry's view it is concerned that this was not categorically and formally closed off given the seriousness and significance of the issues in the action plan.

The 2011 trustees stated that the executive did not inform them about the 18 July 2011 allegations.

Overall the Inquiry finds that the former trustees did exercise oversight over the organisational risks arising from the internal investigation and how the executive proposed they would be addressed. However, the Inquiry was not completely satisfied that that oversight and scrutiny of the information and assurances provided by the executive were sufficient to enable the trustees to be satisfied that they were carrying out their legal duties and responsibilities and that the executive were effectively held to account for the decisions they had made and on matters of such significance.

On reporting to other agencies, the 2011 trustees naturally delegated reporting to the executive and relied on their assurances this was correctly done. The 2011 trustees say they did know about the decisions taken by the executive not to report matters to the local police authorities on the basis that no reportable crime had been committed. The 2011 trustees state they recall they were not made aware of the 18 July 2011 allegations from and about the alleged 13 year olds.

Overall the Inquiry is not completely satisfied that the combined oversight, scrutiny of the information and assurances given to the 2011 trustees by the executive, or the accountability measures in place, were sufficient in the circumstances. This meant that the trustees could not have had the assurance they needed regarding the discharge of their legal duties and responsibilities and that the executive were effectively held to account for the decisions they had made on matters of such significance.

10. Philippines 2013

In summary, it is the Inquiry's view that Oxfam GB have taken all reasonable steps possible to verify the allegations about conduct in the Philippines in 2013. In the absence of any further evidence and due to the length of time that has elapsed since the incidents, it is not possible for the Inquiry or Oxfam GB to progress this matter further.

Part 2: Oxfam GB's wider approach to safeguarding, historically and currently

1. The role of the Independent Review

The Inquiry's findings in relation to Oxfam GB's wider approach to safeguarding, both historically and currently, has been informed by the results of an Independent Review originally commissioned and paid for by Oxfam GB, as well as by other evidence available to it. This has included the responses and documents provided by Oxfam GB, former employees and former trustees of Oxfam GB on the Inquiry's emerging findings.

Following the opening of the Inquiry the Commission put in place steps to ensure it had direct supervision of the Independent Review, agreed its terms of reference and that the results would be fed directly to the Inquiry and Oxfam GB concurrently. The Independent Review was carried out by members of Ineqe Group Ltd ("Ineqe") and led by Jim Gamble QPM, CEO of Ineqe ("the Independent Review Team"). The Independent Review was overseen by Kate Gallafent QC but the Independent Review Team had final editorial control on the findings and content of the review report. The results of the Independent Review are for Oxfam GB and Oxfam to respond to. They are not owned by the Commission but have informed the Inquiry's regulatory findings and action required by the Commission. The Inquiry considered and took into account the results of the Independent Review in its own findings and conclusions, in the same way it would if the review had been conducted by an Interim Manager.

The Independent Review's findings and recommendations were based on engagement with Oxfam GB between March and September 2018. The final results of the review including recommendations were provided to the Commission on 4 February 2019.

In summary, the purpose of the Independent Review was to examine Oxfam GB's:

- current safeguarding arrangements
- management of safeguarding allegations since 2011 (excluding the 2011 Haiti events and Philippines allegations)
- reporting of all relevant incidents accurately and to the levels required[5]:
- as serious incidents to the Commission under its regulatory regime
- to law enforcement or other respective agencies in the UK and in other countries where appropriate
- to statutory funders in the UK and other principal donors

A summary of its key findings together with all the recommendations are published in annex 3 of the full report.

As well as the findings of the Independent Review, the Inquiry has also taken into account the results from the Commission's own direct regulatory engagement with Oxfam GB on safeguarding matters, including the regulatory compliance case in 2017, an externally-led HR related review commenced by Oxfam GB in January 2018, and direct engagement with Oxfam GB's current leadership during this Inquiry.

In many places the results of the Independent Review Team confirm or endorse the Commission's findings from its regulatory engagement during November 2017 and the Inquiry.

[5] Full details of the Independent Review's terms of reference are contained in the Independent Review Report's Executive Summary contained at annex 3.

2. Safeguarding governance and leadership within Oxfam GB (including assurance and improvement systems and trustees' safeguarding skills and training)

The Commission established during its review in 2017, prior to the establishment of the Trustee Safeguarding Group, that the Council's oversight of safeguarding was exercised in the first instance through the Trustee Audit, Finance and Risk Committee, TAFG. This oversight was supplemented by a lead trustee for 'people risks' including safeguarding. At that time TAFG received information on safeguarding at its meetings on a 6 monthly frequency, although prior to 2016 reports had been provided to it on a quarterly basis. Since 2016 TAFG has received an annual report on people risks for review and discussion. The annual report included analysis of safeguarding, security and health and safety. In addition the Safeguarding Steering Group (a management committee), meets on a quarterly basis reporting to the executive Leadership Team. The Inquiry was informed that specific cases were not discussed and the detail of them not shared at TAFG but the most serious cases were flagged with the Chair and sometimes the other honorary officers through an escalation process.

The Inquiry was informed by the representatives for the former trustees and former employees that this was part of several lines of defence; line management itself in country, support through expert staff with a dotted line relationship to the Head of Safeguarding, and thus to the Head of Audit, internal audit, the management safeguarding group and regular reporting through TAFG to Council.

The former trustees reported to the inquiry that they took their oversight duties and responsibilities extremely seriously and that a minimum commitment as a trustee involved providing between 12 and 25 days a year including attendance at one of the governance committees as well as the main Council meetings.

It was explained by Oxfam GB to the Commission that TAFG had heavy workloads and that this reduction in frequency of reporting on safeguarding occurred to improve how TAFG receives information at its meetings on safeguarding and synchronise it with other areas of reporting on 'people risk' such as security and health and safety matters. It was separately reported to the Inquiry that concerns had been raised internally on more than one occasion with Oxfam GB management and a trustee about the reduction in frequency of reporting to TAFG, given the continued pressures and challenges faced by staff on safeguarding work. Notwithstanding these concerns, the reduction in frequency of reporting to TAFG had not been reversed by Oxfam GB prior to the Commission's engagement, in part because the Safeguarding Steering Group, a cross departmental management committee within Oxfam GB, continued to meet quarterly reporting to the executive leadership team and because of the other communication channels on safeguarding which existed.

The management and performance information, produced both for the executive and TAFG, was mainly data on the number and nature of safeguarding cases being handled by the safeguarding team. The Commission found limited evidence of reporting information driving the effective management of strategic, thematic/tactical and performance matters on safeguarding.

Oxfam GB agreed as part of the 2017 action plan to include safeguarding as part of a governance review, which had already been commissioned by Oxfam GB prior to the Commission's intervention in November 2017. This governance review was tasked with reporting back on improvements that could be made to governance in the context of safeguarding by 31 March 2018. This governance review was largely overtaken by two events:

- The opening of the Inquiry and the associated appointment of the Independent Review Team to conduct a broader review of safeguarding at Oxfam GB
- The decision of the trustees to establish the Trustee Safeguarding Group as an interim governance measure in March 2018.

In summary the Inquiry found that prior to the improvements in 2018, there were systemic weaknesses in quality assurance and accountability on safeguarding matters; including systems and processes to regularly monitor key performance indicators (KPIs), case auditing activity and inadequate safeguarding case records and records management. These hampered Oxfam GB's ability to provide reports of sufficient quality to ensure effective audit and oversight of the issues, and so exposed Oxfam GB to undue risk. These risks included: that some aspects of Oxfam GB's safeguarding casework were not being carried out in compliance with procedures and/or recognised practice standards; that its policies and recognised practice standards were not being properly or consistently implemented by staff; and that the charity was not able to provide necessary assurance to its staff and the public that safeguarding risks were being properly managed. The Commission considers this to be mismanagement in the administration of the charity.

The Independent Review Team confirmed to the Commission that governance oversight of safeguarding had now improved within Oxfam GB although further work remained to be done. The improvements made include the establishment of an interim Trustee Safeguarding Group ("TSG") in March 2018, which has met on a monthly basis to review safeguarding matters. The TSG also approved a set of safeguarding KPIs which provide quarterly measures of progress to the trustees in key priority areas. Monitoring of these began on 1 January 2019.

The Independent Review Team made several recommendations to improve Oxfam GB's safeguarding capability through the introduction of a new safeguarding operating model. Further details are provided in annex 3 of the main report. These recommendations also include further strengthening of Oxfam GB's governance and leadership with the appointment at executive level of a Director of Safeguarding, with reporting lines direct to the CEO, and establishing a new safeguarding committee, which *'whilst sitting within Oxfam GB's overall governance structure will provide an enhanced and transparent level of professional scrutiny.'*

Oxfam GB is implementing the recommendations to adopt a new safeguarding operating model. Trustees will decide in July 2019 on the composition and terms of reference of the safeguarding committee which will permanently replace the interim TSG. A programme of work is underway to strengthen assurance systems by enhancing the management information provided to the interim TSG and the safeguarding committee, when it replaces the TSG. The global planning and reporting process now includes strengthened information on safeguarding and will give the global leadership a top line indication of the plans, progress, and financial investment levels on safeguarding activities at country level. A new risk framework was approved by trustees in December 2018 and Oxfam GB is working with Keeping Children Safe to roll out a similar framework to countries and programmes.

3. Oxfam GB's safeguarding strategy and strategic approach

The Inquiry finds that until 2018 an area of weakness in the corporate oversight of safeguarding arrangements at Oxfam GB is connected with the gap between its strategy, the strategic intent behind it and its implementation. Its effectiveness in this area was dependent in part on ensuring the necessary assurance mechanisms were both in place and effective. These were necessary for the trustees and executive to be confident the organisation's strategic level response was robust, kept pace with developments and was being implemented as they intended.

The Commission established Oxfam GB's senior management had intended to commission a strategic safeguarding review in 2015. They had informed TAFG, the committee of Council, of their intent. This review was intended to consider concerns raised by the then Head of Global Safeguarding. However this strategic review did not take place in 2015.

When questioned by the Commission in 2017 about its safeguarding strategy, Oxfam GB told the Commission that they had 'rolled it over' and were applying the charity's safeguarding strategy for the period of 2012 to 14. It is the Inquiry's view that Oxfam GB had no up to date safeguarding strategy in place in 2017. However, the Inquiry did see a safeguarding operational plan for 2016 which reflected ongoing work under the 2012-14 strategy. It also saw some efforts made by Oxfam GB to prepare an updated safeguarding strategy document prior to the Commission's regulatory engagement in 2017. This included KPI targets to enable trustees and management to track Oxfam's performance against the strategy.

The Inquiry found no evidence that TAFG or the full Council monitored delivery of the intended 2015 strategic safeguarding review or held the executive to account for this. In addition, the Commission did not find the expected evidence in minutes of meetings and papers that the 2012-14 strategy was being used either by Oxfam GB's trustees or executive to measure and monitor progress against strategic safeguarding objectives or targets. The Inquiry acknowledges that they were receiving periodic safeguarding reports.

The Commission advised Oxfam GB in 2017 that it considered the self-assessment exercise which underpinned the formulation of the draft updated strategy to be too optimistic. Oxfam GB's self-assessment in 2016-17 concluded that none of the eight components[6] for effective safeguarding delivery were weak and that five out of the eight elements had improved since the last self-assessment in 2012. This was not a view the Commission shared in its 2017 engagement[7].

In summary, the Inquiry is critical of the failure of the former trustees to ensure that a 'rolled over' strategy was used to effectively measure and monitor progress against strategic targets, and the failure to ensure that the intended 2015 strategic safeguarding review took place and support and hold the executive to account for doing so. This is particularly since Oxfam GB were put on notice at that time about the increasing safeguarding challenges for it and the resourcing issues which the safeguarding team faced. There should have been adequate assurance processes and systems in place to ensure this strategic review took place.

The Inquiry notes the record of the Council's commitment at the time to championing safeguarding and to placing a high priority on addressing and denouncing sexual violence in Oxfam. Both Oxfam and the charity's former trustees pointed to a range of positive measures in support of this including:

- Programmes designed to combat violence against women
- Holding female only meetings when female senior staff and trustees visited overseas locations to encourage a culture of speaking out.
- The actions taken on programmes to encourage beneficiary complaints or reports of abuse
- Raising 'front line' awareness through training
- Establishing central safeguarding resources to support and co-ordinate safeguarding delivery.
- Reporting on the number of safeguarding incidents handled by Oxfam GB in the Trustees' Annual Report

Oxfam and the former trustees highlighted to the inquiry that in some aspects of safeguarding they were regarded by their peers as delivering best practice.

[6] The eight defined areas of performance for the self-assessment exercise were: Governance and Accountability; Policies; Management; Information and Knowledge Management; Plans and Procedures; Learning and Development; Resourcing; Monitoring and Evaluation.

[7] At the time of the Commission's engagement in 2017 Oxfam highlighted the study by Professor Dyan Mazurana and Affiliated Student Phoebe Donnelly of Tufts University in their research on sexual assaults against humanitarian and development aid workers. This study cited Oxfam as a model of best practice in the sector in addressing sexual harassment and assault against aid workers. Given the context and methodology of this study the Commission advised Oxfam that it would be inappropriate to use the study as a form of assurance that the charity was taking reasonable steps to mitigate safeguarding risk and protect people from harm. Further information is provided on this study in the executive summary of the Independent Review report at annex 3. [Mazurana, D. and Donnelly, P. (2017). *Stop the Sexual Assault against Humanitarian and Development Aid Workers*. Somerville USA: Feinstein International Centre]

However, in the Inquiry's view insufficient steps were subsequently taken by the trustees and senior executive at the time to deliver and follow through on this intent. As a consequence, this exposed the charity to undue risk. The Inquiry regards these failures are intrinsically linked to the decisions by Oxfam GB in respect of its organisation, management and resourcing of safeguarding. The Commission considers the failings in both of these areas between 2015 and 2017 as collectively constituting mismanagement in the administration of the charity.

The Inquiry has observed significant progress made by Oxfam GB in this area since 2017. Following the Commission's intervention in November 2017, Oxfam GB agreed to and produced an updated safeguarding strategy. This was implemented in May 2018 (the 2018-21 strategy) following approval by the trustees in Council.

The Independent Review Team[8] considers the structure of the strategy to be sufficient, although they made certain recommendations connected with strengthening the strategy and the strategic planning process. Oxfam GB have agreed to ensure that these changes will be completed in 2019.

Delivery of the safeguarding strategy is now specifically monitored and reviewed by a new Trustee Safeguarding Group.

4. Oxfam GB's organisation, management and resourcing of safeguarding

Since its formation in 2012, the Global Safeguarding Team ('the safeguarding team') has formed the hub through which most of Oxfam GB's safeguarding activity has been co-ordinated. The Commission is clear that Oxfam GB's initial decision to invest in this dedicated resource was a significant and positive measure and one which many other charities do not have.

However, the Commission reached the view that the safeguarding team was not fulfilling its intended purpose or potential in and before 2017. During its regulatory engagement in 2017, the Commission found that Oxfam GB's organisational approach to safeguarding and the limited resources of the safeguarding team meant that it was almost exclusively occupied in undertaking reactive safeguarding case work with very little time dedicated to proactive strategic, thematic or preventative work[9]. This was confirmed by Oxfam's own analysis in 2017 which assessed that: "*Outside of the Trading Division it is estimated that only 5-10% of activities carried out by the Safeguarding Team focus on preventing sexual exploitation or abuse from happening in the first place."* The Commission found that this had largely been the case for the safeguarding team since at least 2015. At around this time, the then head of the safeguarding team had brought to Oxfam GB executives' and a trustee's attention the resourcing and capacity issues facing the safeguarding team[10]. Following their departure from Oxfam GB the former head of the safeguarding team also contacted the Commission in 2015 about their concerns in relation to DBS checks on volunteers in shops, resourcing of Oxfam GB's safeguarding team and inconsistent reporting of incidents to the Commission.

The Commission engaged with Oxfam GB on these matters between June 2015 and January 2017, and it received assurances from Oxfam GB on the steps it had taken or was taking, including measures being taken by Oxfam GB to increase resourcing of the central safeguarding team. Oxfam GB reported to the Commission in January 2017 that it would be increasing the resourcing of the safeguarding team, however

[8] The Independent Review Team's analysis was restricted to analysing content of the strategy rather than performance against it.
[9] The Commission was provided with evidence of time dedicated to proactive, thematic and preventative work within the Trading Division and its shops, which dealt with a numerically high proportion of safeguarding allegations within Oxfam GB.
[10] Following their departure from Oxfam GB the former head of the safeguarding team also contacted the Commission in 2015 about their concerns in relation to DBS checks on volunteers in shops, resourcing of Oxfam GB's safeguarding team and inconsistent reporting of incidents to the Commission. The Commission engaged with Oxfam GB on these matters between June 2015 and January 2017 and it received assurances from Oxfam GB on the steps it had taken to improve the level of DBS checking in its trading shops, to improve the consistency of reporting safeguarding serious incidents to the Commission and on measures taken by Oxfam to increase resourcing of the central safeguarding team.

evidence was provided to the Inquiry that Oxfam GB failed to deliver these promised resources. At the time of the Commission's engagement in October/November 2017, these resources were still not in place; the safeguarding team comprised of 3 posts: 1 safeguarding head; 1 safeguarding advisor; and 1 co-ordinator. The latter post was vacant in October 2017[11], although there had been dialogue prior to this between the trustees and executive on increasing the team's resources. The need to review these resourcing levels was incorporated into the 2017 Action Plan.

The intended strategic safeguarding review planned for 2015, which could have addressed these issues and the concerns of the then head of the safeguarding team did not take place. Instead, a modest increase in the safeguarding team's resources occurred in an effort to alleviate the challenge faced by the team. It is the Inquiry's view that this was simply placing a bandage on the problem. The Inquiry has been provided with evidence that internal concerns continued to be raised within Oxfam GB about safeguarding resourcing up to 2017. Had the strategic review taken place in 2015, the Inquiry considers it more likely than not, that a large proportion of the weaknesses identified by the Commission in 2017 and by the Independent Review Team in 2018, could have been addressed earlier. The 2018 CEO in his evidence to the International Development Select Committee in February 2018 acknowledged that Oxfam GB had not taken the warning in 2015 about overstretch of the team seriously enough and *"….responded gradually rather than dramatically"* to the need for additional resource in the central safeguarding team. It was accepted that Oxfam GB *"should have acted faster"*.

Ultimately it is for the trustees of a charity rather than the Commission to decide how to organise their charity and allocate resources[12]. The Commission's role is to hold the trustees to account for those decisions. The Commission noted that Oxfam had taken decisions in respect of a number of competing priorities however was not satisfied by Oxfam GB's assurances about the adequacy of resourcing dedicated to safeguarding to manage the risks. In its 2017 regulatory engagement the Commission required Oxfam GB to review the organisation, management and resourcing for safeguarding as part of a workstream in the 2017 action plan, originally due for completion by March 2018.

The Inquiry finds that the decisions on safeguarding organisation and resources made between 2015 and 2017, meant resourcing and capabilities did not adequately match the level of risks faced by the charity, its global reach and nature of the activities it carried out. They were also not sufficient to promote and implement the strategic level improvements that were necessary to adequately manage those risks. These decisions and the lack of resource put undue pressure on the safeguarding team. This in turn led to undue and unmanaged risks about the quality, timely progress and effectiveness of Oxfam GB's safeguarding responses. The Commission considers these failures are intrinsically linked to the decisions by Oxfam in respect of its strategic development and response to safeguarding (as covered in the section above). The Inquiry considers the failings in both of these areas between 2015 and 2017 to collectively constitute mismanagement in the administration of the charity.

The 2017 action plan work to address this area was overtaken by the increase in the number of safeguarding incidents being reported to Oxfam GB following the public attention on it in February 2018. This required additional temporary resource support for the safeguarding team to be provided, and by the appointment of the Independent Review Team, to review safeguarding arrangements in Oxfam GB including its organisation management and resources.

The Independent Review Team recommended a new organisational model to improve Oxfam GB's arrangements, which is outlined in annex 3 of the main report. The review concluded that the safeguarding team should be retained within the new organisational safeguarding model but with a more strategic remit "*as the single point of contact for all safeguarding concerns, but their capacity to hand-off cases to other skilled and trained professionals needs to increase"*.

[11] Alongside this, safeguarding in the Trading Division and UK shops was overseen by the Deputy Director of Trading, a part time safeguarding adviser working 3 days per week and 8 HR business partners.
[12] Section 20 of the Charities Act 2011 prohibits the Commission from exercising functions of a charity trustee in relation to a charity, or otherwise be directly involved in the administration of a charity except to the extent permitted by the use of specific powers.

The Inquiry and Review Team has noted that Oxfam GB has made a significant improved investment and commitment in its safeguarding resourcing and capacity to respond, following the Commission's regulatory engagement in 2017:

- Oxfam GB has quadrupled funding for its dedicated safeguarding team from around £120,000 in 2017-18 to £496,000 in 2018-19.This has resulted in the size of the central safeguarding team more than doubling from 3 to 7 full time staff[13]
- Globally, Oxfam has now trained more than 100 people so they are able to investigate safeguarding issues globally and to ensure that they have at least one dedicated safeguarding lead in every country in which it works. This has enabled Oxfam GB to implement partially the Independent Review Team's recommendation to revise Oxfam GB's safeguarding team role into more strategic and co-ordination based functions
- Oxfam GB is also securing safeguarding focal points for the UK-based divisions. They now have 2 new advisors specifically in its Humanitarian Department, able to be deployed to any part of the world
- Seven HR staff in Oxfam GB's Trading Arm, which runs its shops network in the UK, have now been trained to work alongside the existing Trading Safeguarding Advisor.
- Oxfam GB has agreed that it will also ensure there is a safeguarding focal point at all festivals and fundraising events organised by Oxfam GB
- The Safeguarding Director, who reports directly to the CEO, was appointed on 18 February 2019

In summary, Oxfam GB has made good progress in implementing a range of measures to improve its capacity and capability to handle and respond to safeguarding issues but there is more action required. Further work remains for Oxfam GB to complete this phase of organisational development.

Further changes in the role of Oxfam GB's safeguarding team will be implemented in 2019 in line with the Independent Review Team's recommendations as Oxfam GB expands its overseas safeguarding capability.

5. Culture, HR policies and practice

The findings from both the external HR review[14], commissioned by Oxfam GB as part of the 2017 action plan agreed with the Commission, and the Independent Review Team's work highlight some significant past weaknesses in Oxfam GB's culture, HR policies and practice both at a general level and in the specific context of safeguarding. These weaknesses include:

- the ineffectiveness of review mechanisms to ensure Oxfam GB's HR policies and control framework were and remained fit for purpose
- the inadequacy of assurance mechanisms to ensure that the charity's control frameworks were consistently being complied with
- a pattern where documented procedures, policies and practices were not consistently followed
- a culture "*where the organisation's mission and values are not sufficiently embedded in the day to day actions and behaviours within the organisation to reinforce the expected ways of working in line with the code of conduct*"
- ambiguity created by the confederation structure

These findings confirm and reinforce some of the concerns identified by the Commission in 2017.

[13] This is separate from safeguarding resources within the Trading Arm which is overseen by the Deputy Director of Trading, and consists of a p/t time safeguarding adviser working 3 days per week and 8 HR business partners.
[14] The HR review covered the programme related work and did not cover any UK operations or Oxfam GB's Trading division.

The findings from the HR review echoes the concerns raised by others to the Inquiry, which included reported issues of inconsistency and poor behaviour in overseas offices.

In addition, some of these same issues were highlighted in the interim findings of the Independent Commission on Sexual Misconduct, Accountability and Culture Change, published in January 2019 which is examining all aspects of culture, policies, and practices relating to safeguarding across the Oxfam confederation. On tolerance of poor behaviour across the Oxfam network internationally that report gave examples of hearing multiple staff concerns about poor behaviour of the type that *"can create an atmosphere that allows harassment, sexual abuse, and other forms of abuse to take place"*[15] . On inconsistencies and issues with culture on safeguarding it noted "*accusations of various forms of nonsexual misconduct that either have not been reported or did not appear to trigger a human resources investigation"* and *"examples where the speed and quality of an investigation relied on the individuals in country, rather than a high quality system being in place."* The report quotes one member of human resources staff saying *"Communications about safeguarding do not reach across the organisation to staff in the field*."

The Inquiry was informed by the former trustees and former employees' representative in response to the Inquiry's findings that *"Oxfam's assurance processes were designed to provide a clear line of accountability from country level through to the management line. They were in accordance with policies developed through the Human Resources function."*

As illustrated by the results and recommendations of the HR review there were clearly a number of weaknesses in the HR policies and practices and their implementation at Oxfam GB prior to 2018. These include on vetting and referencing practices, recruitment and induction processes, training, performance management and management oversight. The lack of effective and robust centralised and local oversight on culture, consistent implementation of HR policies and practice and lack of accountability – failure to consistently hold people to account for poor behaviour and ensure there was robust and consistent action taken against them in practice – exposed Oxfam to undue risk. This exposure and the fact that the assurance mechanisms that were in place were not effective at identifying these issues earlier and addressing them with the senior executive was mismanagement in the administration of the charity.

The Inquiry observed that, through the Commission's work listening to those who have tried to speak up in Oxfam and in other charities, individuals who have been the victim of abuses of power or position have indicated that a perceived culture of tolerance of poor behaviour is likely to put victims off speaking up. If victims do have the confidence to speak up, they are often concerned they will not be genuinely listened to. Alongside this is a lack of trust in the system, that processes and procedures which exist to protect them will be implemented consistently in practice by people who should ensure action will be taken. For example, the Inquiry was informed by safeguarding professionals that there are barriers in communities in aid camps to raising concerns as the people and agencies they are to report to are often the same people and agencies involved in camp management and who control camp registration. One person gave evidence that they witnessed cases where beneficiaries who raised complaints against Oxfam GB and UN staff were removed from camps and repatriated back to conflict zones by staff who wanted to protect their colleagues. The issue about lack of trust in the system and reporting portal is also reflected in earlier findings connected to the events in Haiti in 2010 and 2011.

The Commission has seen evidence of significant effort by Oxfam GB to take action to improve its culture, policies and practice since the HR review was conducted. The HR review recommended around 40 actions to mitigate risks identified from the review. Of these, Oxfam GB and the Oxfam Confederation are taking forward 35 and Oxfam GB reported to the Inquiry on its last progress update that it has now completed 28 of these actions (70%) and estimate that with, one exception, the remaining outstanding actions will be completed in 2019. Example areas addressed by Oxfam GB include improved vetting and recruitment practices, mandatory induction training, the introduction of new standard operating procedures for

[15] https://independentcommission.org/interim-report-listening-to-people-rebuilding-trust/

safeguarding casework and updating and strengthening Oxfam GB's core values and behavioural expectations.

The Inquiry is clear that what is required is not just putting in place policies and procedures. Culture improvement must be embedded through the day–to-day actions and behaviours of trustees, leaders, staff, volunteers, contractors and partners. Good behaviours must be role modelled from the top and across the network. People who call out poor behaviour need to know they will be supported at all levels. Breaches and poor behaviour should be dealt with fairly, in a consistent and timely manner, with support to immediately change behaviour where possible. Equally, where needed or because of the seriousness of it, policies and practices will be deployed and robustly enforced.

Follow up oversight work will be conducted on behalf of the Commission in 2019 to ensure the remaining work on implementing these recommendations from both the HR review and the Independent Review Team is completed and to evaluate their effectiveness in addressing the cultural and practice issues and risks identified by the respective reviews.

6. Oxfam GB's safeguarding related policies and procedures

The Independent Review Team confirmed to the Inquiry that a number of improvements were made to Oxfam GB's safeguarding related policies in response to the 2017 action plan agreed with the Commission.

While taking into account the recent improvements to its policies, the Independent Review Team identified a number of further improvements which could be made to policies which would assist Oxfam GB to support the adoption of further good practice principles by staff including following relevant statutory guidance.

In addition, the Independent Review Team also reported to Oxfam GB and the Inquiry that it considers that limited supporting procedures have been a factor in the practice issues which it has identified in the handling of some past cases. For example, it has highlighted weaknesses in procedures and past case records which fail to evidence adequate consideration of potential criminality, or assessment of whether there is a need for an appropriate referral to statutory and law enforcement agencies when an allegation or incident is brought to Oxfam GB's attention. In the Inquiry's view, these gaps and weaknesses expose Oxfam GB unnecessarily to further risks.

The Independent Review Team made 23 recommendations relating to policy and procedural changes. Oxfam GB has reported to the Inquiry that it has now completed most of these recommendations, including the implementation of standard operating procedures and protocols to address the practice issues identified by the Independent Review Team. This will be monitored and evaluated during follow up work with Oxfam GB by the Commission.

7. Handling of safeguarding incidents and allegations – case management practice

Several areas for improvement in Oxfam GB's handling of safeguarding incidents and allegations were identified as a result of the Commission's regulatory engagement in 2017, including:

- ensuring improved consistency of handling of investigation and disciplinary processes and achieving appropriate outcomes
- improving the quality of record-keeping and case management records in respect of safeguarding incidents and allegations

The Independent Review Team's findings supported these findings and highlighted a number of issues in respect of case management and practice on some of Oxfam GB's past cases.

The Independent Review Team also found that poor record-keeping and case files meant that there was an inadequate audit trail in a number of historic cases to evidence or explain:

- the scope or terms of reference that had been applied for the investigation or whether any disciplinary action had been undertaken as a consequence of the investigation
- the decisions taken on a case and the reasoning for those decisions
- what consideration was given to relevant legislation and Oxfam GB policies and how these had been complied with
- what consideration by Oxfam GB was given to potential criminality or appropriate referrals to relevant statutory or local law enforcement agencies; for example the Independent Review Team assessed that 76 out of 129 UK cases it analysed met the criteria for a LADO referral[16] but could only find evidence on the file records examined that one of these cases had been referred
- why the use of electronic or virtual means to interview subjects of concern or vulnerable witnesses was considered appropriate

The findings from the Commission's regulatory engagement in 2017 and from the Inquiry are in line with many of the issues highlighted by the Independent Review Team. The Inquiry's view is that without compliance with the basic requirement to make, store and file relevant case records in a structured system (whether manual or electronic) and ensure this is enforced as core practice, it is not possible for the charity or its trustees or executive to either evidence or provide themselves or others with the necessary assurance internally or externally on the robustness and quality of handling of incidents and allegations. The Inquiry is extremely critical of this failing and the lack of adequate assurance, audit and quality systems in place and lack of adequate oversight and scrutiny by the trustees to identify this at an earlier stage.

The Inquiry was also concerned about the Independent Review Team's findings, corroborating weaknesses and inconsistencies identified by the Commission in 2017, about the consistency of investigation and disciplinary handling. The review noted the cases examined by them "revealed a mixed approach to discipline, ranging from very prompt investigations and expeditious disciplinary action to less structured investigations that failed to hold potential wrongdoers to account". The Inquiry appreciates and accepts that there will always be some occasions in any organisation where by human error or oversight some aspects of procedure or policy might not have been strictly adhered to in a particular case. However these would be minor deviations and/or isolated occasions where, in any event the audit, quality and assurance systems and/or management oversight should be able to identify these and provide a safe and constructive environment to ensure they are improved upon and learnt from for the future. In this case, it is evident from the results of the Review that the assurance and oversight mechanisms were not adequately identifying and managing these risks.

The weaknesses in the records management systems had already been identified as part of the Commission's regulatory engagement which Oxfam GB committed to address in the 2017 action plan. Since then a new Oxfam wide case management system, NAVEX, was selected and implemented in June 2018.

The Independent Review Team has provided assurance to the Inquiry that "*The Review has had sight of this system and is reassured that focus is being applied and action is being taken to improve the way in which Oxfam GB collects and stores relevant information"* and that *"This positive step should improve case recording and tracking in future"*. The Independent Review Team also reported to the Commission that they had seen evidence of improving case work practice particularly in the Trading Arm, which oversees the shops network.

[16] Either because the incident involved children or the Independent Review Team considered that the SoC could pose a risk to children.

Further work remains to be carried out by Oxfam GB in developing a case file structure within the new case management system, to improve the handling and storing of safeguarding recording, alongside developing key templates on which Oxfam GB staff and managers can record their activity and decisions, and also to ensure that the updated standard operating procedures and protocols are consistently applied across cases.

Progress on this will be monitored to ensure this is fully implemented and its impact evaluated during follow up with Oxfam GB by the Commission after the Inquiry.

8. Patterns, themes and profile analysis of identified incidents

The Independent Review Team found from its analysis that of 146 incidents, between 2011 and 2018, which it considered met the Commission's serious incident reporting criteria, the alleged victims included:

- 27 individuals under 18 years old – 16 of these were in the UK's trading arm
- 16 beneficiaries
- 11 adults at risk
- 51 members of Oxfam staff
- 10 adult volunteers
- 18 third parties

The Independent Review Team also found that *"the most common allegations contained a sexual element. Unsurprisingly the vast majority of victims were female and the majority of subjects of concern were male. Whilst beneficiaries feature in the victim profile in EA [Executing Affiliate] countries, over half the victims were Oxfam GB staff members, as were the majority of SoCs".*

It is difficult to set an expected level for the identification and reporting of abuse and exploitation for the charity, given its broad geographic footprint, the lack of available benchmarking data and the complexity of the local situations in which it delivers aid. However, the Commission's regulatory engagement in 2017 confirmed that the number of reported safeguarding incidents[17] had increased from 12 in 2011/12 to 87 in 2016/17. This increased to 155 incidents in 2017/18, including 73 reports received between 10 February and 31 March 2018 after Oxfam GB appealed for those who have experienced abuse and harassment to contact its safeguarding team.

Nevertheless, the findings of the Independent Review Team corroborate findings from the Commission's work that the number of reported safeguarding incidents where the alleged victim is a beneficiary remain extremely low in proportion to the large volume of beneficiaries which Oxfam GB supports through its front-line work on an annual basis. This is an issue which has been recognised by both the charity and international aid sector more widely, including Oxfam GB, and which was highlighted in the International Development Committee's report on *'Sexual exploitation and abuse in the aid sector'*[18] published on 31 July 2018.

The Inquiry recognises the particular complexities and challenges which are faced in encouraging dependent and vulnerable beneficiaries to make complaints against organisations and charities which are providing them with support and the intent of trustees to address this matter.

The Inquiry recognises the intent by trustee to address the issue of under-reporting by beneficiaries. It has seen some evidence of efforts to address this particular matter since 2011, including women to women sessions when visiting programmes and more recently in 2018 improving the whistleblowing hotline by making it independent and available in five languages, so that allegations of sexual misconduct can be reported confidentially. Oxfam GB has had a whistleblowing hotline since 2011, but its assessment is that this new external service is now more visible to staff, volunteers and the communities it comes into contact

[17] (not just limited to beneficiaries)
[18] https://publications.parliament.uk/pa/cm201719/cmselect/cmintdev/840/84002.htm

with. However, more needs to be done if the intent is to be realised and there is a range of measures and practices other INGOs and charities working overseas use to build trust in communities and amongst staff and encourage reporting of issues of concern.

Overall the Inquiry found limited evidence between 2015 and 2018 of proactive or strategic initiatives by Oxfam GB to address the issue of under-reporting amongst beneficiaries and limited evidence of monitoring to assess the effectiveness of actions that did take place. The Inquiry considers that this is an area that needs particular focus within Oxfam GB's safeguarding strategy going forward.

9. The disclosure of other safeguarding incidents and allegations from 2011 to 2018 (excluding Haiti and the Philippines)

A key part of the Independent Review was to examine the safeguarding incidents, allegations and complaints reported to Oxfam GB from 2011 (excluding Haiti and the Philippines incidents referred to above) to March 2018, alongside the work of the Commission's inquiry team. The purpose of this was to assess whether or not:

- *"all relevant matters had been reported as Serious Incident Reports (RSIs) to the Commission*
- *all matters involving conduct which may give rise to a criminal offence had been reported to law enforcement or other respective agencies*
- *the circumstances of the notifiable incidents have been fully disclosed to the Charity Commission and*
- *the charity has adequately and accurately disclosed information about these matters to statutory funders and other principal donors"*[19]

The next sections summarise the key findings in the following areas:

- serious incident reporting to the Commission
- disclosure of potential or alleged criminality to statutory agencies
- other engagement with UK safeguarding agencies
- disclosures to statutory donors

(a) Disclosure of serious safeguarding incidents[20] to the Commission (excluding Haiti)

The Independent Review Team analysed 245 safeguarding cases or incidents handled by Oxfam GB between 2011 and March 2018 and concluded that not all incidents that should have been reported were, and for some of those that were they were not reported contemporaneously to the Commission in accordance with good practice at the time. In summary, the Independent Review Team assessed that 146 out of 245 safeguarding cases or incidents handled by Oxfam GB between January 2011 and March 2018 met the Commission's criteria at the time for serious incident reporting.

The Independent Review found that after 2015, no serious safeguarding incidents were reported – either individually or in a multiple report submission – by Oxfam GB to the Commission until 8 February 2018. At that point the trustees provided "a periodic serious incident report for 'safeguarding' cases in the year 1

[19] Extract from the terms of reference for the independent review

[20] Since 2007 charities and their trustees have been subject to the requirements of the Serious Incident Reporting ('RSI') regime. Although some of the detail of what has been required to be reported has been updated over the years, the principle is the same. The regime requires charities with an income of over £25,000 to report serious incidents to the Commission - what happened, how the charity is dealing with it, including confirmation that it has reported appropriate matters to the police, and/or other agencies as required.

April 2016 – 31 March 2017". Two further individual safeguarding incidents were also notified by Oxfam GB, and in total, these reports covered 36 safeguarding incidents. The Independent Review Team noted that "Whilst this represented a significant improvement in the quality of information provided, these reports fell outside the timeline expected for such notifications". The Independent Review considered that only the most recent 36 Safeguarding RSIs made by Oxfam GB in February 2018 were sufficient in respect of content, albeit outside of expected timelines. The remaining serious incidents identified by the Independent Review have now been reported to the Commission.

Based on the information examined and evidence collected, the Inquiry considers that there was a general intent within Oxfam GB and by its staff to make reports and comply with the Commission's guidance on reporting serious incidents. There is evidence to indicate individual incident reporting was taking place on non-safeguarding matters, particularly on counter fraud and counter terrorism/extremism related matters and was generally timely[21].

However, the Inquiry found that the same was not true of safeguarding serious incidents until 2018[22]. They were not individually reported and the incidents that were reported were generally not reported in a timely manner and/or with insufficient information to comply with the Commission's RSI guidance at the time, save for one exception. The Inquiry has not seen any evidence that this situation arose because of a deliberate intent to withhold information from the regulator. The Inquiry's view is that this arose due to a combination of control and oversight weaknesses. The Inquiry found that there were limited assurance mechanisms within the charity until 2018 which would provide assurance to the trustees and executive that the Commission's guidance on serious incident reporting on safeguarding matters was being complied with and that the declaration in the annual return that all serious incidents had been disclosed was correctly made.

The Inquiry has taken into account Oxfam GB's prompt and regular reporting to the Commission on other types of incidents, including on frauds and financial matters. However, the Inquiry is critical of Oxfam GB, in the same way it is of other charities, for not promptly reporting safeguarding related incidents.

The Inquiry will not regard this in itself as mismanagement in this case. However, the lack of systematic assurance internally at trustee and senior executive levels to ensure RSI reporting was complied with is of concern given the annual return statement submitted by the charity each year confirms that all reportable serious incidents have been submitted. This Inquiry is also concerned by the apparent lack of trustee or senior executive oversight or other effective assurance mechanisms internally in Oxfam GB to identify these issues at an earlier stage and ensure that matters which should have been reported were reported. As a result, it is not clear that the trustees could be satisfied that they were adequately managing the wider risks to the charity and were unable to use external reporting requirements to identify potential weaknesses in their overall control framework, including assurance that they complied with their duties and responsibilities under charity law. In the Inquiry's view this contributed to the mismanagement in the administration of the charity identified elsewhere in this report.

The Inquiry is satisfied that Oxfam GB has now put in place improved assurance and internal oversight mechanisms to ensure Oxfam GB and its trustees comply with the Commission's guidance on reporting serious incidents to the regulator. Since March 2018, safeguarding serious incidents has been reported to the interim Trustees' Safeguarding Group, headed by the Chair of trustees. This group now oversees the reporting of serious incidents to the Commission. Further engagement took place between the Commission and Oxfam GB during from the Inquiry to act on the emerging lessons and themes from the Independent Review Team's work and its recommendations on RSI reporting. This engagement included a meeting on 13 September 2018 to discuss multiple reporting. The Inquiry provided regulatory advice and guidance to Oxfam on the proposed amendments to Oxfam GB's RSI policy and approach to reporting. This has resulted in Oxfam implementing further changes to its incident reporting policy and procedures

[21] The Inquiry is not commenting on whether all non-safeguarding serious incidents were reported to the Commission over the years - this is not in scope of the Inquiry.
[22] In reaching this view the Inquiry has taken into account the submission of a redacted version of Oxfam GB's safeguarding register in response to regulatory enquiries in 2015.

and assurance mechanisms to ensure compliance with the Commission's guidance and expectations. These changes were formally approved by the trustees in November 2018.

Oxfam GB needs to ensure that an appropriate level of trustee and senior executive focus and priority on the robustness of its assurance mechanisms in this area continues into the future.

(b) Reporting suspected criminality to law enforcement or other respective agencies

Where criminality is suspected, charities are expected to act responsibly and take action to report it to the relevant authorities. The Commission's RSI guidance sets out clear regulatory expectations that a charity should report suspected crimes to the police and that in some cases a charity must do so. The more serious the crime, or risk of harm to individuals, the more difficult it is to see how trustees could discharge their duties to act in the best interests of the charity and their duty of care to protect the charity, its assets and beneficiaries if they do not. In some circumstances when dealing with children and adults at risk a charity may be legally obliged to report an allegation or concern to the relevant statutory agency. Even where no legal obligation exists, the Commission expects charities to refer relevant matters to statutory agencies to ensure they are acting responsibly to protect people at serious risk of harm.

Where an incident takes place overseas, incidents should usually be reported to local law enforcement authorities and/or safeguarding organisations overseas, in the location where the incident and suspected offence has taken place.

There will be some occasions, where reporting to the police and law enforcement authorities overseas may not be possible. There may be issues with victim consent which may be a legal requirement to reporting in some countries and/or the need to consider that in doing so it may endanger the life or safety of the victim. In some cases this might also apply to the alleged offender. Charities need to consider these carefully and assess the risks, including the risk of harm to others if the matter is not reported, to decide what action to take in these cases. A charity is expected to be able to explain why a case or incident has not been reported and show that that is a reasonable and justified decision in the circumstances.

The Commission is also conscious that charities need to be sensitive to and take account of the different laws and international cultures, including the risk of harm to the victim. In some countries depending on the incident, there may be a real risk of harm or criminality for the victim for cultural reasons (for example in situations of pregnancy outside of marriage, prostitution or sex with teenagers or of people of the same sex). In other cases the victim may not consent or there might be real risk of human rights abuses in that legal system, or of corruption or of individual perpetrator protection in the local judiciary, or a likely risk of community justice or vigilante action.

The Inquiry heard evidence that one of the biggest challenges encountered in getting consent to reporting referrals to local authorities at field level was that often the victims were refugees or displaced minorities who particularly did not trust local authorities or the criminal justice system to uphold or protect their rights.

In cases where a charity has decided not to report incidents to the local authorities, it will be for the charity to explain why a decision not to report is a reasonable and justified one in the circumstances of each case: does it stand up to public scrutiny. The importance of good and systematic record-keeping requirements is underlined particularly when a charity decides not to refer such matters to the relevant law enforcement or statutory agencies.

The Independent Review Team assessed 129 case files involving Oxfam GB and the trading arm. It considered that *"51 cases between 2011 and 2018 may give rise to a criminal offence in the UK, 28 of which were reported to the police or other appropriate statutory authority. In 12 cases it was clear from the case files that the victim either did not wish to pursue a case or make a report to police."* In 11 cases involving potential crimes, the Independent Review Team could not find evidence in Oxfam GB's case files that they had been reported to, or advice sought from, relevant statutory agencies.

The Independent Review Team analysed 83 overseas safeguarding incidents or allegations and found that there were there were 31 cases where the files did not enable clear conclusions to be reached about whether there were potential crimes which should have been reported to statutory authorities but which were not.

The Inquiry is particularly concerned about the finding of the Independent Review that it cannot be evidenced from the files whether potential crimes which should have been reported to statutory authorities were reported and the absence of records to justify decisions not to disclose such incidents or allegations, and is critical of the charity in this regard. The Commission considers that the failure to ensure effective assurance mechanisms were in place to identify these issues at an earlier stage was mismanagement in the administration of the charity.

Recommendations to address this matter in future practice have been made to Oxfam GB. In addition, the Independent Review Team provided recommended actions to Oxfam GB to address the risks on the handling of historic cases where there was no evidence on the files confirming either reporting had taken place to the relevant statutory agency or that there was a conscious decision not to and why.

Oxfam GB has reported to the Commission that it has actioned these recommendations on the historical cases and has contacted identifiable and locatable victims in relevant unreported cases to ascertain their wishes and consent to now reporting those incidents which should have been reported previously but were not. Oxfam GB has also where appropriate established further detail concerning the status of each incident. It has advised the Commission that it has now reported all relevant historical cases to the appropriate law enforcement or statutory agency.

(c) Oxfam GB's engagement with Local Authority Designated Officers on safeguarding incidents or allegations in the UK

All charities must comply with the general law. There are additional legal obligations on certain charities to comply with the relevant legislation and statutory guidance in respect of children and adults at risk. Even where a charity, such as Oxfam GB, does not fall within the specific organisations listed in the guidance, there is a regulatory expectation that it will follow the statutory guidance which aims to protect children and adults from harm as a matter of good practice in relevant cases. This includes reporting certain types of safeguarding incidents involving children or adults which occur in the UK to the relevant local authority or statutory agency.[23&24]

This is relevant and important as the public expect charities to adhere to high standards in how they go about their activities and in safeguarding children and adults at risk from harm. In addition, the fact that a charity is going beyond legal minimum standards and following good practice is often evidence to show that trustees are meeting their trustee duties in acting in the best interests of a charity and taking all steps they can to ensure that they are actively managing and protecting the charity, and people who come into contact with it, from undue risks.

The Independent Review Team assessed the safeguarding cases which took place in the UK to assess the extent of referral and engagement with UK statutory agencies as part of Oxfam GB, and the Trading Arm's handling and response to potential safeguarding concerns. The Independent Review Team's screening process of Oxfam GB's UK based cases assessed that 76 out of 129 met the criteria for a Local Authority Designated Officer ('LADO') referral. Only one of these could be confirmed from the records examined by the Independent Review Team as having been referred to a LADO. Sixteen of these incidents assessed by the Independent Review Team involved persons aged under 18 years. The 60 other incidents did not

[23] *For Children & Young People:* In England - Working Together to Safeguard Children 2018 / In Wales - All Wales Child Protection Procedures / In Scotland – National Guidance for Child Protection Scotland / In N Ireland – Co-operating to Safeguard Children & Young People in Northern Ireland.

[24] *For Adults:* In England - The Care Act 2014 / In Wales - The Social Services and Well-Being (Wales) Act 2014 and Social Care Wales./ In Scotland – The Adult Support & Protection Act (Scotland) 2007 / In N Ireland - Adult Safeguarding: Prevention and Protection in Partnership key documents (2015)

involve children but the individual worked with under 18 year olds. In their view the Review Team assessed that the behaviour of the individuals at the centre of the complaint indicated that the individuals may pose a risk of harm to children and therefore met the statutory guidance referral criteria. The Inquiry is particularly concerned about this finding.

The prudent thing for a charity to do is to report all incidents which appear to meet the referral criteria to the relevant LADO and take advice from them, irrespective of whether the LADO subsequently agrees with the assessment that the matter is a reportable incident. If the LADO assesses there is no risk, then the charity has that assurance on record and the charity will be discharging its duties to take reasonable steps to manage the risks and act in the best interest of the charity. By not reporting in those cases – and in the absence of records of the reasons why – it is not possible to conclude the charity discharged its duties and met the standards expected of a charity of this nature and size.

Recommendations have been made by the Independent Review Team to Oxfam GB to manage the risks arising from this finding, address these weaknesses in Oxfam GB's safeguarding case management and to improve early engagement with UK LADOs on relevant cases.

Oxfam GB is actioning the recommendations:

- Notwithstanding Oxfam GB have expressed concern to the Inquiry about Ineqe's approach to assessing when a referral to a LADO should be considered and made, it is notifying the relevant LADO of all remaining non-recent cases identified by the Independent Review Team as reportable for which no record exists of previous notification[25]
- It has also
    - taken more action to establish formal general links with local LADOs
    - rolled out training with a local LADO to Oxfam GB's HR Business Partners
    - tasked Oxfam GB's new Director of Safeguarding with work to oversee the development of a specific referral document for Oxfam HR Business Partners, and endorsed by a LADO, to assist Oxfam GB decision-making in what to and what not to report to LADOs in the future
- It has, where appropriate, established further detail concerning the status of each incident. Oxfam GB has advised the Commission that it has now reported all relevant historical cases where it is not clear to the appropriate LADO.

(d) Disclosure of information to statutory funders and other donors

Oxfam GB advised both the Commission and the Independent Review Team that, due to the nature of the legacy systems, it was unable to locate any records of the information previously disclosed to statutory funders in the UK, including DFID.

The Inquiry therefore agreed in the circumstances that the Independent Review Team should review a sample of four recent donor reports to statutory funders. The Independent Review Team assessed that: *"Each of these were found to be comprehensive, focused and evidence based and, in the opinion of the Review met the needs expected for such reporting. Oxfam GB has now developed a comprehensive Reporting Misconduct Standard Operating Procedure (SOP) which the Review recognises as good practice."*

[25] As at 22 April 2019, 40 cases had been referred to the relevant LADO; 11 cases had been tracked down and now need reporting, and work continues on the others. Of the 40 incidents reported to LADOs so far 28 have generated advice or responses from the LADOs that the referrals do not fall within the LADO's scope. Some of the LADOs' responses or reasoning, as reported by Oxfam, are of some concern to the Inquiry and further clarification on these particular referrals will be sought by the Commission.

10. Safeguarding risk management in Oxfam GB's shops

Oxfam GB's Trading Arm operates a large estate of over 600 retail shops, which is supported by around 1200 employees, and a, mainly adult, volunteer base of over 22,000 which also includes around 2,200 young people aged under 18 years. It is the Inquiry's view that the potential safeguarding risks are enhanced by the decisions of the trustees to accept in their workforce both volunteers who are subject to a community service order or who are transitioning from prison ('CSO volunteers'), as well as young people.

It is fully recognised that volunteering is an important part of rehabilitation for CSO volunteers: it enables ex-offenders to participate in positive activity, build confidence, rehabilitate and can be part of a package of resettlement support.

Oxfam GB informed the Inquiry that it was important to them corporately as a way of supporting a vulnerable group at risk of moving into poverty. Also, as "*Oxfam's value of inclusiveness is central to its Volunteering Policy: working with ex-offenders, with all appropriate safeguards in place, is one way by which Oxfam lives that value."*

Trustees are under a duty to ensure that the risk management frameworks are adequate to mitigate and manage enhanced potential risks and that Oxfam GB's employment and other policies and procedures designed to identify and manage higher risks are followed. At the time of the review, the Independent Review Team identified 12 individuals transitioning from prison and 57 serving community sentences who were volunteering in Oxfam's UK stores. The review established that seven of the individuals serving community sentences had not been subject to a risk assessment, in accordance with Oxfam GB's policy. These seven instances related to three trading shops. Oxfam GB gave evidence to the Inquiry in May 2019 that they had already identified and were dealing with issues in one of the shops.

One particular area of enhanced risk is with managing known registered sex offenders. In particular, Oxfam GB must ensure that the charity's procedures for the handling of registered sex offenders, including previously undisclosed or suspected sex offenders ('undisclosed RSOs') subsequently identified within the volunteer base are scrupulously followed. This is particularly important when an individual would be volunteering alongside other volunteers under 18 years old or adults who may be regarded as at higher risk of harm. The Independent Review identified nine undisclosed (or suspected undisclosed) RSOs who had undertaken volunteering in Oxfam's shops[26]. Within these, in a small number of occasions shop managers/staff appeared to have suspected or known about an undisclosed RSO volunteering in Oxfam GB's shops but did not deal with it in the way expected. The shop staff/manager had "*allowed the risk to continue*", contrary to Oxfam GB's policy. The review found "*some of the practice involving these cases demonstrates a clear lack of understanding of safeguarding".*

In response Oxfam have provided evidence to the inquiry that this related to 2 instances out of 9 occasions where undisclosed RSOs were identified. In both of these cases Oxfam state that the *"invitation to volunteer was withdrawn as soon as senior management became aware of the RSO status*".

Oxfam also stressed to the inquiry that to date none of the safeguarding incidents or allegations which had been dealt with the by the Trading Arm involved CSOs or undisclosed RSOs.

Oxfam GB have taken further steps to strengthen this area and have reported to the inquiry that they have now addressed all the Independent Review Team's recommendations in this area.

The Independent Review Team reported to the inquiry that *"Oxfam GB's Trading Arm (TA) is the most 'recognisable' in the sense that its safeguarding functions mirror what would be seen in many other UK based operations. The eight regional Business Partners (HR trained professionals) provide a good framework to support the many staff and volunteers working in Oxfam GB's shops across the UK. Whilst this team needs to strengthen its engagement with UK wide LADO arrangements, it is delivering responsive and valued support."* The independent review also reported *"In terms of the investigative process….. the*

[26] Six of these cases were from 2017, the other 3 cases were from 2016 or older.

Review did see evidence of tangible improvements, especially in the Trading Arm, where casework was assessed by the Review as being higher in quality."

The inquiry has been provided with evidence by Oxfam which demonstrates a progressive and proactive approach to the management of safeguarding risk within its Trading Arm. This includes safeguarding training programmes for shop managers, improvements in the vetting of shop managers and key volunteers through DBS checks. It is currently exploring how it can enable basic DBS checks for all of its volunteers. The Trading Arm now has an internal audit function which aims to ensure that each store is audited every two years to assist with compliance, risk and performance management of its shops.

While the inquiry has seen evidence of a proactive and developing approach to risk management in Oxfam's shops, in particular since 2016, there are some matters arising from the internal audits which concern the Commission:

Overdue audits/audit completion rates

Although Oxfam has an aspiration to internally audit each shop once every two years there are currently 161 shops (approx. 27% of the network) which are overdue an audit and 50 shops which are currently without an allocated auditor. The annual internal audit report for 2018/19 notes that *"Over the last number of years several of the volunteer auditors have dropped shops to reduce their workload due to age/health reasons. This scattering of shops has made recruitment difficult due to the distance between sites".*

The inquiry requires Oxfam to review and address this matter to ensure that it has in place an adequately resourced internal audit programme which can provide the trustees with appropriate and timely assurance on risk management in Oxfam's shops.

Shop volunteer worker risk assessments

Oxfam GB's Trading Division's policy is to risk assess *"all volunteers, not just CSO volunteers, children and adults at risk".* The inquiry considers that these risk assessments are an important measure given the results of the Independent Review Team's work which assessed that at least 80% of safeguarding allegations and incidents in Oxfam's shops involve volunteers[27].

The inquiry requested information from Oxfam's internal audit work on shop volunteer workers risk assessment forms. The information provided shows that 9.7% of shops audited in 2018/19 were marked down for not having the required documents in place/incomplete documents on file. Although this is an improvement on the 2017/18 results (13.9% of audited shops were non-compliant) the non-compliance rate is a cause for concern for the inquiry since it indicates that potentially around 60 stores are not adequately complying with Oxfam's risk assessment policy.

Although the inquiry accepts that it may not be possible to obtain 100% compliance it requires Oxfam to review this matter and consider what further reasonable steps it can take to improve compliance in this area.

Tolerances for non-compliance and risk weighting

At present compliance with each audit question carries equal weight. However, it is the inquiry's view that the organisational risk arising from non-compliance can vary from question to question and that the current approach will not necessarily identify higher risk thematic areas, such as shop volunteer worker risk assessments, which require management attention and/or trustee scrutiny. As such it is the inquiry's view that Oxfam should review its approach to tolerance levels for non-compliance for individual questions or areas. A revised or weighted approach to non-compliance may also alter those stores which are flagged as red or high risk.

[27] The independent review assessed from a sample of from 65 safeguarding allegations and incidents recorded in the Trading Arm, that 80% (52) of the subjects of concern were volunteers.

Red/High risk stores

The inquiry recognises that there will always be a proportion of stores with some compliance and performance issues in an estate of over 600 shops. The inquiry also notes the reduction in red audits from 60 in 2017/18 to 25 in 2018/19. However of some concern to the inquiry is that a small core of 12 stores with compliance issues have between them received 34 consecutive red audits in 2018/19. A similar pattern arose in 2017/18.

The inquiry requires Oxfam to review the mechanisms and frequency by which the Trading Arm management are held to account for their audit reports and for the delivery of effective action plans to remedy poor compliance.

It is imperative that the trustees and executive ensure that there are appropriate measures in place to provide them with assurance of compliance in this area going forward. This area will be specifically followed up on and tested by the Commission as part of its monitoring and oversight follow up work after the Inquiry.

Conclusions and wider lessons

Conclusions

No charity is more important than the people it serves or the mission it pursues.

The charity's governance and culture with regard to safeguarding has repeatedly fallen below standards expected and failed to meet promises made. Whilst it is clear that after the events in Haiti in 2011, the trustees voiced their commitment to prioritise safeguarding, decisions on safeguarding made between 2012 and 2017 meant resourcing and capabilities did not adequately match the risks faced by the charity. The charity's actions were not sufficient to implement the strategic level improvements they themselves identified and committed to as necessary. These decisions and the lack of resource put undue pressure on the Oxfam GB safeguarding team, who raised their concerns with the senior executive and trustees at the time. As late as 2017, promises that the resources for safeguarding would be increased were not delivered.

Oxfam had a responsibility to provide a safe environment for its beneficiaries, staff and other charity workers in the delivery of its overseas work and here in the UK. It did not always do that. This is evident in what happened in Haiti in 2011. A culture of tolerating poor behaviour existed in Oxfam in Haiti at the time. There were early warning signs of this from 2010; ultimately some individuals took advantage both of the charity's presence in Haiti and the culture of poor accountability that existed.

Oxfam GB's approach to reporting to donors, agencies and the Charity Commission as its regulator was not as good as it should have been. The Inquiry concludes that Oxfam GB's initial reporting of Haiti should have been more full and frank – the current leadership of Oxfam GB agrees. Oxfam GB have explained why this happened and have accepted the criticism and learning on this. The Inquiry is also critical of how the charity presented the resignation of the Country Director at the time.

The events in Haiti in 2010/11 and concerns about how they were handled have become a focal point for the resulting damage to public trust and confidence in the charity and other charities over the last year. The then trustees and executive did take time to reflect on lessons learnt from the events of Haiti in 2011 and put actions in place to address these. However, the Inquiry is critical of aspects of Oxfam GB's handling of those incidents and other allegations at the time. The combination of these incidents and the way in which Oxfam GB reported and dealt with them undoubtedly damaged Oxfam's reputation as a major aid charity and the confidence its beneficiaries, staff and volunteers and public need to have in it. Neither the actions of those people involved in the events in Haiti nor the harm done can be justified or minimised by reference to the vital humanitarian relief work of Oxfam.

Ultimately Oxfam GB's culture and response on safeguarding matters throughout the period from 2011 to 2017 fell short of expectations and the commitments made:

- safeguarding was not ignored by the trustees, but neither the resources committed nor the executive's implementation was enough to constitute an adequate organisational response
- the importance of responsible behaviours and conduct was not embedded in part of its daily activities across the organisation and its work and people
- this led to a workforce that was not empowered or confident enough to challenge poor behaviours
- nor did the workforce have the necessary confidence in management and systems for reporting concerns
- the risk to, and impact on, the victims appeared to take second place at times and was not taken seriously enough; victims, whistle blowers and those staff who tried to raise concerns were let down.

At the beginning of the Inquiry, Oxfam GB's Chair provided an unequivocal commitment to the Charity Commission that Oxfam GB, its staff and trustees would co-operate fully with the Inquiry, and they have done so; she also committed to resolving the issues faced by the charity to restore public trust and confidence in Oxfam GB and enable the critical work of the charity to continue.

The Charity Commission has given an official warning to Oxfam GB as a sanction for past failings. The Inquiry concludes and recognises that the charity, through its leadership, has made significant progress to improve weaknesses in its safeguarding since 2017 and during the period of this Inquiry. Significant further cultural and systemic change is required to address fully the failings and weaknesses identified by the Inquiry so the Charity Commission has issued a regulatory direction to provide continued public assurance that the outstanding actions necessary will be implemented.

Some of the issues highlighted in the inquiry are not confined to Oxfam GB, as other reports and events over the last year demonstrate. Charities now need to ensure they learn the lessons from these findings. Keeping people safe is an integral part of their front line operations. It is not an added extra.

Wider lessons

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.

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.

Operating internationally, across multiple legal jurisdictions and cultural contexts and in the midst of humanitarian crisis, is a profoundly complex and difficult endeavour and lives depend on the work of UK charities and the thousands of charity workers and volunteers across the world. Public expectations of charities operating in this space are high precisely because of the critical importance of this work. Failure to take reasonable steps to protect people cannot be excused by the difficult context a charity is working in, nor can incidents of harm be justified in relation to the importance of the cause.

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.

Raising concerns often takes courage, and those who do so deserve to be taken seriously and treated with respect and sensitivity. It should be clear how to raise concerns in a charity, there should be a proper process for listening to and assessing concerns raised by a whistle blower, and whistle blowers should be told what has happened as a result of their report.

Dealing properly with incidents of harm to people, reporting them, and ensuring lessons are learned and acted on will protect the reputation of a charity in the long term; it means that donors, stakeholders and the wider public can be confident that the charity operates with integrity and delivers on its charitable purpose. Focusing on avoiding negative or critical media coverage when incidents have happened will not fulfil the trustees' duty to protect a charity's reputation, nor serve the shared responsibility to uphold the reputation of charity as a whole.

Charities must never lose sight of why they exist and must demonstrate how their charitable purpose drives everything they do, and most especially how they respond when things go wrong.

Regulatory Action

On 7 June 2019 the Commission exercised its legal powers and issued an official warning under section 75A of the Charities Act 2011 on the grounds there has been some areas of mismanagement in relation to Haiti and its safeguarding governance prior to 2018. The Commission considered using the power was appropriate and proportionate to promote compliance and assist with repairing public trust and confidence. The action will give public assurance the charity was being held to account for past failings, corporately and collectively and also assist in giving confidence to current and potential donors and funders that there has been sanction for previous failings where the charity has fallen short on safeguarding.

On 10 June 2019 the Commission exercised its legal powers and made an order under section 84 of the Charities Act 2011 directing the trustees to take action expedient in the interests of the charity to give continued public assurance that the outstanding actions to implement the recommendations made by the Independent Review and related matters will be carried out.

The order directed the trustees to take actions including to submit an action plan for the Commission's approval by 30 June 2019 which sets out the steps by which it will, acting in the best interests of the charity, implement the outstanding actions relating to 1) recommendations and other actions required by the Commission related to safeguarding risk management and assurance matters in respect of Oxfam's UK shops, and 2) other matters arising from the final report recommendations and findings of the Independent Commission on Sexual Misconduct, Accountability and Culture. Further, to then implement those actions by the specific, agreed dates for each one, provide written progress updates until the completion of the work and provide assistance to the follow-up verification work directed, supervised or undertaken by the Commission.

In closing the inquiry the Commission provided general regulatory advice and guidance under section 15(2) of the act in relation to trustee duties on safeguarding and trustee duties.

Oxfam GB's response

In February 2018, Oxfam GB issued a statement, which is still on its website at the date of this report that said:

"You will have seen reports of the sexual misconduct of some former Oxfam employees in Haiti in 2011 and in Chad in 2006. We are so sorry for the appalling behaviour that happened in our name. We are an organisation that fights for women's rights, and that makes this disgraceful behaviour particularly hard to bear. We want you to know we're doing everything in our power to help stamp out abuse, and we'll be keeping this page updated with information as we continue this vital work."

The current Chair, Caroline Thomson, issued a further statement that said that "*things have to change and we will learn from these mistakes"*.

The current Chair and the 2013 CEO signed a joint letter dated 17 February 2018 to Oxfam's supporters and volunteers. In a statement on Oxfam GB's website the Chair apologised for the sexual misconduct of some former Oxfam staff in Haiti in 2011 and in Chad in 2006. They also apologised to the people of Haiti and Chad, who they confirm "*had a right to expect the very best of us*".

Oxfam GB's 2017-18 annual report, published in October 2018, included a statement from then Chief Executive Mark Goldring that: *"From 2011, we began to make improvements to our safeguarding practices but it is a matter of deep personal regret that we did not go far enough fast enough. There are no excuses. Since February, we have embarked on a process of deeper transformation."*

In 2019, the current Chair wrote to the Chair of the Charity Commission apologising on behalf of Oxfam for all the failings identified by the work of the Inquiry and explaining that the Council continue to feel a sense of shame that the behaviour in Haiti in 2011 happened in the organisation. The current Chair said that she is particularly sorry that Oxfam did not in 2011 investigate adequately the allegations of 18 July 2011 that minors were being sexually abused by Oxfam employees, nor report them to the Commission or law enforcement at the time, stating: *"Today, such a serious allegation would be dealt with very differently".* With the agreement of the Charity Commission, Oxfam referred the allegations to the law enforcement agencies during the course of this Inquiry.

The current Chair apologised that in 2011 Oxfam had allowed the then Country Director to resign without investigating and reporting matters that came to their attention before and immediately after he resigned – particularly for allowing him to have a *"phased and dignified exit"*. The current Chair further apologised that prior to 2018 Oxfam had not fully complied with the Commission's serious incident reporting regime in relation to safeguarding incidents, due to control and oversight weaknesses, and that Oxfam's safeguarding case records and management were inadequate meaning record-keeping and effective oversight were hampered.

In 2019, giving the keynote speech to the NCVO annual conference, the new and current CEO of Oxfam GB promised to address the power abuses that the High Level Independent Commission on Sexual Misconduct, Accountability and Culture Change at Oxfam had identified as a key factor in enabling abuse.

*"The cause of our **safeguarding** failures lay not only in faulty procedures or policies, but in an institutional culture that privileged and protected certain people and practices.*

"The changes we need to make at Oxfam are both systemic and cultural. They include our policies and practices….. But they also include our attitudes and behaviours. We need to make a concerted, explicit effort to deconstruct the power inequities that are all too easily built into, and perpetuated by, institutions like ours."

The current Chair has also assured the Commission of Oxfam's continued focus on learning and improving, noting that Oxfam sees the Commission's Inquiry report as being an important step in its journey of improvement and of rebuilding trust with Oxfam's key stakeholders.

Oxfam GB has overhauled its processes for reporting serious incidents to the Charity. Oxfam GB has accepted all 79 recommendations from the Ineqe Independent Review. The trustees of Oxfam GB are actively monitoring their implementation and have reported to the Commission that 59 recommendations had been implemented as of 31 May 2019.