

REPORT OF THE INDEPENDENT SCRUTINY TEAM

INTO

**THE ADEQUACY OF THE CHURCH OF ENGLAND'S
PAST CASES REVIEW**

2008-2009

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June 2018

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EXECUTIVE SUMMARY

1. This Executive Summary is followed by the main body of the report which provides background, the approach of the scrutiny team and the findings. The report concludes with some considerations, recommendations and acknowledgements.

2. In summary: A Curate's Egg.

More specifically:

- The House of Bishops decided on the need for a review of past cases in May 2007. This followed court appearances by several clergy and church officials charged with sexual offences against children. A working group was established to advise on how the review should be conducted. The protocol which emerged provided for the then diocesan Child Protection Adviser to draw up a list of known cases of child safeguarding concerns relating to clergy and other church officers and to submit this to an Independent Reviewer who would advise the Diocesan Child Protection Management Group on whether any further action was required. Following that the reviewer was to read the files of all licensed clergy; all readers and those in lay ministry; employee files of those having access to children via the Church; and the files of all clergy with permission to officiate. If any new concerns arose from this work then names and relevant details were to be added to the list of known cases for further action to assess and manage risk. When this was completed, the Diocesan Child Protection Management Group was to prepare a report for the bishop who would send it to the National Safeguarding Adviser together with an anonymised copy of the Known Cases List and a statistical report, the format for which was later prescribed by the National Church.
- The Independent Scrutiny Team found the protocol to be a thoughtful and well-intentioned piece of work. Advice was taken from agencies with relevant expertise and the Church embarked on the initiative without knowing what the outcome would be. There were some shortcomings in the protocol, principally a lack of clarity about which roles were within the scope of the review; the exclusion of parish employees and volunteers; little involvement of church bodies and institutions outside episcopal oversight; an absence of involvement by victims and survivors; and a lack of clarity about some of the reporting requirements. But as one person commented: "We were working in the dark. Nothing like this had happened before."

- Whilst compliance with the protocol was generally high there were some exceptions in relation to the choice of independent reviewers; the conduct and comprehensiveness of the file review; and the mixed quality of recording in relation to the actions taken and the outcomes.
- Some diocesan staff experienced difficulty in locating files and independent reviewers commented adversely on the quality of case recording, file content and maintenance. Notwithstanding this, over 40,000 files were reviewed – a not inconsiderable achievement.
- The evidence is that most independent reviewers adopted a thorough approach to their task with any indication of a child protection issue being identified and noted for further action.
- We were not asked to examine or sample individual case records although we have seen some case vignettes and summaries. Consequently, it was not possible to adopt a wholly consistent approach to forming views on the judgements which had been exercised in 2008-09 in relation to names put on the known cases lists, action plans or outcomes. Our assessments have, of necessity, been made on highly variable data. However, three quarters of the current diocesan safeguarding advisers, most of whom were not in post in 2008-09, regard the Past Cases Review as having been competently conducted in their dioceses and have evidenced their views. Many of the cases have been reviewed several times: by the Independent Reviewer; the Diocesan Child Protection Management Group; by subsequent diocesan safeguarding advisers; and in some dioceses, by later external reviewers. And with a small number of exceptions, the number of cases per diocese which might have been identified in 2008-09 but were not and which have subsequently come to light is none or one.
- We found little evidence of work with victims or survivors as a direct consequence of the review.
- There were considerable inconsistencies in the completion of the statistical reports such that care should be exercised when drawing conclusions from the returns. The form itself was confusing; the instructions accompanying the form contained ambiguities; and the form was only available after many dioceses had commenced or almost completed their reviews.
- A decision was taken by the House of Bishops to report publicly only on newly identified cases and those requiring formal church action. “Formal church action” was narrowly defined. Consequently, the public statement, made via a press notice, whilst factually accurate in most respects, failed to reflect the true extent of

the issues which needed to be addressed. Moreover, its claim that “... nobody representing the Church in a formal capacity has allegations on file that have not been thoroughly examined...” could not be wholly evidenced.

- Whilst acknowledging that the staffing resources available at the time were scant, the National Church’s oversight of the past cases review process was limited to seeking reports whilst engaging – with some exceptions in relation to the statistical returns – in little interrogation.
- In considering whether any form of repeat activity is required by dioceses, we conclude that no further work is needed in 35 dioceses and the provinces. An updated form of PCR is recommended in 7 dioceses.
- In relation to all dioceses, files not available or known not to have been examined in 2008-09 should be independently reviewed including any files of diocesan employees working with children not considered in 2008-09 or since.
- We also make recommendations to:
 - ensure that all safeguarding concerns relating to parish employees and volunteers working with children have been notified to the diocesan safeguarding adviser
 - arrange for Cathedrals and all other parts of the Church with their own decision-making bodies to conduct a suitably updated review if they were not involved in the PCR or have not subsequently undertaken such a review
 - engage with these other parts of the Church to facilitate a “Whole Church” approach to safeguarding
 - recognise the minimal response which the Church made to victims and survivors following the PCR and more generally improve the Church’s responses to those who have suffered abuse by clergy and church officials
 - give renewed impetus to enhancing the quality and consistency of recording, file maintenance and appropriate cross-referencing of safeguarding issues and develop its thinking and practice for preventing child sexual abuse and not just responding to it
- In conclusion we found the Past Cases Review to be well motivated and thoughtfully planned given the limited resources available at the time. It led to hundreds of cases of concern being reviewed and additional actions taken where appropriate. There were some limitations in relation to its execution and the public statements which were subsequently issued. Recommendations have been made

to address these shortcomings and to help the Church to build on the strong policy, procedures and training foundations which have now been laid.

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June 2018

INTRODUCTION

3. In May 2016 Roger Singleton was asked by the National Safeguarding Advisor (**NSA**) of the Church of England to lead a moderation panel to consider the accuracy of judgements made from a screening process conducted by two assessors on behalf of the Church's National Safeguarding Team (**NST**) earlier in the year. This screening process was in relation to the Past Cases Review (**PCR**) carried out by all dioceses of the Church between 2007 and 2009. He recruited Ms Amanda Lamb and Mr Donald Findlater to join the moderation panel. Both had extensive experience of safeguarding matters and our short biographies are at Appendix C. None of us had any involvement in the PCR until asked to carry out this scrutiny assignment, except that Mr Findlater contributed to the Lucy Faithfull Foundation's comments on the draft of a protocol which was to prescribe the modus operandi of the PCR (see para 11).

4. For purposes of clarity we refer to the moderation panel as the Independent Scrutiny Team (**IST**). The title Child Protection Adviser (**CPA**) refers to diocesan safeguarding staff in post at the time of the PCR itself. The role, in most dioceses, was renamed Diocesan Safeguarding Adviser (**DSA**) and we use this for the staff engaged in subsequent and contemporary work.

5. We had access to the two NST assessors' brief notes of their telephone interviews with the current **DSAs**; copies of statistical reports submitted to the National Church in 2009/10; and an assortment of other emails and documents. The limitations of the screening process soon became apparent and it proved impossible to form a credible judgement on the adequacy of the PCR in each diocese based on the information made available to us. Following consultation with the Church's National Safeguarding Steering Group in January 2017 our task and terms of reference were revised:

- a) *To review the process and content of the PCR 2007-09 in relation to the objectives and procedures set for it in the House of Bishops' Protocol (described below at para 16) and having regard to the reports and returns made by the dioceses at the conclusion of the PCR; the follow-up sought in October 2010; the reflection on the standard of the PCR requested as part of the Review of Deceased Clergy Files in October 2013; and the screening exercise carried out on behalf of the NST in 2016;*
- b) *From the available documents, to assess the extent to which the PCR was conducted effectively in each diocese;*

- c) *In dioceses where reliance cannot be placed on the thoroughness of the PCR, to identify, seek and evaluate additional information relating to further work which has been done since the PCR which may address its shortcomings;*
- d) *In making these judgements, to have regard to the Social Care Institute for Excellence (**SCIE**) audits of contemporary work in each diocese to assess whether a repeat form of PCR is necessary; and*
- e) *To produce a final report setting out findings and recommendations which for the purposes of transparency will be published and submitted to the Independent Inquiry into Child Sexual Abuse (**IICSA**).*

6. We were subsequently given access to substantially more information relating to the PCR and following appraisal of this we invited dioceses to submit any additional documents which bore on the thoroughness or otherwise of the PCR 2007-2009 and any follow-up work undertaken. Whilst there have been a number of clarifying conversations and e-mail exchanges with persons directly involved in the PCR and follow-up work and with the current DSAs, this report has been principally compiled from the documents we have read and the judgements we have made.

7. We are aware that since 2009 there have been cases of actual or alleged historical abuse against some senior clergy which have received significant national publicity. These have been the subject of separate inquiries. We have limited ourselves to commenting on whether these cases, if known about in 2007, were considered as part of the PCR process and dealt with appropriately.

BACKGROUND

8. At its meeting on 22 May 2007 the House of Bishops considered the need for a review of past cases. This was prompted by a number of high profile convictions involving child abuse by clergy and church officials and in particular by the sentencing the previous month of Peter Halliday, a former choirmaster at St Peter's Church in Farnborough, who had admitted to 10 counts of sexual abuse of boys between 1986 and 1990. We understand that in 1990 the rector and the Bishop of Dorking were informed about the abuse but that they did not notify the police. Instead Peter Halliday was told that he could leave quietly as long as he had no more contact with children. He went on to be a governor at a secondary school and work with a children's choir. The Church was accused of a cover-up.

9. The day after the sentencing hearing, the then Archbishop of Canterbury issued a statement expressing his deep sorrow over the suffering experienced in child abuse cases involving the Church.

10. The outcome of the House of Bishops' debate in May 2007 was a request to the Church's Central Safeguarding Liaison Group (**CSLG**) for advice on how a review of past cases should be managed. On Radio 4's Today programme the Archbishop of Canterbury explained that the House of Bishops had agreed to take advice "*... on how we should best conduct a review. We don't just want to look good, we want to do it properly, and so we need to have the best professional advice on how we might review these historic cases.*"

11. In the weeks following the Archbishop's interview the CSLG established a Past Cases Review Working Group (**WG**) to develop a protocol for the PCR. The protocol was to be based on best practice for reviewing historic cases and the WG drew on the experience of the (Roman) Catholic Office for the Protection of Children and Adults, the National Society for the Prevention of Cruelty to Children, the Lucy Faithful Foundation and the Churches' Child Protection Advisory Service.

12. A draft protocol was put before the House of Bishops at its meeting on 3 October 2007. Although the discussion centred around the draft protocol, it also involved a range of related matters. It covered practical areas including the location of files of retired clergy; the question of costs and resources, nationally and for dioceses; the role of the NSA (then being only a part time post); publication of statistical data; whether and how to request information from past senior office holders or from all retired clergy; whether the scope should include lay workers and volunteers; and the fact that many historic files had apparently been shredded in accordance with perceived data protection requirements. The discussion also addressed more substantial issues concerning the nature and purpose of the review and

ambivalence was expressed by some in this regard. A concern was raised as to whether there was a danger of over-reaction and whether the review process should proceed as planned. On the one hand, it was pointed out that the process could not be 'fool-proof', that the Roman Catholic Church's approach had proved destructive of clergy morale, and that the real victims could include those clergy and church officials about whom unfounded allegations had been made. On the other hand, it was noted that there was widespread expectation that the review would be carried out and that a failure to proceed might be taken as evidence of a church culture which colluded with child abuse.

13. In the light of these comments, the WG made amendments to the draft and on 5 December 2007 the House of Bishops' Standing Committee agreed to sign off the Protocol. On 10 December 2007 the Lead Bishop on Safeguarding at the time, the Bishop of Hereford, wrote to diocesan bishops enclosing a copy of the Protocol; explaining that the CSLG was working on a question and answer document; and that there would be a 'low-key' press announcement the following day. In relation to deceased clergy, the letter said, "*the reviewer will not often have the necessity to review the file of a person who is deceased... unless information arises, which necessitates further examination of all the issues including the file*".

14. The letter advised that a copy of the Protocol would be sent to Church bodies and institutions with their own decision-making arrangements – Cathedrals, Religious Communities, Theological Colleges, the Central Council for Church Bell Ringers, Missionary Agencies, Royal Peculiars and the Royal School of Church Music. It was suggested that bishops may wish to be in touch with such groups in their own dioceses.

15. The letter raised concerns about the need to ensure, as far as possible, a consistent and thorough approach across the dioceses. Dioceses were, therefore, invited to work with the model Protocol as approved and adopt it as fully as possible. In the preface to the Protocol, the Lead Bishop on Safeguarding said that the Protocol should be adopted by each diocese to ensure consistency in good practice and emphasised that it was important to ensure that there were no situations where either there were outstanding allegations that were unaddressed or where children may still be at risk. It was anticipated that the PCR would be completed by June 2009.

16. The Protocol identified six "purposes":

1. *"Bishops, together with their Diocesan Child Protection Management Groups (DCPMG) and Child Protection Adviser(s) (CPA), should ensure that any cases which were known of in the past but not adequately responded to, should be the*

subject of urgent review, reported to the statutory authorities wherever appropriate, and that follow-up action is taken.

2. *The key purpose of the review is to ensure that in every case, the current risk, if any, is identified, and appropriate plans are made to manage the identified risk to children and young people and take any action necessary in the light of current statutory and good practice guidance.*
3. *The review is to cover any cases involving any clergy, employees, readers and licensed lay workers or volunteers in the Church about whom information of concern exists. These concerns could relate to a child who is or may have been ‘at risk’, or to a continuing risk that an individual may pose to children or young people.*
4. *If the review identifies anyone who has suffered abuse in the context of church life, they should be offered support as suggested in ‘Promoting a Safe Church – Recommendation 4.*
5. *The independent review is to be undertaken by a suitably qualified, independent Reviewer (under the direction of the DCPMG), as detailed in Section 5 and Appendix 5.*
6. *As part of our consistent approach and in order to achieve transparency and accountability, the results of the review will be collated and a summary report will be made publicly available.”*

17. The Protocol then provided guidance on the scope of the review and the process which should be undertaken to conduct it. In short, it required each diocese’s CPA to compile a “Known Cases List” in a prescribed format. This was to include all known cases, past or present, involving clergy, employees, readers, licensed lay workers or volunteers, in relation to whom there were or had been child protection concerns or allegations. Bishops were to write to their predecessors and former senior staff asking to be notified of safeguarding concerns or allegations they may be aware of which may have not been recorded. Any such cases were to be added to the Known Cases List.

18. Each diocese was to appoint an Independent Reviewer (**IR**) who would review the Known Cases List compiled by the Child Protection Adviser (**CPA**) and prepare summaries for the Diocesan Child Protection Management Groups (**DCPMG**) on each case where child protection issues or concerns arose in order that appropriate action could be considered and taken. Following that, the IR was to read all files of licensed clergy; all readers and those in lay ministry; employee files of those having contact with children; and the files of all clergy with permission to officiate. Details of any new child protection concerns emerging from this scrutiny were to be referred to the DCPMG for action and appropriate cases added to the Known Cases List.

19. At the conclusion of this work, the Protocol required the DCPMGs to prepare a report for the bishop who would then send a copy to the NSA together with an anonymised version of the Known Cases List and a statistical report, the content of which would be prescribed by the National Church.

20. The Protocol contained a flow chart identifying the key actions and their sequencing. The Protocol also included five appendices which covered:

- a) the content of the Known Cases List;
- b) a table to record responses from former senior church officers to whom the bishop had written;
- c) a format for the Independent Reviewer to record cases of concern;
- d) suggestions for inclusion in the letter which the bishop should send to former senior colleagues requesting any information on past cases of child abuse; and
- e) a person specification for the Independent Reviewer.

21. In total the Protocol comprised 17 pages of detailed guidance on the scope of the Review and the procedure to be followed. In addition, the NSA was available to respond to queries from dioceses in line with paragraph 1.12 of the Protocol.

22. The National Church prescribed the format of the statistical report, but it was not developed until late 2008, by which time the PCR had been underway for almost a year. The statistical report sought to quantify some of the data which the Protocol had required dioceses to examine. It also had regard to discussions within the House of Bishops and its Standing Committee about which information would be published.

23. The House decided that information about the scale of the reviews should be published, e.g. total number of files reviewed, number of Independent Reviewers appointed; the number of cases referred to statutory authorities; and the number of cases referred for formal disciplinary processes (either Clergy Disciplinary Measures or employee procedures). In relation to the formal disciplinary processes, the House rejected an option to publish the number of cases subject to other forms of action such as other disciplinary processes, risk assessments, risk management plans or dismissal following criminal conviction.

24. On 24 February 2010, following completion of the reviews by all dioceses and the provinces and completion of their respective statistical reports, the National Church issued a press notice which contained this information – see paras 71-86.

25. In July 2010 the National Church sent a letter to all DSAs requesting information about the progress of cases identified by the PCR. The letter also enquired about the

implementation of recommendations for the diocese made by some IRs as well as about any points useful for national learning. Most but not all dioceses replied.

26. In October 2013 a note was sent to all dioceses by the Lead Bishop for Safeguarding concerning, principally, a proposal that each diocese should carry out a review of the files of deceased clergy. This note invited dioceses to first reflect on the standard of their PCR posing four questions:

- a) Was this undertaken by a safeguarding professional external to the diocese?
- b) Have all recommendations been implemented in relation to individual cases?
- c) Is a process in place to review progress against any strategic recommendations?
- d) If any of this work remains undone, it needs to be addressed immediately as a priority.

27. Whilst most dioceses subsequently conducted a Deceased Clergy Review (**DCR**), few commented on the adequacy of the PCR and there appears to have been no follow up by the National Church to this lack.

28. By November 2015 a small number of dioceses had recognised the limitations of their PCR. Some did take or had taken steps to remedy the deficiencies with varying versions of a repeat PCR. However, concerns were expressed about inconsistencies in how the PCR had been conducted in that a number of cases were coming to the attention of contemporary DSAs which ought to have been identified and responded to as part of the PCR. In the same month the IICSA announced that, as part of its investigation into the Anglican Church, the scope of the investigation would include “.... the adequacy of the Church of England’s 2007-2009 ‘Past Cases Review’”.

29. In the light of these developments, the Archbishops’ Council was advised in February 2016 that a screening process would be undertaken with all dioceses to assess how well they carried out the PCR in accordance with the House of Bishops’ Protocol. This was with a view to identifying which dioceses might need to repeat some form of PCR, managed or co-ordinated by the National Safeguarding Team. The screening process involved a telephone interview, by or on behalf of the National Safeguarding Team, with the current DSA or other diocesan colleagues, informed by documentary evidence from the diocese to establish how the PCR had been conducted and its outcomes. This resulted in a rating of each diocesan PCR by the NST assessor of high, medium or low concern. It was intended that the summary of the interview, the documentary evidence and the rating would be shared with dioceses. However, it is now clear that, with a change of staff, this did not happen in all cases. As a second stage, we were asked to form an Independent Scrutiny Team to review

both the process and the content of the PCR as well as the screening process and its ratings. We were asked to conclude whether each diocese had undertaken its PCR well or whether additional work was required. Our Terms of Reference (modified following discussion at the National Safeguarding Steering Group) are set out in para 5.

30. We reported on progress to the National Safeguarding Steering Group in January 2017 when it was proposed that in making our diocesan assessments as to whether a repeat form of PCR was necessary, we should have regard to those aspects of the contemporary SCIE audit reports which were relevant to issues of particular concern in the PCR process, namely, record keeping, handling allegations, case management, file maintenance and engagement with external agencies.

OUR APPROACH

31. We have been provided with all documents which could be identified by the NST which are relevant to the PCR including all those submitted to IICSA. In addition, we have read the reports of the deceased clergy file review and as many of the contemporary SCIE audits as have been published. We then prepared a short draft summary of our findings in relation to each diocese and asked current DSAs to check these for accuracy and to provide any further information we may not have seen whether it was supportive or critical of their diocesan PCR to help inform our final assessment.

32. We specifically asked whether there were any cases which have arisen since 2007 which might reasonably have been identified as causes for concern in the PCR process but which were not. We also asked DSAs to confirm that all cases identified as part of the PCR had been closed or were being effectively managed. A copy of the check-list we used is attached as Appendix B.

33. Whilst our findings derive principally from our reading of hundreds of documents, we met with the former CPA from the Diocese of Oxford who had assisted the WG with the drafting of the Protocol and the analysis of statistical and narrative reports on the PCR. He had also co-authored with the then NSA a report: "Past Child Protection Cases Review: Issues from the narrative reports." Roger Singleton visited two dioceses who had raised concerns about the adequacy of their PCRs. He also met with one of the two NST assessors involved in the screening process. The three members of the Independent Scrutiny Team have had contact by email or telephone with a number of DSAs to clarify some of their responses to the checklist and to seek further information.

34. In the late summer Roger Singleton was asked by the NST to prepare a witness statement for IICSA in response to 17 questions posed by the Inquiry in relation to the PCR. The statement drew heavily on the emerging findings of the present scrutiny whilst making it clear that some of the assessments and judgements were provisional until our assignment was concluded.

FINDINGS

The content of the Protocol

35. By and large we regarded the House of Bishops' Protocol as a competent piece of work. It reflected both the statutory guidance at the time (*Working Together to Safeguard Children 2006*) and was consistent with the Church's own guidance (*Protecting All God's Children: The Child Protection Policy for the Church of England 2004*). It introduced a form of review and evaluation with which the Church in general was not familiar and diocesan safeguarding teams (such as they were) had little experience. There were, however, some limitations.

36. Exactly who was within scope of the PCR was variously described. Categories ranged from

1.3 clergy, employees, readers and licensed lay workers or volunteers in the Church....

to

4.1 all cases in which it is alleged that a person who holds office in the church, ordained or lay, paid or voluntary....

The flow chart refers only to licensed clergy, diocesan lay ministry and diocesan lay employee files.

37. Precisely which lay employees were to be included was inconsistently described. Paragraph 3(11)(e) of the Protocol prescribes "*those in contact with children or young people*" yet a statement in the Question and Answer document says, "*all Diocesan Lay staff in full or part-time posts....*"

38. Similar confusion existed about whether parish as distinct from diocesan employees were within scope. The clear response from the NSA in the Question and Answer document was that diocesan employees were included but as for parish employees "*.... we must encourage the employer to do the appropriate review... [as in] ...Diocesan Child Protection Policy*. The IST has not seen any evidence that this expectation was communicated to parishes or that any parish files were received by CPAs or cases referred as a direct consequence. It may be that given awareness of the PCR, all cases of concern had already been notified to the diocese but that would be a big assumption especially considering that the Question and Answer document is not consistent in its advice as to

whether bishops should inform clergy that the PCR was taking place. We make a recommendation in relation to these issues – see para 121.

39. We found some variations in the ways dioceses and IRs interpreted “a person who holds office in the Church”. One diocese wrote to all church wardens about possible concerns and some Known Cases Lists included organists, choir members and vergers. Whilst we think it likely that any parish employees or volunteers whose concerning behaviour was known to a diocese were included in the Known Cases List there remains the possibility that parish workers who had engaged in inappropriate conduct were not included because they were considered outside the scope of the PCR or because parish clergy were unaware of the review or because concerning cases had not been referred to the diocese. There was no requirement in the Protocol to enquire of active clergy whether they had current concerns at parish level which had not been reported to the DSA. This is a gap in the comprehensiveness of the PCR and we make a recommendation in relation to this matter – see para 121.

40. In para 14 we refer to what the Protocol said about involvement of Church bodies and institutions with their own decision-making arrangements. We have not seen any responses by such bodies or institutions to the National Church or dioceses with the exception of some Cathedrals and one theological college. It is clear from some Known Cases Lists and from current DSAs that some Cathedral staff were included in some diocesan PCRs; but this was by no means so everywhere. We have not seen any evidence that other independent Church bodies and institutions conducted their own PCRs and took appropriate action.

41. We regard this as an area of weakness. Whilst the PCR was an initiative of the House of Bishops, we consider that the general public’s expectation is that statements from the Church of England include all parts of the Church whether under episcopal oversight or not; and most certainly the Cathedrals. We make a recommendation in relation to this issue – see para 121.

42. Another limitation of the Protocol was the advice it gave in relation to victims and survivors. It said: “**Only in the most exceptional cases and when deemed absolutely necessary, should an alleged victim, or de facto victim be contacted at the time of the review process. This is in order to minimise the distress to the person concerned that may be caused by several agency contacts. Other approaches could be investigated in order to corroborate information e.g. newspaper coverage archives. In such cases the focus always needs to be on the care and support that the victim themselves may need and that decisions to contact parties are made on a ‘case by case’ basis.**” The emphasis is copied from the Protocol.

43. The decision to limit the PCR to a file review and to exclude direct contact with victims and survivors (other than in exceptional circumstances) had a constraining impact on the value of the initiative. The guidance is confusing in that it is difficult to see how care and support for victims and survivors could have been provided without contacting them. Undoubtedly the nature of the PCR would have been very different had victims and survivors been invited to have an involvement. By not including them, their views were absent from the review and perhaps particularly from the lessons learned. We have not found any reasons to explain this exclusion beyond what is said in the Protocol. It may have been to avoid precipitate victim contact and ensure that appropriate referrals to the statutory authorities were made. It may also have been a continuation of the outlook reported by several IRs that the needs of victims and survivors had been marginalised whilst the focus was to support, care for and rehabilitate the perpetrator. But these are speculations.

44. The final criticism of the Protocol is that it could have been clearer about the reporting requirements to the National Church. Different things were said in different places. But, totalling the reporting requests these amounted to:

- a copy of a narrative report by the DCPMG for the Bishop
- an anonymised copy of the Known Cases List
- a statistical report.

45. All dioceses produced a statistical report and most dioceses produced a narrative report written by either the IR or the DCPMG though not all were sent to the National Church in 2009/10. Fewer Known Cases Lists were submitted to the National Church and some have not yet been located although there is evidence in other documentation that most were compiled. It is unfortunate that there was not a more sustained effort by the NSA to obtain a fuller response in 2009/2010. The content of the narrative reports also varied from substantial documents (133 pages) to a half page summary.

46. Whilst these limitations do have consequences for the findings of the PCR, we repeat that we consider that the Protocol emerged from a conscientious attempt to identify all cases of concern in the past and review those together with all cases which were currently known. It sought to bring consistency and coherence of approach to 44 dioceses in an institution which has a complex pattern of internal structures.

Compliance with the Protocol

47. Our findings are that most dioceses adopted the processes prescribed by the Protocol substantially if not completely. In assessing the degree of compliance, we have ignored those features which do not bear on the adequacy of the PCR, choosing instead to concentrate on the identification and thorough scrutiny of relevant files and cases, the appropriateness of the responses to concerning cases made by dioceses, the independence of the reviewers, the response to victims and survivors, the accuracy of the reporting both within the Church and to the general public, oversight by the National Church and the lessons learned. These elements were all germane to the central purposes of the PCR.

The identification of relevant files and cases

48. It may be helpful to distinguish between information relating to known cases of abuse or risk, and information derived from the examination of diocesan files of thousands of clergy and specified church officers.

49. The House of Bishops' Protocol prescribed the scrutiny by an IR of the papers held in connection with individuals on the Known Cases List where there was a risk to a child or children including "past" or "historic" cases. The identification of all cases was a key feature of this process and the Protocol prescribed that this should be carried out by the diocesan CPA. It appeared to the IST that this had been done in most cases. However, in one diocese, the area bishop carried out the task and withheld four cases because they were currently active and in two it was done by retired archdeacons of the dioceses.

50. In relation to the scrutiny of files the Protocol did make an underlying assumption that files on all the specified categories of clergy and office holder had been created, that these files had been retained, that they could be located and that sensitive and potentially relevant information had not been "weeded".

51. The recovery of all relevant files for the IRs scrutiny proved to be challenging in many dioceses. Whilst the maintenance of "blue files" on clergy was mandated centrally, this did not apply to files which pre-dated that system. Moreover, the experience of many IRs was that the content and structure of blue files varied considerably both within and between dioceses. Instances of illegibility, chaotic structure, minimal recording and lack of key identifying information were frequent. Some files were duplicated but with different content in the respective versions. These limitations notwithstanding, we have some confidence that the files of the vast majority of clergy who were active in the dioceses at the time of the PCR were reviewed.

52. It was clear that the files of clergy with permission to officiate was less systematic, either because of the dispersed location of some files or because no such files existed. Files were inconsistently held in:

- a) the clergyperson's final diocese of full ministry;
- b) the diocese where the clergyperson had permission to officiate; or
- c) the diocese where the clergyperson had permission to officiate before retirement.

53. Files relating to other categories of church officer and lay employees raised further complications. Some dioceses maintained files on readers whilst others only did so when there was "an issue". Dioceses varied in the length of time for which files were retained. Whilst the IST believes that most of the available files were read by IRs, in some dioceses these went back to the 1940s/1950s and in others only to the 1990s. Moreover, some records did not state explicitly the nature of the concerns. We make a recommendation in relation to completing the review of all available files – see para 121.

54. The physical location of files presented another problem. The files were located in various places including:

- a) county record office;
- b) in garages and stores;
- c) in the CPA's home if self-employed; and
- d) in different offices in the diocese such as the bishop's office and/or the area bishop's office, in the archdeacons' offices, in the CPA's office etc

55. Some dioceses did not know where the files were, or whether the total available files had been located. In addition, some files came to light after the statistical returns had been completed, resulting in amended returns and confusion as to which version was the accurate one. In these circumstances, it was not possible to fix a date from which files were reviewed and to apply that consistently across the Church.

56. The IST saw evidence of considerable efforts by many diocesan staff to locate files for the review. However, in the circumstances the possibility remains that records of inappropriate behaviour by some clergy and church officers towards children in the past were not seen by IRs because some files could not be located or had been lost or destroyed. Furthermore, some records referred vaguely to an 'unfortunate saga' or 'past difficulties'. Whilst the evidence is that IRs enquired further into such entries, the state of many files does generate a risk that safeguarding concerns were not recognised as such.

57. In June 2010, a summary report on the PCR for the Archbishops' Council, the authorship of which is uncertain but was probably the retiring NSA, included the following:

“.... we need to address further:

- *How records of any safeguarding concern are made and retained.*
- *How records are moved between dioceses or other locations (for example a college or religious community) when clergy or other office holders move on.*
- *How records are shared between dioceses when clergy / other office holders have permission to officiate in more than one diocese.*
- *How records are shared when a priest is employed as chaplain, such as by a non-church organisation”*

58. Potential weaknesses in the process of reviewing file information is the dependence on the thoroughness and competence of the CPA in compiling the Known Cases List and of the IRs in scrutinising the files. Ultimately there is no way of knowing whether every case of concern was notified and passed to the IR or was appropriately identified by the IR. The IST has not seen anything to suggest that cases were withheld from the IR (with the exception referred to at para 49 above in relation to active cases). We asked dioceses for details of any cases which have come to light since 2007 and which could reasonably have been identified by the PCR. We report on this in paras 63 and 64.

59. In summary, we have distilled the following issues in relation to the identification of relevant cases and files:

- a) location and condition of files;
- b) the fact that some roles within the scope of the review, especially readers and priests with permission to officiate, did not have files;
- c) the ambiguity about whether lay and parish employees should be included;
- d) the fact that only files which existed could be reviewed;
- e) the partial duplication of some files so that it was unclear whether key information was missing from scrutinised files and
- f) the absence of a commencement date for the reviewing period.

60. In conclusion, the PCR was essentially a retrospective desk review with a number of flaws and limitations. It must, therefore, remain a possibility that some cases of concern were overlooked and not placed on the Known Cases Lists or could not be identified because files were incomplete, illegible or missing. However, this possibility has to be weighed against the relatively few cases which have emerged since 2007 which could have

been identified by the PCR as well as against the professional experience and competence of most of the IRs.

Dioceses' responses to cases

61. The most difficult aspect of our scrutiny work has been to form a consistent view on the judgements exercised by CPAs, IRs and DCPMGs in relation to the cases selected for inclusion on the Known Cases List, the assessments made of the cases, the actions taken both historically and as a consequence of the PCR, and the outcomes. The data available to us has been highly variable and not consistent between dioceses. Our views have been formed by piecing together an assortment of evidence from a variety of sources including:

- Available Known Cases Lists
- Independent Reviewers' and DCPMG (narrative) reports
- PCR Statistical Reports
- Minutes of DCPMG meetings
- Examples of cases sought by the NSA
- Case details contained in some dioceses' documentation
- Assessments made by subsequently appointed DSAs who have reviewed cases
- Reports of reviews conducted since the PCR including those by SCIE.

62. From these sources we have noted a cautious approach by most CPAs and IRs with the smallest indications that there may be child protection issues resulting in a file being additionally scrutinised. Where concerns were confirmed, there was good evidence of relevant information being passed, where appropriate, to other dioceses and/or the statutory authorities. We would wish to have seen more information about the specific actions taken, the reasons and arrangements for on-going monitoring, the outcomes achieved, clarity about case closure and the process adequately recorded. But we have not had access to the work done in the months following the PCR which would have revealed this information. The evidence, therefore, was 'bitty'. Our findings have had to rely, as already noted, on the competence of the CPA, the IRs and the DCPMG; on the confidence which their work has given us; on the narrative reports of the IRs or others who authored these reports; on the responses to the 2010 follow-up questionnaire (29 from the 44 dioceses); on the views of the small number of Independent Reviewers who examined deceased clergy files in 2014 and reflected on the adequacy of the PCR; on the reviewing process which current DSAs have carried out in order to respond to both the screening interviews in 2016 and our recent questions; and to the follow-up PCR reviews which some, though by no means all, dioceses

have conducted subsequently. We have also had regard to the reports of the SCIE audits which included a number of reviews of cases which go back 4 years and some associated documentation.

63. Another factor which has given us grounds for some confidence that most cases were identified, assessed and responded to appropriately are the replies we have received from current DSAs (very few of whom were in post in 2007-2009) to two of our recent enquiries. The first asked whether there are any cases which have arisen since 2007 which might reasonably have been identified as causes for concern in the PCR process but were not. Of the dioceses: 23 have said they have none; 11 dioceses have said 1 case each; 4 dioceses have said they have 2 cases each; 1 diocese has said it has 3 cases. The data is not reliable in 3 dioceses and enquiries are on-going in 2 dioceses. In one of the latter, the police are engaged in a major operation.

64. The second enquiry sought the DSAs' confirmation that all cases identified as part of the PCR have been closed or are currently being effectively managed. 33 of the DSAs said that to the best of their knowledge all the cases considered by the PCR have either been closed or are still being effectively managed; 2 DSAs have been unwilling to commit themselves because records are insufficiently adequate; and the IST is recommending a repeat PCR in 7 dioceses and so any such commitment would be premature. Whilst uncertainties remain this provides some assurance that in most of the cases identified in 2007-09 the current risk to children either no longer exists or is subject to active management.

The independence of the Reviewers

65. The evidence we have indicates that these requirements of the Protocol were met in the majority of cases. Most had relevant experience and some extensively so. Most were independent of the diocese (independence being prescribed by the Protocol). However, there were a small number of exceptions. We had insufficient information to assess the IRs in a few instances. In two dioceses the review was conducted by a former senior clergyman of the diocese. In another the IR was also the chairman of the diocesan safeguarding panel. In another the Area Bishop reviewed his own files. In others the CPA of another diocese was the IR - in one instance it was a straight swop. We were not persuaded that the appointment of another CPA as the IR would be perceived as independent and we regard that as a shortcoming of the Protocol because it was permitted.

66. Whilst some reviews took longer than the prescribed 18 months only 2 of the current DSAs reported in their screening interviews that they were aware of difficulties in relation to time, resources or access. In one of these cases the Bishop refused to co-operate and no IR was appointed. The CPA worked alone on the PCR. A second diocese has subsequently commented that the IR had insufficient time.

67. We also noted that in some cases there appeared to have been a process of pre-selection of files to go to the IR. In one diocese the Bishop personally reviewed all the files initially and withheld 4 because “... *this would be a duplication as the files had been reviewed by the DCPA*”. In others, diocesan staff (permanent or recruited for the purpose but without manifest safeguarding expertise) reviewed the files and passed those with concerns to the IR. In one diocese which adopted this approach the IR did dip sample some additional files. None of these arrangements accorded with the requirements of the Protocol. But overall, we were satisfied that appropriately experienced and independent people had been appointed to the role of IR.

Victims and survivors

68. We commented in paragraph 43 above on the Protocol's guidance and are not aware of any exceptional cases where a victim or survivor was contacted. We are aware of one survivor's offer to participate which was refused.

69. We found little evidence in the PCR documentation that victims and survivors were offered the "support" referred to in the Protocol although the advice not to approach victims and survivors referred to at para 42 at the time of the review may have proved confusing. We asked current DSAs for any information they had about work done with victims and survivors as a direct consequence of the PCR. The response to this was that hardly any victims or survivors, whether in contact with the Church or not, whose cases were identified by the PCR, were known to be offered the support which the House of Bishops' Protocol had advised. In one respect this is a surprising finding. The opening paragraph of the Church's guidance *Responding Well to those who have been sexually abused*, whilst not published until 2011, says:

"In 2002, Churches Together in Britain and Ireland published a report 'Time for Action, Sexual Abuse, the Churches and a New Dawn for Survivors'. Since then the Church has increasingly recognised the need to minister to survivors of sexual abuse"

70. On the other hand, it was clear from the documentation that some dioceses were no longer in contact with the victims and survivors of abuse carried out by people on the Known Cases Lists. Others took a considered decision not to seek out victims and survivors but to respond if and when they approached the diocese. We make a recommendation about this in para 121.

Accuracy of the reporting both within the Church and to the wider public

71. At para 44 above we identified three reports required by the Protocol from each Diocese: a copy of the PCR narrative report prepared by the DCPMG (or others); an anonymised copy of the Known Cases List; and a statistical report.

72. We have not been able to establish with clarity the number of narrative reports which were received in 2009/10 by the National Church. The then CPA for the Diocese of Oxford (who was assisting the National Church with its examination of diocesan submissions) and the then NSA produced a report in January 2010 of issues raised by 11 dioceses and one province. It is clear that rather more dioceses had submitted narrative reports, though some of these contained only case vignettes with no summary or analysis of the review itself. We encountered similar difficulty in identifying how many Known Cases Lists were sent in to the National Church in 2009/10

73. All dioceses submitted a statistical report. Indeed, some dioceses sent in more than one version and it was not always clear which was the final, authentic edition as they were not required to be dated. In the following paragraphs we discuss issues relating to the statistical reports because these bear on the public statements which the Church made at the time.

74. Whilst the statistical reports, once summarised, provide a broad, if incomplete, picture of the situation revealed by the PCR, the IST consider that considerable caution should be exercised both in placing reliance on the specific numbers and drawing finely defined conclusions from them. Our reasons for this caution include the following:

- a) Some returns were only partially completed;
- b) Some returns had internal inconsistencies;
- c) Some had unexplained manual amendments, although consideration of the accompanying emails clarified some of these;
- d) Versions varied particularly in relation to the number of files reviewed;
- e) Some entries did not add up in circumstances where they should have done. Confusion as to the basis for an entry may have contributed to this;
- f) The categories of people to be included in the return were not clear. For example, it appears that some dioceses included members of congregations on “contracts”, “covenants of care” or “safeguarding agreements” even though these people had not previously been employed or engaged by the Church in any capacity and so were out of scope according to the House of Bishops’ Protocol.

75. The reasons for these variations may include the fact that some priests had involvement with more than one diocese; there were some borderline and definition issues including a lack of clarity about what was being requested; and the unavailability of the statistical report format until late 2008 when some of the requested information could only be gathered by re-examining the files.

76. Some dioceses found the statistical report difficult to complete. Two CPAs said:

“Our reviewer didn’t think the statistical form quite matched the reality on the ground or the nature of the content of the files”.

“I have spent the best part of two days trying to make sense of it. I have consulted two well-experienced colleagues who can’t make much sense of it either.”

77. Once received by the National Church, the statistical reports were examined by a small team. Some obvious inconsistencies were clarified in email exchanges with the dioceses and amendments made. The principal focus was on the number of cases which had been newly *“identified through the review process”* and which required *“formal church action only”* or *“referred to statutory bodies”*. *“Formal church action”* was defined as *“... formal and substantive actions, not simply informal discussions”*. Some changes to the statistical reports were made.

78. The process for amending the statistical reports was that, following enquiries from the National Church to diocesan CPAs around November 2009 and consideration of brief summaries of all the identified cases, the then Head of Central Secretariat wrote to at least 18 diocesan bishops seeking agreement to amend the numbers reported from their dioceses. Whilst the adjustments achieved the stated objective of bringing greater consistency to the statistics they also had the effect of reducing the number of cases on the reports which led to church action. The IST has calculated that at least 46 known cases were newly identified consequent upon the PCR which needed some form of further action and this was reduced to 5. Moreover, in February 2010 it emerged that the categories of formal action described on the statistical report were not consistent with the House of Bishops’ definition of formal disciplinary processes as described in para 23 above. There followed a further reduction to count only cases which met the tighter definition. The press notice of 24 February 2010 announced that 2 cases warranted *“formal disciplinary actions by the Church.”*

79. There were at least three shortcomings to this approach:

- a) The restriction to newly identified cases through the PCR process had the effect of excluding known cases but ones where the IR or DCPMG considered additional actions should be taken;
- b) By limiting the definition to formal church action (as decided by the House of Bishops) this removed from the calculation cases where action was taken of a type which did not meet the limited criteria, such as a meeting with the bishop or undergoing a risk assessment, or being withdrawn from ordination.
- c) Cases were excluded which came to light after 2007, even if they concerned allegations which dated back before then. The consequence of this was that any cases reported after the Church's news release of 11 February 2007 (which, arguably, would have drawn the attention of survivors to the review) and the end of the reviewing period in June 2009 would not be included in the statistics although such cases may have been included in future updates to the Known Cases Lists.

80. If the Church had wanted to adhere to reporting the number of new cases in which strictly formal church action had been taken then it would have been more transparent to have added two further categories:

- a) Informal or less formal action on newly identified cases; and
- b) Further actions on cases already known to dioceses.

81. The inevitable conclusion is that part of the reporting to and by the National Church was unsatisfactory and could expose the Church to the accusation that it did not report the full picture. The scope of the data sought was limited and the interrogation of the statistical reports by the National Church seemed to have been restricted to enquiries about whether the actions taken were formal actions and in relation to new cases.

82. Turning to what the Church said to the public, the outcome of the PCR was announced in a press release of 24 February 2010. In many respects the content of the 2010 press release was factual and fair. It contained the (rather limited) information to which the Church had committed and its tone was not complacent, acknowledging that allegations not recorded in the past might surface in the future. However, there were three aspects of the press release which the IST considers were unsatisfactory.

83. First, the release stated:

“As a result of this Review, we are now able to say that nobody representing the Church in a formal capacity has allegations on file that have not been thoroughly re-examined in the light of current best practice, and any appropriate action taken.”

Given the weaknesses in comprehensiveness of the file review which would be known to the National Church at the time, notably the inconsistent inclusion of Cathedral cases and file reviews and the exclusion of parish employees, this was a statement which could not be justified by the facts. Moreover, at the time the National Church had regard to narrative responses from only 11 dioceses and one province. Not all these reports contained information about the actions taken or the outcomes and there had been no verification checks on the decisions of DCPMGs. So the claim to have taken “appropriate action” in all cases rested on the reports of a small proportion of dioceses. That paragraph in the 2010 press release was an under-evidenced assertion.

84. Secondly, the paragraph relating to PCR outcomes involving the need for further action said:

“As a result of the diocesan reviews of 40,747 files, 13 cases were identified requiring formal action. Eleven cases were referred to the statutory authorities, eight of which involved a member of the clergy and three of which involved a non-ordained person holding some form of church office.....

A further two cases where action by the statutory authorities was not possible, each relating to members of the clergy, were deemed by the independent Reviewers to warrant formal disciplinary actions by the Church.”

85. As already explained, whilst technically accurate (apart from serious doubts about the precise number of files), this presentation omitted other important actions both in relation to known and new cases and could not be said to represent the true extent of the concerns that needed to be addressed. However, the IST has not encountered any evidence to suggest that there was any planned intention to make the figures look less damaging for the Church.

86. Thirdly, we had some concerns about the claim in the press notice that the IR’s recommended action “*was passed to the Diocesan Child Protection Management Group in each diocese, formed by senior diocesan clergy and external professionals from the public safeguarding sector*”. That was certainly true in some dioceses but in others the decisions were taken by senior clergy with the CPA and without external contributions or challenge. We have not, however, encountered any cases where the decisions were inappropriate even if alternative courses of action might have been preferred.

Oversight by the National Church

87. Oversight by the National Church during the progress of the PCR appears to have been limited to responding to questions and querying entries on the statistical report which we refer to in paragraph 77. There was some limited monitoring of the implementation of recommendations made by the IRs and progress in addressing cases of concern.

88. In July 2010 the National Church sent a letter to all DSAs requesting information about the progress of cases identified by the PCR; the implementation of recommendations made by the IR; and any points useful for national learning. We have seen responses from 29 dioceses ranging from minimal answers to extensive replies.

89. In October 2013 a note was sent to all dioceses concerning, principally, a proposal to carry out a review of the files of deceased clergy. However, this did invite dioceses to first reflect on the standard of their PCR posing four questions:

- a) Was this undertaken by a safeguarding professional external to the diocese?
- b) Have all recommendations been implemented in relation to individual cases?
- c) Is a process in place to review progress against any strategic recommendations?
- d) If any of this work remains undone, it needs to be addressed immediately as a priority.

Few dioceses responded to this aspect of the DCR.

90. The IST has seen no evidence of follow up by the National Church to the responses or lack thereof. It does have to be remembered that until 2015 the only dedicated resource available to the National Church was a part-time safeguarding adviser who was shared with the Methodist Church. Moreover, the NSA involved from the outset and who had overseen the PCR retired in July 2010. This disrupted any pro-active monitoring or checking by the National Church that the assurance that all recommendations had been implemented was valid or even that replies to the PCR reflection had been received from all dioceses which clearly they had not.

91. However, this is not to say that the findings from the PCR narrative reports (or at least some of them) were not considered nationally. In June 2010 the Archbishops' Council considered the Executive Summary Report of the PCR referred to in para 57. This summarised the findings and identified six lessons learned. In essence these were:

- a) allegations not recorded in the past could re-surface in the future;

- b) policies and procedures were needed but these would not succeed without a culture of constant, informed vigilance;
- c) record keeping needed to be addressed further;
- d) all clergy and church officers should undergo training;
- e) information must be shared when clergy move from one diocese to another; and
- f) safer recruitment policies needed to be followed.

92. The Archbishops' Council passed the Executive Summary report to the Joint Safeguarding Liaison Group (**JSLG**) - the renamed CSLG - who sent it along with the request for the progress report referred to in paragraph 88 above to all dioceses. The JSLG also discussed the report based on the 11 diocesan and one provincial PCR narrative reports received by the National Church (see para 72) and written in January 2010 by the then CPA from the Diocese of Oxford and the NSA. The report's 28 recommendations covered a range of issues including record keeping; recruitment of ordinands; management of allegations; "Safe to Receive" letters; Permission to Officiate issues; licensing of chaplains; training for clergy and churchwardens; and monitoring management agreements.

93. Senior staff in the National Church found the number of recommendations somewhat daunting and decided to uncouple the report procedurally from the PCR, regarding the recommendations as future ideas for "raising the game". However, the JSLG monitored actions taken which, in effect, implemented many of the recommendations. This was particularly evident in three subsequent and significant sets of House of Bishops' guidance produced in the ensuing months:

- a) Protecting all God's Children 2010;
- b) Interim guidance on safer recruitment (issued in 2010); and
- c) Responding Well to those who have experienced Sexual Abuse 2011.

94. It is clear that the guidance was influenced and informed by the experience gained from the PCR.

Individual Dioceses and the Independent Scrutiny Team

95. Once all the documentation available at Church House Westminster had been considered by the IST we prepared a short draft report on each diocese. DSAs were asked to comment on the draft report relevant to their diocese, to respond to a checklist which posed specific questions and to supply any further information which had a bearing on our assessment. We then considered this further information and prepared a final report on each diocese which contained:

- Documents reviewed
- A compliance review of the PCR compared with the House of Bishops' Protocol including the rating of the NST's assessor
- The response to the 2010 follow-up questionnaire
- Any reflections on the adequacy of the PCR included in the Deceased Clergy Review of 2014
- The outcome of the SCIE audit in relation to the response to allegations; referral to and relationship with statutory bodies; the judgements exercised; and the quality of case recording and file maintenance
- Information about any further reviews carried out since the PCR
- Responses to the general and specific questions put by the IST
- A final assessment on the adequacy of the PCR and a recommendation as to whether further work needed to be carried out in the diocese.

96. We should explain and emphasise that rather than adopt the Low/Medium/High concerns approach of the NST assessors we have opted for a No Further Work or Further Work categorisation. We have formulated our judgements based on an assessment of the factors in para 95 whilst focussing on shortcomings relating to the identification of cases and appropriate remedial actions. A copy of our final assessment report will be made available to each respective diocese and province in the hope that it may contribute to ongoing learning and improvement.

97. We were asked to advise on what a repeat PCR would look like and we are working with the NSA to produce a revised protocol which avoids the shortcomings in the original document.

98. In summary, our recommendations in relation to individual dioceses are:

- 7 dioceses should in essence repeat the PCR using an updated process

- 35 dioceses and the two provinces have no need for further work other than that being recommended for all dioceses and provinces

Lists of the dioceses in each category have been passed to the National Safeguarding Adviser

99. For ALL dioceses we are recommending that any relevant files which have subsequently been discovered or which are known not to have been examined in 2008-09 should be independently reviewed. We are also recommending that all parishes be asked to pass to the DSA the details of parish employees and volunteers who have not previously been notified and whose behaviour towards children has given rise to concerns currently or in the past. The DSA should treat these cases as new referrals.

100. The review of files in the provinces comprised two elements:

- Examination of the files of clergy whose behaviour had triggered action under the Clergy Discipline Measure and
- Examination of the blue files of active and retired bishops which, since the 1980s, had been held in the relevant provincial offices

101. We considered all the available documentation which together with helpful clarifications from the Archbishop's Chaplain at Bishopthorpe and the provincial safeguarding adviser at Lambeth led us to conclude that the reviews had in one case been very satisfactorily conducted and in the second adequately so. Given additional work subsequently undertaken in the second province there could now be assurance that issues raised in relation to clergy who had been subject to CDM were either closed or being dealt with by the relevant dioceses. In relation to the three bishops whose circumstances the IST would have expected to have been identified via the PCR process: one was so identified; a second had died before the arrangements for locating bishops' files in the provincial office came into being; and the blue file of the third could not and has not been traced.

CONSIDERATIONS

102. The House of Bishops' Protocol prescribed a process for identifying those clergy and church officials whose behaviour or alleged behaviour towards children gave rise to concern. CPAs identified all known cases; bishops wrote to former senior diocesan staff asking them for potentially relevant information which may not have been recorded with few cases emerging which were not previously known to dioceses; and there was a trawl of over 40,000 files for evidence of concerning, potentially inappropriate behaviours which had not previously been addressed. Reviewers, mostly independent of dioceses and with significant safeguarding as well as reviewing expertise, were appointed to advise on identified cases and to conduct the file review. Their recommendations were to be considered by the DCPMG whose membership should have included people with multi-disciplinary expertise including some from statutory agencies. The entitlement of the IR to take action unilaterally if dissatisfied with the diocesan response was recognised. Notwithstanding some limitations in design and implementation of the Protocol which have already been referred to, this was a major new undertaking for the Church, genuinely motivated and carried out, for the most part, in accordance with the Protocol and to a standard consistent with the background and experience of IRs.

103. In an exercise of this magnitude, carried out in 44 dioceses and the 2 provinces against a background of limited resources, it is inevitable that there would be variations in the scope and quality of implementation and reporting. Our report has drawn attention to these. However, we have avoided focussing our proposals simply on the basis of conformity with the Protocol unless they bear on:

- Identification of cases of concern
- Appropriateness of responses to cases of concern
- Work with victims and survivors
- Scrutiny by the National Church
- Other Church institutions
- Public statements made at the time, and
- Lessons learned.

Our assessments are based on whether appropriate outcomes have been achieved rather than whether the Protocol process was followed exactly.

Identification of cases of concern

104. We noted that the initial review of files in some dioceses was not carried out by the IR but conducted either by diocesan staff or temporary staff engaged for the purpose. Few appeared to have relevant safeguarding experience. We were not comfortable with this departure from the Protocol and considered whether dioceses which had adopted this approach should be asked to repeat the file trawl. We decided against that unless there were grounds for believing that the method adopted led to a noticeable number of cases which might have been identified as causes for concern being overlooked. From information supplied by DSAs, we found that of the 40,000+ files reviewed 34 dioceses had none or just one case come to light since 2008-09 which might have been identified via the PCR. A further 5 dioceses had 2 or 3 cases. And in the remaining 5 dioceses either the data was unreliable or enquiries were on-going. We decided on grounds of proportionality that a repeat review of thousands of files was not justified. However, it should not be assumed that there are no more victims and survivors. It is well established that some victims and survivors delay disclosing the abuse they have suffered for many years and for many reasons. The publicity associated with IICSA enquiries into the Church may encourage more people to come forward and dioceses need to be prepared for that possibility.

105. There was also the issue of whether all appropriate files had been located including the circumstances of some dioceses who did not know whether they had files missing. Given the efforts which CPAs and other diocesan staff made in 2008-09 to locate relevant files it did not seem to us that further searches 10 years later were likely to be more fruitful. However, we are aware that some dioceses have subsequently located further files (and more may be found in the future to comply with recent Data Protection requirements) so we are making a recommendation that all such files be independently reviewed along with any others which are known not to have been examined in 2008-09 if this has not already been done. A similar requirement should apply to files which may come to light in the future.

106. We commented in para 38 about the ambiguity surrounding the inclusion of some diocesan employees and the exclusion of parish employees and parish volunteers. Whilst we do not have evidence that there may be such people currently posing a risk to children we believe this to be a significant gap in the design and thoroughness of the PCR. We do recommend, therefore, that all dioceses should check the files of diocesan lay employees whose work involves or has involved engagement with children and young people and that all parishes be asked to confirm that any instances of safeguarding concerns about the

behaviour of parish employees or volunteers both currently and historically have been reported to the DSA.

Appropriateness of diocesan responses to cases of concern

107. In para 61 we described the difficulty we have experienced in forming a coherent view of the judgements exercised on cases and the actions taken. This could only have been fully remedied by reviews of all individual cases, which would have been hugely time-consuming and could only be justified on the basis of persuasive evidence that cases had not been competently dealt with. It is important to remember that there were a number of independent elements in the process – the independent reviewer; the participation of the DCPMGs some of which had independent members; comments by the NST on some newly identified cases; the fresh looks carried out by changes of DSA; repeat PCRs in some dioceses; and the SCIE audits of practice in recent years. These elements are not fool-proof but it is important to maintain a sense of proportion and in most dioceses, there are reasonable grounds for confidence that justifiable and appropriate responses were made.

Work with victims and survivors

108. We reported on our findings in para 69.

109. With some benefit of hindsight the decision, in effect, not to involve victims and survivors in the PCR was mistaken. Whilst we have a better understanding of the impact of abuse on people today than a decade ago the Church had some knowledge of this as its 2002 publication, *Time for Action, Sexual Abuse, the Churches and a New Dawn for Survivors*, reveals. We do not know how many victims and survivors were in contact with the Church in 2008-09 but from the evidence we have seen there was minimal action by dioceses to offer support to anyone identified by the review who had suffered abuse in the context of church life as required by the Protocol. However, the requirement not to contact victims contained elsewhere in the Protocol (see para 42) may have had the effect of actively discouraging involvement. The degree of hurt and distress which betrayal of the sacred trust and abuse by clergy and church officials can cause is such that compassionate work seeking to achieve a balance between healing action, resource management, the complications of insurers and re-building trust is likely to require on-going commitment for some years.

110. Our recommendation is that the Church needs to give greater impetus to its work with victims and survivors. It is one area where greatest progress needs to be made and to be demonstrated.

Scrutiny by the National Church

111. We acknowledge that the resources available within the National Church to exercise effective oversight of the PCR process and critically appraise the reports it sought were very limited and consequently fell significantly below what was required. Had the reporting requirements of the Protocol and the statistical return been clearer and more timely and had the scrutiny been sharper, then weaknesses could have been identified and addressed earlier and before the Church reported publicly. Whilst sending follow-up questionnaires in 2010 and as part of the DCR in 2013/14 were sensible steps, the National Church seems not to have insisted on responses nor done anything with the ones it did receive.

Other Church institutions

112. With a few exceptions, we have not found evidence that the National Church or individual dioceses made approaches to those parts of the Church with their own decision-making bodies such as Religious Communities, Theological Colleges and Courses or organisations closely associated with the Church such as the Central Council of Church Bell Ringers, Missionary Agencies, the Church Army and the Royal School of Church Music. Some but by no means all Cathedrals provided names for the Known Cases Lists and/or arranged file reviews. But our picture of their overall involvement is unclear and incomplete. We know of only one Theological College which was involved in the process of the PCR.

113. We consider that if the notion of a “Whole Church” approach to safeguarding is going to have real meaning then consideration should be given to how these parts of the Church can participate in a fully integrated network of safeguarding policy and practice. This must include conducting a retrospective file review if they have not already done so, in order to identify individuals whose behaviour has previously caused concern or against whom safeguarding allegations have been made.

Public statements

114. We have little to add to our findings in paras 71-86. We believe that shortcomings in the statement arose because of the tight definition of formal action; the omission of known cases where further action was taken; lack of clarity about which statistics were required; and incomplete and inaccurate statistical returns.

Lessons learned

115. Whilst it is not possible to separate out entirely the lessons learned from the PCR from an increasing emphasis being placed by the Government and children’s organisations on the

need to improve safeguarding policies and practices, it is clear that subsequent sets of Church guidance drew on the experience of the PCR. Whilst the report of the NSA and the DSA in Oxford Diocese (see para 92) may have received a cool reception at the time, most of its recommendations were implemented in whole or part during the ensuing years. DBS checks for clergy and church officials have become more robust; the National Church provides safeguarding training for bishops and senior clergy; a national safeguarding training scheme has been developed; there have been changes to the Clergy Discipline Measure in relation to the suspension of clergy; there have been improved arrangements for the transfer of clergy files; and the Church's safeguarding arrangements at national and diocesan levels have been professionalised with regulations governing the appointment and functions of DSAs. There is a duty on relevant persons and bodies to have "due regard" to the House of Bishops' practice guidance. A consistent theme emerging from the work of many if not most of the IRs relates to the poor quality of recording and record keeping and that same theme recurs in most of the SCIE reports into contemporary practice. That said, there are also some good examples of quality recording and these should be shared between dioceses. However, the evidence generally suggests that sound case recording in safeguarding needs continuing attention and at an absolute minimum it is essential that every diocese should have a system whereby safeguarding files, in relation to both historic and current cases, contain all relevant information and are clearly identifiable. Attention is also drawn to the Church's guidelines on document retention.

116. There is evidence from the 2010 follow-up that most dioceses identified learning from their own PCR and subsequently showed, or at least stated, that they had implemented the lessons.

117. The Church has adopted a more realistic approach to the resourcing of safeguarding both nationally and in dioceses. There is now an NST instead of a part-time adviser and appointments of DSAs in each diocese. Some of these developments may have taken place had there not been a PCR but at the least its outcomes contributed towards a momentum for change.

Two further thoughts

118. We have endeavoured to limit our work strictly to our Terms of Reference and avoid "mission creep". However, two issues have emerged which, whilst outside our remit, warrant further attention in our view. The first is the importance of prevention.

119. As we worked our way through the Known Cases Lists and the reports of the Deceased Clergy reviews we noted the extent of the sexual abuse which had occurred over

many years albeit by a tiny minority of priests and church officials. This emphasised, for us, the vital importance of creating a climate in our churches in which abuse is prevented as well as having sound policies and procedures for dealing with it when it does occur. Amongst the many demands for priority action we hope that the promotion of prevention will find a significant place in the Church's safeguarding activity over the coming months and years.

120. The second issue relates to the time period over which the further work we recommend in in para 121 (1-3) should extend. The PCR drew a line at 2007. Would the National Safeguarding Steering Group wish to be assured that all relevant files which have been compiled since 2007 have been reviewed and all cases of concern which have emerged since then have been closed or are being effectively managed? We know that dioceses are in very different places in relation to reviews which have been undertaken since the PCR and we would not wish to see thorough work unnecessarily repeated. But we do wish to draw attention to the danger of the Church creating an anomaly whereby a process has been completed for examining all available records prior to 2007 but no similar assurance exists in relation to the 2007-2018 period. Such an assurance could range from a simple statement endorsed by the Diocesan Safeguarding Reference Group that any concerns or allegations recorded or emerging since the PCR have been, or are being, appropriately dealt with to a more substantial requirement to have these later files and cases independently reviewed.

RECOMMENDATIONS

121. We have resisted the temptation to make recommendations on every aspect of our scrutiny. Instead we have limited ourselves to those which may help to improve the safety of children from people whose risk has not been recognised or managed and to make better provision to meet the needs of victims and survivors:

1. We recommend that ALL dioceses and the provinces ensure that relevant files (including those of diocesan lay employees working with children) which are known not to have been examined in 2008-09 or which have subsequently been located and not examined, are independently reviewed and any cases of concern which emerge dealt with by the DSA as if they were new referrals.
2. We recommend that ALL dioceses should be asked to check with every parish that all safeguarding concerns about the behaviour of any parish employee or volunteer towards children both currently and historically have been notified to the DSA.
3. We recommend that an up-dated version of the PCR, as prescribed by the National Safeguarding Steering Group, should be conducted in the 7 dioceses where further work is considered necessary.
4. We recommend that approaches are made to those parts of the Church with their own decision-making bodies which have not conducted an equivalent PCR, to carry out an independent file review and to examine all known cases of concern both current and historic ones.
5. We recommend that all parts of the Church co-operate to ensure that there is a “Whole Church” approach to safeguarding which will minimise the risk of unsuitable people being appointed to positions of trust with children and vulnerable adults and provide for appropriate action to be taken in all circumstances which give rise to concern.
6. We recommend that arrangements to improve the Church’s responses to victims and survivors receive enhanced priority from the NST and diocesan safeguarding teams and that the Church develops and disseminates its learning on effective means of responding to victims and survivors.
7. We recommend that all dioceses give continued attention to the need to maintain improvements in the quality of recording and where necessary, enhance record keeping, file maintenance and cross referencing of safeguarding issues.
8. We recommend that the NST should provide guidance to all dioceses regarding the implementation of these recommendations. It should evaluate and report on the outcomes to the National Safeguarding Steering Group so that the shortcomings of National Church oversight, evident in the PCR, are not repeated.

9. We recommend that the National Safeguarding Steering Group considers the issues of prevention and time period raised in paras 118-120.

ACKNOWLEDGEMENTS

122. Finally, we want to express our appreciation to both the professional and administrative staff of the National Safeguarding Team. Despite their exceptionally high workload they have sought out whatever information we have requested. They have provided us with hospitality, accommodation and facilities with unerring willingness. And they have respected to the full the fact that our scrutiny is an independent one.

123. We also appreciate the assistance given by today's Diocesan Safeguarding Advisers. Doubtless they would have much preferred to spend their time dealing with current issues rather than searching files and records relating to matters a decade and more ago. But they recognised that this was work to ensure that unsuitable people who should have been identified 10 years ago did not still have access to children via our churches and they responded accordingly. Thank you.

APPENDICES

A. Abbreviations used.

Central Safeguarding Liaison Group **CSLG** later re-named Joint Safeguarding Liaison Group **JSLG**

Child Protection Adviser **CPA**

Diocesan Child Protection Management Group **DCPMG**

Diocesan Safeguarding Adviser **DSA**

Independent Inquiry into Child Sexual Abuse **IICSA**

Independent Reviewer **IR**

Independent Scrutiny Team **IST**

National Safeguarding Adviser **NSA**

National Safeguarding Team **NST**

Past Cases Review **PCR**

Past Cases Review Working Group **WG**

Social Care Institute for Excellence **SCIE**

Appendix B. DSA check-list

PAST CASES REVIEW

Response to questions raised by the Independent Scrutiny Team (IST)

Check list for completion by the DSA ofDiocese

1. Please review the documents listed under **Documents considered** of your Diocesan PCR Summary. There is a clear indication of documents we have seen but there may be others which we have not seen. If you have copies of any which have not been seen, please attach them to this check list and list them here. Please give a NIL return of any of the key documents you do not have:

2. If there is any further relevant information you have which bears on the adequacy or otherwise of the PCR, please list and attach it. The Church has committed to an open, constructive and transparent approach to IICSA, so please include any data which may be supportive or critical of the PCR in your diocese such as subsequent reviews, repeat PCRs, visitations etc.

Additional documents attached – please list them here:

3. The documents examined so far contain little information about work done with survivors of abuse as a direct consequence of the PCR. Please attach any information you have about this. We do not need to know about work done with people whose abuse has occurred since the PCR.

Additional documents attached – please list them here:

4. In relation to Cathedrals within the administrative area of your diocese:

..... Cathedral *was/was not/don't know* involved in the PCR

Cathedral known cases *were/were not/ don't know* included in the statistical return from the diocese

Cathedral files *were/were not/don't know* examined and the figures included in the statistical return from the diocese.

5. In relation to the diocesan summary:

Do you believe the summary to be accurate? Yes/No

If not please draw attention to issues which may affect the summary:

6. Are there any cases which have arisen since 2007 which might reasonably have been identified as causes for concern in the PCR process, but were not? The person(s) involved may have been working in another diocese at the time of the PCR, so you would not necessarily know whether grounds for concern were identified. In either situation, there is no need to provide details. Just indicate below that there are some cases and a member of the team will contact you.

Cases *have/have not* arisen since 2007 which could have been identified in this or another diocese.

7. Please confirm that all cases identified as part of the PCR (i.e. on the Known Cases List) have been closed or are currently being effectively managed. If you are not able to give this confirmation, what further work is required?

I confirm that all cases identified as part of the PCR have been closed or are currently being effectively managed.

.....
Diocesan Safeguarding Adviser

.....
Date

Sir Roger Singleton CBE

Roger Singleton has a background and qualifications in education, children's services, risk assessment, policy and management. From 1984-2005 he was chief executive of the children's charity, Barnardo's, where he led the change from an association running residential homes and schools to one supporting children and young people principally in their own homes and communities. From 2007-2012 he chaired the Independent Safeguarding Authority, a Home Office agency created to decide who should be statutorily barred from working with children and vulnerable adults because of the risk they posed to them. Since 2005 he has had his own consultancy specialising in safeguarding. He advises organisations on their safeguarding policies and practices carrying out both statutory and in-house audits and reviews of child protection issues. He is a member of the Home Office Independent Family Returns Panel and the Social Care Route Chair of the Institute for Apprenticeship.

Amanda J Lamb

Amanda Lamb is a qualified social worker with many years' experience of children's and adults' casework, both in the voluntary sector and mainly in local authorities. She has management qualifications and was a senior manager, including 6 years at Assistant Director level, in two large metropolitan authorities. Amanda has experience of complex safeguarding work at a strategic as well as case based level and also of project management and change management of children in care services. Since leaving local authority work she has operated as a self-employed consultant for the last 4 years working on a number of substantial service reviews in children's services and serious case review work in child care deaths. Amanda has been a member of the scrutiny team of the past cases Review since its inception.

Donald Findlater

Donald Findlater is a social worker and probation officer by profession. Following a career in the probation service, he joined the child protection charity, the Lucy Faithfull Foundation (LFF), to manage their residential sex offender assessment and treatment provision, the Wolvercote Clinic. He established the child sexual abuse prevention campaign and helpline **Stop it Now: UK and Ireland** and was a subject matter expert for the DCSF (now DfE) in developing their **Safer recruitment in Education** training for Heads and Governors of Schools following the Bichard Inquiry into the tragedy of Soham. He sat on Lord Nolan's Review of child protection arrangements in the Catholic Church and was a Board member of the Independent Safeguarding Authority and Disclosure and Barring Service from 2008 to 2013 taking a particular interest in casework. He left LFF to become an independent Consultant in August 2016.