# Independent Overview Report

# WSF – Lessons Learned

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## 1. Introduction and executive summary

1.1 This review was commissioned by the Church of England (the Church) following the arrest and conviction of William Scott Farrell (WSF) for a number of sexual offences, some of which had children as the victim. These offences were so serious that they resulted in a lengthy custodial sentence (5 years) being imposed. For the purpose of this report, I will refer to Mr Farrell as WSF.

1.2 The offences occurred whilst WSF was employed as Assistant Director of Music and Director of Music at Ely and Rochester Cathedrals respectively (he was also employed in Newcastle Cathedral). Each of these three Cathedrals have conducted an internal review, guided by the same terms of reference (ToR). These reviews produced individual reports that will be summarised and commented upon within this document. Each report has been considered by this review and together they provide the bulk of the information relied upon for the observations and recommendations made. The second phase of the review involved the Church commissioning an independent safeguarding professional to produce an overarching report for publication. This report is the end product of the latter stage of the review.

1.3 It is important that when reading a report that aims to improve safeguarding practice for the future, we do not lose sight of the impact this case has had on individuals, families and friends. I would like to take this opportunity to acknowledge the impact and distress caused to people by the circumstances that surround this case. Whilst this document will not seek to comment on culpability of individuals, agencies or communities I hope that when reading, those directly involved will be able to see that its aim is to improve practice and do all we can to ensure similar safeguarding issues are not repeated in the future.

1.4 It is clear from the Cathedral reviews that have been completed that there are areas of learning for individuals and Cathedrals. Despite representation made to me I do not believe it is the place of this review to make judgements where there appears to be individual failings. The ToR supplied for this review do not seek a view from the Independent Overview Report on such individual failings. The correct process would be for the Church of England to consider the issues in an appropriate disciplinary process that affords individuals an opportunity to make representations and offers appropriate protection to all concerned. Such issues should be taken forward on a local level. This report will concentrate on larger systemic issues that, if addressed, will improve safeguarding provision across the Church.

1.5 The review found that there were a number of opportunities to challenge WSF’s behaviour, with safeguarding concerns raised at regular intervals. These opportunities were missed for a number of reasons that are discussed in this document. Key areas for improvement were identified including safeguarding culture, governance and leadership, recognition of risk and impact of cumulative risk, status of individuals and music departments, information exchange, safer recruitment and review processes. A total of eleven recommendations are made to improve culture, support and develop existing good practice, remove barriers and improve safeguarding outcomes.

1.6 The Church of England should now consider the recommendations and if they accept them an action plan for delivery should be agreed. It is essential that any such action plan is owned by individuals who are accountable for progress. Those in senior positions should support work-streams and monitor progress to prevent drift. Without genuine commitment from the very top of the Church there is a risk that safeguarding will not be improved at the required pace.

## 2. Terms of Reference (ToR)

2.1 The ToR for this review is published on the Church of England website. A full copy of the document can be found in Appendix A.

2.2 The website post introduces the review and its objectives stating:

*'the objective of the Review, to be undertaken by independent safeguarding chair Chris Robson (see Terms of Ref) is to allow the Church of England to take steps to enhance and improve its response to allegations of abuse and, thereby, to ensure a safer environment for all. The Review will consider both good practice and failings in the Church of England's safe recruitment practices in respect of William Scott Farrell, and the appropriateness of responses by Church of England bodies to allegations and anonymous concerns raised across each diocese in which he held any post.'*

2.3 The published ToR give some context so the reader can understand the methodology employed in this two-stage piece of work. The document sets out three key areas for this review to satisfy:

*1. Once all Cathedral reports have been completed, the Independent Reviewer will review those reports and produce an Independent Overview Report which summarises the key facts and lessons to be learnt, it will not be necessary for them to review any of the records held by the Cathedrals but they may do so if they consider it to be necessary. They may also seek clarification on any questions which arise by approach to the Diocesan Safeguarding Adviser, Independent Reviewer or the relevant agency.*

*2. The Independent Overview Report will be written for publication, with appropriate steps taken to anonymise any individuals and redacted to prevent identification. The overview writer of the report to draft it considering the requirement to avoid the identification of any survivor by any direct references of jigsaw identification.*

*3. The Independent Overview Report will be submitted to the Director of Safeguarding within three months of the commencement of this part of the review.*

## 3. Identification of individuals involved

3.1 The purpose of this review is to examine practice, identify learning and make recommendations to assist the Church to provide the best possible safeguarding. It is not to apportion blame or to cause victims of abuse further distress. Every effort has been made to ensure the identity of those who were abused by WSF remain confidential and their privacy is respected. This means that the review does not go into detail regarding the method of offending, locations or specific ages of those offended against as this may lead to jigsaw identification. WSF committed sexual offences against children and adults that were so serious he received a five-year prison sentence. To detail those offences would risk identifying those he abused. However, some of the detail needed to fully understand the context of his employment and behaviour will result in many of those that read this document making assumptions or drawing conclusions as to individual's identity. As the reviewer I would ask that such speculation is avoided; it is not helpful and will only result in increased anxiety for individuals who should be offered nothing but support and respect.

3.2 It is also of note that both WSF and another close associate, Sam Rathbone (SR), have been convicted of sexual offences against children. These convictions are a matter of public record and

will be referred to in this review.  Other safeguarding concerns will also be discussed. When reading these sections, it is important to concentrate on the opportunity to learn rather than try to piece together information that may identify individuals. Individuals whose actions or practice have been commented on have been offered the opportunity make representations to the reviewer.  This has resulted in some changes being made to the report.  However, where the comments were not about accuracy or did not significantly impact learning no change was made.  I would ask those people to consider this review as a 'learning lessons' exercise rather than a commentary on individuals.

## 4. A timeline of significant events

4.1 The following timeline of significant events in this case has been taken from the three reviews completed by the Cathedrals concerned in this review. This timeline is included to afford the reader some understanding of references made in the report.  It does not seek to detail every event that took place.

**1992 - 1993** - WSF gains a Post Graduate Certificate in Education.

**1993 - 1998** - WSF employed as Assistant Deputy of Music, St Edmundsbury Cathedral.

**1999 - 2002** - WSF employed as Assistant Organist, Ely Cathedral.

- ***During his term of employment as Assistant Director of Music WSF commits sexual offences against children. He is convicted of these offences in May 2019 having pleaded guilty.***
- Late 1998 – WSF is recruited as assistant organist, the application process for the role made no reference to safeguarding or working with vulnerable children.
- August 2002 - Vice Dean at Ely writes a letter addressed to WSF, cc'ing the Dean and Chapter, Dean of Newcastle Cathedral and Deputy Headmaster of Kings school Ely. The letter appears to deal with allegations of professional misconduct with or towards children by WSF.  Information held regarding how this letter came about, whether it was part of a formal discipline investigation and indeed if it was an appropriate course of action cannot be found.

**2002 - 2008** - WSF employed as Organist and Master of Music, Newcastle Cathedral.

- It is of note that WSF was not charged with any offences that arise from his time at Newcastle Cathedral.  Despite this there are a number of concerns raised and missed opportunities to deal with inappropriate behaviour.
- April/May 2002 - Throughout WSF's recruitment, employment and subsequent move to Rochester it is unclear who is aware of the Ely letter and when they become aware of its content.  Matters are summarised but accounts differ.  It is clear that the letter was kept separately to WSF's personnel file.
- During his employment in Newcastle, concerns were raised with parents regarding trips WSF organised with choristers to the cinema and then his home address.  No action resulted.

- July 2004, significant safeguarding concerns raised and not acted upon.

- Further concerns raised regarding WSF's behaviour with a young person at a family address, no action taken.

**August 2008 - November 2018** - WSF Director of Music, Rochester Cathedral.

- October 2010 - A significant associate of WSF (SR) appointed Assistant Director of Music, Rochester Cathedral.

- September 2013 - SR arrested for sexual offences.

- July 2014 - SR sentenced to 3 years in prison.

- October 2014 - Bishop initiates a 'Bishop's Visitation' at the request of Chapter to examine the circumstances of SR's conviction and make recommendations.

- January 2015 - Independent Visitation Report first produced.

- April 2016 - A redacted Visitation Report shown to Chapter.

- 15.11.2017 - WSF arrested for sexual offences against children, the offences occurred during his employment at Ely Cathedral.

- 15.11.2017 **-** WSF suspended from work.

- 12.09.2018 - WSF further arrested for sexual offences against children and adults, some of which related to his time in Rochester.

- 02.11.2018 - WSF resigns from his job at Rochester Cathedral.

- 28.05.2019 - WSF pleads guilty at Cambridge Magistrates Court to all charges.

- 13.08.2019 - WSF sentenced to 5 years in prison.

## 5. Summary of Cathedral Reviews

5.1 Three Individual Management Review Reports were supplied to this review. Each review was commissioned by the Cathedral using a TOR that the National Safeguarding Team were involved in preparing. I will deal with each in turn, summarising the content and main findings. It should be noted that it is not the purpose of this review to 'reproduce' or simply 'copy' the reviews. This review will not detail every bit of information contained in these documents, rather highlight key information and findings.

5.2 ***Ely Cathedral***

Ely Cathedral produced a ten-page report that was authored by the Independent Chair of the Cathedral Safeguarding Group.

- It is noted that some of the offences of which WSF was convicted of took place during his term of employment as Assistant Director of Music at Ely Cathedral between 1999 and 2002.

- A helpful summary of the policy governing recruitment of staff is provided and it is noted that Bichard did not report until 2004. The Bichard enquiry that followed the tragic deaths of two children in Soham was significant in many ways but specifically in terms of safer recruitment.

- WSF was recruited as assistant organist in late 1998. The job description made no reference to safeguarding or working with vulnerable groups. Whilst applicants were required to disclose details of criminal convictions the application form did not require disclosure regarding causing harm to children, as set out in the 1995 Child Abuse policy. References were contacted and they highly commended WSF for the role. Neither raised any concerns regarding working with children or vulnerable people.

***Comment – References provided throughout WSF's employment failed to raise concerns. Indeed, many of those received were extremely positive and none seem to have raised any safeguarding issues.***

- One of the individuals with responsibility for the recruitment process (the selection was made by a panel) stated, when interviewed for the review, that he was not aware of any concerns regarding WSF whilst he was employed at Ely. This person agreed that he would have had responsibility for WSF's management but also stated that there was no recognised or formal line management structure.

- The Ely review identifies that in November 2002 WSF was to leave Ely for a position at Newcastle Cathedral. No request for references could be found. Within the records examined there are no indications that there were any incidents that caused concerns regarding WSF's behaviour or employment.

- The Ely reviewer identified that during the criminal investigation into this case it became apparent that a letter was written by the then Vice Dean at Ely Cathedral, dated 21st August 2002. This is after WSF started his employment with Newcastle in July 2002. The letter is addressed to WSF and cc'd to Dean and Chapter, the Deputy Headmaster of Kings School Ely and the Dean of Newcastle Cathedral. The letter relates to a meeting between WSF, the Canon and Headmaster of Kings School Ely following an allegation of 'professional misconduct' made by a year 8 student. The letter also referred to a text message, invitations to students to attend his flat and 'horseplay' in a swimming pool. The letter stated that the author was prepared to accept that there were no 'sinister overtones.' There is no record of this letter or the incidents referred to in either the Cathedral or Diocese files. A copy of this letter has only been obtained by Ely as a result of this review from Rochester. It is not known when this letter was actually sent to or received by Newcastle Cathedral, it is acknowledged that the Dean and later the Canon Precentor at Newcastle did have the letter in their possession (see Newcastle review summary). The lack of recording does not allow any further understanding of the rationale for the letter and whether this formed any part of a disciplinary or other investigation or, indeed, whether the formal warning referred to in the letter was the appropriate course of action.

***Comment – This letter features in all three Cathedral Reviews. It is clear that the allegations made were dealt with by senior clergy within the Cathedral. No records of disciplinary decisions made,***

***rationale for actions taken or future monitoring of behaviour is recorded. In fact, as will be demonstrated later in this document this letter was found by chance in WSF's possessions in November 2018, rather than within Cathedral records.***

- The Ely reviewer then details a letter contained within the files examined that has a date stamp of 22 November 2013. The letter is anonymous but makes allegations that WSF committed child protection offences whilst he was employed at Ely and Newcastle.

- In September 2015 there is correspondence that suggests WSF may be returning to Ely in an exchange of role. This led the Residentiary Canon to make enquiries with the Diocesan Safeguarding Advisor. It is reported that the Canon was informed that the issues raised in the letter detailed above had been addressed and found to be malicious. The Cathedral Safeguarding Officer at Ely advised that on the current information there was no reason for the exchange not to go ahead. The Canon proceeded to put a robust safeguarding package in placed including DBS checks, safeguarding induction for WSF, designated supervision of WSF and an exact programme of his work. Whilst the exchange did not go ahead the package put in place by the Canon is correctly identified as good practice. The author identifies that this may be an indication of how practice has changed throughout the review period.

***Comment – This is evidence of good practice.***

- WSF's employment included a role to support Kings School Ely. There are no records held by the school that indicate there were any concerns regarding his behaviour. That said it is clear that there were allegations made as detailed in the 2002 letter.

- The Ely reviewer then goes on to detail what they believe to be the 'learning points' of this case. They comment on five specific areas - safer recruitment, dealing with allegations and concerns, recording of concerns, staff management and good practice.

- On safer recruitment the Ely Reviewer points to a lack of consideration of whether WSF was suitable to be working with children or vulnerable persons. There is no evidence that this was explored during the recruitment process and no request for personal disclosure was made (Child Abuse Policy 1995).

- The Ely review acknowledges that it is difficult to comment on the appropriateness of the 'warning letter' but does question if a different course of action may have resulted in WSF's offending being 'inhibited or mitigated'.

- The Ely review points to a lack of recording on Cathedral's and school files regarding the 2002 allegation, the fact that there was no evidence of any management structure and again highlights good practice regarding the planned music exchange in 2016.

- Having spoken to the Ely reviewer it is clear that he felt the ToR and process for this review (overview) were flawed from the outset. A more immediate commissioning of the overview author and his/her involvement in the process would have been of great benefit.

5.3 ***Newcastle Cathedral***

Newcastle Cathedral's report was written using the same ToR as that was provided to Ely. The report is 21 pages long and accompanied by a number of appendices.

- WSF moved to Newcastle Cathedral in 2002. He was employed as Organist and Master of Music following a recruitment process conducted by an interview panel chaired by the Dean of the Cathedral.

- He remained in post until 2008 when he moved to Rochester Cathedral. A reference was prepared by the then Dean and sent to Rochester at the time of his appointment.

- The Newcastle reviewer contacted a number of individuals who worked with WSF or were involved with his tenure. Their contributions are summarised within the review. Taking each contributor in turn:

  The Dean of Newcastle at the time WSF was appointed recalls the recruitment process that he chaired. He describes others being involved in the selection process including the Precentor, two Lay Members of Chapter and possibly a musical expert from another cathedral. The Dean believed that all proper procedures were followed. He stated that references were obtained and followed-up. He informed the reviewer that information regarding WSF's recruitment and time in post was accurately recorded, retained and shared. He commented that he had had a telephone conversation with the Dean of Ely which he noted on paper. At the time of the interview, he was not made aware of concerns about WSF's time in Ely. He reported his conversation with the Dean of Ely to Canon Precentor as he was the Organist's line manager. The Dean stated he did not personally have any concerns regarding WSF whilst he was in post and he was not aware of any concerns about WSF that may have been expressed or held elsewhere in the Diocese. He described WSF as a charismatic and lively young man who worked well and inspiringly with young people. He had no concerns about any of the relationships WSF formed in the Diocese. He was not aware of any concerns that may have been raised anonymously. He believed that effective safeguarding processes were in place, and much time was spent on them.

  A new Dean was appointed in 2003 at which point WSF had been in post for about a year. This individual stated he was very conscious of WSF's work, albeit the Precentor was his Line Manager. He was unaware of any past history which might have been considered a safeguarding concern and no issues were raised with him by colleagues, until WSF left the diocese and was appointed to a new post in Rochester. It was at this point that his attention was drawn to a file which had been held separately by the Cannon Precentor and contained information regarding a safeguarding matter raised during WSF's time in Ely. He describes that he had been shown a letter which referred to an incident in which 'boundaries' had not been appropriately observed but which had been dealt with by the Vice Dean at the Cathedral in Ely. He stated that WSF had been "CRB checked" and nothing untoward had been raised. As far as he was aware the information from Ely had not been shared with Newcastle's Safeguarding Officer at the time of his appointment. This is confirmed as the letter was not sent until after WSF's appointment. No risk assessment had been undertaken. He also informed the reviewer that, in his opinion, recruitment details had not been appropriately recorded. He informed the review that he had made it very clear that all material relating to appointments needed to be held in one place and appropriately shared.

The Canon Precentor contributed that he was involved with the appointment of WSF. It was his opinion that WSF had been safely recruited and that all relevant policies had been followed. He stated that all the information relating to the appointment and his time in post at Newcastle Diocese had been accurately recorded, retained and shared. He discussed the 'Ely letter' stating the Dean had received it. When he left (the Dean), it was passed to him and he in turn passed it to the new Dean at the point when he was preparing references for WSF's move to Rochester. In summary, the Canon Precentor stated he had no concerns personally about WSF and as such nothing was recorded by him. He was not aware of any other concerns held elsewhere, so no response was required. It was his opinion that effective safeguarding was in place at Newcastle Cathedral.

***Comment – Whilst the recall of the individual involved varies it is accepted that the 'Ely letter' was received by Newcastle. It is also apparent that a decision was taken to keep this letter separate from WSF's personnel file. This decision prevented its content being considered when concerns were raised or when he moved to new posts.***

- The Newcastle reviewer details contributions from the Residentiary Canon at the time of WSF's employment in Newcastle and a Diocesan Safeguarding Advisor. These accounts discuss information that was circulating at the time WSF left Newcastle and a challenge regarding some of the activities he organised with children. The Canon believed the matters raised with WSF had been dealt with and a protocol put in place. This individual's account does reference 'uneasy feelings' he had and also discusses what would have happened if there had been any 'concrete evidence' for individuals to act upon.

- The Newcastle review sought input from a member of the music department during the period WSF was at Newcastle Diocese. Whilst he was unable to comment on whether he was safely recruited he did state he was aware of the concerns raised in Ely but not at the time of the interview. He became aware later by 'rumours passed by word of mouth'. This individual offered significant insight into the time WSF was in post in Newcastle. He made specific reference to three areas which were a cause of concern to him. The review records his comments on these matters verbatim. In summary, he describes WSF's impact on the Cathedral community, pointing to his ability to motivate and influence those around him. He comments that he had a very large ego and enjoyed being the centre of attention. The three areas which caused him concern were as follows:

1. WSF arranged cinema trips with some of the choristers, followed by visits to his home. The person felt a little uncomfortable about this and spoke to parents to ensure they were happy with the arrangements, they appeared to be so.

2. In summer 2004 there was a significant safeguarding issue raised. Despite the serious nature of the allegation no action was taken and no referral to any safeguarding professional or agency was made.

3. An incident where WSF spoke to a young person whilst at her family home is also described. On this occasion he made inappropriate sexual comments and had previously sent the same child inappropriate texts. WSF was never invited to the house again.

- The contributor goes on to say that he reported these concerns to the Canon Precentor. He also describes several rumours that were circulating about WSF, some of which would

indicate possible sexual offences and child safeguarding issues. He was unable to comment on whether these concerns were followed up.

- A further contribution was taken from a parent whose child had contact with WSF in the music department. This contribution comments on a number of concerning safeguarding issues including some that have already been mentioned. Some of the information contained would cause issues regarding identification of individuals and as such is not included explicitly in this review. What is of interest is that the parent welcomed WSF into his house and even when confronted with safeguarding issues did not feel in a position to report or escalate them.

- The Newcastle reviewer then sets out their consideration in each area they are asked to comment on in the ToR. Having laid out the information available they conclude that the Vice Dean of Ely considered the matters arising in their Diocese to be serious enough to advise Newcastle Diocese of the facts. The fact that the letter did not arrive until after the appointment means that it's content could have no impact on the recruitment process.

- The Newcastle reviewer then summarises WSF's time in Newcastle and details a number of conclusions drawn from the information. Concerns raised following the incident in summer 2004 were not followed up in accordance with policies and procedures. It is clear that if line managers were informed of these concerns, failure to deal with the allegations would have been a serious dereliction of duty. The Newcastle review also considers 'obstacles' to sharing information. These obstacles revolved around working relationships rather than safeguarding policy. These difficult working relationships may have been an obstacle to effective communication and risk management. In addition, the culture within the Cathedral was considered with one individual failing to act on safeguarding concerns because he was "worried about his position at the Cathedral". The Newcastle review rightly questions both the culture and support available to individuals.

- Further support to a concerning culture is added to when examining the content of the "The Newcastle Cathedral Quote Book", a document that had contributions from a number of individuals in the Cathedral. This book and its content are rightly identified as an insight into the culture and what appeared to be acceptable standards of communication and behaviour at this time. The content of the quote book supports the hypothesis that the culture in Newcastle Cathedral at the time was unprofessional and inappropriate. Some of its content is shocking and has no place in any church setting. It is described as a testament to the witticisms and general banter that arises on a daily basis. The reality is that it is an offensive document that should have raised concerns by those who saw it.

- The Newcastle review goes on to consider the impact of decisions taken and if any abuse could have been prevented. It is reasonable to think that the manner in which WSF was employed by Newcastle Cathedral presented him with opportunities to behave in a way which was likely to cause harm to individuals. Furthermore, it is clear that there were serious concerns about WSF whilst in post, which, had they been shared and dealt with appropriately through discipline or supervision would have impacted on his employment in Newcastle and subsequently elsewhere.

5.4 It is of note that the Newcastle review then clarifies that individual failings are being considered by the Diocese and that core groups are in place to progress this work. This overview report acknowledges that 'local' resolutions to safeguarding issues need to take place outside this review.

5.5 ***Rochester Cathedral***

Rochester Cathedral commissioned an Independent Reviewer to complete their review. The review was subject to the same ToR. The result was a 44-page report. This report was supplemented by a further report by the same independent reviewer that highlighted specific learning for Rochester Cathedral.

- The Rochester review details the offences committed by WSF, including method, ages of victims and locations of offences. I have considered the merit of including this information within this review and decided that it is unnecessary. As previously stated WSF committed serious sexual offences against children and adults whilst he was in a position of trust. His offences were so serious as to merit a five-year custodial sentence, to describe them would only serve to cause embarrassment and distress to those whom he offended against.

- In April 2014, during WSF's time at Rochester Cathedral as the Assistant Director of Music, a close colleague {SR) was convicted of a sexual offence against a child chorister in his care. He received a 3-year prison sentence. WSF had oversight of this individual and some management responsibility for him. The conviction triggered a Bishop's Visitation by two independent reviewers. Their report highlighted significant concerns about the Cathedral's safeguarding culture, practices, procedures and management oversight associated with the Music Department. This is dealt with in greater detail later in this report.

- The Rochester review outlines a lack of investment in the role of Safeguarding Advisor during WSF's tenure. For most of the 10 years of his time at Rochester, the Cathedral did not have its own professionally qualified safeguarding adviser. On appointment in 2008 the Bishop's Adviser for Child Protection, covering the Diocese, did not have responsibility for the Cathedral. In September 2010 an individual took over as Diocesan Safeguarding Adviser (DSA) for children and vulnerable adults. This was a part-time appointment with 20 hours per week to cover over 200 parishes, spread over a large geographical area covering four Local Authorities and two police forces. This individual did advise the Cathedral on serious safeguarding issues if requested to do so. In December 2017, a Cathedral Safeguarding Officer (CSO) was appointed, their first professionally qualified adviser.

- Dealing with the music arrangements during WSF's time at Rochester Cathedral the reviewer sets out the various choirs that existed both within Kings School Rochester and the Cathedral. Of note is the fact that WSF led the boys' choir, with children aged between 8 and 13 and had overall responsibility for the girls' choir which consisted of children aged 11 to 16. When at school the children were under the care and supervision of their respective schools. When in the Cathedral or at other singing functions on behalf of the Cathedral the children were under the care and supervision of the Cathedral. Oversight of the Music Department, including direct line management of the Director of Music, was the responsibility of the Canon Precentor and or the Chapter Clerk during this period. The reviewer points to the 'general agreement' that WSF produced high standards amongst the choirs he directed. During his oversight one chorister won the BBC Young Chorister of the Year award and another chorister was a finalist.

***Comment – The status of music departments, the supervision or lack of supervision provided and lack of safeguarding risk assessment is a strong theme within this case.***

- The Music Department also had a number of Organ Scholars and Choral Scholars on small bursaries. The Organ Scholars were provided with accommodation by The Kings School Rochester and the Choral Scholars were housed by the Cathedral in a Cathedral owned property in the precinct. There were usually 3 Choral Scholars at any one time. The Choral Scholars joined the lay clerks singing with the choir

- In terms of the recruitment process for the role in Rochester, the Rochester reviewer concludes 'I consider that the administrative part of the recruitment process reflected good personnel practices at the time'. He goes on to deal with references received for WSF. One was received from his most recent employer, the Dean of Newcastle Cathedral and the other from a personal friend of WSF who held a senior position in a church music department. Both were complimentary with the one written by the Dean described as more balanced. Neither appear to have highlighted any safeguarding issues.

***Comment – References that are written by personal friends should be avoided or considered in context. To fail to disclose safeguarding information on an individual is extremely poor practice and if discovered should heighten risk assessment.***

- The issue of the 'Ely letter' is then discussed under the heading 'Reference from Ely'**.** It is acknowledged that this letter was found following WSF's arrest and therefore was not included in the Rochester recruitment process. The Rochester reviewer provides details of the text of the letter and lists the recipients, saying 'A copy of the letter was listed as being sent to: Ely Dean and Chapter, the Headmaster and Deputy Headmaster at the Kings School Ely and to the Dean of Newcastle'. He then reaches the conclusion that it is likely that the friend who provided WSF's second reference would 'known about these allegations when he wrote his unequivocally positive reference'. He highlights the fact that had he known about the allegations they should have been referred to in his reference. The Rochester reviewer then deals with the fact that there was some exchange of information between Newcastle Cathedral and Rochester Cathedral that highlighted they should be aware of some allegations made against WSF when he worked at Ely Cathedral. The source of this information could not remember the details other than it involved some inappropriate naïve behaviour and he was cleared of any misconduct. WSF was spoken to and said that he had made a mistake. Advice was sought from an independent HR advisor, a system still used today. The advice provided was that the records of the concerns brought to his attention should be destroyed including any notes he had made for WSF's personnel file. This was said to be in line with data protection legislation on the basis that WSF had been exonerated of any misconduct, he had been interviewed by the Dean about the incident, he had a clear CRB disclosure and in effect his name had been cleared. Further detail and comment follow detailing exchanges between Rochester and Newcastle regarding WSF.

***Comment – Better recording, including detailed narrative, would have resulted in the cumulative impact of WSF's behaviour becoming apparent. This in turn would have highlighted safeguarding risks that existed and should have led to interventions.***

- In December 2008 an anonymous letter was received by Rochester Cathedral. It was short, just two paragraphs, written on a "scrappy" piece of A5 paper. The gist of the letter was that WSF should not be appointed Director of Music at Rochester as he was a danger to children because of his behaviour where he worked before. The letter had a Newcastle postmark. Advice was again taken with the following result - 'discussed options but nothing further employer can do as anonymous and given clean CRB and good

references etc so under DPA (Data Protection Act) principals will not retain and will shred." The Rochester reviewer comments '*My view is that a professional adviser with a safeguarding background would not have suggested such a course in these circumstances, even without the benefit of hindsight. I consider the decision unwise. I also question the wisdom of seeking professional safeguarding advice from private HR specialists outside the Church context and experience when there was a Diocesan Child Protection Adviser locally'*.

***Comment – This review agrees with the observations of the Rochester reviewer, whilst those involved followed advice given it does not appear to have considered safeguarding implications. Representations have been made to this review that the jurisdiction of the Diocesan Safeguarding Adviser did not extend to the Cathedrals. Whilst this is accepted, it remains the case that no approach appears to have been made to seek out advice from a safeguarding expert. Reviews deal with 'moments in time' so it is inevitable that change will have taken place, this should be regarded as a positive.***

- The Rochester review then details the appointment of a personal friend of WSF, SR, as Assistant Director of Music in 2010. Whilst the reviewer acknowledges the fact that the review is not about SR, he argues that the behaviour that preceded this person's arrest illustrates the culture of the Music Department in which he and WSF worked. There is a significant amount of time spent on SR within the Rochester review.

- WSF played a primary role in SR's employment and when the Chapter questioned his actions it is reported that he became angry and indignant. There is a clear conflict of interest in the role he played in the recruitment of a friend. The cathedral reviewer was told that he sent a letter around to all members of staff and to the Dean, writing that they had been "unkind and unchristian". The appointment included references being provided and an unblemished CRB check obtained. An anonymous undated memo which was sent to WSF in his position as Director of Music at Rochester Cathedral, seemingly at the time of SR's appointment, has been seen. It was from a member of the congregation at a parish in which he was an organist and describes SR as "unreliable and immature" and "not the right person to be employed at a school and in a Cathedral at this time". There is no other reference to this memo on the file. It is not known whether or not WSF discussed it with his managers or whether or not any follow up enquiry was made of the vicar in the parish as good common-sense practice would suggest.

- A timeline of complaints and observations of practice follows. The period covered is December 2012 to September 2013. These include SR organising meals for choristers and allowing alcohol to be consumed (breach of policy), issues regarding the administration of organ lessons, the Music Department not following safeguarding policies, particularly with regard to telephone / social media. Complaints by children that SR favoured others, WSF and SR both refused to use their business mobiles, preferring to use their private phones instead. Complaints of inappropriate sexual language and behaviour with a child which resulted in the Dean considering suspension of SR (this did not happen, an investigation was commissioned instead). Reports of safeguarding concerns some of which led to SR's arrest. Post arrest SR was suspended from work, a letter was sent to choir parents from the Dean saying that he was on sick leave. This was contrary to police advice, which was for the true reason to be given to allow other possible victims to come forward *(this is disputed by the then Dean who has commented that he has no recollection of being asked by police to make an announcement about an unsubstantiated offence)*. SR was bailed. He was later

remanded in custody for breaching his bail conditions by contacting the victim on social media and seeing her.

***Comment – It is clear that there were a number of opportunities to address the behaviour of SR, in particular what appeared to be a developing, inappropriate relationship with one child. The decision to send a letter, which said he was sick, is of concern and could go to the fact that the church was more concerned with the impact on its reputation rather than ensuring safeguarding measures were put in place.***

- In July 2014 SR was convicted of a sexual offence against a child and received a 3-year custodial sentence. As a result, the Chapter requested a Bishop's Visitation which the Bishop agreed to. This is an independent inspection that would make recommendations regarding safeguarding within the Cathedral. This will be discussed later in this document.

- The Rochester review then turns to the period between SR's arrest and conviction, listing a number of complaints and concerns raised regarding WSF. The Rochester reviewer comments that 'It was very difficult to unravel from the file the process of the investigations by the police and Rochester DSA'. Cross border issues, anonymous allegations and 'historic' concerns all added to this difficulty. Some of these concerns were shared with police. Given the circumstances of SR's arrest, the reviewer comments that it would have expected heightened safeguarding awareness because of this. There is comment regarding the lack of professionals' meetings and that there is no detailed chronological safeguarding record of the investigations or what actions were taken by Rochester Cathedral as a result of the concerns raised. It is difficult to determine the extent of Rochester Cathedral's involvement in the process.

***Comment – The observations regarding lack of detail contained on WSF's file are valid. I would expect a summary of any investigation be included on a Cathedral safeguarding file. It would also be good practice to record all referrals made, multi-agency or professional conversations, feed-back from agencies and safeguarding risk assessments that result.***

- The Rochester review then turns to the Visitation and report that followed. It is important to remember that this inspection was commissioned as a result of the SR case rather than as a result of WSF's behaviour. That said, it is clear that it makes recommendation and comment that deal with a culture in which he was operating. Following a period of inspection by two independent reviewers, the commissioning Bishop was provided with a written report in mid- January 2015. It is noted that a redacted form of the report was provided to the Chapter in April 2016, more than a year after it was received by the Bishop.

- The Visitation ToR included reviewing 'the culture, policies and procedures which relate to safeguarding in the Cathedral context, in relation both to the choirs and to other areas of Cathedral life and ministry." The reviewers were also asked to make recommendations to ensure best safeguarding practice.

- The Visitation report recognised the high musical standards of the choirs and found no issues of concern in other areas of the Cathedral's work with children beyond the choirs – such as the Sunday School. However, they concluded that "significant aspects of the safeguarding culture, policies and procedures fell far below what can be described as good practice, and this culture had contributed to or failed to prevent what took place in the SR case and beyond." Their report highlighted the following main areas of concern.

**1. Failure adequately to investigate act or communicate**
Opportunities to investigate then act on areas of concern were not progressed. The report is critical of senior Cathedral staff and states 'We believe that they failed in their duty of care to report their own concerns and the concerns of others to the Diocesan Safeguarding Adviser, to the local authority and to the police'.

**2. Unprofessional Behaviour**
Use of personal phones, meals where alcohol was consumed and being alone with female choristers provide evidence of this observation.

**3. Poor Governance**
Lack of adequate safeguarding training, no Chapter member with a responsibility for safeguarding and inadequate policies and practices for staff recruitment, supervision, staff appraisal and disciplinary matters.

**4. Poor Management**
The reviewers pointed out a lack of understanding about managing staff and 'an unhealthy culture developed where girls and their parents are criticised and little individual or corporate responsibility is taken for the role of the Cathedral in safeguarding the welfare of choir children'.

**5. Lack of Record Keeping**
This included staffing issues, follow up actions and supervision discussions.

**6. Lack of Safeguarding Policy and Oversight**
No one in Chapter was taking a lead regarding safeguarding policy formulation and implementation, training, investigating or reporting concerns and the updating of choir handbooks.

**7. Inadequate Safeguarding Training**
This was at all levels of the Cathedral.

***Comment – The review makes over 30 recommendations and includes a view that the Bishop and Chapter should consider if disciplinary action should be taken against any individuals.***

- Two further issues are then detailed. The first is a safeguarding allegation dealt with by WSF who had responsibility for the one of the parties involved. It appears that WSF took no action in this case. This again goes to the culture that had been nurtured in the Music Department. The second revolves around a positive reference written by WSF for the same person when he applied for a role at another Cathedral. WSF was invited to reconsider the reference given the allegations detailed above, there is no evidence to suggest he did so.

- The Rochester Reviewer then details his understanding for the delay in supplying the Chapter with a redacted copy of the review. The redaction process was complete some 12 months before the report was passed to the Chapter. One of the authors of the Visitation report has been spoken to and stated that their report recommended the Dean and Chapter Clerk should begin disciplinary proceedings against WSF, because of his failure to follow Cathedral policies, failure to adequately supervise the Assistant Director of Music, failure to report safeguarding concerns and failure of duty of care toward child choristers. This was not their only recommendation in terms of disciplinary considerations but it is the most significant for this review. It is noted by this review that the delay and the fact that these

recommendations were redacted or changed into generalised statements apparently followed legal advice.

***Comment – There is evidence that the Church of England considers identification of individuals within documents to be of utmost importance. This is good practice but should never become so important that it compromises children or vulnerable people. Those advising should and could have considered parallel processes to deal with these recommendations. A detailed risk assessment balancing both issues and mitigating the impact on individuals should have been considered. There is no evidence this was considered. This review does accept that those advising do so on the information they are provided.***

- The Rochester review acknowledges that there has been some safeguarding progress achieved since the Visitation report was completed, including a widespread training programme across the Cathedral for staff and volunteers, improved safe recruitment of volunteers and sharpened up the DBS checking system. Coupled with changes in the safeguarding processes in the national church and wider society, this all helped raise the profile of safeguarding within the Cathedral community. Closer links were also forged with the DSA.

- The Rochester review then sets out a number of criticisms of the way the Visitation report's recommendations were dealt with at the highest level. These criticisms are widespread but appear to indicate that the delay in sharing the report and the critical redactions lessened its impact and provided another missed opportunity to deal with WSF and the culture he had helped create. Perhaps of greatest concern is that no evidence can be found to corroborate the Bishop's view that 'I am confident that appropriate actions have been taken where warranted'. No records of WSF being spoken to about the issues raised in the Visitation Report have been found by this review.

- Details of the Chapter's response and a meeting with the Bishop are then discussed before the reviewer summarises his observations on the Visitation process.

***Comment – The Visitation report presented the clearest opportunity to challenge, address and deal with WSF's behaviour. It is clear that this did not happen. Recommendations made by this review will seek to ensure the Church of England deals with systemic issues to prevent any repetition occurring.***

- The Rochester review then deals with the period July 2016 to November 2017. This time included the appointment of three new senior Cathedral posts, one of which had direct responsibility for WSF and the music department. It is clear that improvements were made and WSF's autonomy was challenged. Despite this there were still concerning safeguarding issues noted around WSF's behaviour.

- In July 2017 WSF attended a celebration dinner to mark the end of SR's prison sentence license. SR attended the dinner as did a number of significant individuals with close ties to the Cathedral, past and present. WSF attended a meeting with senior church staff to discuss the event. He agreed he had attended the event and amongst other comments said that he thought SR was not a safeguarding risk. Those interviewing him took HR advice on what, if any, disciplinary action could be taken. Having received advice they decided to monitor his action very carefully. The reviewer comments that the circumstances 'sharply highlights the lack of boundaries, safeguarding understanding, responsibility, professional standards and regard for the reputation of the Cathedral'. This is an opinion that this review agrees with.

- In November 2017 senior Cathedral staff became aware that WSF was a member of a WhatsApp group for boy choristers. They visited him and told him to leave the group immediately. An appropriate message was sent out to parents informing them that Cathedral Staff were not permitted to connect with children via social media. This was evidence of good safeguarding practice.

- Whilst considering next steps in terms of disciplinary action, the following day WSF was arrested. The Rochester review then considers the period between WSF's arrest and his sentence in August 2019. I do not intend to mirror the detail contained within the Rochester review but it is acknowledged that a series of meetings followed. These meetings addressed WSF's suspension and continued management, parent communication and multi-agency safeguarding. There is evidence of good practice and strong management of a difficult set of circumstances that arose from a protracted police investigation and a divide within the Cathedral community in terms of support for this individual. Given the circumstances it is clear that those in senior positions within the Cathedral were aware of the threat WSF posed and took steps to reduce the risk. WSF was arrested for further offences in September 2018, these offences had occurred whilst he lived and worked in Rochester. As a result, further safeguarding measures were put in place.

- The Rochester reviewer takes us through his views on the management of the situation post WSF's suspension. He highlights some specific issues and then affords the reader his overview, stating he was 'struck by the sheer complexity of the issues that confronted the Cathedral. There were so many threads that had to be considered: the survivors; the choristers; their parents; Kings School Rochester; complaints; WSF himself; his partner; confidentiality; the wider Cathedral community; allegations; liaison with other agencies locally and further afield and press involvement – to name but a few. Not only that, but the Chapter had to face the high emotions of those supporting WSF and rightly to refrain from passing on confidential information which would have better explained their actions and tempered the destabilising hostility. Whilst all this was going on there was WSF literally and metaphorically outside the Cathedral door'. The Rochester review concludes that the Cathedral Chapter handled the period around the investigations well.

- On 13 August 2019 WSF received a 5-year prison sentence. After the hearing the Dean immediately wrote to all ex-choristers, choir parents, Kings School Rochester, the Cathedral community and a range of people and organisations who might have been associated with WSF during his 10 years at Rochester. In the letter people were offered a range of appropriate contacts should they wish to discuss the case or refer any concerns.

- In September 2019 the Social Care Institute for Excellence (SCIE) conducted a Cathedral Safeguarding Review. Overall, the review is positive referring to 'rapid progress and development of safeguarding awareness practice across the cathedral.' They acknowledge that the events surrounding SR and WSF's convictions have inevitably had an enormous impact on the entire Cathedral community which will likely continue for some time. Whilst noting the trauma on some choristers and the loss of confidence, the report firmly stated that the steps taken to address the very collusive culture of the past regime were necessary and appropriate.

***Comment – The SCIE review noted that the most critical aspect of safeguarding relates to the culture within a Cathedral and extent to which priority is placed on safeguarding individuals as***

***opposed to protecting the reputation of the Church. This is an issue throughout this review and one that is of the utmost importance to address if safeguarding is to be improved.***

- The Rochester reviewer then addresses the six questions posed within the ToR. Again, I will seek to summarise rather than simply copy his observations.

*1. Was WSFform safely recruited? Were relevant policies followed? and*
*2. Was information shared appropriately as he moved between Cathedrals?*

He concludes that WSF was safely recruited following acceptable personnel practices at the time. However, the safe recruitment became compromised over his references and the sharing of information. Poor advice which lacked safeguarding knowledge is highlighted and the need to consider passing on additional information outside a formal reference. He acknowledges that new records guidance had only just been published, but the importance of retaining safeguarding records reflected current thinking at the time. The review makes an excellent reference to the Bichard Enquiry that had highlighted the dangers of destroying safeguarding records and concludes that any professional with operational experience of child safeguarding would not have advised or even contemplated the destruction of the records in relation to WSF.

*3. Was information accurately recorded, retained and shared?*

The Rochester review looks at the 10 years WSF was at Rochester Cathedral and concludes that information was generally not adequately recorded until January 2017. There is a sea change in recording from then onwards. The period of WSF's suspension up to his conviction was meticulously recorded. The problem pre 2017 was that the many concerns and complaints about the behaviours of WSF and other members of the Music Department were rarely documented and even when recorded virtually nothing found its way onto his personnel file. His file contained no record that disciplinary action should be taken against him as recommended by the Visitation reviewers, no mention of the Visitation itself and no record that SR, the Deputy Director of Music, for whom he was responsible was sent to prison for the sexual abuse of a child. The lack of information recording and sharing has resulted in there being no coherent narrative written about WSF's behaviour or events over time.

4. *Were all concerns followed up in accordance with procedures*?

The Rochester review revisits the allegations dealt with in the main body of the document and illustrates the fact that procedures were not followed including those set out in documents such as the House of Bishops safeguarding guidelines operating at the time (Protecting All God's Children 2004). Where investigations were carried out there is no evidence that WSF was spoken to either during or after the investigative process. During the period reviewed by the visitation it appears that some concerns raised by parents and Cathedral personnel with oversight of children were ignored.

The core group system is discussed and whilst it is acknowledged that it was not used to underpin safeguarding investigations prior to 2015 there is an observation that a multi-agency meeting may have benefitted the management of the allegations. Post arrest these meetings took place and safeguarding procedures were adhered to.

*5. Was appropriate weight given to the concerns raised anonymously?*

The Rochester reviewer concludes that anonymous letters received in 2008 and 2014 were not given sufficient weight.

*6. What was the impact of decisions taken e.g., could any abuse have been prevented?*

The Rochester review clearly states the following 'It is impossible to say with certainty whether the abuse of the three individuals in the context of Rochester Cathedral could have been prevented. However, I believe that there were points when opportunities were missed to curb Scott Farrell's boundaryless concerning behaviour. Whether this would have prevented the offending I cannot say, but it would have given him cause to reconsider the way he conducted himself and given him the message he was under management controls accountable to the Chapter'. Four specific occasions are then highlighted:

A. His recruitment
B. His angry outburst at Chapter in 2014
C. The investigation into allegations made in 2014
D. The visitation Report

7. *Was the working relationship between the choir school (Kings School Rochester) and Cathedral effective in safeguarding?*

The Rochester review highlights that since the appointment of the current Principal of Kings School Rochester in April 2019 and the Headmaster of the Prep School in September 2018 the liaison with the Cathedral has been most effective in ensuring robust safeguarding procedures and the operation of those procedures. Prior to that WSF enjoyed positive relationships with senior staff at the school and he was admired for his musical ability. He was popular with most chorister parents. Often senior staff had been chorister parents and/or had sung as lay members in the choir. This period was not conducive to effective joint safeguarding working.

*8. Did the Cathedral work effectively with statutory agencies?*

Again, the Rochester review has difficulty in evidencing multi-agency working in any detail prior to WSF's arrest. During the period following his arrest the Cathedral worked extremely effectively with other agencies.

*9. Were appropriate efforts made to identify victims and survivors to support and to seek their input? What was the outcome of this?*

Whilst the Rochester reviewer states he hesitates to evaluate this he does acknowledge the efforts made regarding the three known survivors in Rochester. He also comments on the letters to survivors describing full and frank apologies made. Post- conviction efforts were made to contact choristers and put resources in place to respond to individuals who did wish to speak.

## 6. Police input on the review

6.1 The reviewer has met with the Investigating Officer for this case. Cambridgeshire police were invited to respond to a number of questions to assist the church review. This review has seen their responses and they are summarised below:

6.2 **What the church could have done better?** – The police acknowledge the complicated nature of the investigation and that the church had safeguarding at the forefront of its mind. However, requests

for information from various representatives and a lack of a single point of contact increased pressure on the investigating officer at crucial stages of the investigation. In addition, some of the information requested could not be provided. The police indicate that some requests implied a lack of training and knowledge on the part of those making these requests.

6.3 **What the church did well**?- The police provide an extremely positive response to this question. They note excellent communication, good information sharing, care for victims and a wish to work in collaboration as things done well.

6.4 They decline to comment on the suitability of the recruitment process and say they have not identified any improvements that could be made in terms of survivor engagement.

6.5 Police were asked to send a letter to survivors by Church. Having assessed the impact this may have on some individuals they declined as they felt it would not be appropriate to forward the letters.

6.6 Having read this response and met with the Investigating officer and her Detective Chief Inspector I made a similar request regarding survivor engagement. A letter was drafted and I asked that they consider forwarding it to any survivor they believed would want to be offered the opportunity to engage with the review. I am grateful to them for agreeing to do so. The decision as to who the letter was sent was correctly left in police hands.

## 7. Survivor engagement

7.1 As part of this review, I have attempted to engage with survivors. Cambridgeshire police hold the details of individuals who WSF offended against and I am grateful to them for passing a letter I drafted to those they assessed as being able to make the decision. I am conscious that this review may be read by survivors who the police are unaware of or who were not passed my letter. If this is the case firstly, I would like to offer my own sincere apologies for not hearing what you wanted to say and secondly, I would be happy to discuss the content of the review with individuals if they wish.

7.2 I was able to speak to one survivor and the mother of a young person who had contact with WSF during the time he was offending. I am very grateful for the insight both gave me. I was struck by the manipulation WSF used in his offending and the fact that he was 'in plain sight'. His behaviour would now be recognised as grooming, not only with the children but also with their parents. The fact that WSF was trusted by parents gave him an additional layer of security. It made disclosure more difficult and caused anxiety about not wanting parents to feel responsible for what he had done.

## 8. Engagement with WSF

8.1 This review has sought to engage with WSF through the National Safeguarding Team. At the time of completing the report the Independent Reviewer had not been given an opportunity to speak with WSF.

## 9. Summary of the key facts and lessons to be learned

9.1 This section of the review will discuss key strategic areas where lessons can be learned and safeguarding practice improved going forward. Recommendations are made which, if agreed, will afford the church an opportunity to devise Specific, Measurable, Achievable, Realistic and Timely (SMART) action plans to improve practice and outcomes. I have considered if it is the place of this review to suggest some SMART actions but I believe this could restrict those charged with making improvements.

**Safeguarding culture and the priority it is given within the Church of England**

9.2 The circumstances of this case, missed opportunities to address WSF's behaviour, lack of governance or leadership, status of music departments and individuals within it, risk assessment, information exchange and safer recruitment will all be addressed in this section of the report. Whilst individually each issue carries with it areas that can be addressed, learning and practice improved, it is imperative that the Church continues to improve its culture around safeguarding to maximise the impact of change. Recommendations made in this and other similar reports will provide opportunities to learn and improve in specific areas but the overriding issue remains that of culture, specifically the importance placed on safeguarding children and vulnerable people.

9.3 This review has examined circumstances that have arisen over a protracted period of time. During this time there has been significant, positive change made by the Church. It is important that steps to improve safeguarding and its place in Church culture are acknowledged. These changes include, but are not limited to, significant investment in safeguarding including the introduction of more local safeguarding advisors and the development of the National Safeguarding Team show real commitment and affords the best opportunity to deal with safeguarding issues in a professional, robust way at the earliest opportunity. Changes to policy such as 'safer recruitment and people management' are also evidence of good practice. Responses to the Independent Inquiry into Child Sexual Abuse (IICSA) and Past Case Review 2(PCR2) have been positive and again show that the Church is committed to learning and improving. Reaching out to and advising Church communities through publications such as the Parish Safeguarding Handbook and safeguarding events are examples of good practice that promote safeguarding.

9.4 Whilst there are many positives it remains essential that the Church demonstrates that safeguarding is prioritised in its day-to-day business. Many Statutory Safeguarding Partnerships that sit outside the Church have moved to a stance where they ensure ***'safeguarding is everybody's responsibility'***, challenging communities to understand that we are all responsible for ensuring children and vulnerable adults are protected. There are many challenges within this stance that are specific to various faith groups, their structures and cultures. These have to be overcome through clear messages, learning and leadership if the Church and its wider community is to become the safest place possible for our most vulnerable. It is imperative that policy is 'lived' rather than simply referred to. This 'lived policy' needs to be reflected in the day-to-day behaviour of the entire community and must start with those that lead and influence.

9.5 Forgiveness, trust and trying to see the best in individuals are all central qualities to most faith communities. Whilst this review does not seek to diminish these qualities, they must be balanced against the need to provide a safe environment where children and vulnerable individuals can thrive without fear of being exploited or abused. The review believes that with the correct culture, policies and practice, high quality safeguarding can be achieved without compromising faith.

9.6 As the reader goes through this report it will be apparent that there were missed opportunities to deal with an individual who went on to offend against children and adults. Whilst it is impossible to say when or if the abuse he carried out would have been stopped, the existence of a culture where individuals have responsibility and support to challenge, report and be confident they will be heard would have increased the opportunity to intervene and reduce the risk.

**Recommendation 1** – The Church of England considers a national campaign that raises safeguarding as a priority across the entire Church community. This campaign should concentrate on ensuring people, whatever their position in the community, have the knowledge and confidence to deal with safeguarding issues. The campaign should promote the message that 'safeguarding is everybody's responsibility'. Simple, effective direction on what good safeguarding is and how it can be achieved should be given.

The absolute necessity to safeguard children and vulnerable people must become a priority in the Church of England culture. Where this is not the case action must be taken.

***Comment – Initiatives such as 'Safeguarding Sunday' have the potential to reach a wide audience, engaging small parishes through to Cathedral communities. Such initiatives need to be invested in, promoted by Church leaders and success measured. At the conclusion of such events, it is incumbent on leaders to ask 'So What?', what real difference have we made through these events?***

**Evidence to support the necessity for culture change**

9.7 This review will deal with issues which show evidence that safeguarding was not prioritised. More detailed evidence was provided by the individual reports completed by each of the Cathedrals. The example outlined below is a recent indication of where systemic change is required.

**Commission of the Review and delay in full engagement with the Reviewer**

9.8 The delays in submitting papers to the review illustrate how the Church, despite significant progress, still has systemic issues in terms of prioritising safeguarding issues.

9.9 WSF pleaded guilty to a number of offences in May 2019. His offences, vulnerability of this victims and easily identified safeguarding concerns should have made the commissioning of a review into the way in which the Church had managed the situation a priority. This individual had been employed in roles that involved direct access to children, he had abused his position of trust and a number of opportunities to reduce the risk to others had not been appropriately acted upon. The Church should have sought an immediate review to ensure appropriate recommendations to reduce the possibility of similar safeguarding concerns were reduced. What followed was a response that has left individual safeguarding experts frustrated and concerned by the pace at which the work was completed.

9.10 It should be noted that once the issues were identified an appropriate course of action was developed. Each of the three main Cathedrals commissioned a reviewer to deliver Individual Management Reviews and the ongoing situation was managed through a series of core groups.

9.11 A decision was taken to engage an independent reviewer to produce an overview report. This report would bring together the reports completed by the Cathedrals and make recommendations for learning, change and improvement. The Reviewer was identified and the process of engagement began in in January 2021. It was not until late July that the reviewer was given access to papers and a ToR agreed. The delay was the result of a number of factors. These included, but were not confined to, poor information sharing, co-ordination between safeguarding teams and concerns

raised by solicitors who act for the Church. These concerns centred on the possible identification of victims within the report and what steps could be taken to avoid unnecessary litigation. These delays were unacceptable and whilst it is absolutely correct that those charged with considering reviews should be guided by legal advice, those who advise should not be so risk averse that their advice, or more likely the delay in receiving it, could impact safeguarding. This report has done everything possible to avoid identifying victims - as the reviewer my primary concern is the distress this could cause. However, it is important that the prevention of further, similar safeguarding concerns through the delivery of recommendations and examination of the circumstances should always outweigh issues of potential litigation.

9.12 Further evidence of judgements that sought to protect individuals' privacy over good safeguarding practice are also evident. Advice given was not challenged and resulted in the destruction of records that could have been used to inform later safeguarding enquiries.

9.13 It is apparent from the information provided to this review that senior clergy seem to have considered the 'reputation' of religious establishments or individuals on a par or perhaps of even greater importance than safeguarding children. This is illustrated in the manner in which the Visitation Report, a key document that set out a number of recommendations for improving culture and practice, was kept from those who could in fact deliver change, namely the Chapter.

**Recommendation 2** – The Church of England should review its instructions to professionals or professional bodies who represent them. This would include but not be exclusive to solicitors, barristers, HR experts and consultants. Clear, documented instructions should be given to individuals or organisations who are engaged by the Church that state safeguarding children and vulnerable adults is an absolute priority when considering matters referred to them. Decisions and advice that may impact on the safety and welfare of such individuals must be made in a timely manner to reduce the potential for individuals being put at risk.

This message should be expected to be communicated at the start of any instruction given.

**Governance and Leadership**

9.14 The way in which the Church is governed is complicated. Its structures are such that individual sections of the Church, including Cathedrals are governed by 'local' bodies with leaders having autonomy for decisions made. As an independent reviewer who sits outside of this structure, I am concerned that it is too complex and affords decision making that relies on individuals rather than process. Whilst it is not within the scope of this review to comment specifically on the structure, it is important to understand how this impacts upon safeguarding. It is clear that different Cathedral governing bodies dealt with the various allegations made against WSF in different ways. Leaders and governing bodies failed to 'grip' the various allegations, preferring to deal with them in isolation and issuing, at best, warnings regarding his conduct.

9.15 Many institutions rely on leaders to make decisions regarding the conduct of employees, and the Church is not unique in its approach. Often local decision makers are aware of the facts, context and individuals involved. This affords them the best opportunity to assess the information available to them and reach a sound conclusion. It is however, imperative that those who make the decisions follow policy and procedure. The Church has published a number of documents that deal with policy and guidance regarding safeguarding issues and professional experts are now available for consultation and advice. This is good practice but will only improve outcomes if leaders are aware of

it and use it. There was a lack of recorded reference to such documents by those making decisions. I have seen no evidence of rationale for decisions made being documented.

***Comment – Good practice would be to document how allegations were dealt with, include rationale for decisions made and therefore afford future employers an opportunity to make informed decisions and consider cumulative risk.***

9.16 Senior leaders (in this case the Dean and the Chapter) were required to consider allegations made against individuals. The introduction of and investment in Safeguarding Advisors has improved practice providing decision makers with independent advice and analysis of situations on which to base decisions. That said, it still remains the case that senior leaders are responsible for making important decisions on how such allegations are dealt with and what action is necessary to safeguard those involved. These decisions are often difficult to make and even harder to communicate to individuals. It is essential that those who are charged with making them are confident to do so. Conversations with individuals regarding safeguarding allegations are seldom easy so it is important that the Church provides senior leaders with the correct training, supervision and reflective practice opportunities to develop skills and confidence. There is evidence within the Cathedral reviews of a lack of intervention when allegations are made. There is also evidence of a reluctance to 'share' decisions and the result of interventions.

9.17 This review has seen no evidence of decisions being the subject of supervision or peer discussions. Without these checks and balances poor decisions and their impact are left unchallenged. In addition, those making such decisions have no opportunity to reflect, learn and improve.

9.18 This lack of scrutiny in this key area of the safeguarding decision-making process has been the subject of positive intervention by other large organisations. Models of independent scrutiny can be found throughout safeguarding. The Rugby Football Union have developed a reference group who make independent observations on the suitability of individuals to be in positions of trust with children and vulnerable adults. This group is chaired independently and is made up of subject experts from within and outside the game. Whilst the primary role of such groups is to give sound, independent advice on cases brought to their attention, their existence focusses the minds of those receiving information, ensuring good practice and thorough examination of the facts is completed before presentation.

**Recommendation 3** - The Church reviews all training offers for all senior staff, clergy and others in senior posts. Training should focus on issues that arise in this review including policy, procedure, risk assessment and recording decisions.

Leaders should receive bespoke training in safeguarding and should be afforded the opportunity to partake in reflective practice sessions. This would allow them to develop their own skills and understanding of how to manage safeguarding allegations, support available and Church policy. Such sessions should include discussions about current and past cases.

**Recommendation 4** - Safeguarding decisions should be the subject of supervision and/or peer review. This would ensure those making such decisions have a sound rationale, have considered current and future risk to all and are supported in their role.

The Church considers developing reference groups that can provide independent oversight and scrutiny to safeguarding decisions.

The Church should develop a robust system of central reporting that affords the opportunity to review decisions made, provide support and monitor safeguarding cases.

**Recognition of risk / Impact of cumulative risk**

9.19 The behaviour of WSF caused a number of concerns to be raised. Allegations were received from a number of sources including anonymous letters, formal complaints and first- hand observations of his behaviour. His behaviour described ranged from inappropriate invitations to young people to attend his home, sexualised comments, voyeurism, verbal aggression, refusal to use allocated phones and culminated in the disclosure of sexual offences against children and adults.

9.20 The response to individual concerns, prior to the involvement of other statutory agencies, ranged from no action being taken to a warning letter being issued. There appears to have been, at best, an ignorance of how to manage the allegations, at worst, no appetite to take appropriate action. From the information supplied to this review it is not possible nor is it appropriate to give a view on which of these best describes the way the Church dealt with the allegations. It does however provide an indication of the status placed on safeguarding at various periods.

9.21 The review has seen no evidence that there was any formal risk assessment carried out when allegations were made. Whilst some of the concerns were raised some time ago it is apparent that there were several missed opportunities to consider the risk WSF posed. His behaviour went largely unchallenged. Records of responses to allegations made were sparse and lacked any rationale for decisions made. Where detail was given, it provokes greater concern with WSF's behaviour, in part, being excused (never inviting a lone child to his residence).

9.22 In addition to allegations being made about WSF's behaviour, safeguarding awareness should have been heightened by the conviction of SR for sexual offences, a close colleague and someone WSF fought to have employed in the Cathedral Music Department. When SR was convicted the Chapter showed good practice in requesting a Visitation (inspection). The Visitation was commissioned by the Bishop and made recommendations/comment on issues including failure to adequately investigate act or communicate and unprofessional behaviour. Whilst this was good practice the fact that the redacted report provided to the Bishop was not shared with the Chapter for over a year is of great concern.

9.23 In conclusion, the lack of risk assessment both when provided with a single allegation or, as in this case a cumulative series of concerns may have resulted in missed opportunities to address WSF's behaviour.

**Recommendation 5** – The Church develops a common approach to risk assessment that can be used in conjunction with threshold tests to assess current and future safeguarding risk. This approach should ensure that appropriate checks are carried out to ensure any cumulative risk is taken into account. The approach should be delivered as national guidance/policy. Details of final assessment and rationale must be recorded.

The Church should ensure it continues to sign-post referral pathways for individuals who have safeguarding concerns. Such pathways should be simple, easily accessible and support individuals to make appropriate decisions about safeguarding issues.

**Status of individuals and Music Departments within the Church Community**

9.24 One of the most striking aspects of this review was the elevated status WSF was given within the Church community. In this case that status also appears to have crossed into education with WSF and his position having a significant impact on how professionals, families and children viewed him. The Church is not unique in creating roles or positions that are deemed so important by people that inappropriate behaviour and practice is accepted or ignored. Recent reviews into sport have provided examples of 'good coaches' in high level sport abusing children in plain sight. When individuals are revered because of the position they hold this adds to their 'power base' and affords them greater opportunity to abuse their position of trust.

9.25 This review believes that WSF's ability to manipulate children and families was, in part, helped by his position and status within the Church Music Department. It is apparent that some believed him to be a charismatic individual with outstanding skills in teaching music. References for roles within the Church were, on the whole, extremely complimentary and did little to raise concerns regarding his behaviour. He seemed to work with little or no supervision. Even when challenged about verbal aggression and recommendations to seek anger management were made, no checks or further intervention by managers took place.

9.26 Further evidence of this elevated status is apparent when examining his relationship with SR. His position afforded him the opportunity to ensure his friend was recruited to a position in the Music Department. He would go on to offend and receive a custodial sentence.

9.27 Individuals who are put in a position of trust and can impact disproportionately on children's lives should be the subject of close supervision and support. Their decisions and conduct require scrutiny to safeguard them and those they teach.

**Recommendation 6** - Music Departments and other areas of the Church that deal with children and vulnerable people should be the subject of a high level of supervision. People employed in positions of trust should receive appropriate training, supervision and support to minimise risk to children. Clear management structures should be put in place with clear lines of accountability.

**Recommendation 7 -** Music Departments should have a joint safeguarding policy with schools whose pupils are choristers and musical scholars within Cathedral settings. Each institute should understand their own and each other's responsibilities and ensure they have appropriate procedures in place to protect children.

**Recommendation 8 -** The Church should consider an internal inspection regime or scrutiny role that will provide assurance that such departments are providing the highest level of safeguarding and accountability.

**Recommendation 9** - The Church should put in place systems that ensure decisions regarding selection for musical scholarships, choirs or similar positions are the subject of scrutiny. Those making these decisions should receive support and specific training to ensure they are aware of their responsibilities. Reports of favouritism, inappropriate associations with families or individual children should be dealt with in a timely and robust manner.

**Information Exchange**

9.28 The best safeguarding practice involves excellent information exchange to ensure risk can be assessed and steps taken to safeguard individuals. The barriers to high quality information are well known and have been at the centre of a number of safeguarding reviews including Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. Given this, the safeguarding community and those who lead in this key area should be addressing any systemic barriers that are preventing people from sharing information that would safeguard vulnerable people and children.

9.29 The exchange of information can cause individuals to be anxious. Legislation such as the Data Protection Act (DPA) and General Data Protection Regulation (GDPR) have heightened this anxiety but it is important to create an understanding that such legislation is not designed to prevent agencies from exchanging information that will safeguard individuals.

This case highlights the importance of information exchange in a number of areas:

- Exchange of information when an individual moves to a different geographical area.

9.30 WSF moved a number of times during his employment with the Church. On each occasion good practice would have included an exchange of information regarding any safeguarding concerns. These exchanges should have been recorded and formed part of this individual's employment record. Whilst it is apparent that there was limited information sharing between locations it fell well short of providing an adequate basis to assess the risk WSF posed.

- Exchange of information when changing role.

9.31 Similar to changing locations in which individuals work, a change of role should result in information exchange with new employers or supervisors. Again, there is little evidence to suggest this happened in this case.

- Challenge and curiosity.

9.32 Whilst the responsibility for exchanging information lies with the holder it is also essential that a culture is developed where those 'receiving' the individual are expected to challenge and be curious about information they are given. Questions such as 'Were any safeguarding issues raised about this person whilst he/she was employed by you?' should be seen as good practice. Seeking clarity about references given rather than simply accepting them is also good practice. If such practice becomes 'the norm' then those providing information will expect to be challenged. This in turn increases the likelihood of open, honest exchange from the outset.

- Exchange of information when providing references.

9.33 The concept of an individual being asked to provide references is in itself somewhat flawed. It is of course a natural instinct to seek references from people who will provide the best possible testament and speak highly of the person. It is essential that references are challenged and when they are found to be false or omit key information appropriate action taken. Good practice is to seek a reference from the individual's last manager and to seek comment on key safeguarding questions within the document. Some of the references given to WSF were extremely supportive and went unchallenged. However, there was some evidence of his concerning behaviour being highlighted to those who were considering employing him in new positions. The behaviour described should have resulted in formal risk assessment taking place. A letter to new employees in Newcastle, detailing a number of safeguarding concerns whilst employed in Ely, was found when WSF's office was cleared out following his resignation. This letter and its content are extremely

concerning. That said, the fact that it was found more by luck than good practice is of even greater concern. The letter contains some admissions from WSF regarding his behaviour and is a record of a formal verbal warning. There is no evidence that this letter was ever attached to his personnel file. This was a missed opportunity to allow future employers to have a fuller understanding of the risk he posed. Such documents need to be appropriately recorded as does the risk assessment and action taken as a result. Further concerns regarding his interaction with choristers were passed from Newcastle to Rochester. The detail of this information is unclear as it was destroyed on the advice of a HR expert. Had that expert been sighted on the Ely letter it is unlikely they would have given this advice.

- Exchange of information with other safeguarding agencies.

9.34 It is essential that safeguarding information is shared between agencies to afford best practice and outcomes. The decision to inform other agencies of an individual's behaviour is perhaps one of the most difficult to make. The Church has employed a number of Local Safeguarding Advisors and developed a National Safeguarding Team who can advise on such issues. In this case WSF was in a position of trust and information exchange with the Local Authority Designated Officer at an early stage should have taken place. There is clear evidence within the reviews that when Safeguarding Advisors are notified of concerns appropriate contact and referrals are made with safeguarding agencies. This is good practice.

**Recommendation 10** – The Church develops a strategic plan to ensure that all safeguarding concerns are recorded (the review is aware that a national recording system is being piloted) and are available to safeguarding professionals for assessment. This plan should seek to develop a culture where information exchange, challenge and understanding of legislation are seen as positive ways to safeguard children.

**Safer Recruitment**

9.35 This review and those carried out by the Cathedrals deal with events over a twenty-year period. The way in which organisations recruit staff and volunteers has changed significantly. The Bichard report in 2004 made recommendations that have resulted in the development of policy and practice in 'safer recruitment'. I have read the most recent Church of England safer recruitment policy which is available on its website. The latest version of this document, accompanied by an introductory voice recording, was published in June 2021. It is an excellent document that signposts the reader and, if followed, will provide clear guidance on recruitment.

9.36 There is some evidence that WSF was recruited using a degree of safer recruitment policy or its equivalent at the time of his employment. Recruitment was compromised through a lack of challenge, appropriate questions regarding safeguarding and a reliance on references that reduced the effectiveness of the processes adopted. Safer recruitment policy does not come with absolute guarantees. Often those who offend or pose safeguarding risks are manipulative or do not have convictions recorded against them. It does however, provide agencies with the best possible opportunity to recruit appropriate individuals. It also acts as a deterrent to those who may seek employment to further opportunities to offend.

9.37 This review is satisfied that the current policy is of a sufficiently high standard and if applied will reduce safeguarding risks. As with all policy it is imperative that it is 'lived' and promoted throughout the Church.

**Review Processes**

9.38 There is much to learned from a review such as this. This review was complicated from the outset, it spanned a number of diocese and Cathedrals. The National Safeguarding Team were involved post arrest and three Cathedral reviews were commissioned. Whilst the ToRs were the same the resulting methods deployed were different and reports varied in their structures. The engagement of a reviewer to write an overview report was delayed. This meant that there was no discussion at the outset of this process that would have perhaps led to greater understanding of each other's roles.

**Recommendation 11** - The NST consider holding a de-briefing session with those involved in this process to understand areas of good practice and areas where improvements can be made. Using feedback from this session, reference to current review structures in Local Safeguarding Children Partnerships and guidance from central government, they should produce a policy that directs how diocese should approach such reviews.

## 10. Conclusion

10.1 This report presents an overview of the lessons that can be learned from the circumstances that resulted in the conviction of WSF, a man who was employed by the Church in a position of trust for twenty years. The review has sought to concentrate on areas of systemic learning that will improve safeguarding outcomes. As previously stated, individual learning highlighted in the Cathedral reviews should be progressed at a local level.

10.2 The review has seen evidence of significant improvement in Church policy, practice and culture but the pace of change is far too slow. When speaking to one individual about this apparent lack of urgency the pace was described as 'glacial'. Whilst this remains the case it impacts negatively on internal, public and political confidence. More importantly it affects safeguarding outcomes for children and vulnerable people who deserve to be safe within their faith community.

10.3 The review has identified key strategic areas for consideration. These are:

- Safeguarding culture and the priority it is given within the Church of England
- Evidence to support the necessity for culture change
- Commission of the Review and delay in full engagement with the Reviewer
- Governance and Leadership
- Recognition of risk/impact of cumulative risk
- Status of individuals and Music Departments within the Church Community
- Information exchange
- Safer recruitment
- Review processes

10.4 Eleven recommendations are made to improve culture, support and develop existing good practice, remove barriers and improve safeguarding outcomes. These recommendations are set at a strategic

level but it is the view of this review that any resulting action plan should include consultation with the wider church community, ensuring change has a positive impact at all levels.

10.5 Individuals who are directly concerned in some aspects of this review have been contacted and provided with extracts to check for accuracy. Their views have been considered and as a result some changes have been made. The purpose of this review is not to criticise individuals. Its primary function is to provide an opportunity to learn lessons and improve safeguarding.

10.6 WSF abused his position of trust over a protracted period. The review doubts that the true extent of his behaviour will ever be known. It has not been possible to deal with the impact his behaviour had on so many people but I would like to acknowledge the distress it has caused and hope that improvements that occur as a result of this piece of work will reduce the possibility of similar abuse happening again.

**Chris Robson**

**Independent Reviewer**