# Past Cases Review 2 (PCR2)

## National Safeguarding Team (NST)

## Executive Summary

## 1. Introduction

In June 2018 an independent scrutiny team reported on the Past Case Review of 2007, recommending a fresh review of files held by the 42 dioceses and 2 provinces of the Church of England. (PCR Report of IST - final version June 2018.pdf (churchofengland.org)

Subsequently, the 'Past Case Review 2' (PCR2) project was commissioned with a more wide reaching remit than the 2007 review.

The PCR2's objectives included:

- *identifying all cases of concern relating to clergy or church officers causing harm to children or adults (including where domestic abuse is alleged) and ensuring they have been independently reviewed;*
- *ensuring that all identifiable safeguarding concerns relating to living clergy or church officers have been referred to the DSAs;*
- *ensuring any allegation made since the original PCR took place have been handled appropriately and proportionately to the level of risk identified and that the support needs of survivors have been considered; and*
- *ensuring that cases meeting the relevant thresholds have been referred to statutory agencies and that all cases have been managed in line with current safeguarding practice guidance.*

As part of PCR2 two experienced independent reviewers (IRs) were engaged to examine all relevant files held by the National Safeguarding Team to identify any evidence of individual and/or institutional failings in relation to how allegations of abuse had been handled.

## 2. NST PCR2

The PCR2 guidance document stated that files held by the National Safeguarding Team (NST) would be included in the review and there was a commitment to ensuring independent scrutiny of the NST records. Subsequently, the PCR2 Protocol and Guidance document stated that all safeguarding casework would be included in PCR2 since the inception of the NST in 2015.

The NST PCR2 review commenced in June 2021 and a total of 68 cases were reviewed. At the conclusion of each case review, the IR completed a narrative report, commenting on how the case had been managed and whether, in the view of the IR, there was unmitigated risk or safeguarding concerns. Where such concerns were identified, the report included operational recommendations which in the professional view of the IR, should be undertaken. In some cases, where no such concerns had been identified, the IRs made thematic recommendations which they considered had the potential to lead to improvements with safeguarding practice in respect of NST cases.

**At the conclusion of the NST PCR2, there were no new safeguarding cases identified which had been previously unknown to the NST.**

## 3.Governance of PCR2

The NST PCR2 Reference Group provided governance for the duration of the review to ensure independent oversight. The group members included a former senior police officer skilled in conducting independent reviews (Chair), a representative from The National Association for People Abused in Childhood (NAPAC), National Coordinator for Operation Hydrant which is in a national police role, retired senior social worker a Church of England bishop, and senior members of staff to the Archbishop of Canterbury and Archbishop of York. The IRs and members of the NST attended the Reference Group periodically to provide updates and highlight emerging thematic risk issues. All updates were open to independent scrutiny from the members and detailed minutes were compiled to ensure transparency. In December 2021, a detailed report was completed in respect of the cases that had been reviewed, which contained a total of 20 thematic recommendations which were subsequently accepted by the NST PCR2 Reference Group.

## 4.Implementation of Local Recommendations

The NST PCR2 made 20 recommendations which the reviewers believed could contribute to improvements in safeguarding practice within the NST and the dioceses. In April 2022, the independent chair of the NST PCR2 Reference Group requested an update on the recommendations and how the actions were being progressed. The Reference Group also requested reassurances about how the NST would demonstrate ongoing governance of the recommendations. Subsequently, it was clarified that the National Safeguarding Steering Group (NSSG) would be providing governance to the implementation of the recommendations.

All of the recommendations were accepted by the NST and subsequently an action plan was put in place to manage and monitor the progress being made. The action plan is now included on the NST business plan which is a standard agenda item at the NST Senior Leadership Meeting.

Each recommendation has a specific owner, and several are being addressed through the implementation of revised policy and guidance and projects such as the National Case Management System. An initial review period of 6 months was built into the plan, although it was identified that some recommendations would require a bespoke review period.

## 5.Survivor Strategy

One of the objectives of PCR2 was to ensure that the support needs of survivors had been considered. In several cases there was evidence that individual victims' and survivors' needs were considered during the investigations. There was also evidence that the NST made use of survivor advocates and external support.

However, there were also cases where the service given to individual victims and survivors was insufficient and their needs were not met. This was particularly apparent in respect of abuse cases which were "non-recent". It was identified that in order to help gain the trust and confidence of victims and survivors, it was essential that they were treated in a consistent and empathetic way according to their needs. Several strategic recommendations were subsequently made to the NST which would improve the standard of service given to victims and survivors of abuse in respect of both professional practice and organisational culture.

## 6.Themes Identified

The NST PCR2 highlighted several safeguarding themes and areas for improvement and 20 individual thematic recommendations were made, all of which have been accepted by the NST PCR2 Reference Group and the NST leadership team. It is clear that some of the areas for improvement identified through PCR2 had already been identified by the NST prior to the beginning of the review and a number of projects were already being progressed. It is hoped the projects will address some of the recommendations highlighted by this review. A specific example of this is the Church of England National Safeguarding Case Management System (NSCMS) which will significantly improve some of the safeguarding issues highlighted in this report, particularly in respect of information sharing and the management of risk.

A summary of the main safeguarding themes identified from the NST PCR2 is as follows:

- ### The Role of the NST and Core Groups

  The effective use of national core groups is a significant requirement in NST led cases. Its purpose, according to the Practice Guidance: Responding to, Assessing and Managing Safeguarding Concerns or Allegations against Church Officers (2017), is to oversee and manage the response to a safeguarding concern or allegation, ensuring the rights of the victim and survivor and the respondent to a fair and thorough investigation. Whereas there were many individual examples of well managed core groups, particularly in respect of more recent cases, it was felt that there should be a more consistent approach to the governance and the management of core groups. The Practice Guidance states that the NST will lead and coordinate complex inter-diocesan cases, it was concluded that there was still a need for further clarity regarding the specific functions, roles, and responsibilities of NST and diocesan staff in complex cases.

- ### Definitions

  In order to apply safeguarding policy consistently, there is a need for further clarity in respect of the interpretation of specific definitions. Whereas the Church of England has applied its own definition of "vulnerable adult", there was evidence that the definition was occasionally applied differently between dioceses and the NST, which could potentially cause inconsistent treatment of victims and perpetrators alike. It was also noted that the Church of England definition of "spiritual abuse" was subject to a degree of inconsistency across dioceses.

- Engagement with Statutory Authorities

  There were examples of non-recent cases where vulnerable victims had disclosed abuse by a member of clergy or church officer, and the cleric or person receiving the disclosure had not made the appropriate referral, or shared relevant information with statutory agencies at the time. However, notwithstanding that there was an absence of safeguarding policy or guidance at the time of the disclosure, the IR's formed the view that senior leaders within the church still had a responsibility to refer allegations to the statutory agencies.

  There is a wealth of evidence that engagement with the police and local authorities is now enshrined into Church of England policy both within the NST and dioceses and this happens appropriately and routinely. In recent cases there was evidence of appropriate, timely liaison with the police where suspected criminal offences had been disclosed. However, there were examples where the police engagement should have been more effective in the interests of managing safeguarding risk in a church environment.

- Risk Management

  As highlighted above, there is considerable evidence that safeguarding policy and practice has developed within the Church of England, compared to some non-recent cases where risk management and information sharing were not managed according to the policies and practices used today. In recent cases there were frequent examples of effective liaison and information sharing, where safeguarding agreements were used effectively and proportionately to manage the risk posed by those who may present a risk to children and vulnerable adults in a church setting.

- Safer Recruitment

  A key element of effective safeguarding is to ensure policies are robust in identifying individuals who may pose a safeguarding risk to vulnerable adults and children. There was evidence that there was insufficient guidance and support for clergy on writing references, especially in respect of members of the clergy and church officers who were also in employment outside a church setting. In particular, the safer recruitment practices and information sharing in respect of musicians in church settings was considered a vulnerability.

- Information Management

  Information sharing is a fundamental aspect of safeguarding. There was good evidence of information being shared appropriately to manage the risk posed by suspected perpetrators of abuse with statutory authorities, dioceses, and other denominations. The development of the Information Sharing Project will ensure the Church of England has the legal framework to manage information effectively and consistently.

## 7. Conclusion

The challenges presented by the findings of PCR2 resulted in twenty recommendations which the NST has embraced. This included the need to provide an effective, responsive service to survivors of abuse. It should also be recognised that there was good evidence of improvement seen over the last 18 months in respect of the quality and management of investigations, which is considered to be positive by the IRs.

## 8. Recommendations

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| 1 | Communications and written records should be professional and inclusive, not referring to terms such as “low level allegations” or past failings which minimise the impact of abuse on victims and survivors. |
| 2 | The role of the NST and the diocese or other setting in a survivor’s journey should be clearly communicated from the outset to the survivor and relevant stakeholders. The NST should be realistic on how it can best support survivors when geographically distanced from them. |
| 3 | The NST should develop a separate survivor's charter which sets out the minimum standards of service and timescales that should be delivered following a safeguarding disclosure or referral. |
| 4 | The review of the Practice Guidance (2017) should include specific guidance about supporting vulnerable survivors with additional needs, to include support available from external agencies. |
| 5 | The NST should review how it manages its approach to providing information transparently to victims and survivors whilst operating lawfully. It is suggested that engagement is made with other institutions and law enforcement agencies to consider if any lessons have been learnt in this regard. |
| 6 | Where a complex NST led case involves different dioceses, the chair of the core group should formally agree the respective roles and responsibilities of the NST and diocesan staff in order to ensure the effective undertaking of an investigation whilst managing the ongoing risk locally |
| 7 | In order to ensure clarity of understanding, the rationale for deciding that a safeguarding case will be managed or coordinated centrally by the NST should be recorded in core group minutes. |
| 8 | The survivor management strategy, reflecting the survivors wishes, should be clearly documented and key roles allocated. |
| 9 | It is recommended that the NST ensures that core groups are held in line with the new managing allegations policy. Where this has not been possible, the reason for the delay should be captured in the minutes. |
| 10 | The NST should undertake a review of core group guidance to address specifically:<br>• The standards and expectations regarding the quality of minute taking in support of core groups should be reviewed. This should include a better way to record minutes to support future GDPR requests.<br>• Meeting apologies should record the reasons for non-attendance.<br>• A standardised action grid and tracking of actions system should be introduced to ensure a consistency of approach and tracking of delivery |

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| 11 | The NST should consider the use of confidentiality agreements signed by all participants in a core group, to ensure a more robust management of private information. |
| 12 | The NST should provide clarity about the definition of “vulnerable adult”, to include clear guidance and examples. |
| 13 | The NST should develop policy and practice guidance on the term defined as spiritual abuse to ensure the Church can align its response to appropriate standards. It is recommended that clarity is given on spiritual abuse and its intersection with safeguarding. This information should be widely disseminated with safeguarding professionals. |
| 14 | Decisions on the referral processes to statutory agencies, including the meeting or not of thresholds should be routinely recorded. LADO’s and other key roles within statutory agencies should be consulted with where there is any ambiguity. |
| 15 | Engagement is made at a strategic level by the NST with the National Police Chiefs Council to seek to agree a memorandum of understanding with the police during criminal investigations into church officers to respect the integrity of the police investigation whilst managing risks within the Church of England. |
| 16 | It is recommended that information sharing with other denominations, organisations and agencies is included in core group agendas to ensure that risk is appropriately managed. |
| 17 | The recruitment of church musicians, including casual recruitment, is reviewed to ensure the process fully complies with safer recruitment policy and delivers a high standard of safeguarding compliance. |
| 18 | It is also recommended that a DBS check should be undertaken, and safer recruitment policy is enforced before any transient musician is able to perform in a Church of England setting where they are potentially in a position of trust or responsibility |
| 19 | The NST should develop guidance for members of the clergy and church officers on the writing of references in order to manage safeguarding risks more effectively |
| 20 | In line with recommendations from the National Safeguarding Panel, the CDM Working Group should review and consider the appropriateness of a time limit on the CDM process |