THE CHURCH OF ENGLAND

Past Cases Review 2

NATIONAL SAFEGUARDING REPORT

PUBLISHED BY THE NATIONAL SAFEGUARDING STEERING GROUP

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Acknowledgements

The Past Cases Review 2 (PCR2) has benefited from the contributions of survivors, victims[1] and those with a lived experience of abuse within the Church of England; those who have come forward to speak to the independent reviewers and in local and national forums. We are indebted to them for their considerable courage in sharing and re-living their experiences and trauma in supporting this work.

Our thanks go to all those involved in the provinces, dioceses and other church establishments and institutions for their commitment and conscientiousness which was critical in completing the requirements and ensuring the integrity of PCR2. It placed considerable demands upon people in addition to their daily workload.

The support provided by the independent reviewers across all settings was greatly valued. The reviews were conducted rigorously, diligently and impartially with the subsequent findings reported presented accurately and objectively.

Finally, we must not forget those who did not have the trust or confidence to share their personal trauma. Our hope is that our ongoing commitment towards safeguarding and demonstrating a resolve to listening, learning and supporting will help survivors and victims to take this next step.

1 We recognise that the terms 'survivor' and 'victim' used throughout the report are labels. Labels are not always helpful and do not represent all personal experiences and journeys. They are only used as a shorthand for the purposes of reading this report.

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Foreword

As clergy, most of us come into our roles out of a sense of calling by God and love for the Church and so it is always with great sadness and profound shame that we, again and again, come face-to-face with the brokenness and failings of our church in its day-to-day interactions and in its processes and leadership. There are no possible excuses, no rationalisations for our church's failure to share the love of God and value each and every person; our very Scriptures consistently tell us to care for the weak and vulnerable and yet, as a church, we have failed to do so. This is why we, together with the whole church, are conducting reviews, trying to learn from the past in order to construct a better future. We do so by learning from others who can help examine our lives, shine light in hidden and difficult places and acknowledge the truth and identify how we can move on.

PCR2 was our next step in extending our search for the truth and being satisfied that past abuses and the misery suffered by survivors, victims and their families was uncovered. As a matter of priority, we took immediate action to manage concerns with procedures in place to best support the needs of the victim. This was the very least that children and vulnerable adults who have experienced such abuse deserved and was at the heart of our approach.

As a church, we have a specific commitment to engage and distinct lessons to learn that relate to our Christian faith. Safeguarding is no different. Caring for children and the vulnerable, as well as confronting the reality of human sinfulness, is at the heart of our very being.

We cannot have a culture that sees safeguarding as a separate add-on. It needs to be part of our DNA, as an expression of our love for one another and our commitment to the Gospel. This means not just putting in place rigorous and professional processes, it also means that as a church we need to understand this and teach it as a core part of our faith and practice.

Our aspiration is for a church where children, young people and the vulnerable can worship, learn, socialise and develop in a safe and caring environment, with the knowledge they have a voice and can confidently raise concerns.

We sincerely apologise for our failures and want to reach out to those who are still suffering from the pain and misery they endured. We extend this apology to wider family members affected from this past abuse. We are so sorry that this ever happened. It was not your fault and you are not to blame. We should have been better at listening and responding to survivors' and victims' concerns. Our faith compels us to take safeguarding with the utmost seriousness; to prevent abuse from occurring; responding appropriately where it has in support of our undertaking to making church communities and institutions safer places.

Foreword

We remain acutely aware that some survivors and victims may not have the faith, trust or confidence to report abuse or concerns. Our message and commitment to you is steadfast. We encourage you to come forward. We recognise that you do have a voice. Members of the clergy, church officials, volunteers and safeguarding professionals are spread throughout the church community, and are willing and trained to respond. They understand that the welfare and well-being of our church family is of paramount importance, treating you with the respect, compassion and care you deserve.

Finally, we want to extend our thanks to all those who have been involved in the PCR2 process. It has been a huge undertaking throughout the Church – in parishes, chaplaincies, religious communities and theological colleges. It has taken many people in many different places to be able to do this, safeguarding advisers, administrative support staff, National Safeguarding Team, safeguarding professionals, drafters, diocesan staff, clergy and lay people, the National Safeguarding Steering Group and Project Management Board, and the Church Commissioners who made funding available. But most of all, thank you to all survivors and victims who trusted us with their stories and shared their experience. What you have shared is invaluable, and we hold it with gratitude, sorrow and prayer, as we commit ourselves to continue to work to make our churches safer places.

The Most Reverend and Right Honourable Justin Welby, Archbishop of Canterbury

The Most Reverend and Right Honourable Stephen Cottrell, Archbishop of York

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Glossary

ALM	Authorised Lay Minister
CDM	Clergy Discipline Measure 2003
CSO	Cathedral Safeguarding Officer
DBS	Disclosure and Barring Service
DiE	Diocese in Europe
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
GDPR	General Data Protection Regulations
IICSA	Independent Inquiry into Child Sexual Abuse
Incumbent	The holder of an ecclesiastical benefice
IR	Independent Reviewer
ISA	Information Sharing Agreement
ISB	Independent Scrutiny Board
IST	Independent Scrutiny Team
LADO	Local Authority Designated Officer
LLM	Licensed Lay Ministry
MDR	Ministerial Development Review
NCIs	National Church Institutions
NSP	National Safeguarding Panel
NSPCC	National Society for the Prevention of Cruelty to Children
NSSG	National Safeguarding Steering Group
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR	Past Case Review
PMB	Project Management Board
PSO	Parish Safeguarding Officer
PTO	Permission To Officiate
RSO	Registered Sex Offender
SCIE	Social Care Institute for Excellence
SOPO	Sex Offenders Prevention Order
TEI	Theological Education Institution

Any policy or guidance document referred to in this report can be found on the Church of England website

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Executive summary

Introduction

The Executive summary of the Past Cases Review 2 (PCR2) National Report provides a summation of the full report and is set out as follows:

- **Background and Approach**
  The history of PCR2 is explained setting out why PCR2 was required. Following on is the approach to planning and undertaking PCR2; including the scope of the work to achieve its purpose and objectives.
- **Findings**
  This provides a brief overview of the findings collated from the 45 individual reports presented by 65 independent reviewers working in the dioceses and other church settings; and which are arranged under eleven theme headings.
- **Conclusions and Recommendations**
  There is a summary of the main conclusions. The number of recommendations within each of the three categories for action are stated. The recommendations are set out in full at the end of the report.

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Executive summary

Background

Past Cases Review 1 (PCR1) was commissioned because of several Church of England clergy and church officers being charged with sexual offences against children. PCR1 was conducted between 2007 and 2009.

In May 2016 concerns were raised regarding the judgements presented from PCR1. An Independent Scrutiny Team (IST) chaired by Sir Roger Singleton was convened and it concluded that whilst the review was well motivated and thoughtfully planned, limitations existed in relation to its execution. As a result, Past Cases Review 2 (PCR2) was commissioned by the Archbishops' Council in 2019 as part of the overall commitment to improving the way in which the Church responds to allegations and concerns.

Approach

The principal aim of PCR2 was to examine records across the provinces, dioceses, and other church institutions including the National Safeguarding Team, to establish if material contained allegations of abuse where the perpetrator was a member of the clergy or church officer. The purpose of PCR2 was to identify both good practice and institutional failings into how allegations of abuse had been handled, and provide recommendations leading to improvements in response to concerns and safeguarding practices and help create a safer church environment for everyone.

A key aspect of the process was to make sure that survivors and victims were the priority and involved throughout the process to ensure that their voices were heard. Two key documents were produced to support the process. *Background and Overview* provided the context and purpose of the review, whilst *Protocol and Practice* developed with the support of victims and trauma-informed professionals, set out the scope, approach and methodology.

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With regards to the scope of the review, following considerable consultation with a range of groups, it was agreed the review would incorporate both children and vulnerable adults to ensure that the Church could fulfil its safeguarding obligations.

In order to identify written records containing allegations of abuse or neglect, files relating to every living clergy person and living church officer were considered within the scope of PCR2 irrespective of whether the clergy or other church officers were engaged in ministry, paid or voluntary work at the time of the review.

To meet this commitment and with the added benefit of learning from previous reviews, suitably qualified independent reviewers were recruited to ensure an impartial and unbiased assessment of material was conducted. The person specification was clearly set out in the guidance document, which directed that all independent reviewers had to demonstrate proven experience in safeguarding work and possess good communication and interpersonal skills.

The specific responsibilities of the independent reviewers were detailed in the guidance, which in summary, required them to read files and write reports; make recommendations or highlight actions; engage with survivors and victims wishing to make contact; and report on matters assessed as requiring immediate attention. The independent reviewers were briefed on data protection compliance and provided with a designated point of contact to advise on matters of a local nature.

There was a strong emphasis on governance and oversight arrangements, to ensure national and local structures, systems and processes were suitably robust and rigorous. Whilst the Archbishops' Council maintained oversight of the process throughout the initiative and provided some financial support to dioceses, decision making was delegated to the National Safeguarding Steering Group (NSSG).

A Project Management Board (PMB) was established to provide national leadership and guidance to oversee and coordinate the implementation of PCR2 and reported directly to the NSSG. The PMB was also the recipient and arbiter of all reports to ensure the content met the PCR2 obligations. This responsibility included the authority to seek clarification on any aspect of the contents prior to a final endorsement by the PMB.

Such was the scale of the work required of the PMB, a dedicated project management team was formed.

At a diocesan level the Diocesan Bishop, the Independent Chair of the Diocesan Safeguarding Advisory Panel (DSAP) and the Diocesan Safeguarding Advisor (DSA) were held accountable for implementing a plan to progress PCR2. The DSA was the primary point of contact for statutory partners and the independent reviewers.

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As part of the governance process, reference groups, in each diocese, were introduced with a remit to monitor, progress and manage issues emanating from the review. The full terms of reference were outlined in the guidance. Membership of the group included key diocesan representatives and experienced safeguarding professionals, including police and other statutory agencies.

Cathedrals not directly engaged with their local dioceses introduced structures and processes that reflected these forums. Likewise, the National Safeguarding Team and provinces formed a joint reference group replicating diocesan arrangements.

Other settings, such as Theological Education Institutions (TEIs), religious communities, and defined in scope, were also engaged in the process despite being legally separate from National Church Institutions, cathedrals and dioceses. Written guidance was issued by the PMB to support these establishments and in many cases, collaborative arrangements were in place with local dioceses. Where this was not the case, the PMB project manager engaged with representatives of these settings to set up suitable reporting structures.

In terms of survivor and victim engagement, *Background and Overview* and the guidance were explicit in defining the requirement. The guidance, produced with the support of trauma-informed professionals and those who had previously raised concerns of abuse allegations, advised on appropriate survivor and victim engagement approaches. It led to reference groups appointing nominated leads to ensure the needs of those impacted by PCR2 were provided for.

Dioceses were also encouraged to produce survivor care strategies, which promoted the PCR2 initiative and publicised local advocacy arrangements and referral processes. These plans were subject to periodic review by the local diocesan reference groups.

A dedicated, confidential helpline independently run by the NSPCC was introduced to coincide with PCR2 to allow survivors and victims to speak to someone in confidence and independent of the Church.

Survivors and victims have also been involved in supporting the production of this report, with representatives attending nationally led survivor and victim workshops, to consider and provide advice and contribute to the findings, and ensure the subsequent actions were considered from a survivor and victim perspective.

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Findings

The review of the 75,253 files within the scope of PCR2 was conducted by independent reviewers across the dioceses and other church bodies between July 2019 and April 2022. There were 65 survivors and victims who were able to speak to the independent reviewers about their experience of safeguarding in the Church. The findings are the compilation of the information provided by 65 independent reviewers and from the 45 individual reports they submitted which the PMB considered and accepted. The independent reviewers identified 383 new safeguarding cases relating to children and vulnerable adults.

The findings from the diocesan reports form the main part of this report and provide the analysis of what the independent reviewers identified following their thorough review of the files in scope. The findings reflect the reoccurring and cross-cutting issues across dioceses, cathedrals and other settings and emphasise where significant improvements still need to be made by the Church of England. Each theme features good practice and illustrates the impact of changes in church settings that have already been made. They conclude with a summary of the analysis which supports the suggested improvements that are required to still be made across the Church and the recommended action to be taken.

The findings are organised and described under these eleven different theme headings:

1. Survivors and Victims
2. Managing those who pose a risk
3. Managing risk
4. Case management
5. Managing information
6. Safeguarding teams
7. Safer recruitment
8. Support and accountability
9. Learning and development
10. Strategy, leadership and governance
11. Culture

Executive summary

CONCLUSIONS

PCR2 has been a significant undertaking and is believed to be the most extensive review of records ever conducted by the Church of England. Whilst the review has resulted in considerable financial cost, this pales into insignificance compared with the emotional, physical, and mental anguish that survivors, victims, and their families have suffered. The summaries and quotes incorporated into this report illustrate, first-hand, the experiences that many survivors and victims have endured. Their anger, frustration, and criticism should act as a stark and timely reminder of the ongoing need to improve, develop and remedy our safeguarding measures to ensure that persistent mistakes and failures are not repeated.

The detail with which this review has been completed has demonstrated a thoroughness and transparency, requiring compliance with *Protocol and Practice*, combined with the added benefit from the advice and expertise of the independent reviewers. Nevertheless, the report narrative shows the complexity of collating the information and data, which was significantly more than had originally been anticipated. From this the key conclusion must be the need for consistent application and adherence to existing guidance, policy and best practice. Nonetheless it is clear that this is not always achieved when dioceses are confronted with very traumatic, complex cases of survivors and victims who have experienced abuse. The review identified broad, cross-cutting themes across the provinces, dioceses and other institutions that have highlighted concerns in safeguarding arrangements and identified where the responses to survivors and victims must be improved.

Our approach to safeguarding is changing and improving, but it is taking time and there is more to be done to prevent abuse happening in the first place. Through engaging, listening and learning lessons, we will continue to involve survivors and victims in the safeguarding work of the Church. When needed we will change our practices, improve our approaches and do things differently, as we continually strive to make our church communities safer places for everyone.

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RECOMMENDATIONS

The 26 recommendations made in response to the findings and the conclusions are set out thematically and prioritised under the following three headings:

"Keep doing well" – Four of the 26 recommendations fell into this category. These recommendations are based on what the Church has put in place and deemed good practice and where the independent reviewers have provided evidence which shows consistency of application in the majority of settings and affirmed that this should be continued and maintained across all settings and church bodies.

"Continue to do, but more effectively and consistently" – Eighteen of the 26 recommendations were in this category, which was where the bulk of the recommendations were located. These are recommendations where the reviewers found evidence of Church policy and guidance and good practice which was not followed or implemented consistently and therefore was having a detrimental impact on safeguarding.

"Must improve" – There were only four of the 26 recommendations in this category. These are the recommendations made by the independent reviewers where new pieces of work are required to be undertaken to improve safeguarding practice, outcomes and survivor and victim experience.

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INTRODUCTION

This report is presented by the Church of England at the end of the Past Cases Review 2 (PCR2) project. This has been a vast and lengthy process only recently concluded and is believed to be the most extensive independent review of records ever conducted by the Church of England. It is based on the findings presented by 65 independent reviewers, across 42 dioceses and a number of other church settings, who have examined 75,253 files and as a result have identified 383 new safeguarding cases. The review formed part of our overall commitment to improve the way in which the Church of England responds to allegations and concerns of abuse, having recognised our past failures as well as the pain and suffering that survivors and victims have endured.

We sought and included the views of survivors and victims during PCR2. This formed a key part of the PCR2 guidance which specified as an objective *"To ensure the support needs of known survivors have been considered".* The guidance encouraged dioceses to offer the opportunity for survivors and victims to contribute to the review and meet with independent reviewers. The Project Management Board (PMB) was attentive to this objective encouraging each diocese to have in place a survivors' care strategy. What has become apparent is the keenness of survivors and victims to work with the Church of England at all levels, offering advice and knowledge. The independent reviewers wanted to ensure we consistently listen, and actively and routinely involve and engage with survivors and victims. The outcome of PCR2 is the implementation of the recommendations which we, the Church, must deliver to bring about sustained improvements in our safeguarding practice to secure a safer environment for all. PCR2 has highlighted areas where practice is consistent and in line with recommended policy and practice and which need to be shared and applied across the Church.

The report begins with a summary of the background to PCR2 including its purpose and the objectives. The report then explains the approach that has been taken, setting out how robust and detailed this has needed to be to achieve these. The main part of the document is the presentation of the analysis of all the findings from 65 independent reviewers from across all church settings. The findings section highlights what the independent reviewers identified as areas of concern, where there are gaps and where we need to make improvements. These findings are described under eleven different theme headings. Each theme draws out the elements of good practice and shows the impact of changes that we have already made. There is a dedicated section on the involvement and engagement of survivors and victims which provides further evidence of the ways in which we can improve our response to them and ensure their voices and contributions are a catalyst for change.

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The report's third and final section includes the conclusions. These have been drawn from the analysis and consolidation of all those presented in the individual reports as a result of the extensive independent review of the files which were in scope of PCR2. Importantly it ends with strong recommendations which we are committed to implementing. The report describes the steps to be taken in the coming months to ensure the changes required become a reality. These steps include providing further evidence and information to current projects and initiatives or establishing new ones. We will make sure that evidence of progress towards the recommendations and their achievement continue to be made public.

This report does include terms and abbreviations which are set out in the glossary. Throughout the document you will see the findings of the independent reviewers reflected in their own words, in short vignettes or direct, but anonymised, quotations and those which describe the experiences and feelings of survivors and victims. It is impossible to remain unmoved by these and indeed some may find the contents of the report distressing. If you are affected by this report then please access the support that is available from Safe Spaces, see page 128 for more details.

This second PCR was commissioned by the National Safeguarding Steering Group (NSSG) and entrusted to a Project Management Board (PMB) which, supported by the National Safeguarding Team's professional staff, has now completed its work. The review has benefitted immeasurably from the expertise and perspectives of independent members of the PMB, among them a trauma informed psychologist, a DSAP chair, an independent safeguarding consultant and, vitally, someone with lived experience of abuse.

The PMB tenders this report to those with responsibility for oversight of policy and good safeguarding practice in the Church of England. We recommend it in particular to the NSSG which commissioned it, but also to the wider Church of England, in the expectation of timely consideration and an equally timely implementation of its recommendations.

The Rt Revd Mark Sowerby
Chair, PCR2 Project Management Board and Principal of the College of the Resurrection

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Background and purpose

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Section One provides the context for this report. It describes the background of PCR2 and the approach taken to conducting both the review and the completion of this report which summarises the findings of the reviews undertaken across the Church of England.

This report has been compiled from the information taken from the review of files in scope between the publication of the guidance in July 2019 and the final diocesan report which was received by the Project Management Board (PMB) in April 2022.

Background

The original Past Case Review (PCR1) conducted between 2007 and 2009 was commissioned because of several Church of England clergy and church officers being charged with sexual offences against children. The objectives of the initiative were two-fold. Firstly, to identify concerns of past abuse and on-going risk towards children and secondly, to ensure appropriate risk management measures had been taken. The outcome resulted in large scale, comprehensive examination of church clergy and church officers' personnel records.

In May 2016 concerns were raised regarding the judgements presented from the original inspection and ensuing screening processes. Consequently, Sir Roger Singleton, then Chair of the Independent Safeguarding Authority was appointed to lead a moderation panel to consider the accuracy of those decisions. Sir Roger was supported by two individuals with an equally extensive background in safeguarding and distinct from the original study. This panel of experts became known as the Independent Scrutiny Team (IST)[2].

In presenting their findings the report of the Independent Scrutiny Team into the adequacy of the Church of England's Past Cases Review (2008-2009), the IST concluded that whilst the review was well motivated and thoughtfully planned, limitations existed in relation to its execution although it concluded that no further work was required in 35 dioceses and provinces.

Three of the recommendations made related to the re-examination of the PCR1 as follows:

1. We recommend that ALL dioceses and the provinces ensure that relevant files (including those of diocesan lay employees working with children) which are known not to have been examined in 2008/09 or which have subsequently been located and not examined, are independently reviewed and any cases of concern which emerge are dealt with by the Diocesan Safeguarding Advisor (DSA) as if they were new referrals.

2 Independent Scrutiny Team Members: Sir Roger Singleton, Amanda Lamb, Donald Findlater.

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2. We recommend that ALL dioceses should be asked to check with every parish that all safeguarding concerns about the behaviour of any parish employee or volunteer towards children both currently and historically have been notified to the DSA.
3. We recommend that an updated version of the PCR, as prescribed by the National Safeguarding Steering Group, should be conducted in the 7 dioceses where further work is considered necessary.

As a result, Past Cases Review 2 (PCR2) was commissioned by the Archbishops' Council in 2019 as part of the overall commitment to improving the way in which the Church responds to allegations and concerns.

Prior to the launch and following a significant period of consultation the scope of PCR2 was widened to include all concerns relating to vulnerable adults at risk of abuse, demonstrating a determination and undertaking to reach out and listen to survivors and victims not previously identified or engaged during PCR1.

Two key documents were produced to guide the review process. *Background and Overview* provided the context and the purpose of the review; whilst *Protocol and Practice Guidance* (the guidance) and its *Appendices for Practice Guidance* set out the detailed requirements that would be followed. The guidance was written with reference to the current House of Bishops' Safeguarding Policy '*Promoting a Safer Church*' (2017) which can be found on the Church of England website.

The guidance defined the scope, approach and methodology that was to be adopted to ensure all activity was robust, rigorous and focused; a product developed in cooperation with survivors, victims and trauma-informed professionals. It provided direction and advice on a number of issues; the introduction of national and local oversight and quality assurance arrangements; approaches on survivor and victim engagement, to ensure their voices were heard; formation and membership of the collaborative consultative arrangements, known as national and diocesan reference groups. These structures, systems and processes are similarly described in the following paragraphs.

The purpose of PCR2

The overall purpose of PCR2 as set out in the guidance was to:

> identify both good practice and institutional failings in relation to how allegations of abuse have been handled, and to provide recommendations to the Church of England that will lead to improvements in its response to allegations of abuse and in its overall safeguarding and working practices; thereby ensuring a safer environment for all (p.3 of the *PCR2 Practice and Protocol Guidance, 2019).*

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Commencing in summer 2019 the principal task of PCR2 was to examine records held across the provinces, their dioceses and other church institutions or bodies, to establish if any material contained allegations of abuse, where the alleged perpetrator was a clergy person or other church officer.

The objectives of PCR2

The specific objectives of PCR2 as set out in the guidance were:

- To identify all information held within parishes, cathedrals, dioceses or other church bodies, which may contain allegations of abuse or neglect where the alleged perpetrator is a clergy person or other church officer and ensure these cases have been independently reviewed.
- To ensure all allegations of abuse of children have been handled appropriately and proportionately to the level of risk identified with the paramountcy principle[3] evidenced within decision making.
- To ensure that recorded incidents or allegations of abuse of an adult (including domestic abuse) have been handled appropriately demonstrating the principles[4] of adult safeguarding.
- To ensure the support needs of known survivors have been considered.
- To ensure that all safeguarding allegations have been referred to the Diocesan Safeguarding Advisors and have been responded to in line with current safeguarding practice guidance.
- To ensure that cases meeting the relevant thresholds have been referred to statutory agencies.

The following paragraphs explain the approach that was taken by the Church to achieve the purpose and objectives of PCR2. The outcome of this approach has been to gather a great deal more information about

3 The Children Act 1989 – The current child protection system in England is grounded in the *Children Act 1989,* as amended. The Act establishes a number of key principles, including
- the concept of parental responsibility.
- the paramount nature of the child's welfare when a matter under the Act is before a court.
- that children are best looked after by their family unless intervention in family life is essential.

The Act places a general duty on local authorities to promote and safeguard the welfare of children in need in their area by providing a range of services appropriate to those children's needs. It additionally sets out what a local authority must do when it has reasonable cause to suspect that a child in its area is suffering, or is likely to suffer significant harm– see, for instance, section 1. Children Act 2004 extended this by placing a duty on a range of agencies, including local authorities, the police and health services, to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions. Therefore, the Children Act 1989 does not enshrine generally in law that the welfare of the child is paramount, it is only in relation to certain court proceedings.

4 Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability. Care Act 2014

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our previous and current safeguarding practice and its effectiveness and make clear recommendations about how we can set ourselves more ambitious goals for change. This will lead to better assurance of the Church of England as a safer environment for all those who work and worship in it.

The National Safeguarding Team (NST)

Prior to 2014 safeguarding provision consisted of the National Safeguarding Adviser which was a part-time position in the Central Secretariat. The National Safeguarding Team (NST) was established from 2014. The NST is a department of the Archbishops' Council, one of the seven National Church Institutions (NCIs), which support the mission and ministry of the Church at a national level. The NST provides expert advice and support to dioceses, cathedrals, NCIs and other Church of England bodies regarding safeguarding policy, learning and development, and casework and it is responsible for implementing the recommendations from the Independent Inquiry into Child Sexual Abuse (IICSA) report.

The NST is overseen by the National Safeguarding Steering Group (NSSG) which holds the responsibility for the strategic oversight of national safeguarding activity including making recommendations on strategic developments.

Neither the NSSG nor the NST can compel any of the church bodies described above to comply with guidance and policy. The debate on such matters takes place in the House of Bishops and the NSSG and NST can only prompt, inform and influence these discussions supported by the National Safeguarding Panel (NSP) and the recently established Independent Safeguarding Board (ISB), set up in response to the IICSA report. The NSP is there to provide high level strategic advice and offer guidance on policies and practice in safeguarding to ensure the Church meets accepted best practice. It does this through its scrutiny and challenge to the church for its work on safeguarding. The ISB was set up in 2021 to provide vital independent external scrutiny and oversight of the Church's safeguarding activity.

The approach

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The scope of PCR2

During the planning phase for PCR2, significant consultation took place to consider a proportionate approach to the scope of this work. Considering both survivor and victim care and risk mitigation, the advice to the Archbishops' Council was that a child and adult safeguarding focus was the only way that the Church's commitment to safeguarding everyone could be upheld.

In order to identify written records which may have contained allegations of abuse or neglect, the guidance set out the terms that required dioceses to undertake an independent review of all the files of all living clergy and church officers (whether in active ministry or not), or provide evidence that previous independent reviews had included potential risk to adults within their scope.

Legally, a child is defined as anyone under the age of 18[5]. Therefore, safeguarding children is about protecting all those under 18 from harm. It was acknowledged that considering the broad definition of a vulnerable adult, discretion would need to be exercised in some cases, having regard to a person's entitlement to exercise choice and their mental capacity. For the purposes of PCR2, the definition of vulnerable adult contained in the Safeguarding and Clergy Discipline Measure 2016 was used.[6]

Likewise, the definition of 'church officer' was open to some interpretation. For the purposes of the review the guidance stated *"A church officer is anyone appointed/elected by or on behalf of the Church to a post or role, whether they are ordained or lay, paid or unpaid"*, this therefore encompasses all clergy, including those with Permission to Officiate (PTO), clergy such as hospital, school and prison chaplains where they hold the Bishop's Licence, readers and licensed lay workers and volunteers, and diocesan and parish lay employees and volunteers, and who performed in a role that included direct involvement with children and vulnerable adults.

The judgement to be made in these cases was whether the role would have, in the past, currently, or in the future, provided opportunities for the abuse or neglect of children or vulnerable adults whilst engaged in church organised activities and whether the role involved a relationship of trust.

Instances of alleged domestic abuse as an indicator

5 A child is defined in "Working Together to Safeguard Children – July 2018" as: Anyone who has not yet reached their eighteenth birthday. That is the definition to be utilised for the purposes of PCR2.

6 "….vulnerable adult" means a person aged 18 or over whose ability to protect himself or herself from violence, abuse, neglect or exploitation is significantly impaired through physical or mental disability or illness, old age, emotional fragility or distress, or otherwise; and for that purpose, the reference to being impaired is to being temporarily or indefinitely impaired." (section 6)

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of vulnerability were also included in the scope.

Files in scope

The files subject to PCR2 consisted of clergy personal files (commonly known as blue files), which are the equivalent of Human Resources (HR) files for those in ordained ministry. It also included the variety of HR type files in relation to church officers, such as lay individuals who are volunteers, those holding a licence or commission and those who undertake pastoral care of children and/or adults who may be vulnerable.

The files of chaplains working in prisons or hospitals, schools and universities etc. were only reviewed where the person had Permission to Officiate (PTO) or Bishop's Licence. Otherwise, their personnel records are held by their employing organisation, and they are expected to adhere to the safeguarding policies of that organisation.

The records held by the NST involve complex cases, often managed between several dioceses and the NST. All of the records held by the NST in its current format from 2014 were subject of independent scrutiny. Including this work in PCR2 assured that the same quality of response in relation to safeguarding was being provided across every context of the Church's safeguarding work.

Independent reviewers

There was a commitment to ensure independent scrutiny of all records was conducted within both the spirit and the reporting structures of PCR2. Listening and learning the lessons from previous audits, independent reviewers were recruited and deployed to ensure an impartial and unbiased assessment of all the material examined was achieved.

The guidance was explicit in the standards to be met for the appointment of these independent reviewers. An essential principle of those recruited was one of being 'manifestly independent of any diocese or other church institution.'

Applicants needed to satisfy certain specification requirements to fulfil the role, including having suitable experience in safeguarding investigative work within a relevant profession, possessing the inter-personal skills and experience to engage sensitively with survivors and victims and experience in child safeguarding practice reviews.

The NST approved several individuals who met the selection criteria to assist in the process and notified dioceses of their availability. Regardless of this endorsement, dioceses were expected to conduct their own formal interviews to be satisfied of an applicant's suitability for the role.

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The approach

Each diocese, cathedral and church body had to ensure that those recruited as independent reviewers, were conversant with the data protection law that was relevant to their work location. It was also advised that independent reviewers were provided with a point of contact, in addition to the DSA, who could provide advice to them on matters such as diocesan structure, key officials and local policies and procedures.

Dioceses were not prevented from undertaking their own advertising, recruitment, and appointment processes, provided the published criteria was met. In these cases, the planning of recruitment campaigns and interview processes was suitably managed through the existing DSAP arrangements.

The roles and responsibilities of the Independent Reviewer were detailed in the guidance and are summarised as follows:

- Read files of all church officers within scope and record cases of concern
- Consider the known cases lists and assess the arrangements for managing cases
- Prepare summaries of cases where further or different action should be taken
- Engage with survivors and victims who wish to make contact
- Prepare summary reports including recommendations that the Independent Reviewer considers will improve safeguarding performance
- Attend Reference Group meetings to present findings and discuss cases
- Where necessary liaise with independent reviewers of other dioceses and National Church Institutions to fulfil their responsibilities
- Notify the DSA (or if operating at a national level, the Casework Manager) where issues were identified requiring immediate attention.

The processes to follow and the documentation to be completed by the reviewers were clearly outlined within the guidance.

Survivors and victims

The *Background and Overview* and the guidance reinforced the importance of a survivor and victim centred approach in conducting PCR2. In particular, the guidance was carefully compiled following advice from selected dioceses; trauma-informed safeguarding practitioners and feedback (positive and negative) from those previously raising concerns and complaints about their abuse allegations.

For example, Section 10 of the guidance stated *"Undertaking PCR2 is central to the Church's proactive approach to identifying where abuse allegations have not been managed appropriately or safely, or with the needs of the vulnerable at the centre of its decision making."*

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The approach

The guidance provided specific advice on involving and consulting with survivors and was written in the spirit of co-production, taking input both from those with a lived experience of abuse who have provided positive feedback about the Church's response, and from those who had previously raised concerns and complaints about the Church's handling of abuse allegations.

A member of every diocesan PCR2 reference group was expected to be the nominated lead for survivor support and engagement, which encompassed working with the DSA to ensure the support needs of all those impacted by PCR2 were considered and provided for.

Survivor care strategies were encouraged to be produced as part of this process, ensuring that support provisions were in place for those adversely affected by the review of old cases and the discovery of any new concerns. The locally produced plans provided information on advocacy arrangements and referral processes and were subject to endorsement by the DSA, DSAP and diocesan bishops prior to circulation. They were also the subject of continuous review by PCR2 reference groups.

A dedicated telephone helpline was introduced to coincide with the launch of PCR2. This support facility was operated by the National Society for the Prevention of Cruelty to Children (NSPCC) and intended for survivors and victims who wished to speak to someone independently of the Church. In commissioning this service, the Church was aiming to consider the wider needs of survivors and victims.

In the lead up to the publication of this report, survivors and victims were engaged in the consultation process, advising on the broader content of the report and ensuring a survivor-centred approach to its dissemination and the implementation of its recommendations. This has involved participation in workshops organised by the PCR2 Project Team and facilitated by the NST's Partnerships and Engagement Lead, where survivors and victims have shared their views and experiences and contributed to the findings and recommendations.

To further support survivors and victims of abuse, the Safe Spaces initiative was launched in September 2020. This two-year pilot scheme is an ecumenical project jointly delivered in partnership with the Catholic Church in England and Wales. This service was promoted at the commencement of PCR2 and posted onto the Church of England and diocesan websites.

Governance and oversight

As the commissioning body for PCR2, the Archbishops' Council maintained oversight of developments throughout the process and provided some financial support to conduct the work required.

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The approach

Responsibility for decision making was delegated by the Archbishops' Council to the NSSG. A Project Management Board (PMB) was formed, as a sub-group of the NSSG, taking accountability for ensuring PCR2 was completed and reported upon.

The PMB provided regular written updates on progress, whilst the NSSG formally reported on developments to the Archbishops' Council.

Project Management Board

As described above, the NSSG recognised that PCR2 would benefit from comprehensive guidance and national leadership, resulting in a Project Management Board (PMB) being established to oversee and coordinate implementation of further PCR2 work, delivering governance and oversight. The membership of the PMB has included those with lived experience of abuse and professional backgrounds who brought a level of independent scrutiny.

The key aspects of the PMB role were as follows:

- Ensuring that the PCR2 project achieved a balance between proportionality and rigor in the production of written guidance and in its implementation
- Ensuring that the best interests of children and of adults at risk of abuse were given paramount consideration throughout the PCR2 process
- Operating a quality assurance function across all aspects of project delivery.

Such was the scale of this work, a dedicated project management team was recruited to support the project.

Each diocese and other settings in scope of PCR2 were asked to submit a final report which has been compiled by the Independent Reviewer, accepted by the DSAP and confirmed by the Diocesan Bishop. There was a requirement for the PMB to ensure the PCR2 objectives have been achieved and therefore, they had the responsibility to review and sign off the local reports as evidence. Local reports set out the way the review was conducted, the findings, conclusions and recommendations highlighting the themes relating to children and adult safeguarding in each diocese.

If necessary, the PMB would seek clarification from the Independent Reviewer or the DSA on any aspects which were unclear or gave rise to questions, ensuring that the local reports were able to fully inform the national overview report development.

Local reviews

The guidance also made recommendations on oversight arrangements for dioceses. The Diocesan Bishop (as well as their nominated lead for safeguarding), the Independent Chair of the DSAP, and the DSA were responsible and accountable for implementing a plan to progress PCR2.

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The approach

The DSA coordinated the preparation for the review and were the diocesan point of contact with statutory partners and the independent reviewers. As part of this preparation dioceses were requested to set up a PCR2 reference group to support the DSA, monitor progress and manage issues emerging from the review.

The remit of a reference group was:

- Ensuring robust risk management
- Providing dispute resolution when there were differing professional opinions between the DSA and the Independent Reviewer
- Ensuring the right care and support was in place for anyone that is impacted upon by this review
- Reviewing the recommendations from the DSA regarding the exemption of a proportion of previously reviewed cases/files and ensuring that agreement to seek exemptions is unanimous.

The guidance included details of reference group membership which can be summarised as follows:

- At least half should comprise people who are independent, experienced safeguarding professionals including representation from both the police and a local authority
- Bishop's nominated lead for safeguarding
- Bishop's nomination of an additional senior staff member as a standing member to ensure a senior staff member is part of the decision-making group
- Diocesan communications director/officer
- An individual with lived experience of abuse, or a named person from a group whose role it is to advocate survivor perspectives
- The DSAP chair nomination of a lead for survivor support and engagement.

In the cases of cathedrals' response to oversight arrangements, Cathedral Chapters[7] adopt and implement the House of Bishops' safeguarding policy and practice guidance, with structures to manage safeguarding in a cathedral including the appointment of a Cathedral Safeguarding Officer (CSO) to work with the Dean, the Chapter and cathedral staff.

In many cases, diocesan reviews incorporated their cathedrals in this process and therefore governance and oversight was provided through the diocesan reference groups. In the cases where cathedrals conducted their own reviews, reference groups were established as outlined in the guidance which mirrored the diocesan set up.

7 The administration of the affairs of cathedrals are directed and overseen and administered by their Chapters (Cathedrals Measures 2021), which are formed of both clergy and lay people and also manage cathedral affiliated reviewers. The Chapter is chaired by the Cathedral Dean.

SECTION 1

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The approach

National Safeguarding Team and Provinces

A NST and provinces reference group was established, which replicated diocesan arrangements.

The independent reviewers appointed to review the NST cases referred by dioceses, prepared reports on the number of cases and broad outcomes. Their final report was endorsed by the Secretary General of the Archbishops' Council and was reviewed and recommended to the PMB by the Reference Group.

Other settings

The PMB was clear that for the Church to be confident in the findings of this PCR2 process, 'other settings' (Theological Education Institutions (TEIs), religious communities and other church bodies) must be engaged with the PCR2 process.

These organisations, which are separate legal entities and therefore, legally separate in governance and charitable terms from the NCIs, diocesan bodies, and cathedrals, could not be required to participate in PCR2, but were invited to assist in meeting the PCR2 objectives. Clergy living and licensed within such institutions would be covered by diocesan PCR2 processes. However, there was a strong desire to encourage these bodies to participate in PCR2 to capture any concerns around non-ordained staff, volunteers or other contacts.

In cases where there were already clear, collaborative arrangements in place between institutions and the diocese in which they were sited, or where specific arrangements were in place for the management of safeguarding, the guidance recommended that the church bodies approach PCR2 in partnership with the diocese. Where no formal safeguarding arrangements existed between an institution and its diocese, discussions were held at the time between the institution and the PCR2 Project Manager as to how that engagement would be managed.

The National Church Institutions and their HR records as deemed within scope were also reviewed.

The Diocese in Europe

The Diocese in Europe (DiE) comprises more than 40 countries including Turkey, Morocco and Russia. Travel restrictions imposed during the Covid-19 pandemic delayed the research that had to be done for PCR2 in continental Europe. The necessary work reviewing all the files has now been completed. The Diocese aims to report on the findings before the end of the year.

SECTION 2

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THE FINDINGS

Section Two presents the numerical data as well as a summary of the narrative provided by the independent reviewers describing how the purpose and objectives of PCR2 were achieved; these opening paragraphs include the findings from other settings. Other settings include the NST, NCIs, Theological Education Institutions (TEIs), peculiars, royal peculiars, religious communities, cathedrals and all other church bodies as defined in the scope of the guidance. Section Two sets out the compilation of the findings reported by 65 independent reviewers from the 45 individual reports which the Project Management Board considered and accepted.

The report findings form the main part of this report and provide the analysis of what the independent reviewers identified following their thorough review of the files in scope.

The findings reflect the recurring and cross-cutting issues across dioceses, cathedrals and other settings and emphasise where significant improvements still need to be made by the Church of England. The findings are organised and described under these eleven different theme headings:

1. Survivors and Victims
2. Managing those who pose a risk
3. Managing risk
4. Case management
5. Managing information
6. Safeguarding teams
7. Safer recruitment
8. Support and accountability
9. Learning and development
10. Strategy, leadership and governance
11. Culture

Each theme features good practice and illustrates the impact of changes in church settings that have already been made. They conclude with a summary of the analysis which supports the suggested improvements that are still required to be made across the Church and the recommended action to be taken.

Achieving the purpose and objectives

The overall purpose of PCR2 as set out in the guidance was to:

> "identify both good practice and institutional failings in relation to how allegations of abuse have been handled, and to provide recommendations to the Church of England that will lead to improvements in its response to allegations of abuse and in its overall safeguarding and working practices; thereby ensuring a safer environment for all" (p.3 of the *PCR2 Practice and Protocol Guidance, 2019).*

The specific objectives of PCR2 as set out in the guidance were:

- To identify all information held within parishes, cathedrals, dioceses or other church bodies, which may contain allegations of abuse or neglect where the alleged perpetrator is a clergy person or other church officer and ensure these cases have been independently reviewed.
- To ensure all allegations of abuse of children have been handled appropriately and proportionately to the level of risk identified with the paramountcy principle evidenced within decision making.
- To ensure that recorded incidents or allegations of abuse of an adult (including domestic abuse) have been handled appropriately demonstrating the principles of adult safeguarding.
- To ensure the support needs of known survivors have been considered.
- To ensure that all safeguarding allegations have been referred to the Diocesan Safeguarding Advisors and have been responded to in line with current safeguarding practice guidance.
- To ensure that cases meeting the relevant thresholds have been referred to statutory agencies.

Protocol and Practice (July 2019) provided three appendices, Appendix D, Appendix E and Appendix F. Appendix D was used by the independent reviewers to record cases of concern. The reviewers used these as a means of auditing where information was incomplete or not recorded which has helped to assure the PMB on the thoroughness of the review. Appendices E and F were originally all the independent reviewers were asked to submit as their report. Appendix E was specifically designed to report on numbers on files and cases relating to children and Appendix F for those relating to vulnerable adults.

The PMB was provided with a wealth of evidence from the reviewers in the narrative reports which were submitted. The findings show the complexity of both analysing and acting on information relating to safeguarding concerns.

Achieving the purpose and objectives

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Collection and validation of the data

While dioceses were directed to collect the data as specified in the guidance, based on, and using appendices E and F, the amount of information and its complexity made it difficult for the independent reviewers to collate the data in a consistent way. It was necessary therefore for a validation exercise to be undertaken at the end of the review to establish and present numerical data that was correct and which illustrated the points the independent reviewers were making. The data also provides evidence that the PCR2 purpose has been been successfully achieved.

Summary of the data

PCR2 was launched in the summer of 2019 and the review of files in scope concluded in April 2022. In this time the 65 reviewers looked at a total of 75,253 files as defined in scope in *Protocol and Practice*.

The number of new safeguarding cases referred to in this report are those which the reviewers felt needed further action based on present day safeguarding practice standards. This included allegations which had not previously been identified as requiring action or which only came to light as a result of the independent reviewer and the collation of information. The independent reviewers, in the original PCR2 guidance, were directed to prepare summaries of cases where:

- further or different action should be taken
- any allegations that were not handled proportionately to the level of risk identified.

Independent reviewers based their judgements on the criteria summarised in the guidance as follows:

- Behaviour which has harmed, may have harmed or is likely to harm (including neglect) a child or vulnerable adult
- Possible commission of a criminal offence against or related to a child or vulnerable adult
- Behaviour that indicates that the person is unsuitable to work with children or vulnerable adults
- More than one low level concern which would not, taken individually, meet the threshold for referral but taken together would justify further exploration
- Allegations that indicate a church officer was seen as being in a position of responsibility or authority, where they were trusted by others and used this position to groom or exploit children or vulnerable adults
- Any cases where survivors and victims have reported abuse but where, following investigation, there has been insufficient evidence to substantiate the claim or report.

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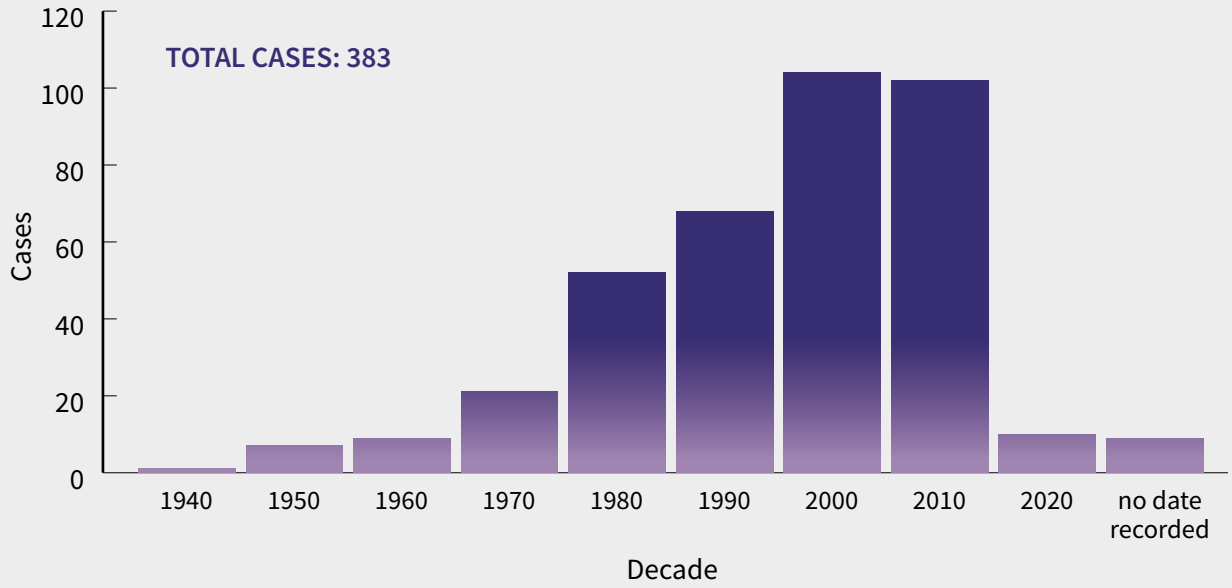
From these files the independent reviewers identified 383 new safeguarding cases relating to children and vulnerable adults and across all settings in scope. These cases were across a significant time-period from non-recent to present day. This is illustrated as follows:

FIGURE 1: Timeline

The 75,253 files contained information that ranged as far back as the 1940s up to the present day. The following bar chart shows each decade in which the new cases originated.



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Achieving the purpose and objectives

These cases are based on information that was on the files, but which had not been managed either centrally by the dioceses or appropriately in relation to the PCR2 objective to 'ensure all allegations of abuse have been handled appropriately and proportionately to the level of risk identified and with the paramountcy principle or not handled appropriately demonstrating the principles of safeguarding.'

This data supports many of the comments made by the independent reviewers and reflected in this report in the Findings section; particularly within the themes of safeguarding teams; learning and development; and strategy, leadership and governance.

FIGURE 2: Types of abuse

The following diagram shows the percentage of the 383 new safeguarding cases in respect of each type of abuse.

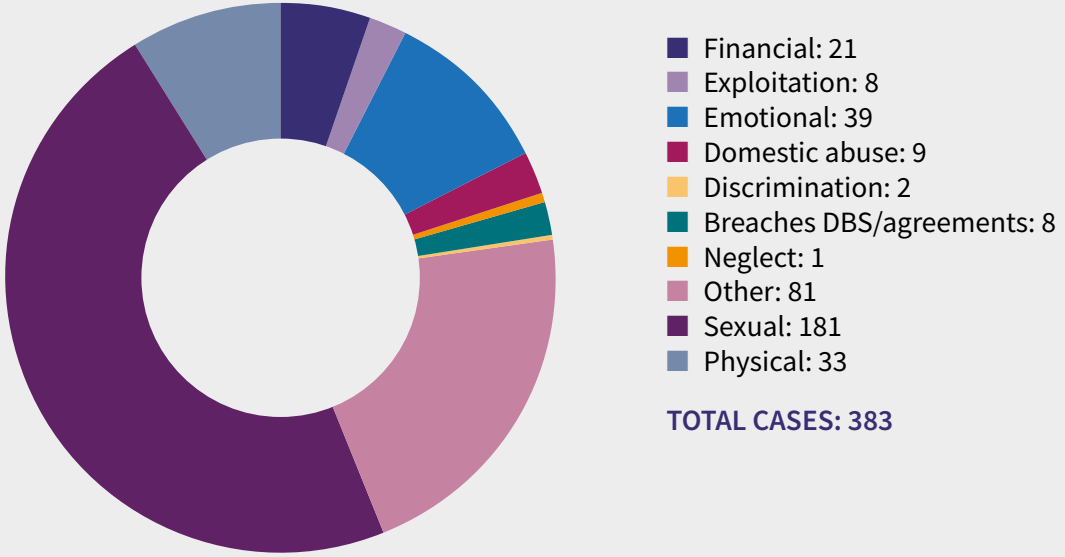

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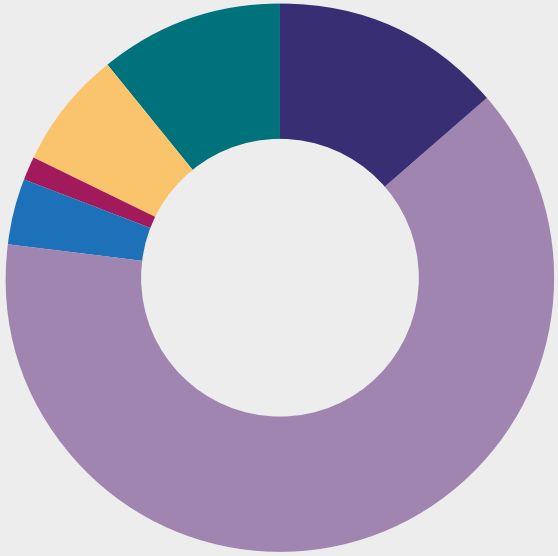
FIGURE 3: Alleged perpetrators

The guidance defined church officers as anyone appointed/elected by or on behalf of the Church to a post or role, whether they are ordained or lay, paid or unpaid. In the analysis below, the information relating to the perpetrators of the abuse and the 383 new safeguarding cases has separated members of clergy (that is, those who are ordained) from church officers and others.



TOTAL CASES: 383

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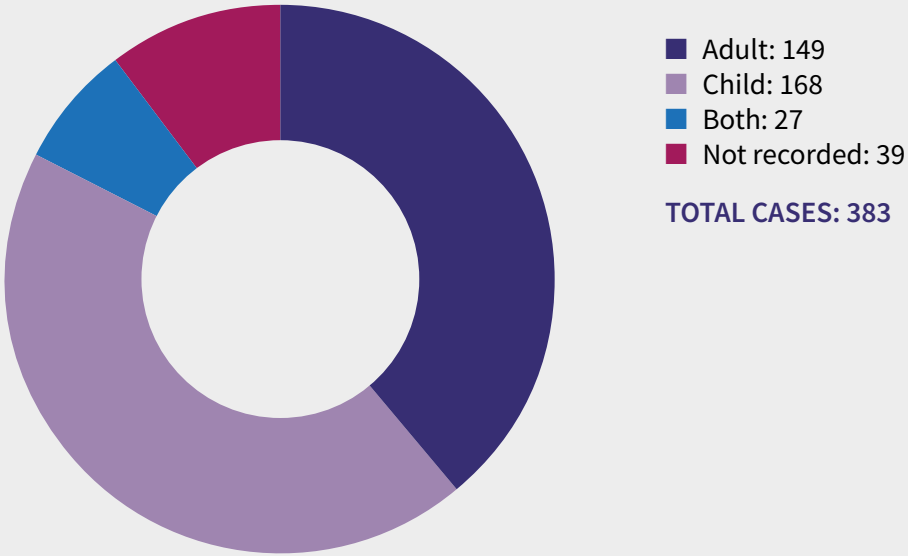
FIGURE 4: Children and Vulnerable Adults

The independent reviewers found that of the 383 new cases 168 related to children and 149 related to vulnerable adults, with 27 recorded as both and 39 no recorded data being available.



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Ongoing assessment

At the end of August 2022, the DSAs were continuing to assess information relating to 208 safeguarding concerns raised by the independent reviewers. It is possible that a small proportion of these could also potentially lead to an additional number of new safeguarding cases.

Findings from other settings

There are many 'other settings' that are closely associated with the Church of England but separate from diocesan or cathedral structures. These settings include:

- 14 Royal Peculiars and 10 Non-Royal Peculiars[8]
- 30 Theological Education Institutions (TEIs). TEIs vary in size and are based across England and are responsible for training people for ordained ministry or licensed lay ministry and independent students. Some TEIs provide training for just a small number of stated dioceses while others take students from a much wider geography.
- 52 religious communities which were all different in size, purpose, and structure. It is a complicated environment where the management of safeguarding matters lacked consistency in a number of areas including referrals to the DSA and training.

The inclusion of these settings within the PCR2 reviews was necessary to ensure confidence in the process across all parts of the church structure and organisation. Three distinct approaches were adopted to the way these reviews were undertaken, as described in the following paragraphs.

A local approach applied to the category of 'other setting' which has close links with their geographical or visitant diocese. The proximity of these links justified the settings being included as part of the diocesan reviews, in a similar manner to the way the parish returns were managed. That is by returning a proforma to indicate the number, if any, of safeguarding cases.

A national approach applied to the category of 'other setting' which has more of a national reach, or which do not have established links with any one diocese. If a setting was not included within a local diocesan review, they were contacted by the PCR2 Project Team who requested the setting to make a return based on a proforma provided to them (based on the same principle as a parish return).

A full review was applied where independent reviewers were secured to process all relevant files within the setting specified.

8 A peculiar is a Church of England parish or church exempt from the jurisdiction of the Diocese and the Province in which it lies. Additionally, a Royal peculiar is a peculiar, which is subject to the direct jurisdiction of the Monarch.

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The findings from the work conducted in other settings were collated and reported separately to the PCR2 Project Management Board in April 2022. As stated, there was some disparity in the way the review in these settings were undertaken. This was in part due to the level of interpretation allowed by the PCR2 guidelines as set out in the *Protocol and Practice*. Therefore, whilst other settings have met the objectives and requirements of PCR2, any benchmarking or identification of national recommendations relating to these defined other settings has not been possible.

Findings from the National Church Institutions (NCIs)

The National Church Institutions (NCIs) comprise the seven bodies which undertake work for the Church of England. Their purpose is to support those who serve in parishes, dioceses, schools and other ministries, and with partners at a national and international level.

Forty-one NCIs' HR records were reviewed as meeting the scope of PCR2. Since March 2020 a paperless system has been introduced and documents have been stored electronically. This means that some employees have paper and electronic records, and some have just electronic (19 records).

The findings of the independent reviewer were mainly around record keeping in a very small number of the files reviewed; such as new starter checklists not being completed in full, or references not being obtained, and unexplained gaps in employment histories.

The Independent Reviewer concluded that:

> "There is evidence that with the revision of HR guidance and policies, together with the current review of the important post of the HR Business Partner Safeguarding, the National Church Institutions Human Resources is on a journey towards improvement.
>
> However, the lack of consistency in HR practice needs to be addressed. It is anticipated that the development of the Staff Movement Tracker and the implementation of the Oracle People System, which is planned to 'go live' in October 2022, should address this, job descriptions and person specifications should fully reflect the safeguarding responsibilities of the role. In essence, safeguarding should become a 'golden thread' through the recruitment and retention processes".

The Reviewer made a number of recommendations for the NCIs to develop an action plan and where appropriate these are included within this report.

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TOWARDS A SAFER CHURCH

The data and the narrative information provided under the themes illustrate the depth of PCR2. From the numerical data it is possible to confirm that the PCR2 purpose as set out in the guidance and this document was achieved but describe how complex this information is. The 75,253 files reviewed indicate the lengths that were taken to identify and review all information held with parishes, cathedrals, dioceses and other church bodies which may contain allegations of abuse or neglect where the alleged perpetrator could be a member of clergy or other church officer.

The independent reviewers were complimentary about the local relationships between diocesan safeguarding advisors and statutory agencies and where they found cases had been referred to those agencies this had been done appropriately.

The national case management system which is in the process of being adopted by dioceses will allow for the recording of referrals made to statutory and other agencies in the future. This will ensure accountability and appropriate scrutiny of referrals by dioceses.

All other settings engaged with and completed PCR2, either as part of a diocesan review or by returning information requested on a proforma. There were only a few exceptions that undertook PCR2 themselves through dedicated independent reviewers. All safeguarding concerns or cases raised as a consequence of PCR2 have been notified to the NST and referred to the DSA in the appropriate diocese. The numbers associated with other settings are included in the total data specified in this report.

Nevertheless, the PCR2 guidance relating to 'other settings' was not sufficiently explicit and too open to interpretation. Other settings however are responsible for their own safeguarding arrangements and should, where required by law, have in place safeguarding policies and access to training.

The NCIs' PCR2 report was detailed and the findings aligned with other findings in dioceses relating to record keeping and management and the implementation of Safer recruitment policy which can be found on the Church of England website.

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RECOMMENDATIONS

The recommendations which are set out in this report are designed to ensure further steps towards a safer church and the immediate and ongoing improvements in safeguarding policy and practice which the independent reviewers determined were required.

The complicated environment and lack of consistency of safeguarding practice and procedures requires the Church to consider how it oversees the quality of safeguarding practice and processes. The recommendations are set out in the final section of the report under three distinct headings:

"Keep doing well" – These recommendations are based on what the Church has put in place and deemed good practice and where the independent reviewers have provided evidence which shows consistency of application in the majority of settings and affirmed that this should be continued and maintained across all settings and church bodies.

"Continue to do, but more effectively and consistently" – These are recommendations where the independent reviewers found evidence of Church policy and guidance and good practice which was not followed or implemented consistently and therefore was having a detrimental impact on safeguarding.

"Must improve" – These are the recommendations made by the independent reviewers where new pieces of work are required to be undertaken to improve safeguarding practice, outcomes and survivor and victim experience.

Delivering the recommendations

Each of the recommendations has been located within specific organisations, church bodies and/or departments and has an allocated lead who will be responsible for the implementation plans and successful delivery of the recommendations. The NSSG will retain responsibility for ensuring the overall delivery of the recommendations. This includes securing the necessary resources, ensuring survivors' voices and participation and for establishing the appropriate arrangements to ensure accountability and mechanisms which will enable ongoing reporting of progress towards, and impact assessment of, these recommendations.

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Survivors and Victims

The PCR2 process has made clear the significance, across all dioceses, of the benefits and importance of listening to survivors and victims. The PCR2 PMB and team as well as the NST encouraged all dioceses to engage with survivors and victims and ask them to provide feedback to the independent reviewers on safeguarding practice from the perspective of their own experience. Across the Church settings involved in PCR2 a total of 65 survivors and victims met with independent reviewers.

In each diocese, the Diocesan Bishop, the DSAP and the DSA were required to agree on the Survivor Care Strategy which was expected to be kept under continuous review by the local reference group during the PCR2 process. This was to make sure that "the welfare of children or adults at risk of abuse would be of paramount importance in the planning and execution of PCR2".

Listening and responding to survivors and victims

Several dioceses committed themselves to using local newspapers and social media as well as internal communications to encourage survivors and victims to come forward to speak to the independent reviewers. Where there were ongoing relationships then dioceses encouraged and supported survivors and victims to meet the independent reviewers, but all were extremely careful to ensure the approach taken was sensitive to the needs of those survivors and victims.

Sharing the message about PCR2 with other agencies and charities ensured a wider network of partners engaging with the project and offered broader access to safeguarding pathways for those needing support. This encouraged survivors who had not given their accounts to the Church to come forward.

There was real benefit in nominating a Survivor Engagement Lead to work alongside the DSA throughout the process. Aside from the more general support and advice provided, there were examples where the DSA and the Survivor Engagement Lead created a framework that ensured good practice in engaging with survivors and victims who came forward because of the publicity surrounding PCR2. For example, in one of the cases not previously reported, the survivor came forward as a direct result of this publicity.

Of particular significance a member of a PCR2 reference group with a lived experience of clerical abuse commented:

> "My hope and prayer is that any concluding report is not seen to bring a close to this issue. The scars on all victims will always remain and our lives have been permanently redirected. Our church must, therefore, remain permanently open to respond to new revelations and new phases within older revelations. Unlike the work on some other focus groups the agenda is never closed or concluded."

Survivors and Victims

In their findings, independent reviewers noted that although there was some excellent work completed in several dioceses there were also examples where the engagement was poor or non-existent. The quality of activity was inconsistent across the Church settings although there is evidence that reference groups considered the voices of survivors and victims at every meeting, which did satisfy the national requirements. As one DSA remarked:

> "Having the input from those who have lived experience of trauma helped us remember the personal cost when abuse occurs within the Church context; bringing their unique perspective helps bring alive the review findings and helps remind us of what we are aiming to achieve in establishing safer worshipping communities".

Some of the independent reviewers were not aware of any proactive diocesan activity which sought to listen to survivors and victims, raise wider public awareness of the review, or lead on the implementation of a survivors' care strategy. This was a missed opportunity for dioceses to be proactive to reach out to known and unknown survivors and victims and meet the purpose of PCR2. Although the inconsistent approach to listening to those with lived experience of abuse is a disappointing outcome, the PMB identified these variations and gained reassurance from dioceses that survivors and victims would be a priority within all future diocesan action plans.

A local survivor care strategy

Overall, within the cases examined, the findings of the independent reviewers illustrated that there was in general a culture which offered support in diverse ways. The support was flexible, tailored to the individual and provided for as long as was deemed useful. In several cases relating to the reporting of non-recent child sexual abuse, there is straightforward evidence of very positive and thorough survivor/victim support. There was compelling evidence of the capability of the DSA to record rationale and decision making and referencing relevant policy and procedures to ensure that the individual's experience was as good as it could be. Achieving the standard of the best dioceses in providing support for survivors and victims should be the aim of all.

There was evidence in some dioceses however, that the survivor care strategies were not published internally or externally, and therefore of "little practical value."

A national response

The implementation of 'Responding Well to Survivors' guidance Responding Well to Victims and Survivors of Abuse | The Church of England has engaged with a number of survivors and victims to ensure that it is effective. However, this guidance cannot be transactional or theoretical, but must be delivered on the ground and in every diocese or setting and to a consistently high standard.

Survivors and Victims

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Survivor and victim experiences of safeguarding

The introduction of safeguarding professionals and the excellence of the post-holders (especially the DSAs) was commented on very positively in many of the independent reviews. Nevertheless, consistency of response is lacking and there are still too many examples of poor practice and a lack of effective engagement. The reviews indicate a real determination amongst DSAs and their teams to improve the response and service provided. More generally, the independent reviewers found that the DSAs were survivor and victim focused, and overall, the culture of support and the ways in which it was offered was often assessed as flexible, tailored to the individual and available for as long as it was deemed useful. These safeguarding professionals cannot achieve this alone, and they need to be appropriately supported locally and by the Church as a whole. Whilst there was evidence of change, there is an urgency required in the Church to ensure that the highest standards are always achieved in this vital area of work.

Independent reviewers in many dioceses found excellent examples of good survivor and victim care. Most recently, there were strong examples where the handling of survivors' cases was considered to have improved on past practice and some difficult and emotive cases were approached very sympathetically. In some complex cases, the survivor and victim contact was described as "outstanding" and regular updates were provided. It would be helpful for all diocesan safeguarding teams to agree a common approach to updating victims.

However, there were still too many cases where the standard of care and of keeping individual survivors and victims updated on their cases needed significant improvement within the bounds of good data protection practice. There are examples, particularly relating to domestic abuse where children were involved, as well as other safeguarding cases, where the support to the survivors and victims was insufficient or there was little recorded evidence of any support being offered by dioceses. Updates on the progress of cases were described by the independent reviewers as generally poor and referrals to support services were not always completed effectively. To put this point into context, one survivor explained how their past experiences of abuse continued to dominate major aspects of their life. This impacted on their health and well-being and has resulted in serious underlying mental ill-health, difficulties in sustaining relationships, low self-confidence and the need for continuing treatment and therapy.

> An independent reviewer commented: "The survivor's impact statement describes the hurt, anger, and tiredness with church processes. Therapy sessions have continued for over twenty years and medication is still required for depression and anxiety."

There were examples where the contact with survivors and victims could have been more regular. In a number of cases independent reviewers confirmed

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that the support provided for survivors and victims, once they had come forward, was inconsistent and the outcome of an investigation was not reported back to complainants. In others the communication between the diocese and survivor/victim could have been better. There was evidence provided where a DSA took initial concerns seriously, but then there were considerable delays and periods of silence and there was no communication or update; this was not helpful or empowering and most reports on progress were given only when the survivor sought them directly.

Continuing contact and transparency in these circumstances is critically important, so that survivors/victims know they have not been forgotten nor feel neglected, and that those involved in their safeguarding investigation are acting with integrity.

> As a survivor said, "the survivors wanted to stress the importance of timely responses that avoid drift or delay, or worse, no response".

A recent example because of PCR2, has highlighted a survivor receiving an initial positive response to a disclosure of non-recent abuse, but then experiencing a considerable delay in getting any update, despite numerous requests and escalation.

> Another was quoted as saying "I feel I have a label on my head that says liar, that every priest is going to think I will accuse them of abuse because [that cleric] got away with it."

"The Voice of the Child"

Although there were examples from the independent reviews of children who had made disclosures, the Church must create environments and processes that give children the rightful confidence and opportunity to disclose abuse. People in the Church must be equipped with the knowledge to spot possible signs of abuse and follow-up on these, even when there are not clear verbal disclosures by children.

It is essential to recognise the importance of listening to children (what they communicate both verbally and non-verbally) to ensure the Church is a safe environment now and that any incidents of current abuse are identified immediately and dealt with robustly and without fear. This means that children within the Church need to be empowered and feel able to come forward with any concerns and that adults, especially those in positions of trust are trained and able to act on these as well as to spot and act upon wider indicators of abuse.

Abuse is more likely to be identified when: a) children have adults in their life who they have safe and trusting relationships with; b) trusted adults regularly check with them about how they are; c) indicators of possible abuse are followed-up with purposeful conversations with children and wider safeguarding action (versus waiting for spontaneous verbal disclosures); d) processes for dealing with disclosures are clear, keep the child safe, and do not catapult them

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into frightening situations outside of their control; and follow necessary data protection requirements relating to children's data.

From more recent safeguarding files, the independent reviewers reflected that the views of children were being listened to and appropriate protective action taken much more often than in the past. However, the independent reviewers' findings from their review of past cases illustrated that it was in adulthood when survivors and victims made disclosures of abuse which had occurred in their childhood.

PCR2 looked at cases in the past, and all the survivors who spoke to independent reviewers and participated in the review are now adults. Whilst the appointment of safeguarding professionals in the Church has led to undoubted improvements in practice, there was little evidence found in the 45 reports of dioceses or the Church as a whole, listening to the 'voice of the child'.

Clergy Discipline Measure 2003 (CDM)

The Clergy Discipline Measure 2003 (CDM) provides for dealing with formal complaints of serious misconduct against members of the clergy. It applies to all deacons, priests, and bishops in the Church of England, even if they are not in active ministry, for example where they have retired.

The lodging of a CDM allegation of misconduct is the start of a legal process. An investigation into the alleged misconduct goes through a number of stages and ultimately can be referred to a tribunal hearing if appropriate. The legal process was acknowledged and was not subject of comment by the reviewers. It was accepted that CDM files were confidential with strictly limited access. As such they could not be accessed by the reviewers and therefore are not subject of their comments.

The findings stated here were as a result of the information the independent reviewers found relating to the experience and process of CDMs in the files that were in scope and accessed as part of PCR2. It was this information which prompted the independent reviewers to comment that the use of the CDM process has not been effective in providing survivors and victims of abuse within the Church with the response or experience they should expect. The reviewers had cause to state that the CDM process has led to real distress and even re-traumatised the survivors and victims. This evidence was obtained directly by independent reviewers from interviews with individuals impacted by clergy abuse. It is therefore very timely that there is work on-going to review the CDM process, and that the NCIs' Implementation Group (which has the role of considering the revision of the CDM process) takes the outcomes of PCR2 findings relating to CDM into account in the proposed reforms. Specific findings from PCR2 have been shared with this group.

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There remains, inconsistent responses to, and inconsistent treatment of survivors and victims across dioceses. While it is encouraging to note that the response to survivors and victims from first disclosure has improved with independent reviewers recognising the diocesan safeguarding professionals' commitment to responding appropriately. The introduction of safeguarding professionals to the Church is acknowledged as a key factor in this improvement. There is however, still evidence that poor practices exist and there is considerable room for improvement.

There was a commitment to engage and involve survivors and victims through the PCR2. This included the requirement for dioceses to develop their own survivor care strategies There is much more to be done at a national and local level to make sure that we are responding to survivors and victims in an appropriate and consistent way that meets their needs and requirements and the safeguarding standards which are set out in current policy and practice.

The independent reviewers recommend that existing national guidance is implemented consistently and in full across the Church to ensure the sustained delivery of high quality, trauma-informed, survivor-focused standards. The independent reviewers proposed that this commitment would be further bolstered with the development and use of a survivor and victim charter, ensuring the response and support expected and then delivered from the Church is clear, transparent and of the highest standard.

The reviewers also emphasised that children must always have the opportunity to speak out and to be listened to when raising their concerns. While the independent reviewers did not determine how this should be done, they were keen to exhort the Church to consider how this can be achieved effectively and incorporated into policies and professional practice.

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RECOMMENDATIONS

Recommendation 1:

Church bodies must ensure that the 2021 *'Responding Well to Victims and Survivors of Abuse Guidance'* is fully implemented across each diocese to support the delivery of consistent, high-quality survivor-focused standards, including visible referral pathways for support.

Recommendation 2:

The National Safeguarding Team must develop and deliver a national survivor and victim charter with survivors and victims. This charter should specifically set out for church bodies how children's views should be sought in all matters that affect them and creating cultures and practices which help them to spot indicators that a child might be being maltreated or at risk, ethically and effectively follow-up on these, and truly 'hear' children when they are expressing distress or communicating that something is wrong.

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Managing those who pose a risk

The Church of England's Vision 2020 'Christ centred, and Jesus shaped: simpler, humbler, bolder' encourages inclusivity and a welcome to all, and this includes those who pose a risk to others. These individuals must be identified, and dioceses must put in place all the required safeguarding measures. This theme sets out the findings of the independent reviewers which relate to the identification and management of those individuals who pose a risk to children and/or vulnerable adults in a church setting. Those who pose a risk could include members of a congregation who are convicted offenders or who might be part of the criminal justice process, as in the case of a parishioner released on police bail because of a criminal investigation. All parishioners are welcome to worship in our church buildings but may in some instances be subject to risk management plans. A key area is the involvement of the Parish Safeguarding Officer (PSO) in the identification of those who pose a risk and the support of diocesan safeguarding advisers with the ongoing management of those who pose a risk.

There is an expectation that members of clergy, church officers, PSOs and other volunteers at a local level understand and recognise individuals posing safeguarding risks through their behaviour. They must then know how and when to make appropriate referrals to safeguarding teams, who should in turn ensure that concerns are recorded, updated and suitably managed in a timely and professional manner.

Risk identification

The independent reviewers shared a general view that in recent years there has been gradual improvement in risk identification across the Church, and more specifically that members of clergy had become more confident in applying the stated risk principles. The independent reviewers gave examples of safeguarding policies referencing and linking to relevant legislation and statutory agency procedures, which provided additional support and direction. They also drew attention to incidents being reported to safeguarding teams at the earliest opportunity in line with practice guidance, information being gathered, and evidence being triangulated resulting in well-reasoned, appropriate outcomes. This included plans that engaged all relevant parties and considered supervisory arrangements, review processes and contingency measures.

Information found within some files demonstrated differing levels of understanding of risk but there was undoubtedly an improvement in the prompt identification of vulnerability and risk through the scrutiny and intervention of safeguarding teams, with evidence of prompt and effective responses to new enquiries and referrals.

Despite these improvements, there remain areas that require further development. There were examples where concerns were reported, but processes were not considered or not followed up. One of these is

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shown below. There were also variances in practice relating to the management, prioritising, and recording of risk. Responding to initial safeguarding and child protection concerns by members of clergy in local settings such as parish churches was varied and on occasions the response was slow and inadequate judgements were made.

> In a relatively recent case, senior clergy failed to identify and manage risks to parishioners and church officials involving a member of clergy with serious mental health problems. It appears no action was taken to assess what, if any, risk was posed or what support should be provided.

The history of individuals who posed a risk was not always considered by those making a judgement on risk, and as one independent reviewer commented *"why has it not been highlighted as to the number of complaints, of the same nature, until PCR2 has taken place?"* The independent reviewers perceived some of the reporting on risk as naïve, indicating a lack of professional curiosity. This could be considered to include over-reliance on the professional's known reputation, a lack of understanding and/or knowledge, or a reluctance to address issues due to the seniority of clergy and church officers. Further concerns were expressed regarding inappropriate relationships involving members of clergy, where no, or limited action was taken.

Consistent application of the risk assessment process

Independent reviewers expressed the opinion that the overarching approach to assessing risk has developed over time from a position where there was little regard or questionable decision making when compared to a current day perspective, to becoming in more recent times, structured and aligned to policies, procedures and partnership working.

A number of risk assessments examined were described as detailed, comprehensive, and thorough, as were the accompanying plans and letters of agreement. There was a high level of adherence to the conditions set, and in cases of non-compliance the appropriate action was taken.

Despite these positive developments, inconsistent practices still exist, particularly in terms of the recording and prioritisation of the assessments of those who are deemed to pose a risk. Concerns included inconsistent record keeping, where a lack of chronologies, timelines, and triangulation of events led to incidents being dealt with in isolation and weakening the seriousness of the complaints, along with compromising the ability to address current and emerging risks, themes, and patterns.

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One case involving risk assessment was described as follows:

> Although several assessments of risk had been obtained, none of them contained sufficient information to provide the structure for a coherent, long-term risk management plan that provided a consistent and well-informed source of information to help manage a variety of situations. Instead, the approach to managing risk was piecemeal and reactive to situations as they arose which created confusion and poor decisions.

Further cases were identified, where clergy and church officers had opted not to acknowledge referrals as safeguarding cases but chose to manage matters locally without any discussion with safeguarding professionals. One reviewer states that:

> … a letter was found alleging significant safeguarding concerns regarding a member of the clergy… In a reply to the letter from the then responsible senior cleric, the allegation was disregarded. The DSA was not informed of the allegations, nor were the statutory agencies informed of the allegations.

Some traumatic incidents were also revealed during PCR2 that had not been disclosed or recognised as safeguarding issues and included non-recent examples of a failure to share risk or offer support following disclosures through the Bishops' Advisory Panel (BAP)[9]. In one case where there was a lack of intervention, with the candidate suffering serious mental breakdowns during their time in ministry.

Management of and compliance with safeguarding agreements

It should be noted that safeguarding agreements themselves were not in the scope of PCR2. What is described here are the findings the independent reviewers gleaned in respect of safeguarding agreements from the files they reviewed which were in scope as described earlier in this report.

A safeguarding agreement is a document prepared by the DSA because of an identified risk posed by an individual, for example, a member of the congregation wishing to worship in a church setting. Its purpose is to set and, where necessary, impose conditions to mitigate those risks with the primary purpose to safeguard children, young people and/or vulnerable adults, but also to include support for the individual themselves. Safeguarding agreements with those who pose a risk should be managed effectively, documented professionally, and enforced where required.

9 The purpose of a Bishops' Advisory Panel was to make a recommendation to a Bishop about whether a candidate should enter training for Ordained Ministry in the Church of England

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A number of agreements which were examined by the independent reviewers appropriately covered situations where members of the congregation or church officers were subject of a criminal investigation, engaged by Offender Management Services post-conviction or where statutory agencies were no longer involved in the management of risk.

An independent reviewer provided an example of where an inquiry had been conducted in line with practice standards:

> Concerns of a possible sexual assault/inappropriate touching of an adult by a Reader which had occurred over a period of time was reported. Overall, the inquiry was well documented with risks, judgements and decisions recorded. The volunteer refused to sign the risk management plan and resigned.

In one diocese, several files inspected were found to be cross-referenced with other information contained in HR and clergy blue files. This is regarded as strong safeguarding practice.

In other examples there was an inconsistent and muddled approach to the process. Thresholds were variable and terminology considered inconsistent and interchangeable, and differences were identified in recording how risk had been managed.

Some of the more recent safeguarding agreements illustrated how the Church failed to prioritise the victim over the perpetrator. In one instance the agreement was primarily intended to try and prevent further allegations against the clergy member arising and to maintain the reputation of the Church. Only then did it consider the protection of children (or adults with vulnerabilities). Other safeguarding agreements inspected had become dormant, and not subject to a review, whilst some contained information that went unchallenged or with an acceptance of non-compliant behaviour, leading to a view that limited significance was given to the existence and benefit of the agreement by those responsible for monitoring or those subject to such an agreement.

There were concerns relating to failures in the safeguarding process. In one case a bishop failed to introduce suitable safeguarding measures to manage an individual, which culminated in them controlling and influencing the Bishop, leaving the offender in a position to commit further offences. Another example showed that upon receipt of a clergy blue file from another diocese, a bishop made a written entry that made ‘fairly alarming reading’. Events that followed continued to be disturbing, with significant harm reported by the victims and witnesses. Despite continued warnings the situation was allowed to continue by senior clergy over many years.

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Independent reviewers cited cases where there were no formal agreements in place and where the approach was more casual and ad hoc. This related to managing safeguarding concerns and reducing the risk and potential for harm. The following two examples illustrate this:

> A church officer was engaged in an inappropriate relationship with a person and there was further reporting of tactile behaviour. There was scant information contained on safeguarding files and the case was described as 'being managed through a series of emails'.

> In the early 90's a Parochial Church Council (PCC) member was convicted of a serious sexual offence. The parish removed the person from all roles, but they were re-elected, despite the incumbent and PCC being aware of the offending history. The issue was discovered in 2018, following changes to safeguarding policy regarding safer recruitment and the requirements for Disclosure and Barring Service (DBS) checks, and the person removed from all positions of trust.
>
> However, there was no information on the file regarding worship arrangements for that person or what had been considered regarding discipline measures or safeguarding awareness training in the parish.

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It was evident that parish safeguarding officers and other volunteers were not always clear about how to identify safeguarding concerns. Further examples of safeguarding matters not being appropriately referred to the relevant diocesan safeguarding advisor was evident in the findings. There is a clear and ongoing need to ensure that safeguarding is embedded in the culture of all the Church's processes and that all clergy, relevant professionals and volunteers are equipped with the necessary level of knowledge and skills.

Whilst there are signs of improvement in the standard of risk assessment, there is still inconsistency in the widespread application. The independent reviewers observed examples of assessments being completed, monitored, and amended appropriately when situations change. They did however, contrast these with examples of poor practice and 'loose' management, with sub-standard recording and no review process when there is a change in circumstances. As a consequence, this remains an area for improvement in our safeguarding practice.

In some cases, the management of risk and associated safeguarding agreements was of an extremely high standard: professional, well-documented and well-managed. But this is not the case throughout the Church, and it must be our objective that the quality of safeguarding agreements will always be of an appropriate standard to protect the vulnerable. Finally, it is also noted that there has been a thorough and effective response from dioceses in addressing the issues and case studies detailed in this section, from their respective local independent reviews.

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RECOMMENDATIONS

Recommendation 3:

Through the Safeguarding Learning and Development Framework, church bodies are to ensure that all clergy, church officers and volunteers are equipped with sufficient knowledge and skills, proportionate to their role, to recognise safeguarding risks and make effective referrals to safeguarding professionals in all dioceses and settings.

Recommendation 4:

Church bodies to ensure that current measures for consistent risk assessment and risk management arrangements are in place for individuals (clergy, church officers or congregation members) who present a safeguarding risk.

Recommendation 5:

Church bodies to ensure that safeguarding agreements are based on effective risk assessments and are monitored, regularly reviewed and actively managed. These should be overseen by safeguarding professionals and the record-keeping must also be consistent and effective.

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In 2015 the House of Bishops issued *'Responding to Serious Safeguarding Situations relating to church officers Practice Guidance'* and *'Risk Assessment Practice Guidance'.* This guidance was updated in 2017. The *'Practice Guidance: Responding to, assessing and managing safeguarding concerns or allegations against church officers'* was issued in October 2017 to further strengthen the Church's approach to responding to concerns or allegations against church officers and the assessment and management of risk. It offers an integrated approach and procedure, brought together in one place, to respond to, assess and manage safeguarding concerns or allegations against church officers. As part of this it aims to use and adapt for the Church context established models of risk assessment from statutory and specialist agencies. It also includes the risk assessment and management of those who may pose a known risk to children, young people and/or vulnerable adults within a Christian congregation or community.

This theme on managing risk summarises the findings of the independent reviewers relating to the management of risk as determined by the practice guidance. This includes the core group process, and the management and administration of records and record keeping.

Core groups

The practice guidance states that every safeguarding concern or allegation involving a church officer should be managed by a defined core group, convened for the specific situation. The purpose of the core group is to oversee and manage the response to a safeguarding concern or allegation in line with House of Bishops' policy and practice guidance, ensuring that the rights of the survivor/victim and the respondent to a fair and thorough investigation can be preserved.

The independent reviewers recognised that the core groups are an important part of the risk management process following a concern being raised or an allegation made. It is essential that they are effective and contribute to the management and mitigation of that risk. However, the views of survivors and victims must not be "lost" in the process, and it is essential that the core group maintains a clear focus on the risk management and the welfare and support of survivors and victims in the case.

A number of independent reviewers observed effective use of the process, reporting that core groups were promptly established, meetings well attended and suitably administered, with positive comments received on the safeguarding plans produced and the subsequent management of resulting actions. In some cases where statutory agencies were involved, a relevant safeguarding lead attended agency core group meetings, and similarly, those agencies were

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represented at diocesan forums. In some dioceses, the DSAs involved the Local Authority Designated Officer[10] (LADO). The following extract from the findings illustrates how core groups are prompted and the impact they have:

> Information was received by an incumbent that a volunteer was possibly having a sexual relationship with [someone] in a church group. The incumbent promptly informed the DSA who notified the relevant authorities and formed a core group. A front sheet was placed on the file and accompanied by an activity log with appropriate action plans.

This was aimed at ensuring all appropriate actions were put in place to protect the vulnerable person.

> An allegation of sexual abuse was made against a member of clergy. Upon receipt of the referral by the DSA, a core croup was convened within the 48-hour period and subsequent core groups were held throughout to manage the case.

Equally a number of contrasting and negative examples were cited that revealed concerns as to how core groups functioned. There were cases where independent reviewers found that core groups were not established when they should have been, and in others considerable time had elapsed before a group was formed.

The finding below is an example of the impact on a survivor/victim and potentially on the safety of the church environment when core groups are not undertaken in line with the guidance and there are time delays.

> A survivor disclosed a [serious sexual offence] which had occurred some years ago and named the perpetrator who was a member of clergy. A police investigation was conducted but the Crown Prosecution Service decided on no action. There were suggestions of a clergy cover-up. In late 2010s, following a past cases review, the [serious sexual offence] was referred back to the police as additional material, not previously disclosed was found on a clergy file. A core group was convened but did not meet again until a few years later, when a church investigation was undertaken, leading to disciplinary action against a member of the clergy and risk assessments conducted on others.

10 The LADO works within Children's Services and gives advice and guidance to employers, organisations and other individuals who have concerns about the behaviour of an adult who works with children and young people.

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Record keeping

More general observations related to poor record keeping of core groups, with variances noted in the amount of detail that either did not reflect the discussions held or were not comprehensive in content. In terms of broader case management, issues from previous meetings were not always considered or progressed, resulting in previously allocated actions being overlooked.

The impact of poor record keeping or not keeping records at all is indicated in this example:

> Following a camp arranged by the Church, there had been an allegation of attempted [serious sexual offence] between [two of the] participants. The matter was not referred or documented, leading to the two being taken to the camp again without those transporting them having any knowledge of the possible risks and therefore being unable to put safeguards into place. There was no record on file about the investigation into the incident, the outcome of the original allegation or the effective management of risk through an assessment.

Survivors and victims

In terms of the position of survivors and victims in assessing and managing concerns, the findings of the independent reviewers reinforced the significance of building relationships carefully and understanding survivor and victim expectations within the core group process. The importance of formalising specific roles and responsibilities, to manage the risk in respect of the victim and perpetrator was further stressed.

It was suggested by survivors and victims that at the conclusion of a core group there should be a 'lessons learned' review involving all agencies and extending the invitation for them to also take part.

Information sharing

Strong safeguarding practice must include information being shared between agencies which are responsible for managing various aspects of risk. This exchange must be proportionate, lawful, and necessary in accordance with data protection legislation.

There were some examples where there had been formal information sharing arrangements and protocols in place that allowed for the timely exchange of information between the diocese, local authorities, and police.

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Instances of strong practice were found in some highly complex cases involving a number of different agencies. There were others that demonstrated effective working relationships including multi-agency meetings, risk assessments and agreements. Many of the independent reviewers explained that few barriers existed that prevented effective multi agency working, with evidence of constructive working relationships forged by safeguarding teams amongst the various relevant agencies. Most reviews found that relationships with statutory partners were generally good and that DSAs and their teams were well-connected to local safeguarding arrangements. Referrals were made to statutory services within appropriate timeframes and dioceses participated effectively in multi-agency plans where information sharing was essential. The outcomes and engagement with partners were clearly recorded. In cases, the safeguarding concerns were initially referred to the police for further investigation.

An initiative highlighted by an independent reviewer which was indicated as good practice was the production of flow charts, which visualised and signposted how the information exchange and referral processes functioned and linked with the various statutory agencies. This was a useful reference for those with safeguarding responsibilities. The extract from a review set out below shows the beneficial impact of sharing information between partners.

> A Parish worker was alleged to have covertly recorded young people and adults without their consent or the agreement of managers. Police and Children's Services were involved, and two core group meetings held. It was eventually agreed that no breach of safeguarding procedures had taken place but there were conduct issues to address. There was good multi-agency information sharing and communication. There was learning from the situation and policy was reviewed and a follow up with the Local Authority Designated Officer (LADO) took place.

On some occasions the independent reviewers reported that issues were still arising when legitimate requests for information are made to statutory agencies as part of the risk management process. This was in part due to the charity (3rd sector) status of the church and the response by statutory agencies who are not obliged to share information. There were also examples where difficulties had been experienced in acquiring this information because local information-sharing protocols were not in place. This further underpins the necessity for information sharing agreements to be put in place.

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PCR2 has highlighted the challenges that are presented to safeguarding professionals in situations where local authorities are not geographically aligned to parishes and dioceses. In these circumstances, an appreciation of the information sharing requirements are needed to accommodate local procedures, different cultures and LADO procedures. This should involve the diocesan data protection officer as this is a data protection activity rather than safeguarding.

Chaplaincy

Chaplaincy is a form of ministry that is authorised by the church, but which is often conducted in a host of organisations other than a church or a church body. Many chaplains are active in places such as hospitals, emergency services, prisons, academic establishments and the Armed Forces. There are many models of chaplaincy, and it is described by the Church of England as *"a missional ministry, going out from the local faith community and meeting people where they are, living and sharing faith there. This also means that chaplaincy works with a significantly younger and more diverse population than those often present within our church communities."* Chaplaincy can be a full time or a part-time role. It can be paid or voluntary and can be fulfilled by lay and ordained alike.

PCR2 acknowledged that where chaplains are employed in an organisation, they are subject to the training and safeguarding process of their employer. This included concerns regarding their behaviour which should be dealt with through those safeguarding procedures.

The review also highlighted the risks that resulted from poor lines of communication between dioceses and the supervisors/governing bodies of those agencies which employ chaplains. In one case, the lack of formal consultative arrangements resulted in a diocese being unaware of ongoing internal disciplinary measures being conducted against a chaplain. The member of clergy returned to work in a parish where further serious breaches occurred, and it was only during PCR2 that the member of clergy was removed from ministry.

Where concerns about a chaplain's behaviour were being investigated, letters were sent by a diocese to the relevant organisation for responses, but the independent reviewers believed there was a reluctance to exchange personal information in these circumstances. The review identified members of clergy with PTO where concerns had been raised, but the diocese was not aware of the extent of the broader chaplaincy activities being undertaken. An illustration of this point is set out below:

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> A retired member of clergy with PTO was suspended for [a short time] due to concerns about a pattern of inappropriate, non-consensual, physical behaviour with employees/volunteers and advised to reflect on their behaviour. A risk assessment concluded 'the risk to vulnerable adults/women specifically is considered to be high'. However, during the process it was revealed that the individual was a chaplain, a position not previously known to diocesan personnel, and further concerns were raised about their behaviour in that role. Despite this, these were not considered 'new concerns' as they did not change the situation and the suspension was lifted after three months.

The files reviewed on clergy who held chaplaincy roles were in some cases limited in the information retained, and there was little or no evidence that indicated liaison between the diocese and the employing organisation. In one diocese, three cases were identified where clergy were undertaking chaplain roles that the Diocese was not aware of, including an individual whose conduct was of significant concern as described in this extract:

> A chaplain had their role terminated following various allegations of sexual voyeurism and an inappropriate interest in sexual matters. In addition, there were issues raised about the chaplain's inappropriate handling of sensitive matters. The detail of what the chaplain is alleged to have done has not been recorded in the file, and the case file refers to the dismissal as an administrative issue rather than a complaint. There was no formal, recorded initial investigation into the complaints made and the diocese took action based on the scant and vague information available. The chaplain was issued with an 18-month conditional PTO which included limitations on their work in chaplaincy, schools and colleges and conditions to attend regular supervision and review meetings. Although the chaplain refuted the allegations, it is noted that there was an apology.

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The practice guidance is clear, and the reviewers suggested that it should be implemented consistently. The guidance advises and the findings confirm that the core group is a key mechanism to ensure all risks are mitigated and statutory and voluntary partners are involved and committed to the process. What the guidance reiterates, and the independent reviewers' findings supported is that it is essential that the views and interests of survivors and victims are not ignored or lost during the process.

Independent reviewers did highlight the benefits of consistent application of the guidance where core groups had contributed to safeguarding outcomes. There are however a sufficient number of instances where this was not the case for it to be a matter of concern and for the Church to ensure the implementation of the practice guidance is audited to ensure compliance and consistency. Unacceptable delays in convening core groups and involving the relevant and necessary statutory partners were also described.

Although there are some examples of effective information sharing, this is not consistent. The issue of information sharing was the subject of two IICSA recommendations. The NST has a specific project undertaking the work to implement these and as of May 2022 there is an information sharing framework and information sharing agreements between the Church of England bodies and the Church in Wales. Work is continuing to develop information agreements between the Church of England bodies, the Church in Wales, and statutory partners (local authorities and police).

The employment of chaplains who can be both ordained priests or lay leaders creates grey areas and the reluctance to share information between organisations and to conduct integrated investigations when concerns are raised poses a significant safeguarding risk. The issue raised above was also related to dioceses not knowing that people had chaplaincy posts this is failure of the diocese to properly record who has a license issued by the Bishop. The National Clergy Register is intended to meet this requirement by ensuring that all licensed clergy information is provided to the Archbishops' Council via the People System. Whilst work is still ongoing, the register is partly in place due to safeguarding requirements to ensure the dioceses knows exactly what clergy are in post.

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RECOMMENDATIONS

Recommendation 6:

The National Safeguarding Team to review how core group guidance is implemented in order to ensure that they are established when required to manage risk, information is shared lawfully and efficiently, they work to time frames and actions are completed. Survivor, victim and respondent needs must also to be considered in core group practice and acknowledged in the guidance.

Recommendation 7:

The National Safeguarding Team and dioceses to develop an information sharing agreement between employers of lay or ordained ministers who hold the Bishop's Licence, such as self-sustaining ministers or part-time stipends. To extend the scope of the Information Sharing Agreement project, responsible for IICSA recommendations five and six, to include the implementation of an information sharing agreement between the organisations who employ Church of England chaplains (lay such as Authorised Lay Ministers (ALMs) or Licensed Lay Ministers (LLMs) or ordained ministers, sea scouts etc.) and the dioceses who grant the chaplains the Bishop's Licence.

Recommendation 8:

Dioceses to review their current Information Sharing Agreements (ISAs) within their local partnership arrangements and update them where required. The ISAs should be robust, withstand legal scrutiny and cover all key and statutory partners.

Case management

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Case management relates to the process used by the Church to manage safeguarding concerns and a case refers to any safeguarding concern that is raised. The process for managing safeguarding cases is clearly set out in the Church of England's *'Practice Guidance: Responding to, assessing and managing safeguarding concerns or allegations against church officers'* issued by the House of Bishops in October 2017 and revised in December 2017. This guidance provides templates for recording the response to a safeguarding concern. There is also *'Practice Guidance: Responding to Safeguarding Concerns or Allegations that relate to Children, Young People and Vulnerable Adults'* issued in 2018. This practice guidance is for use by all those who have a role with children, young people and vulnerable adults in all church bodies and covers the management of allegations made about church officers.

The practice guidance reminds us that:

Under section 5 of the Safeguarding and Clergy Discipline Measure 2016, all authorised clergy, bishops, archdeacons, licensed readers and lay workers, church wardens and PCCs must have 'due regard' to safeguarding guidance issued by the House of Bishops. "A duty to have 'due regard' to safeguarding guidance means that the person under the duty is not free to disregard it but is required to follow such guidance unless there are cogent reasons for not so doing". Failure by clergy to comply with the duty imposed by the 2016 Measure may result in disciplinary action.

All decisions not to pay 'due regard' must be recorded and the reasons clearly stated.

The independent reviewers were aware of the practice guidance and the requirement that all safeguarding cases should be managed effectively by safeguarding professionals, and how survivors and victims should be responded to. It was found that *"Independent reviewers reported that practice across the Church has improved significantly."*

Recording information and record keeping

The review of files in scope relied on the recording of cases and of the record keeping within them. Although the independent reviewers identified strong examples of improvements in recording cases and how they were managed with robust filing systems, they also highlighted numerous examples of incomplete and disordered record keeping. There was too much inconsistency across dioceses in how practice and recording guidelines were applied.

There is no protocol or standard to follow when creating a new file, with some opened in the name of victim and others using the name of the perpetrator. In cases of electronic files, incorrect data recording i.e., spellings and inputting, has caused problems when conducting searches of databases.

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Often, due to different systems in use, there was duplication in the information recorded and, in some instances, it was only by reading both the clergy blue file and the safeguarding file that a complete picture of the case emerged.

There was evidence in many dioceses of current files being well ordered, managed and maintained and some good practical examples identified. This included listing all contact details of those involved in the case, and comprehensive written summaries of visits or telephone calls to perpetrators. However, this detail is not consistent in every safeguarding file.

The independent reviewers' comments provide support for the Church's procurement and implementation of a consistent electronic case management system for all dioceses. This system has been developed and will support safeguarding teams in capturing and holding information on safeguarding cases in an accurate and consistent manner. One of the aims of delivering the system is the standardisation of safeguarding cases and recording. This will also improve outcomes and the all-round service for survivors and victims.

Although record keeping has been poor historically, there were clear examples of improved practices. But there is still much work for the Church to do in this area to provide a transparent and high-quality service for survivors and victims in all dioceses.

Managing safeguarding cases

The independent reviewers explained that there were mixed standards of content and quality found in both non-recent and current investigations involving clergy and diocesan employees. In some cases, difficulties were experienced in locating documents. Some independent reviewers were unable to identify key decisions that had been made without extensive review of the content. In other files the independent reviewers saw the limited or lack of record keeping as a barrier to the case investigation, assessment of any risk and as a result suitable interventions being put in place.

More generally, it is suspected that a great deal of good practice and activity has been lost simply because it has never been documented. This is a missed opportunity for the Church to demonstrate its commitment to creating a safe and welcoming environment for all as the following finding indicates:

> A volunteer was the subject of a local authority led investigation, where the Diocesan Safeguarding Team were tasked with regularly reviewing arrangements around the volunteer's church activities. The file was closed 4 months after the action was allocated, and there is no documented activity as to any further reviews having taken place or of any measures in place to monitor ongoing behaviour.

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The independent reviewers highlighted a consistent theme where no outcome to the allegation or investigation was recorded. Similarly, there was insufficient information logged to provide assurance that all risks to survivors and victims had been mitigated. There were examples of risks that had remained unchallenged, due in part to poor record keeping. Significantly, in some cases patterns of behaviour displayed by an individual were not identified because of the absence of a documented chronology or timeline.

As one independent reviewer remarked; *"The independent reviewers cannot stress enough the critical need to ensure that safeguarding issues are documented well with investigative chronologies and appropriate recording. Without this, safeguarding practice is incomplete, and the organisation is placed in a position of extreme vulnerability".*

It should be noted that any loss of personal data would be considered a data breach. Significantly, decisions made without accurate, complete and up to date data could cause serious harm to individuals, and is a breach of Article 5(d) of the data protection legislation.

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In general, the independent reviewers described the use of and adherence to practice guidelines in managing and recording safeguarding cases was not consistent. The effective supervision of cases was variable across dioceses. In the findings of the local reports there was a theme of decision-making often not being recorded in sufficient detail which contributed to a negative experience for survivors and victims, and respondents involved in the case.

RECOMMENDATIONS

Recommendation 9:

Dioceses, cathedrals and the National Safeguarding Team to support the implementation of a national safeguarding case management system to enable standardised recording and effective case management.

Managing information

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This theme relating to information management indicates what the independent reviewers found about how information was retained and managed aligned to the UK General Data Protection Regulation (GDPR), with which all individuals and organisations must comply with when processing personal data. This section also illustrates the difficulties that the independent reviewers experienced with the physical location of files and how these were managed.

The primary legislation which provided the framework for processing personal data in the UK is the UK GDPR. This legislation contains legal requirements which must be applied by Church of England bodies to all processing of personal data, which will include any files created, used, retained, destroyed whether paper or electronic. Safeguarding records must be held securely and comply with certain conditions because of the sensitive and confidential nature of their contents. The security arrangements in one diocese were described as robust without explaining what 'robust' meant or what measures were thought to be robust. In another, files were described as located in locked cabinets in suitably secured rooms and only accessible by authorised personnel.

Compliance with data protection legislation was a significant concern for independent reviewers. There were examples of incorrect application of data protection legislation in the removal and destruction of papers related to past safeguarding cases and overall, there was little common understanding or consistency in the processes applied. There were non-recent examples of inappropriate "weeding" or "pruning" of files, with unsatisfactory rationale and not in accordance with data protection principles. This may have involved material relevant to safeguarding, although that must be a matter of conjecture as there is little information available about the material removed. In any event this is unsatisfactory and could potentially be a data breach, if data has been lost or destroyed without a sufficient purpose. It is recommended that clear guidance and training on the application of GDPR in these settings needs to be provided and accessed and implemented where they exist.

The independent reviewers provided examples where email correspondence contained personal details relating to other clergy members, their families and matters such as personal finances which appear to be breaches of data protection legislation.

Information retention and cross referencing

The Church of England records management guides are designed to help parishes, dioceses, bishops, and cathedrals develop a consistent and best practice approach to looking after church records in their care, whether paper or electronic. There is a separate guide for each specific set of church records. Each guide contains general records management advice along with detailed guidance on keeping records associated with each area and their retention. Nevertheless, the

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independent reviewers speculated that whilst there is a retention policy for safeguarding material within the Church, this is applied inconsistently and there is also inconsistency about how personnel records (including clergy blue files) are dealt with.

The reviewers stated that some files contained a considerable amount of duplicated material. Whilst it was observed that 'weeding' had been periodically conducted, there was no recorded rationale or details of what records had been removed where this was the case. Independent reviewers noted that there were instances of retained records, ranging from duplicate copies and others of a historical nature with some dating back to the 1960's and 1970's. In contrast, some files had been heavily weeded to the extent that large gaps in history existed – in one case over 40 years of ministry history was absent. In another case cited as a cause of concern, a file that was connected to a safeguarding case contained a memorandum from a bishop, stating that material would be removed from a clergy file as the complaint made "had no bearing on your ministry in the diocese."

There were examples reported of well administered, comprehensive filing systems and in some cases, file management procedures described as being in excellent order, with only the necessary information retained as per guidelines and correctly filed. In more recent records examined, licensed clergy recruitment history, discernment process and curacy were also incorporated within the files which indicated a thorough approach. All dioceses should be aiming to achieve these high standards.

In relation to transferred files to and from other dioceses, in many cases weeding processes had been conducted but with no accompanying record or explanation of what had been removed, or whether the material had been retained in the previous diocese. There were other examples where labelling systems had been introduced to signify that a file had been weeded, although this system did not always indicate which documents had been removed.

There is not always a cross-reference or linkage of clergy blue files and other personnel files which included safeguarding matters. This creates a risk that a decision-maker will not have all the relevant information available when conducting a Ministerial Development Review (MDR) or when considering a matter involving a member of clergy. There were also concerns raised by reviewers about the security of paper files in some dioceses, although it was noted that some dioceses had excellent arrangements in place.

There is an expectation that all files should be appropriately cross-referenced so that no safeguarding matters are overlooked. In the circumstances described however, potentially valuable information was not shared or linked but was reliant upon individual knowledge and relationships rather than there being an established process.

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In terms of content, the reviewers found the type of information available, and the depth of content varied considerably. There were recurring issues of missing information which included minutes of meetings, disclosure and barring checks and records of communication between relevant authorities. Some files made references to risk assessments, but the records were not contained within the file nor are there any entries that provided further clarity.

There were examples of files that contained illegible handwritten notes, with some found on scrap pieces of paper as opposed to formal document templates and no explanation of what the content related to. There was another instance of a handwritten note by a former bishop which stated there were safeguarding issues, but the remaining contents were illegible. Whilst these were non-recent cases, this is clearly unacceptable practice.

The findings of the independent reviewers in terms of the impact of record management that does not adhere to the standards set in guidelines is illustrated in the following extract:

> A member of the clergy had transferred dioceses some years ago, and prior to transfer, had officiated at a senior level in other dioceses. During PCR2 several unexplained entries in the blue clergy file caused concern regarding management of risk. Correspondence from the clergy member to clergy senior leadership (non-recent)[indicated information had been deleted]. It is unclear what this refers to. There are also non-recent records which refer to concerns that this same member of the clergy had advised [another person] to withdraw an allegation of abuse. Similarly, there is no information as to what this is relates to. Several years later, there were further concerns regarding the clergy member's behaviour and comments. There is no information as to any outcome or decision-making re any of these events [in the files reviewed].

Storage systems

The format, maintenance or storage of files in some dioceses was unsatisfactory and the independent reviewers needed to work hard to locate all relevant files, often held in different areas across the diocese.

Across the dioceses, the independent reviewers stated that there was no standardised format on how files are maintained. There was in some dioceses a good degree of organisation shown, with examples of specific sections for complaints, clergy discipline measure files and safeguarding issues. However, the independent reviewers found a mixture of filing arrangements in place. For example, in one diocese, during a search for records, a crate of miscellaneous historic files was found and in another, a number of clergy blue files were located by the reviewers that related to deceased members of clergy which had not been moved following the notification of their death, but remained within current files.

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The independent reviewers found examples of a general lack of understanding of data protection legislation across dioceses and how and when it should be applied to safeguarding information and files.

There were inconsistent practices relating to the retention of information. There was a process of ensuring the information retained was in line with recommended practice guidance and reduced the level of duplicated information. Nevertheless, the independent reviewers stated that there were occasions when information was 'weeded' but no audit trail was recorded.

Independent reviewers experienced the impact of the poor storage and filing systems in place in dioceses. They expressed concern at the potential impact of missing information, the impact on seeing patterns of behaviour or simply in having a full record of someone's career and ministry in the Church.

RECOMMENDATIONS

Recommendation 10:

All Church bodies should maintain good records and must adhere to the legal standards set out in the UK General Data Protection Regulations (GDPR). Diocesan Safeguarding Advisory Panels with the Diocesan Safeguarding Advisors are encouraged to implement information management approaches that make sure information is retained and shared lawfully. As with all Church bodies, the approach should be proportionate.

Recommendation 11:

Diocesan bishops to be satisfied that there are appropriate and robust arrangements in place for the management and control of all blue clergy files and which are conducted in line with existing policy and guidelines to ensure that safeguarding issues are correctly identified, recorded and referred onwards.

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Safeguarding teams

Diocesan safeguarding teams

Diocesan safeguarding teams, led by the Diocesan Safeguarding Advisor (DSA) manage safeguarding cases and provide advice and guidance to bishops, clergy, church officers and volunteers within their diocese. This section focuses on the diocesan safeguarding teams and includes the findings of the independent reviewers on the impact of these teams, their accountability, capacity, and resourcing.

Impact

A considerable number of diocesan reviews described a continual improvement in the response to and management of *child* safeguarding concerns, and it was suggested that this pace of improvement has increased since 2014. This links to the establishment of dedicated safeguarding teams and enhanced procedures directed and guided by the Church.

In contrast, the initial response to *adult* safeguarding concerns was described as variable. When a concern is reported directly to the diocesan safeguarding team, the response is positive and reflects good practice. However, if the report is made to a priest in ministry, or through other internal routes, it is significantly less likely to be dealt with appropriately or in line with practice guidance.

The independent reviewers did make positive references aligned to the wider developments, including the quality of advice and support provided by DSAs. Further evidence supporting these improvements is the number of referrals being processed and investigated in a timely manner. There is consistent evidence of the improving quality and effectiveness of diocesan safeguarding teams in developing good practice, including the first response to concerns raised, initial assessment and information sharing.

As quoted by one independent reviewer *"the approach to safeguarding in this diocese is refreshingly different and positive and this is worthy of inclusion."*

There were examples of internal consultative arrangements in place which included fortnightly meetings between the Safeguarding Manager, Head of Communications and the DSA to discuss the potential reporting of current enquiries or cases. Broader DSA engagement was evident with regional consultative forums comprising of DSAs and safeguarding representatives from the Roman Catholic dioceses, Methodist Circuits and United Reformed Church Synod, and further association with the Baptist Church and the Salvation Army.

However, from a broader organisational perspective, it was noted in a number of dioceses that clarity is required to precisely define the core business of the diocesan safeguarding teams. At present, there remains an ongoing risk of local variations based on available resources, instead of an agreed remit that

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considers the essential strategic and operational work necessary for the delivery of consistent safeguarding across all dioceses.

Accountability

The Diocesan Safeguarding Advisors Regulations 2016 includes a regulation on professional support and development of DSAs.

> Regulation 5(1) states: The bishop of a diocese must make arrangements for ensuring that any person appointed as diocesan safeguarding advisor receives professional supervision at an appropriate level from a person with experience of work that is concerned with the safeguarding of children or vulnerable adults.

Within the current structures, the Diocesan Bishop is responsible and accountable for safeguarding, and the DSA leads on all operational decisions and should have direct access to the Bishop for this purpose. Nevertheless, in some cases, added layers of DSA oversight and line management were evident, and in some cases, dioceses have introduced independent supervisory arrangements by engaging suitably qualified external professionals for that purpose. The independent reviewers considered this to be good practice.

In one particular case, an individual with professional social work experience conducted scrutiny of safeguarding cases, and to some extent provided a welfare function. In another, the DSA reported to a Safeguarding Manager which involved supervision of casework, whilst a diocesan secretary was described as performing a line management function despite having no safeguarding qualification or relevant experience.

Another independent reviewer commented; *"The very different DSA role is now occupied by individuals who are not priests or licensed lay people, thus separating the role from that of direct ministry. However, the oversight and management of the DSA role has not been sufficiently distanced from ministry and this is an area which requires careful consideration to demonstrate the independence of safeguarding and the robust and transparent delivery of safeguarding within the diocese."*

Capacity

The Church introduced the DSA as a professional role in 2014. The DSAs are supported by a team in each diocese, often consisting of an assistant DSA and administrative support and in some cases additional capacity to deliver training. It is the expectation that these teams have the ability to manage the safeguarding caseloads of a diocese and to make appropriate referrals to statutory partners when necessary.

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Safeguarding teams

In one diocese the Independent Reviewer was particularly complimentary, commenting on the thoroughness of reviews conducted by a professional team including the robust processes in place and positive relations with local agencies and within the diocese.

However, the reoccurring and consistent theme related to the limited resourcing of diocesan safeguarding teams; and a view that through increasing safeguarding awareness in the community, the likelihood is that the demand and workloads will increase. Similarly, the impact of PCR2 recommendations, church establishments returning to 'pre-covid' arrangements and more broadly the development associated with the national Learning and Development Framework has the further potential to increase safeguarding reporting and challenge team capacity.

The capacity of the DSAs to cover all the safeguarding tasks required of them was raised by a large number of independent reviewers. In some cases, dioceses have reacted proactively and secured additional resources. Due to increased caseloads, there were concerns about timeliness in responding to concerns, support for survivors, embracing partnership working and ensuring the necessary time required to support PSOs. In many dioceses, due to the added scrutiny of files and growing numbers of safeguarding concerns being identified, the workload of the DSA and diocesan safeguarding teams has increased, resulting in additional money being allocated for the DSA to increase their working hours in order to manage the demand effectively. As one independent reviewer remarked *"it is clear that more resources must be available……and generally be more proactive than reactive".*

Independent reviewers commented that a considerable amount of work involved non-recent reports, many of which had not been identified, recorded, reported or investigated adequately at the time they first came to light. The independent reviewers reported that a number of these enquires had been the subject of prompt and effective remedial attention by diocesan safeguarding teams. As a consequence, general workloads had increased, some beyond reasonable levels and important current casework was put on hold due to this increased volume. In an extreme case, a DSA was reluctant to accept further cases due to the increasing workload and the impact on the safeguarding team from a well-being perspective. There is evidence of well-being support being provided to the DSA in this case.

The independent reviewers identified that the broader impact of increasing workloads was further demonstrated in the slow response to emails due to the sheer volume, and delays in updating safeguarding records due to a lack of capacity. There were issues that have exacerbated this, not least matters being regularly routed to safeguarding teams that are not safeguarding concerns at all; and in dioceses where staff are employed part-time or where their hours have been reduced.

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The independent reviewers were keen to stress that these examples were not cited as criticisms of the staff within safeguarding teams, but to provide evidence that in some dioceses the capacity of the safeguarding team was a significant concern.

In one case the independent reviewer commented "the current case load of the Head of Safeguarding is excessive and is impacting on the ability to manage the team and oversee the more difficult and complex cases. This comment is not intended to be detrimental to the individual concerned, as the post holder was totally committed and dedicated to the role."

Similarly, due to ongoing resourcing issues, some concerns were raised regarding the capacity of the DSAs to provide adequate management oversight of caseworkers. Whilst the independent reviewers are confident professional discussions on casework were being conducted, there were occasions when these conversations were not being recorded within the file, which was considered to represent a risk.

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The independent reviewers were overwhelmingly supportive of the DSAs and their teams. Overall, the performance of DSAs was found to be appropriate and effective. The independent reviewers praised DSAs for their skills in managing cases, often providing excellent care to survivors and victims.

The introduction of safeguarding professionals in 2014 has seen a rise in standards of casework, improvements in survivor and victim experience and appropriate case outcomes. There are many dioceses where the undoubted commitment to safeguarding is matched by the resource within the Diocesan Safeguarding Team to deal effectively with the casework requirements.

However, there are a considerable number of dioceses where independent reviewers expressed concerns about the capacity and available resources. There were instances of diocesan safeguarding teams not coping with the workload, with cases not being managed effectively and delays which were unacceptable. This remains an on-going challenge for some dioceses. The support for survivors and victims was also impacted negatively in some areas due to these strains on the capacity of the safeguarding team.

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RECOMMENDATIONS

Recommendation 12:

Dioceses to review safeguarding resources to ensure these are sufficient, prioritised and in place to deliver the required standard of safeguarding, including training, prevention and support for survivors and victims, risk assessment and management of safeguarding caseloads. This may also apply to cathedrals who do not have arrangements with their diocese.

Recommendation 13:

The role of diocesan safeguarding teams to be clearly defined and understood, including line management and supervision, in line with future planned arrangements contained within IICSA recommendation 1 'Introducing diocesan safeguarding officers in the Church of England'.

Safer recruitment

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One of the areas in which the Church aims to fulfil its commitment to promoting a safer environment and culture across all Church bodies is by setting out safer recruitment and appointment processes and ensuring continued vigilance once someone is in role. *'Safer Recruitment and People Management'* which came into effect in January 2022 goes beyond simply obtaining a Disclosure & Barring Service (DBS) Certificate. The reality is that many people who have abused or will abuse in positions where they are working/have close contact with children and/or vulnerable adults do not have a criminal record.

Reinforcing the safeguarding and wellbeing of children and vulnerable adults throughout the recruitment process and beyond will help create and maintain a safe and positive environment that inspires trust, enabling them to thrive and grow and have the best experience of Christian living through the work of the Church. Safer recruitment aims to:

- Attract the best possible individuals to all roles through inclusive, fair, consistent and transparent processes
- Identify and reject individuals who are unsuitable by following a proportionate but thorough selection process
- Ensure that robust induction, oversight and supervision processes are in place for those working and volunteering with children and vulnerable adults.

This section on safer recruitment sets out the findings of the independent reviewers relating to the implementation of the safer recruitment policy and Current Clergy Status Letters (CCSL) which is explained below.

Implementation of the safer recruitment policy

Individuals recruited into the Church or moving between roles who will be working with/have close contact with children and/or vulnerable adults must have appropriate DBS checks and be recruited in accordance with the safer recruitment policy and procedure.

The independent reviewers reported effective management oversight and administrative processes, ensuring that safeguarding training and DBS records remained current in accordance with the relevant policy requirement. A specific example was given of an administrator being employed by the Diocesan Safeguarding Team as an additional resource to maintain the electronic system for DBS checks.

There were examples too of Permission to Officiate (PTO) files being well managed with confirmation of safer recruitment, safeguarding training and the date of PTO renewal easily identifiable within the file. There was also recent evidence of good recruitment practice prior to an individual's commencement in a role.

Safer recruitment

In some dioceses independent reviewers were not able to find any cases where an individual was practising without a current DBS check (i.e., within the last three years) or had not attended the requisite safeguarding training. This should be the objective for the Church as a whole.

The reviewers found that there were clear procedures in place to manage blemished DBS checks which included appropriate checklists. One diocese, having identified all blemished DBS checks subjected these files to further independent scrutiny to consider if there were any relevant safeguarding concerns.

Whilst there are many positive working practices identified, there were also numerous examples where there was no consistent or coherent process in place to clearly identify the current status of the DBS check on each file. This was exacerbated by a general lack of coordination with other processes such as diocesan sponsorship papers, Ministerial Development Reviews (MDR), notification of Permission to Officiate (PTO), DBS and safeguarding training records were not always present on the clergy blue files.

In one diocese, there were 38 clergy blue files that raised a query on the status of the DBS check and training. In some cases, the records were missing or had expired, and there are examples of letters requesting updates being sent but no subsequent follow up action recorded.

Another example from an independent reviewer revealed a number of individuals who had declared previous criminal convictions or information on their Confidential Declaration Form or Application Form that was of safeguarding relevance. Contrary to standard practice not one of these cases was referred to the DSA for advice, resulting in no risk assessments being considered or conducted.

As one independent reviewer observed *"Of the 158 files requiring further action, 111 files (70.25%) were in relation to expired or absent DBS certification. It is not acceptable to have so many DBS certificates subject of review, and in some cases have persons undertaking the role absent of DBS approval."*

There were other examples of misfiling, where information relating to individuals were placed in the wrong files, and a number of the records not having the evidence to support the fact the post holder had been subject of a safer recruitment process. This could also be considered as a potential data breach i.e., loss of data if the information cannot be found because it has been misfiled. It could also lead to misinterpretation of that person's involvement in a different case. This also constitutes poor records management.

Concerns were specifically raised about the records of those with PTO, with the reviewers finding a substantial number lacked basic and essential information, including whether a PTO had been granted or renewed, and the status of both the DBS

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and Current Clergy Status Letters (CCSL). Issues relating to CCSLs are detailed below.

PCR2 also highlighted a small number of significant cases where individuals posed a safeguarding risk yet there was no mechanism to integrate and centrally store the information to manage the subject effectively, and share information where it was lawful, necessary, and proportionate to do so. An independent reviewer provided this example:

> A minister had not declared previous convictions during more than one consecutive vetting procedures over a certain period. However, in the most recent of these, the error was identified by human resources personnel. Before moving to another diocese, the minister had been representing the church in a number of other organisations that may have been unaware of the convictions at the time. Previous opportunities to address these matters had been missed on at least three occasions during the time working in the previous diocese.

Laity and volunteers

There were broader risks identified that related to laity and volunteers. Whilst some of these roles rely on the results from DBS checks, many do not. There were examples of choir masters or organists moving from parishes where they had been suspected as being a potential risk but moving to another parish without this knowledge being shared with those who were receiving them. In one example, the need to recruit an organist seemed to outweigh any safeguarding considerations.

Musicians are welcomed by the Church, and have the opportunity to travel around the Church environment and can do this freely and generally go unchecked and unregulated. An example of this was a vicar who did not seem to believe the safer recruitment policy should be adhered to when recruiting to a short-term position. In another case, a church musician was a Registered Sex Offender (RSO) who was subject to a Sex Offenders Prevention Order (SOPO). Notwithstanding this, the individual was able to operate on a casual or part-time basis as a musician in a church. Even though there was no direct access to children, this presented an obvious safeguarding vulnerability which needed to be managed.

There were also findings from independent reviewers about lay readers: An independent reviewer commented *"Failure to ensure that licensed Readers hold a current DBS and have completed current safeguarding training is a safeguarding risk which presents both to the individual and organisational risk to the Diocese."*

Specifically in relation to the lay ministry, there has been no format established for what is retained in a file. Although a DBS check was not required in all cases, it was not clear from the individual files examined

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whether one was necessary or not for the role the person was undertaking. In addition, references were not always evident within the documentation.

Clergy Current Status Letter

The Clergy Current Status Letter (CCSL) is a document that is provided when a member of clergy transfers from one diocese to another and includes information about the cleric's performance, whether there is anything in their past that would give rise to concern and their previous bishop's view on their suitability for continuing ministry.

The CCSL should provide the "receiving" diocese with frank and rigorous references about members of clergy moving within the Church and there is an expectation that the principles of "safer recruitment" are applied to ensure that the CCSL is received and does include safeguarding information.

Most files reviewed for clergy transferring into a diocese had 'safe to receive' notes (these were the predecessors of the CCSL) or the CCSL on the blue files. The independent reviewers remarked on good practice where it was found that a DSA shared information with the receiving DSA about any concerns and risks and participated in joint risk assessments.

The independent reviewers remarked when there was a procedure in place that ensured that prior to the cleric transferring, the DSA was able to review the clergy blue file in order to satisfy themselves and provide assurance to the Diocesan Bishop that the individual posed no identifiable risk, this enabled the Bishop to personally sign the CCSL with confidence.

An independent reviewer remarked that in cases of incoming clergy, the Bishop and the DSA received the CCSL as part of the selection process prior to any formal interview. The diocese also required assurance from the current DSA of the home diocese that the clergy blue file had been reviewed, and to confirm there were no matters of risk or concern. There were other examples of effective coordination between DSAs, who shared concerns and risks with each other and included the development of joint risk assessments.

Despite these positive examples, the independent reviewers felt that there was an over-reliance on the CCSL during the recruitment process and it was not necessarily considered a secure basis for assurance that there were no safeguarding concerns prior to appointment. There were occasions where the new member of clergy was already in post before the clergy blue file had arrived, and only at the point of receipt would the receiving diocese become aware of any risks if these were recorded in the file. The current House of Bishops' policy states (para 79):- "Where a priest or deacon moves to take up a new appointment or permission to officiate ('PTO') in another diocese in the Church of England (or to the Church in Wales),

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the sending bishop will not transfer to the receiving bishop the clergy personal file until the point where the priest or deacon's ministry in the sending diocese ends (which, in the parochial context, means in practice the person's last Sunday in the parish). Once the new appointment is confirmed and the ministry in the sending diocese ends then the file should be transferred. It is not necessary to wait until after licensing to the new post before transferring the file…". Therefore, in some cases this guidance was not being adhered to consistently.

There was general uncertainty about who is responsible for the scrutiny of a CCSL when it is being produced and the detail it should contain. Concerns were raised that some of the records were written on the basis of information provided by others, but not necessarily from what was held in the clergy blue file or elsewhere. The perception is that they are likely to be conducted on trust, and with the added time constraints this results in the files not being read in any depth, if at all, before being transferred to the receiving diocese.

An independent reviewer highlighted eleven cases of deficiencies associated with the current CCSL process, where clergy had subsequently been granted PTO. Another example indicated an exchange of telephone calls between bishops to establish a reference for a member of clergy, but there was no record found of the discussions or outcomes. In another diocese the CCSL was missing in 12 cases where the clergy blue files had not been requested, and following a concern raised by the independent reviewer in one case a safeguarding concern was revealed necessitating an immediate risk assessment by the DSA.

One independent reviewer stated:

> "Access to all relevant information is important in such circumstances as these. The quality, completeness and clarity of any reference is of the utmost importance. Problem clergy should have their issues managed and resolved by their host diocese – the problem should not be moved onto other, unsuspecting diocese – especially given how difficult it is to remove a failing and problematic member of the clergy."

The vast majority of the 'safe-to-receive' letters subject to PCR2, contained no useful information other than to state that there were no concerns relating to the person who was transferring. Valuable detail that would have helped to assess and manage risk was not passed on in a large majority of cases, with details of complaints and concerns about conduct often buried within the blue clergy file resulting, in many cases, in clergy relocating to another diocese with few, or no issues raised as causes of concern over their conduct.

For example, a report was examined relating to an individual who was leaving a diocese and had been the subject of safeguarding concerns. The subsequent CCSL letter was assessed by the Independent Reviewer as not reflecting the seriousness of the concerns and

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requested that the safeguarding manager intervene and consider providing further information to the receiving diocese. Similar examples were found during the independent diocesan reviews where the references in the CCSL were overly positive when compared against recorded past concerns.

There are examples of references being provided where issues of concern were raised with accompanying advice provided to the receiving diocese which was subsequently ignored. In one case, the transferring bishop recommended that various steps were taken before a PTO was issued to the incoming member of clergy. The records, however, do not show any of the safeguarding measures having been implemented, and it would appear that the CCSL was disregarded, and the PTO issued, as described in the example given here:

> There was an allegation a priest had sexually touched several women. This was not acted upon despite there being legislation at that time. These incidents would have been indecent assault under the Sexual Offences Act 1956 (as amended), but it was not reported to Police at the time as the offences occurred in another Diocese. They were mentioned in the CCSL when the cleric moved, but the PTO was still granted. There is nothing in the file to indicate there was any consideration of risk or other action taken. It appears from absence of information that the concern and potential risk was ignored.

The process of employment references was described by some independent reviewers as ineffective and in urgent need of review, due partly to the over-generous use of discretion when determining what information to exclude from the reference. It was reported that this inconsistency still exists in the CCSL process, with reports of vague commentary leading to individuals posing a risk being transferred across dioceses. In the past decade or so, on at least one occasion, senior clergy have made written representations to their dioceses raising what they described as 'serious questions' regarding the usefulness, accuracy of references and the robustness of the safe-to-receive process.

One of the independent reviewers offered the following observations on the safe to receive/CCSL process.

> "Firstly, an unequivocal endorsement of 'safe to receive' is a very robust term informed to varying degrees on the information contained in the file, known behaviour or personal belief. The independent reviewers felt it more prudent that the files should be endorsed with 'no identified safeguarding risk' or 'safeguarding information held on file'. This may be considered a nuanced point but would avoid all-encompassing endorsements which cannot in truth be given and on occasion has offered a false sense of assurance."

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The majority of the PCR2 reviewers identified that "Safer recruitment" remains an issue for the Church. This often related to clergy and church officers moving between roles within the Church. Many dioceses did have highly effective processes for managing DBS checks, but compliance was much more limited in others. Inconsistencies in record-keeping within blue clergy files compounded this issue. There is evidence of full and proper checks not being conducted on clergy moving dioceses. The reviewers found a small number of cases where the "references" provided had not been frank or helpful to the receiving diocese. This is a weakness and a risk.

There was a particular concern about transient musicians who move between dioceses and cathedrals (e.g., choir masters and organists) where their files and any relevant risks are not passed to the *"receiving"* diocese or cathedral.

It is crucial that all dioceses play their part in the robust application of all aspects of safer recruitment policy and guidance.

RECOMMENDATIONS

Recommendation 14:

Dioceses and all church bodies to comply with the House of Bishops' Safer Recruitment and People Management Guidance', (issued by House of Bishops came into effect on 4 January 2022) including clergy, parochial and extra-parochial, and also PTOs, church officers, lay ministers and volunteers. DBS renewals to also be consistent and effective and recorded on file.

Recommendation 15:

Diocesan bishops to be satisfied that all relevant clergy and church officers fully comply with the Clergy Current Status Letter (CCSL) policy ensuring that any safeguarding risks or concerns are highlighted as part of the process.

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The theme of support and accountability covers a number of areas which the independent reviewers noted in relation to Church personnel. This included members of clergy specifically, and how they are supported through the Ministerial Development Review (MDR) process. It also includes the reviewers' concerns about parish safeguarding officers.

Ministerial Development Review

The purpose of a Ministerial Development Review (MDR) is set out in the *Ministerial Development Review Guidance* approved by the Archbishops' Council January 2010 incorporating amendments approved by the Archbishops' Council March 2022. The MDR is a guided discussion framed around an office holder's ministry. It is recommended that some form of review take place every year but MDR, in accordance with the regulations, must be carried out not less than once every two years. Reg. 18(1) Ecclesiastical Offices (Terms of Service) Regulations 2009:- Every diocesan bishop shall make, and keep under review, a scheme containing arrangements for a person nominated by him to conduct with each office holder in that diocese a review of his or her ministry to be known as a "ministerial development review" on at least one occasion in each period of two calendar years.

The MDR process is a means whereby clergy are enabled to take stock of their ministry and wellbeing with the help of a reviewer. It is the Bishop who decides who will conduct the reviews in their diocese. In most dioceses the Bishop is unlikely to be able to conduct all the reviews themselves, but is likely to want to conduct the reviews of senior clergy. The Bishop should appoint the reviewers and ensure that they are briefed, trained and continue to meet the required standard.

It appeared to the independent reviewers that there was limited background research or preparation undertaken prior to embarking on the MDRs. It was noted that the clergy blue files are not routinely accessed in that preparation, and no meaningful knowledge or awareness was provided on areas such as safeguarding matters, disciplinary related issues or attendance at required training courses arising from a review of their personnel records prior to the MDR.

The independent reviewers felt that this further highlights the diocesan bishop's responsibility for safeguarding and that the MDR is an opportunity to touch on safeguarding approaches and issues experienced. The current approach adopted seemed to indicate that clergy would not necessarily receive detailed feedback of the quality and effectiveness of safeguarding practices within the cleric's own setting and from their perspective.

It came as a surprise to many independent reviewers that there was not more focused scrutiny on safeguarding as part of these discussions, as in the opinion of some independent reviewers the MDR is a

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useful means of checking that a culture of safeguarding is being actively promoted. It should be noted that this is not the purpose of the MDR, and it is understood that members of clergy value this process as part of the management of their welfare and focused on their ministry. The reviewer in a diocese did find a more recent emphasis on the safeguarding agenda where it had been introduced into this process.

It was commented upon further, that at a parish level, current methods do not provide a structure to consider broader safeguarding development, learning or accountability. More generally the MDR was believed by the independent reviewers to be a missed opportunity to consolidate safeguarding, place it firmly at the heart of ordained ministry and encourage safeguarding to be considered in an open and transparent manner.

While the MDR is not a safeguarding review, but about the ministry and wellbeing of the cleric the reviewers noticed that in relation to the quality and content of the MDR, little evidence was found where concerns of poor safeguarding performance or practices were documented. This was despite references to the contrary being recorded in other personnel or clergy blue files during the time between MDRs. As this quote indicates:

> "IRs have never seen a church officer file, whereby the individual has been informed in their Ministry Development Review (MDR) that they are performing poorly or there are concerns around their practices. This is despite there being clear and very obvious concerns in the time period between MDRs".

The point being made by the reviewers appeared that in the absence of planned follow up in respect of safeguarding concerns then the MDR provided a further opportunity for discussion. There were, however, positive examples where lay members had challenged deficient performance of members of the clergy and on occasions, the decisions of the Bishop, leading to formal complaint procedures.

There were examples of inconsistent practice, including where comments of a negative nature were removed from the MDR record following representations from individuals, as opposed to incorporating and acknowledging the point under disagreement into the report. This led to a perception by the independent reviewers that the process lacked objectivity and did not contribute to the improvement in the MDR process and more generally led to a view that in some cases members of clergy avoided disputes or challenges with fellow clergy. There is an impression that members of the Clergy do not like to upset other clergy and an avoidance of formal management and supervision creating a perception of lack of ownership within the Diocese. The independent reviewers observed evidence of limited challenge, poor or lack of supervision. The following quote states:

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> "An excellent opportunity to drive culture change and a stronger orientation towards the safeguarding is afforded by the ministerial review process, structured as it is in a way to reflect on the past, the present and the future.
>
> The independent reviewers were therefore shocked that in over 3,200 files that were read only one ministerial review was used to harness and record on the safeguarding challenges facing the church, nor [was there] any record of how the appraisee can contribute to making the Church a safer place."

As this example illustrates:

> A complaint was made by Church Officers in 2019 concerning oppressive and dictatorial behaviour, and concerns of 'excessive' one to one contact where clergy were described as aggressive and bullying. Other than the letters, [and] emails of complaint, there is nothing on the file about this, the above incidents don't appear to have been investigated in any way.

Clergy welfare

Other findings included development objectives recorded in the MDR seeking the achievement of a better balance between parish ministry and family life but there was however little evidence documented of resources or support being made available to achieve this. This is not strictly safeguarding, but the reviewers noted it as having a potential impact on behaviour and ability to respond to safeguarding concerns.

The welfare of members of clergy is referenced heavily in several of the independent reviewers' reports. There were generalised concerns that "supervision" within the Church at a diocesan level was inadequate and inconsistent. This is reflected in the MDR comments, but also by the apparent lack of support provided to clergy and their welfare when they may be trying to manage a range of complex safeguarding and other issues

In terms of the welfare and the well-being of clergy, there was one exceptional case, where the follow up, care and kindness shown by the Diocese was considered as proactive and preventative practice, to which the independent reviewer remarked *"working in mental health care over many years, rarely have I seen such professional care, non-judgmental kindness, and compassion for a person……from an organisation that is 'an employer' and the person affected by illness 'the employee'.* This should be the standard of excellence the Church should aim to achieve in all cases.

Another quote supports the reviewers' observation of little evidence of resources or support for members of clergy to achieve a better work life balance: *"The level of distress communicated about lack of support during a pastoral visit and included in a subsequent letter left*

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IRs moved and humbled. Many of the development objectives in the Clergy ministerial reviews were noted to have a better work life balance."

The independent reviewers saw examples where members of clergy had requested help and support into allegations of bullying and intimidation, but the reviewers were then unable to find information contained in the file as to how the Diocese had responded to the request or allegation.

The independent reviewers in some areas explained there were notes which describe difficulties being experienced by individuals, but there was no context, solution or support recorded in the documentation. Some records indicated a serious situation which may or may not have been safeguarding related, but due to the limited description in the notes there was no way of assessing this.

Parish Safeguarding Officer role

The Parish Safeguarding Officer (PSO) is a volunteer role and the key link between a diocese and a parish on safeguarding matters. They should have an overview of all parish church activities involving children, young people, and vulnerable adults, ensuring the implementation of safeguarding policy.

The role is vital as the "eyes and ears on the ground" in a parish. It is essential that these volunteers are supported so they can effectively and in a timely way identify risks and concerns. They also need to be clear about how they make safeguarding referrals.

In one diocese an example of effective practice was highlighted with the introduction of an initiative which invites parishes to review a range of parochial activities including safeguarding. At the time of the PCR2 review, the safeguarding section of this scheme was being updated requiring parishes to use, register and make use of a new Safeguarding Dashboard which is of broader benefit to the PSOs. The objective was for parishes to work towards completing actions and reach certain standards at which stage they would be awarded bronze, silver or gold certificates. There are also similar examples of this in other dioceses.

In terms of professional development opportunities the independent reviewers provided evidence of formal induction programmes being piloted and also examples where PSO forums were scheduled throughout the year and spread across different times and days of the week to maximise attendance. The importance of training and support was emphasised considering the level of risk that was being managed within parishes and the importance of structured support sessions coordinated through the DSA. Whilst there was a willingness to provide this assistance, the reviewers commented that the reality was that it was not always possible to provide this consistently due to the competing demands on time and resources at a diocesan level. There are examples of training

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matrices being developed that differentiate between mandatory and advisory attendance which received positive feedback.

In a number of parish cases the independent reviewers found that referrals to the DSA were made promptly and in accordance with the guidance and included a detailed initial report of information disclosed or concerns identified. In areas where dioceses had an electronic system, updates and outcomes could be reviewed and were subject of DSA oversight. There were good examples of a diocese and the PSO working well on some challenging cases, particularly where the perpetrator and victim were both within the same parish community.

> A church officer was suspended from their lay duties at the time of being charged with criminal offences. Some considerable time before this development, concerns were raised about the person resulting in early intervention at parish level leading to referral to the DSA and suitable safeguarding outcomes. The PCC also used the situation for reflective learning.

There were instances however, where the PSO was dealing with a number of current cases which had not been immediately reported to the DSA. In these situations, it was only when the DSA was aware of the matter that the referral was aligned to the prescribed safeguarding process, and the PSO provided with support to avoid a repeat of the issue. Of particular concern, following the receipt of the parish returns as part of the PCR2 process, it was identified that diocesan safeguarding teams had not been advised of a number of cases. Similarly, a large number of parish returns referred to consulting with current and previous incumbents and Parochial Church Council (PCC) members and were reliant on people's memories to highlight safeguarding matters worthy of reporting, which suggested that many parishes did not have a recording system for incidents and reports that could be referred to.

Parish responsibilities are set out in The Parish Safeguarding Handbook: Promoting a Safer Church (2018, Archbishops' Council). The independent reviewers found examples where a lack of structured case management processes existed to support the PSO, and consequently it was difficult to track progress relating to specific enquiries.

The reviewers raised issues relating to whether people felt confident in reporting concerns to a person who is known to them, as opposed to being able to raise them with a person or organisation independent from the parish. This point was reinforced in cases where the perpetrator, survivor, victim, and parish safeguarding representative were all known to each other or are even from the same family. Where a conflict of interest is apparent, a survivor suggested that a PSO from another area should conduct the enquiry on the basis there was no independent body in the parish where the matter could be reported.

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This is an example extracted from one independent reviewer's report:

> A survivor explained that their current PSO is not equipped to deal with any safeguarding matters or disclosure made to them. The survivor advised that the PSO has attended the church for many years. The survivor suspected if anybody spoke to the PSO about concerns regarding the member of clergy, the PSO's response would not be an independent, objective one. In addition, they raised the point as to the accessibility of PSO and did not feel other than seeing them in church, there was another way to contact them.

From a broader engagement perspective, the independent reviewers noted that the time parishes are able afford to multi-agency engagement, when it is required, is a challenge and may be a barrier to the enacting of investigations and subsequent safeguarding outcomes. Due to the voluntary nature of the PSO role, there can be no expectation of a time commitment and there is limited time to undertake the role, including the requirement to work effectively with other agencies in many cases.

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The MDR process is important as a key mechanism of supervision of members of clergy (in ordained ministry) although it is not intended as a safeguarding review and currently the guidance for these does not include the need for discussion of safeguarding issues. It was perhaps not surprising therefore, that despite it being everyone's business, it was found that safeguarding rarely features as a topic. The independent reviewers found noteworthy evidence to suggest that it could be beneficial if safeguarding was to be part of every MDR meeting.

The independent reviewers identified an apparent reluctance to criticise colleagues and sometimes to raise safeguarding issues involving others. This culture cannot be acceptable and continues to contribute to one of "under-playing" concerns.

PSOs are committed to helping to ensure the Church is a safer place for everyone. They are not however, safeguarding professionals but volunteers who are often members of their local congregations. Whilst some will have safeguarding experience from their personal or professional lives, the independent reviewers were keen to highlight the need for PSOs to be properly supported by professional colleagues for them to fulfil the essential safeguarding tasks required for a safer Church. A part of this support will be to ensure PSOs have no conflicts of interest and feel confident about reporting all concerns immediately to the DSA and their team.

RECOMMENDATIONS

Recommendation 16:

The National Safeguarding Team to provide guidance on the reflective conversations that should be considered when safeguarding situations are explored during Ministerial Development Reviews (MDRs).

Recommendation 17:

Dioceses to ensure that parish safeguarding officers (PSOs) are provided with the correct training and support to enable them to perform their role effectively.

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Learning and development

The theme of learning and development encompasses a number of issues raised by the independent reviewers in their reports. These included the monitoring of attendance at training and for training content to be relevant to current issues and concerns. There was also mention of the importance of implementing the learning from reviews. A specific issue is the need for PSOs, church officers, volunteers, lay and clergy to just be more aware of what constitutes a safeguarding matter and what to do when faced with a safeguarding concern.

Training

There was significant commentary from the reviewers about the 'need for training'. This related to ensuring current training programmes were being accessed by parishes and dioceses right across the Church. Forty-nine recommendations were made locally which highlight the requirement for effective and consistent training.

The NST's Learning and Development Team has already received the evidence from PCR2 relating to this and has confirmed that they have plans in place to respond.

In addition, the reviewers commented that there was a need for training programmes to keep up with 'contemporary issues' such as domestic abuse and modern slavery.

The reviewers consistently raised the importance of the availability of training. This was linked to ensuring effective engagement of survivors and victims. As well as for DSAs and safeguarding teams to build the skills and confidence to ensure that this is a proactive response to safeguarding cases. This quote from a survivor shows how important this engagement is; *"As a young person, I didn't have the courage to reach out to friends, school. I needed someone to reach out to me."*

One concern raised by the reviewers was the need for people to complete the training that is available, and to understand the wide-reaching benefits of this. A reviewer stated, *"The provision of safeguarding training with a clear expectation to complete it, is a positive example which will affect ongoing change."*

Whilst there is clearly safeguarding training available through the Church, those spoken to by independent reviewers were not always aware of what was available and on occasions not clear on its value.

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Knowledge

There were 34 recommendations arising from the 45 (independent reviewers') reports which identified a lack of knowledge about safeguarding from a range of people across parishes and dioceses. There were a further 15 recommendations which related purely to up-skilling people including clergy to understand safeguarding and there was a specific focus on the need to understand and deal with cases of domestic abuse.

The inability of key individuals to recognise safeguarding concerns was seen as a risk by the independent reviewers. The reviewers put in their reports many examples of risks simply not being identified or recognised with the knock-on effect of referrals not being made to safeguarding professionals in a timely way or not at all. Consequently, the reviewers emphasised how this left individuals at risk without safeguarding measures being put in place. This is shown in the following extract from an independent reviewer's report relating to the early 2000s:

> The lack of knowledge and confidence of adult safeguarding led to a delay in responding to an allegation of sexual assault. Someone known to be vulnerable came regularly to church activities. During one of their visits, they disclosed the event. It was clear from the documentation that this adult was not consenting to the physical contact. The documentation indicates the lack of clarity by the member of clergy receiving the disclosure on what to do and they sought advice. Unfortunately details of how to contact the person making the disclosure were not taken. After making the disclosure the person did not return to church activities. This was a missed opportunity to address the concern and investigate. There were other concerns raised after this report about the priest about which the disclosure had been made.

Learning the lessons

There were plenty of examples of "learning reviews" after specific and serious incidents, but reviewers found these were not undertaken in all relevant cases. The independent reviewers noted their lack of confidence that the key messages from these learning reviews when undertaken would be disseminated nationally in a manner that will enable learning and more effective actions in order to prevent the same mistakes elsewhere. They commented that there is no apparent framework for "sharing the good and the bad." Again, the reviewers made recommendations which called for a national approach that could be applied locally to the lessons learned process and implementing consistently the learning outcomes from this.

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Continued Professional Development

The role of DSA is a relatively new professional post and overall, the independent reviewers are very complimentary about their performance. There is however, a disparity in the professional backgrounds and experience of each of the DSAs and this is often reflected in the strengths of their practice. There are some DSAs with a strong background in promoting work with survivors and victims, whilst others have more supervision and case management skills.

In a few areas there is a concern about DSA capability and resilience, whilst in other dioceses it is clear that the DSA is included in the right conversations and issues. The limitations in many dioceses were due to the capacity of the DSA and their team (see the Safeguarding teams section). The addition of some training roles in certain diocesan safeguarding teams is clearly very welcome but is by no means universal.

The reviewers were keen to express their strongly held views that the DSA role needs consistency across the Church with continued professional development for DSAs and their teams in safeguarding and data protection.

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Through PCR2 the independent reviewers were able to note the availability of the range of safeguarding training programmes. They raised concerns about people accessing the available training and the need for the extension of programmes to cover emerging safeguarding concerns such as modern slavery.

The reviewers noted the apparent variability of awareness, knowledge and skills in parishes, as well as dioceses and other settings about safeguarding and what to do when faced with a safeguarding concern which is leading in some cases to children and vulnerable adults being left at risk.

Whilst there are mechanisms in place to learn lessons from any safeguarding concern this process is not applied consistently, and the lessons are not necessarily shared or acted upon.

The independent reviewers were confident that further professional development and support for the DSAs and PSOs will lead to necessary improvements in safeguarding practice, to ensure the Church is a place of safety for all.

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RECOMMENDATIONS

Recommendation 18:

Dioceses to share their lessons learned reviews with the National Safeguarding Team to enable it to ensure the enactment of the existing process to include lessons learned recommendations in the national plan and share learning lessons review outcomes with relevant governing bodies. Ensuring the impact of this strategic work further influences improvements in safeguarding practice.

Recommendation 19:

The National Safeguarding Team to continue to develop effective ways of ensuring that contemporary societal safeguarding issues are incorporated into safeguarding learning, policy and guidance.

Recommendation 20:

The National Safeguarding Team to continue to develop an accredited national safeguarding training programme for all diocesan safeguarding team staff covering induction and a centrally coordinated and structured Continuous Professional Development (CPD) process.

Recommendation 21:

The National Safeguarding Team and dioceses to ensure all training that is available to diocesan safeguarding advisors, their teams, parish safeguarding officers, members of clergy and other church officers is underpinned by a robust communications plan which provides the information using a variety of methods and platforms ensuring all relevant stakeholders know what is available, how it can be accessed and what skills and knowledge it will provide.

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Strategy, leadership and governance

The theme of strategy, leadership and governance has been developed in response to the number of comments and recommendations made by the independent reviewers and their findings of the impact of previous reviews, including PCR1. These comments incorporated the links between strategy and strategic plans, the role of effective leadership in delivering these plans and governance arrangements to monitor and communicate their impact. Strategy, leadership, and governance are interdependent of each other.

There are a number of general statements which highlight the independent reviewers' concerns about the desire to learn from PCR2 and to implement the recommendations that have come from such an extensive review of files. These include:

In dioceses there appears sometimes to be a lack of respect and understanding for the Safeguarding Team's role and the DSA. One reviewer states:

> "… to demonstrate the disdain with which the then bishop, even as recently as 2018, treated the DSA, excluding their expertise at every juncture. He clearly stated that 'he only sees the DSA as involved if we are in receipt of specific safeguarding information.' Clearly this matter was entirely safeguarding related."

The theme on safeguarding teams provides details of the findings in relation to the beneficial impact safeguarding professionals have had. Nevertheless there is still a negative impact where there is a lack of leadership skills as this example shows.

Although the reviewers did find generally that the bishops were engaged in safeguarding and supportive of their safeguarding team members. There are examples of bishops setting high expectations around safeguarding in their dioceses and many of the reviewers commented positively on this. (This was despite examples of where guidance and policy was not consistently implemented by senior clergy.)

In short, the independent reviewers indicated some sense of a lack of trust in the leadership and the governance structures to ensure and enable recommendations or lessons learned from any reviews to be implemented (see above in the section on learning and development). The reviewers have commented extensively on the current inconsistencies in applying good practice policy and standards.

There is evidence of variable practice in qualitative auditing processes across the dioceses. In some dioceses, this auditing was particularly strong, in others there were less robust arrangements in place. The reviewers have observed these practices and the lack of action following other audits and reviews and believe that there is a risk that there could be the same response to PCR2.

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Implementing the PCR2 recommendations

From the analysis of 45 local reports there were 46 recommendations which indicated that the reviewers wanted assurance that the recommendations they had made would be acted upon in dioceses and other settings. This included the requirement for clear action plans being put in place, led by the DSAPs who were expected to track these plans through to completion.

Although there is evidence of safeguarding becoming an established part of diocesan business in many of the independent reviewers' reports, there are still examples of DSAs being marginalised. Across the 45 reports there were 70 recommendations made relating to these issues and many of these were aimed specifically at the DSAP composition, role and governance.

The reviewers expressed anxiety about the governance and leadership of safeguarding practice in dioceses. They wondered how the Church would ensure that all dioceses implemented the recommendations from their reports and how these would be tracked both at a local and national level to ensure they were completed, and their impact was known.

Local Strategy, leadership and governance

The reviewers noted the benefits of strong and trusting relationships between the DSA and DSAP which were empowering and enabling; supporting the DSA and ensuring good practice was consistent and sustained. There were a number of excellent examples given.

PCR2 has indicated again there is inequity in the way DSAPs are constituted throughout the Church of England. In many cases this is reflective of the level of engagement with the PCR2 processes which itself required the setting up of separate reference groups to oversee the work and report to the DSAP on progress and outcomes.

Membership of DSAPs was also found to be variable. Many, but not all, have survivor and victim representation. The lack of engagement by PCR2 reference groups or DSAPs with individual survivors and victims in 15 dioceses was disappointing. Many also had secular representation from statutory partners but again this was not universal. In all cases the PMB subsequently sought and received assurances from the relevant bishop about the continued commitment to ensuring properly constituted DSAPs.

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One comment from an independent reviewer stated:

> "It is recommended, the Diocese introduce a formal process to track recommendations linked to safeguarding, which feature in key reports such as SCIE reviews, lessons learnt case reviews, the PCR2 and other key pieces of work. The obvious place for this would be DSAP or a subgroup of DSAP".

> To test and further strengthen the quality of case work and case management, as well as demonstrate an openness for scrutiny, the Head of Safeguarding should consider the use of focused independent external audits on either case work, or theme-based topics, on a regular basis i.e., every 12-18 months.

It would be expected that this should be done in accordance with data protection law.

National Strategy, leadership and governance

It is not the purpose of this report to set out the national strategy for safeguarding. The reviewers nevertheless reiterated that it was essential that the PCR2 reports, and their recommendations were acted upon and followed through, to make sure that we are not contemplating PCR3 in the future.

The reviewers did suggest that an external auditing process which was undertaken regularly would help to reduce the inconsistency and variability of practice and adherence to existing good practice policy and guidelines. The following statements from one independent reviewer were specific on this issue:

> The Diocesan Safeguarding Team considers an annual review of current live cases by an independent safeguarding professional.

National Safeguarding Steering Group

The National Safeguarding Steering Group (NSSG) is the *"primary driver of standards",* in addition to monitoring the performance of the NST. It makes recommendations on the development of safeguarding processes to the Archbishops' Council, the House of Bishops and the NCIs. The NSSG is the owner of this report and as such has the responsibility for ensuring the recommendations made in it are implemented and the delivery and impact of these recommendations is communicated to stakeholders. This report concludes with details on the next steps which the NSSG propose to undertake to ensure the plans for implementation are sufficiently detailed to ensure resources are directed appropriately and there is a regular and rigorous monitoring process in place to measure the benefits of the recommendations both in and across dioceses, but also the NST.

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The independent reviewers noted the importance of strategic planning, effective leadership and robust governance arrangements and their impact on improvements in safeguarding and therefore on ensuring a safer church for all.

The reviewers' comments were to encourage dioceses and other settings to ensure they had in place a resourced action plan to implement the recommendations. They nonetheless had an expectation that these local improvements and changes would be aligned with the recommendations that are made nationally in this report.

The independent reviewers request is for assurance that the NSSG, will ensure all PCR2 recommendations are implemented.

RECOMMENDATIONS

Recommendation 22:

Diocesan Safeguarding Advisory Panels to ensure they review their terms of reference and membership. They should include an independent chair and survivor representation, with a range of independent statutory and voluntary partners that is appropriate to the diocese.

Recommendation 23:

The Church of England to continue to set in place a strategic objective to undertake regular independent external auditing of its safeguarding policies and procedures, as well as the effectiveness of safeguarding practice in dioceses and cathedrals.

Recommendation 24:

Diocesan Safeguarding Advisory Panel Chairs along with the appropriate persons responsible for vocations and ministry to reach out to TEIs and other church bodies to ensure a whole system approach to safeguarding and adherence to best practices

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Culture

The culture of any organisation is made of the behaviours, standards, attitudes, values and beliefs that contribute to its unique social and psychological environment. In the Church of England its culture is also formed by the theologies of those who work and worship in it. Culture is not a single identity, but is based on the shared attitudes and customs, the written and unwritten 'rules' that exist within and across an organisation and has an impact on the individuals who make up the Church. This is because culture is defined by how we conduct our business, treat those who work for us and worship with us and indeed the wider communities we serve. Culture of course is influenced by changes in wider society and changing attitudes. The culture of an organisation is often difficult to change and requires effective and skilled leadership. The way power and information flow through the Church influences our culture.

In this theme we set out the independent reviewers' findings on a whole range of factors which contribute to the determination of the Church's culture and its impact on safeguarding and in promoting and indeed securing a safer church for all. Things that can create a negative culture, can be summed up as a display of a lack of fairness or respect, lack of dialogue and a misalignment of values. In respect of the culture relating to safeguarding, the reviewers have noticed a number of issues where action should be taken in order to progress a healthier safeguarding culture and in promoting a safer Church for all. The reviewers did note the many positive changes in culture that have already taken place, recognising the impact of the leadership of senior members of clergy and church officers, and understanding that these changes take place over long periods of time.

Deference

The reviewers noted from both the files and from discussions with diocesan staff that there can be a culture of deference within dioceses towards the bishops or other senior members of clergy. The reviewers perceived a long-standing ethos where individuals felt unable to challenge back over safeguarding concerns. An example of this is *"the DSA wrote to the then bishop about their decision not to follow the advice, in discussion it is clear the DSA felt they were in a difficult position and support from the NST was not possible at the time but also there is a perceived lack of confidence in any support from the National Team".*

The independent reviewers described occasions when safeguarding concerns had not been reported to the DSA for advice. Instead, decisions were made about serious safeguarding matters which the clergy and church officers involved did not have the professional safeguarding experience to risk assess in order to make appropriate decisions. For instance, this is a case *"where a church officer had an inappropriate relationship with a young person and a decision was made to deal with the matter in house and not report to the DSA and involve the LADO".*

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There were reports which indicated a legacy of a culture that was too willing to accept accounts from those within the organisation. Allegations were described as often being dealt with informally, without appropriate investigation or record keeping. There were occasions reported when the belief in forgiveness and the right to worship appeared to the reviewers to outweigh the safeguarding concerns.

Disbelief and inertia

There were a number of comments from the reviewers where the seriousness of allegations or cases were minimised. The following examples illustrate this:

> Approximately ten years ago Clergy X was convicted of downloading sexual images of children. A press statement released by the Diocese at the time refers to the charges as "only downloading sexual images of children.' Clergy X was referred to Independent Safeguarding Authority (ISA), now part of the Disclosure & Barring Service, and barred from working with children and adults.
>
> Clergy senior leadership in the Diocese wrote to ISA asking for reconsideration to the barring of Clergy X working with adults. Independent Reviewer expressed their concerns that clergy senior leadership did not give sufficient regard to the seriousness of Clergy X's offences, and this was minimised and condoned by their attempts to override the risk assessment completed by ISA.

This is further emphasised in this reviewer's notes on a case:

> "The approach taken by a member of clergy in the 1990s was grossly unfair and in support of the perpetrator. There is little sympathy for the survivor within the recorded notes with the emphasis being placed on the distress caused to the survivor's mother and the survivor being described as uncooperative. Use of certain words [such as] 'apparently' 'their version' and the phrase 'they seem to think' suggests [the survivor] was not fully believed, and no meaningful emphasis was placed upon their suffering nor the need for [the survivor's] care to be paramount. The response [the survivor] received firmly minimised the abuse and even reference to the minor action taken is phrased as being 'to demonstrate they and we were taking the matter seriously' rather than because it was accepted, as necessary".

A different reviewer states:

> In a letter between two people holding positions of authority and influence in the 1970's an individual makes several complaints about an assistant curate. No explicit references are made about any safeguarding concerns at all, more about their general approach to the role and apparent lack of

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> commitment; however, the letter concludes '... I very much hope that eventually there might be some country parish for which they might care without doing too much harm, but I cannot honestly advise you to appoint them to a living in ….., as I feel it might involve the … in unfortunate and undesirable criticism ...'.

Bias

When reviewing the files in scope of PCR2 the independent reviewers noted instances of bias which they described in a number of ways. These included misogyny, sexism and attitudes relating to women in the Church, especially as ordained priests; as well as to same-sex relationships.

> "The misogynistic behaviour of clergy towards me (a female member of the clergy); I was made to feel it was my fault because of how I looked. I was told I would be good for the parish with legs like that, I would draw in the parishioners".

The findings of a few independent reviewers in some dioceses picked up on the behaviours and values of individuals which the reviewers described in relation to organisations whose purpose is to promote and maintain catholic teaching and practice within the Church of England. This does not mean that there is any correlation between these organisations and safeguarding concerns in general, but more a potential culture of bias. A small number of reviewers made comments referring to this, summed up by one as:

> "In reviewing Blue Files, it became noticeable that a number of clergy who were either on the Known Cases List, or who raised some concern during the review, were members [of such organisations]. The numbers are small and may not be statistically significant across the Church nationally, but the issue is worth noting here and has been raised with the National Safeguarding Team as a possible area for scrutiny".

Again not a safeguarding issue, but something which the reviewers were keen was noted as indicated in the information they reviewed to ongoing issues relating to attitudes and behaviours towards female members of clergy.

Protectionism

"Protectionism" is usually defined as a type of trade policy by which governments attempt to prevent or limit competition from other countries. A number of the independent reviewers used this term to indicate a culture which allows alleged and convicted perpetrators to work and worship unchecked, failure to listen and act, disbelief and in some cases diverting blame onto the victim of abuse.

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These are examples of the notes made by independent reviewers:

> [The early 2000s] a vulnerable adult alleged sexual assault by a member of the clergy. An investigation was carried out by another member of the clergy and a churchwarden who knew the victim. Despite there being evidence that the clergy member had made inappropriate comments to the victim and there being obvious concerns about the conduct of the suspected perpetrator, the perpetrator was believed by the people undertaking the investigation. The victim was considered as "attention-seeking" and was not believed. Following an investigation, it was deemed that the allegations were not substantiated. Although there were allegations of sexual assault, no reference was made to the police.

The Independent Reviewer in their notes commented, *"It is of note that some years later the victim reported the matter to the police".*

Another reviewer writes:

> An example of protectionism within the Church of England is illustrated in the following case. In this case, senior clergy allegedly closed ranks, enabling a convicted paedophile to continue the sexual abuse of children. Allegations of historic child sexual abuse had previously been made against the reverend, following which they were relocated to different parishes by and with the full knowledge of senior clergy, thereby enabling their continued sexual abuse of children. It was not until 2004, that they received a custodial sentence for historical serious sexual abuse of children. Despite knowing of his history of sexual assaults on children many years previously, the Church continued to facilitate his contact with children for [many] years.

In another example which also links to the comments about CCSLs in the section on safer recruitment:

> In the 2010s senior clergy in a neighbouring diocese sent a communication to the Diocese raising what they describe as 'serious questions' over references and the safe-to-receive process. It seems they had raised concerns over the usefulness and accuracy of references and the robustness of the safe-to-receive process. Despite this internal recognition that referencing was relatively ineffective, the process remains in place as validation of appropriateness for ministry in a different diocese.

Independent reviewers found evidence within the same file of senior clergy raising questions as to whether they should destroy certain letters and delete any other records as necessary. It was also noted that actions on file notes include an option to 'shred,' which suggests this is/was common practice. This also relates to the findings in the information management and data protection sections.

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Inaction

Some independent reviewers commented that there were occasions when they noted a culture that allowed people not to act, not even to report their safeguarding concerns, almost as if there was no point in doing so. This quote illustrates this; *"Another clergy suspected but didn't do anything, there was a rumour, but nobody listens."*

Reviewers also noted the impact of a culture where members of clergy or church officers cannot attend safeguarding training, or do not regard it as important and beneficial to themselves and others. Safeguarding is everyone's business, and the training is designed to raise awareness around safeguarding and develop the confidence for people to disclose, report and act in order to ensure a safer church for all. The reviewers commented when they found this not to be the case as in this extract:

> … relates to a case of a member of clergy responding inappropriately, during safeguarding training. The matter was dealt with very positively by the DSA and Diocese, with appropriate, immediate and proportionate action taken to resolve the issue.

Blaming the victim

Throughout this report the reviewers have provided numerous examples of the experiences of survivors and victims and shown how survivors and victims are not listened to, where they are not treated with respect, care nor consideration for what they have gone through and the impact it has had. In this theme the reviewers further expressed that the culture allowed for blame to be diverted onto the victim. A note from a local report shows this:

> An issue that has been observed by the IRs, historically, is that of victim blaming. This has predominantly come from either the accused person or by senior clergy including archdeacons and bishops. Additionally, when an allegation has come to the attention of the public, the [reviewers] have seen strong support for some of the accused clergy by members of the congregation. This too has resulted in blaming of the victim, even when the accused has been charged by the Police and is present at court. Until now, little was done to challenge that behaviour by the senior leaders within the Diocese and resulted in the well-publicised failures of the Diocese to respond consistently to survivors and victims of child sexual abuse.

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And another review stated:

> When interviewed by the bishop about the abuse, the victim was unaccompanied, they were not heard, that they were the person made to feel responsible for what had happened and was accused of being manipulative.

Another reviewer noted that:

> In [2010s] a young person complained that a church worker had been privately skyping them. There was a suggestion that the allegation was not believed, or some fault was levelled against the [person]. Despite this serious allegation there was no update regarding interventions, update training for the alleged offender, sanctions etc.

Earlier in this Section Two under the theme Survivors and Victims there are tragically other examples of the experience and treatment of survivors and victims uncovered by the independent reviewers.

Language

Language and culture are interlinked and the language we use can both express the culture and shape the culture of a group or organisation. This report has already indicated examples and concerns relating to how survivors and victims have been spoken to, and how members of clergy and church officers speak about safeguarding and safeguarding concerns. One reviewer described *"language used to describe an incident, which amounted to sexual assault, which appeared to minimise the incident".*

Domestic abuse

This report has already highlighted the finding of the independent reviewers with regard to domestic abuse in the section on survivors and victims, and learning and development. The approach to cases of domestic abuse also highlights many of the cultural issues identified in this section, for example survivors and victims not being listened to or not being believed and the Church not putting their needs first, protectionism, and minimising the seriousness of domestic abuse. The reviewers noted that the attitude towards domestic abuse was linked to the belief around the sanctity of marriage. The following extracts from the findings of the independent reviewers illustrate these points clearly:

> People were ignored through assumption of their circumstances, for example I spoke to a woman who was sleeping on a friend's sofa with her children after her marriage to a member of clergy broke down and [it was] assumed she was living in a rented house. It was this lack of support that caused her to withdraw her complaint.

An independent reviewer observed *"Clergy and church officers being 'groomed' and manipulated*

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by a perpetrator of domestic abuse, demonstrated when they wrote letters of support for good character references for a court appearance and had not reported the matter to the safeguarding office even though the alleged offender was a church officer."

Another reported – *"Occasionally there was still a tendency for the parish to offer couples work or marriage counselling before the concern about potential domestic abuse is recognised".*

In one case the Reviewer described the following incident which relates to the requirement for a C4 faculty. An Archbishop's faculty (under Canon C4 of the Church of England's Canons) is required for a person who is to be ordained as a member of the clergy, who has been divorced and remarried, or who is married to a spouse who has been divorced. These are granted by the Archbishop of the relevant province, of York or Canterbury.

> A person disclosed that their spouse had previously been married but divorced on the grounds of unreasonable behaviour. They had in fact been a victim of physical domestic abuse. A[n] investigation commenced, and the spouse was asked to provide information about their previous violent marriage. They explained that reliving the events would be very traumatic for them, yet they were still asked to recount those events.

The extracts below seek to show the reviewers' concerns that there is a culture of minimising the seriousness of domestic abuse:

> The number of domestic abuse cases seems low for the size of the organisation and where allegations are made there is an inconsistent approach to investigating and identifying risks.
>
> There were cases where no final outcome was recorded, which could suggest that risks were left unmanaged, and no safeguarding was put in place.
>
> Domestic abuse concerns were only evident in very few of the safeguarding files reviewed. In some cases, it was noted that domestic abuse was known or suspected but had not been dealt with, by means of early intervention or through seeking appropriate guidance and intervention from other agencies.

Domestic abuse is a widescale problem in society and the Church of England has recognised the need to raise awareness about domestic abuse, recently issuing a new training programme which can be accessed by anyone to support improvements in the awareness, reporting of and supporting survivors and victims.

The reviewers felt that there should be sufficient understanding and awareness amongst clergy and church officers to recognise the prevalence and harmful impact of domestic abuse on both men and women, and also children. The reviewers' comments

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indicate that the Church must promote a positive culture towards women in general and that all matters of poor behaviour regardless of the gender of the person abused, such as domestic abuse within the Church are dealt with positively and rigorously.

There are examples where through training events, an improvement in awareness of domestic abuse has been seen across dioceses with this training being delivered to all church officers. In one diocese a growing confidence was reported by clergy and parish representatives responding to reports of domestic abuse or in seeking advice and guidance with appropriate referrals made to statutory agencies. It was highlighted during the review that the availability of support offered by third sector groups should not be a missed opportunity. An example of where agencies worked together and the beneficial impact this had is set out below:

> A recent case related to [a circumstance in which] an ex-partner made an allegation of aggressive and violent sexual behaviour. The case was dealt with thoroughly and in an appropriate and timely manner. Referrals were made to statutory agencies with consideration of the need to safeguard, balanced with the need for support for both alleged perpetrator and victim. A comprehensive risk assessment was conducted with clear considerations and outcomes. The case was appropriately summarised, indicating that the allegation of domestic abuse was taken seriously, and the ability of the safeguarding team to deal with the case appropriately by considering the needs of all parties and working closely with other dioceses and statutory agencies.

The review picked out cases which demonstrated good engagement with survivors and victims, where the DSA and local parish incumbent worked together in an effort to offer support. Of note, was the response to concerns raised by the spouse of a member of clergy. The Diocese provided accommodation to enable one of the parties to safely leave the marital home, whilst the matter was appropriately referred to external agencies.

In another case, matters were dealt with well.

> In [2010s], a safeguarding team received a third-party report disclosing domestic abuse involving a church officer as the perpetrator. The DSA established safe contact details with the complainant and offered a meeting or option to report to police/specialist support services. The victim agreed to meet the DSA, where emotional abuse, developing physical aggression and [other risk was] disclosed. The victim was reluctant to report the matter to the police but accepted a referral to domestic abuse services. Risk assessments were conducted, and the Local Authority Designated Officers (LADO) notified, given the position of the church officer. Further consultation was conducted, but the concerns did not meet the threshold for formal intervention. An ongoing safe contact strategy was agreed, and the

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> victim contacted the specialist support services that were offered.

Despite these developments, many non-recent examples indicated a limited understanding of domestic abuse amongst church officers that at the time resulted in limited recognition and response to issues and poor management of perpetrators. There was a view that not enough had been done to ensure staff and clergy were sufficiently aware to recognise the signs of domestic abuse, or the confidence to get involved to help stop it. This further impacted on survivors and victims, with little thought given to their ongoing needs, especially when there was no wish to pursue a formal complaint.

Repeatedly, there were comments on the low number of domestic abuse cases reported, with concerns only evident in a small number of the safeguarding files reviewed. And, in the cases, where allegations were made, there was an inconsistent approach to investigating and identifying risks. There were indications that where domestic abuse was known or suspected, there had been a lack of early intervention or guidance sought from other agencies. Where the DSA was not made aware of a concern, or was informed too late in the process, the recording and progression tended to be limited and, in some cases, no final outcome was documented.

Files revealed concerns of physical and verbal sexualised behaviour by some male members of clergy towards female parishioners and church officers. There was a sense in the view of those reviewing the files that the experiences and feelings of the women had been minimised, given insufficient weight, and the challenges of raising concerns about a person in a position of authority were not fully recognised by those involved. There were concerns relating to the application of thresholds, and in some cases, a lack of chronology to link events of abusive and aggressive behaviours towards women that had not been perceived as serious enough to warrant an intervention or further investigation.

> A member of the clergy had been a leader within a diocese for [a significant period] and prior to that a priest in another diocese. Over [that time] there were a number of complaints regarding his behaviour from female members of the public, parishioners, and church officers. The complaints describe behaviour as being aggressive, impolite and humiliating and included verbal and written abusive language. Some female complainants described his actions as leaving them feeling 'terrified' and 'uncomfortable' One of the complaints was considered for Clergy Discipline Measure (CDM) proceedings, but no further action was taken. [A short time] after the initial complaint, the complainant produced additional evidence which was reviewed by senior Clergy. Whilst it was agreed that the evidence illustrated inappropriate and was concerning, they did not believe the threshold for CDM to be met and the agreed outcome was for the

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> member of clergy to write a brief letter of apology to the complainant.

It appeared to the independent reviewers that a disproportionate amount of concern was given to the needs of the member of clergy. For example, in one diocese there were references such as *'PTO was part of their identity and removal would adversely affect their mental health';* and *'should be allowed to retire with dignity'.* Whereas the position of women who had described feeling 'extremely uncomfortable' or had 'dreaded' the behaviour of someone in a position of trust and authority, were not fully documented or taken into consideration.

> In [2000s] allegations were made against a married member of clergy who had instigated a relationship with a female parishioner. The victim was vulnerable. They described the priest's behaviour as frightening, persistent and described him as bullying, intimidating and coercive. On one occasion the female claimed that the cleric was being forceful in his approach [resulting in physical harm]. The member of clergy denied the allegations. A formal complaint was made to the bishop, but no further action was taken. Letters held on file state that the priest was deemed to be naive, had made mistakes and that he required pastoral care.

There was a letter referred to by the reviewers from a member of the PCC relating to an incumbent *"terrorising his wife",* but no further information was recorded within the file to suggest that this had been appropriately progressed. In a subsequent meeting with the bishop, the incumbent disclosed being a survivor of abuse and the bishop undertook to refer this to the DSA. Although the referral was a positive response, there is no documented confirmation that this action was ever completed.

One survivor concerned about the Church's response to situations involving domestic abuse stated:

> "Overall, the Church has no understanding of domestic abuse. I wouldn't advise anyone to ask for support through Church of England for domestic abuse unless they had bruises to show… even then I am not confident of the response they would get".

There were references to a member of clergy and church officers being 'groomed' and manipulated by a fellow church officer and perpetrator of domestic abuse. In this particular incident, a church officer was charged to appear before the courts and fellow church officers submitted 'good character references' on behalf of the accused and yet the original concern had not been referred to the safeguarding team to investigate the matter.

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As one independent reviewer observed:

> "From the cases reviewed, we see the legacy of a culture that was too willing to accept accounts from those within the organisation. Allegations were often dealt with informally, without appropriate investigations or records. There were occasions when belief in forgiveness and the right to worship outweighed safeguarding considerations."

Bullying and harassment

Bullying and harassment are defined as behaviour that makes someone feel intimidated or offended. Harassment is unlawful under the Equality Act 2010 when it is linked to discrimination i.e., when it relates to a protected characteristic such as sex, age, race etc; otherwise harassment is a crime under the Protection from Harassment Act 1997. Bullying and harassment are not deemed safeguarding concerns in themselves, but a culture where bullying occurs is concerning due to what it says about the prevailing culture. This culture can then lead to an inconsistent or inadequate response to safeguarding concerns relating to children and vulnerable adults.

The independent reviewers found an apparent culture of tolerating bullying in some dioceses. This was described mainly when referring to the bullying of clergy by parishioners and other church officers and by other members of clergy. (Refer back to Clergy welfare section of Support and accountability).

An example given:

> In [early 2000s] a parishioner was allegedly bullying and harassing a member of clergy. The priest reported that the inadequacy and ineffectiveness in which this issue was dealt by senior clergy, caused significant further greater stress and anxiety to such an extent that [they] had to leave [their] post. Police investigated the allegations; the parishioner was charged with harassment and the matter went to court where a restraining order was issued against [them]. The priest subsequently made a claim for industrial injuries benefit. The priest wrote to a senior member of clergy to raise awareness of the depth of the issue of bullying within the church and how the issues were exacerbated by the well-meaning but ineffective response by senior clergy in the diocese.

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TOWARDS A SAFER CHURCH

There were some positive comments made about more recent indications of a change in culture by the independent reviewers as shown in this quote; *"More recently, there has been a positive change in culture which has been very much led by the current bishop and which has cascaded to ordained ministers."* The reviewers commented on the impact of culture on safeguarding in parish churches, diocesan offices and the whole institutional Church of England.

PCR2 was not intended to describe the culture of the Church of England, but the reviewers could not ignore the impact that culture has on safeguarding, on the survivors and victims, perpetrators, and the wider community, such as delaying taking action, not believing the victim and putting the institution of marriage ahead of a person's safety.

The findings of the independent reviewers provide evidence of cultural issues which need to change to ensure improvements in safeguarding and in making a safer church for all.

RECOMMENDATIONS

Recommendation 25:

Bullying is not defined as a safeguarding issue, but is a significant concern. All church bodies requested to ensure that identified incidents of bullying within the Church are recognised, recorded and dealt with effectively, and in accordance with relevant HR policies or as a safeguarding concern if a threshold is met.

Recommendation 26:

All church bodies to raise awareness of domestic abuse, including the understanding of the harmful impact of domestic abuse on children.

SECTION 3

CONCLUSIONS AND RECOMMENDATIONS

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This last section sets out the conclusions drawn from the findings and 26 recommendations which have been developed from the 800 plus recommendations made through the 45 local reports received and the outcome of PCR2 in other settings. The report ends with a commitment to the next steps to ensure the implementation of the recommendations is planned, resourced and the delivery of these monitored and their benefits and impacts not only communicated but used to ensure a continuous cycle of improvement.

From a safeguarding perspective PCR2 was conducted during a period where the Church was under considerable public scrutiny, following very serious allegations of abuse within church settings and the adequacy of support provided to victims.

As a consequence of the IICSA recommendations and the SCIE report, several safeguarding initiatives were commissioned, and were at various stages of proposal, development and/or implementation whilst PCR2 was being conducted. Where applicable, these facts are acknowledged in the report.

PCR2 has been a significant undertaking and is believed to be the most extensive review of records ever conducted by the Church of England. Whilst the review has resulted in considerable financial cost, this pales into insignificance in comparison with the emotional, physical, and mental anguish that survivors, victims, and their families have suffered at the hands of the Church; perpetrators who have abused their positions, whilst other chose to ignore the concerns of survivors and victims. For many, this has resulted in a devastating and lifelong cost. The summaries and quotes incorporated into this report illustrate, first-hand the experiences that some survivors and victims have endured. Their anger, frustration, and criticism, should act as a stark and timely reminder of the ongoing need to improve, develop and remedy the Church's safeguarding measures to ensure that persistent mistakes and failures are not repeated.

The detail with which this review has been completed has demonstrated a thoroughness and transparency, requiring compliance with *Protocol and Practice*, combined with the added benefit from the advice and expertise of the independent reviewers. Nevertheless, the report narrative shows the complexity of collating the information and data, which was significantly more than had originally been anticipated. The independent reviewers provide a considerable amount of detailed information. The key conclusion must be the need for consistent application and adherence, in the first instance, to existing guidance, policy and best practice. Nonetheless it is clear that this is not always achieved

Conclusion and recommendations

when dioceses are confronted with very traumatic, complex cases of survivors and victims who have experienced abuse.

The review identified broad, cross-cutting themes across the provinces, dioceses and other institutions that have highlighted concerns in safeguarding arrangements and identified where the responses to survivors and victims could be improved; these are described in the Findings section of this report and specified at the conclusion of each theme.

The Church's approach to safeguarding is changing and improving, but it is taking time - there is more to be done to prevent abuse happening in the first place. Through engaging, listening and learning lessons, the Church will continue to involve survivors and victims in its safeguarding work. When needed we will change our practices, improve our approaches and do things differently, as we continually strive to make our church communities safer places for everyone.

Achievement of the PCR2 objectives

Given the evidence presented it is possible to conclude that the original objectives set for the completion of PCR2 have been achieved.

Significantly, the outcomes from the review are considerably more comprehensive than originally envisaged, with the results and implications more wide-ranging than anticipated. Nevertheless, the findings fulfil the broader PCR2 aims and commitment, in that they identify issues that reduce the likelihood of future safeguarding failures and will enhance the support to survivors and victims. These issues will require review, revision and, in many cases, amendment, to further strengthen and develop current safeguarding measures.

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Conclusion and recommendations

The following table reiterates the evidence supporting the achievement of the PCR2 objectives:

PCR2 Objectives	Conclusions
To identify all information held within parishes, cathedrals, dioceses or other church bodies, which may contain allegations of abuse or neglect where the alleged perpetrator is a clergy person or other church officer and ensure these cases have been independently reviewed.	75,253 files reviewed by 65 independent reviewers across dioceses and all other settings in scope. The DiE will report later in 2022.
To ensure all allegations of abuse of children have been handled appropriately and proportionately to the level of risk identified with the paramountcy principle evidenced within decision making.	Where reviewers had found this not to be the case then the 168 cases related to children are included in the total 383 new cases.
To ensure that recorded incidents or allegations of abuse of an adult (including domestic abuse) have been handled appropriately demonstrating the principles of adult safeguarding.	Where reviewers found incidents where this had not been the case the 149 cases related to vulnerable adults are included in the 383 totoal of new cases.
To ensure the support needs of known survivors have been considered.	PMB requested each diocese to have in place a Survivor Care Strategy. 65 survivors and victims did speak to independent reviewers and there were facilitated workshops.
To ensure that all safeguarding allegations have been referred to the Diocesan Safeguarding Advisors and have been responded to in line with current safeguarding practice guidance.	Any that have not met this threshold are included in the 383 new cases.
To ensure that cases meeting the relevant thresholds have been referred to statutory agencies.	Examples of effective action and relationships with statutory agencies are given under the theme of Managing risk.

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Conclusion and recommendations

It was the case that safeguarding staff in dioceses and independent reviewers alike struggled to complete the required data set as set out in the appendices E and F of *Protocol and Practice* due to the complexity of cases and the difficult task of cross-referencing cases and individuals across a whole range of file types, some of which were over 50 years old. Subsequent efforts to provide a mechanism for capturing data was not completely successful and in the end each diocese was contacted by the PCR2 Stakeholder Engagement Officer who assisted with the collation and validation of data.

A summary of the conclusions gathered from the independent reviewers findings and which have guided the recommendations that are made in this report are set out below.

Theme	Conclusion(s)
Survivors and Victims	The findings of the 45 independent reviews showed that overall, there have been improvements in safeguarding practice in relation to survivors and victims. The introduction of safeguarding professionals to the Church is acknowledged as a key factor in this improvement. There was a commitment to engage and involve survivors and victims through PCR2. This included the requirement for dioceses to develop their own survivor care strategies. There is still however much more to be done at a national and local level to make sure that we are engaging and responding to survivors and victims in an appropriate and consistent way that meets their requirements and the safeguarding standards which are set out in current policy and practice. The PMB noted that the survivors and victims involved in the PCR2 process were determined to ensure that the recommendations made in this report would be implemented. The PMB was keen to ensure that survivors and victims are involved in influencing these changes and highlighted the willingness of survivors and victims to work with the Church at all levels, to be involved in workstreams and groups established to deliver the recommendations and monitor their impact.

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Conclusion and recommendations

Theme	Conclusion(s)
Survivors and Victims continued	Every diocese was expected to have in place as part of PCR2 a survivor care strategy. The PMB made a point of ensuring these were in place before accepting the independent reviewers' findings as the conclusion of PCR2. There were significant benefits to involving survivors and victims in PCR2 at the diocesan level and in compiling this report. While there was evidence of improvements in the way survivors and victims are supported; it is clear that much more needs to be done to involve survivors and victims and to improve their experience of safeguarding in the Church.
Managing those who pose a risk	All are welcome to worship in our church buildings, but this has to be balanced with the need to keep these environments safe for everyone too. For convicted offenders and others who are identified as posing a risk, this requires the appropriate risk management plans to be in place and to be monitored and enforced with rigour. Available guidelines were not always applied consistently, PSOs and clergy did not always have sufficient knowledge or skills.
Managing risk	*'Responding to Serious Safeguarding Situations relating to church officers Practice Guidance' and 'Risk Assessment Practice Guidance'* the reviewers were concerned that guidance is not implemented consistently. When the guidance is applied the reviewers noted the valuable contribution of core groups in mitigating risk and involving survivors and victims in the process. This leads to improved safeguarding outcomes. There was inconsistency in the sharing of information, although there is work ongoing to implement the IICSA recommendations five and six. There were, however, specific concerns about sharing information and the potential safeguarding risks related to those in chaplaincy roles between their employers (often public authorities such as the NHS and emergency services) and the Church which licences them as chaplains.

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Conclusion and recommendations

Theme	Conclusion(s)
Case management	Once again the independent reviewers related the inconsistent adherence to practice guidelines in managing and recording safeguarding cases. They highlighted the paucity of recording decision-making which subsequently added to the negative experiences of survivors and victims of the safeguarding process and its outcomes. Poor recording of chronologies and case notes also added to the challenges of how safeguarding professionals understand the "whole picture" in order to properly assess risk.
Managing information	The reviewers found a general lack of understanding of the data protection legislation. They also provided evidence of inconsistent practices relating to how safeguarding information is retained and how records are stored and maintained.
Safeguarding teams	The independent reviewers were supportive of the DSAs and their teams and found them to be effective. The reviewers linked improvements in safeguarding practice and outcomes to the introduction of the DSA role. The reviewers did however, express concern at the capacity and resources available to some diocesan safeguarding teams and their ability to effectively deal with the level of safeguarding need across church settings.
Safer recruitment	The independent reviewers noted the safer recruitment policy but again provided evidence that it was not always followed consistently. There were concerns related to the risks posed when members of clergy move between dioceses, and lay officers who moved between parishes. These were related to the appropriate references and checks being sought or made prior to people commencing in role.

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In terms of existing policy and guidelines the local findings reported by the independent reviewers made clear that there are already in place policies and guidelines setting standards of practice that would, in many of the examples given, have had a beneficial impact on experience and outcome. The reviewers found however, that the policies and guidelines were not applied or used consistently across the Church; nor did they drive sustained change.

This variability is linked to a number of factors such as the need to increase awareness of safeguarding, building the general knowledge, skills and confidence in a wide range of people at all levels in the Church, from clergy, church officers and staff, to volunteers and partners. At present there is no mechanism for checking on a routine basis if and how policy and guidelines are being applied and what the consequent benefits and impacts of their application has on safeguarding practice, managing risk and outcomes for survivors and victims. The same conclusion in respect of safer recruitment was made. The consequences of not following standards as they are set has resulted in concerns not being followed up and increased the risk of perpetrators having opportunity.

Record keeping too was identified as a weakness in some areas. The independent reviewers found a great deal of variability in how files were stored and managed. This applied to the information that was kept in the files too. Importantly the reviewers found crucial details of disclosure, and subsequent investigation and action taken were not adequately or consistently recorded and kept on file. This is linked to the requirement to adhere and apply policy and guidelines consistently, not just in safeguarding practice, but in standards of records management and associated policies such as data protection.

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Theme	Conclusion(s)
Support and accountability	This section highlighted the lack of opportunity to discuss safeguarding as part of the MDR process. The reviewers wanted to emphasise that safeguarding was another vital aspect of diocesan and parish life which was already busy both in ministry and pastoral terms. The Church is reliant on volunteers and this is the case with parish safeguarding officers. The reviewers felt that further support was needed for clergy and volunteers in their safeguarding roles.
Learning and development	The independent reviewers acknowledged there was a range of safeguarding training programmes available, at national and local levels. The available training was not always sufficiently communicated to enable people to access it and to help level up the knowledge and skills across the Church. While there were often lesson learned reviews undertaken the outcomes of these were not always shared or acted upon across the Church.
Strategy, leadership and governance	The independent reviewers noted the importance of strategic planning, effective leadership and robust governance arrangements and their impact on improvements in safeguarding and therefore on ensuring a safer church for all. The reviewers sought to encourage all church settings to have in place a resourced action plan to implement recommendations made from any review undertaken. They wanted assurance that the NSSG would ensure all PCR2 recommendations would be implemented.
Culture	The findings of the independent reviewers indicated a culture of deference, protectionism and bias, relating to attitudes and behaviours and their impact in relation to safeguarding. This was balanced by many positive comments of the indications of changes in culture across the Church.

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The Church has failed individuals over many years. Although practice and culture show some positive signs of improvement, the Church is still at risk of failing others in the future unless there are further significant changes of culture and attitude as well as adherence to more detailed and effective safeguarding practices.

The NSSG, as the national lead for safeguarding, will oversee the response to the resulting recommendations and coordinate, monitor, and advance the activities, whilst consulting and negotiating where further support is required or standards are not being met. It has also undertaken this oversight function in delivering the IICSA response.

It is clear from the numerous reviews that it is not acceptable to use the complexities of church structures as an excuse for weakened or diluted approaches to safeguarding. The Church must now take up the challenges and provide a safer environment, a safer church, for all.

There must also be no let-up in our determination to change and improve the culture of safeguarding and of equality throughout the Church.

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RECOMMENDATIONS

The purpose of PCR2 was to 'Identify both good practice and institutional failings in relation to how allegations of abuse have been managed, and to provide recommendations to the Church of England that will lead to improvements in its response to allegations of abuse and in its overall safeguarding and working practices; thereby ensuring a safer environment for all.'

The Church of England is made up of a wide range of church bodies – parochial church councils, cathedrals, diocesan bodies, bishops' offices, theological colleges and the NCIs, all of which were closely involved in PCR2. All of these church bodies are responsible for ensuring that safeguarding sits at the heart of the mission and ministry of the Church of England and are therefore encouraged to review the PCR2 recommendations and take responsibility for implementing them as indicated below.

This section contains a distillation of the recommendations from the analysis of the findings for each diocese, for each of the themes set out in this report. The recommendations will form part of a national PCR2 action plan that will include timeframes, measurable outcomes and a future governance process led by the National Safeguarding Steering Group

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RECOMMENDATIONS

In some areas the recommendations within this report also link to existing safeguarding workstreams, for example, those resulting from the Independent Inquiry into Child Sexual Abuse (IICSA). The recommendations are set out under three headings:

"Keep doing well" – These recommendations are based on what the Church has put in place and deemed good practice and where the independent reviewers have provided evidence which shows consistency of application in the majority of settings and affirmed that this should be continued and maintained across all settings and church bodies.

"Continue to do, but more effectively and consistently" – These are recommendations where the reviewers found evidence of Church policy and guidance and good practice which was not followed or implemented consistently and therefore was having a detrimental impact on safeguarding.

"Must improve" – These are the recommendations made by the independent reviewers where new pieces of work are required to be undertaken to improve safeguarding practice, outcomes and survivor and victim experience.

Each recommendation has been allocated to the organisation or organisations that the National Safeguarding Steering Group, will hold to account for its delivery; and to the department alongside the role with the responsibility for ensuring the recommendation is achieved. Further detail on the governance and reporting of progress is set out below.

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Theme	Recommendations		Implementation of the recommendation:	Keep doing well	Do more effectively and consistently	Must improve
Survivors and Victims	**1**	Church bodies must ensure that the 2021 *'Responding Well to Victims and Survivors of Abuse Guidance'* is fully implemented across each diocese to support the delivery of consistent, high-quality survivor-focused standards, including visible referral pathways for support.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* Partnerships and Engagement • *Lead:* Deputy Director Partnerships and Engagement		✔	
	2	The National Safeguarding Team must develop and deliver a national survivor and victim charter with survivors and victims. This charter should specifically set out for church bodies how children's views should be sought in all matters that affect them and creating cultures and practices which help them to spot indicators that a child might be being maltreated or at risk, ethically and effectively follow-up on these, and truly 'hear' children when they are expressing distress or communicating that something is wrong.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* National Safeguarding Team • *Lead:* Director of the National Safeguarding Team			✔
Managing those who pose a risk	**3**	Through the Safeguarding Learning and Development Framework, church bodies to ensure that all clergy, church officers and volunteers are equipped with sufficient knowledge and skills, proportionate to their role, to recognise safeguarding risks and make effective referrals to safeguarding professionals in all dioceses and settings.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* Learning and Development • *Lead:* Deputy Director Development		✔	
	4	Church bodies to ensure that current measures for consistent risk assessment and risk management arrangements are in place for individuals (clergy, church officers or congregation members) who present a safeguarding risk.	• *Responsible organisation:* Dioceses and parishes • *Responsible department:* Safeguarding • *Lead:* Diocesan Safeguarding Officers and Parish Safeguarding Officers		✔	

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Theme	Recommendations		Implementation of the recommendation:	Keep doing well	Do more effectively and consistently	Must improve
Managing those who pose a risk (continued)	**5**	Church bodies to ensure that safeguarding agreements are based on effective risk assessments and are monitored, regularly reviewed and actively managed. These should be overseen by safeguarding professionals and the record-keeping must also be consistent and effective.	• *Responsible organisation:* Dioceses and parishes • *Responsible department:* Safeguarding • *Lead:* Diocesan Safeguarding Officers and Parish Safeguarding Officers	✔		
Managing risk	**6**	The National Safeguarding Team to develop how core group guidance is implemented in order to ensure that they are established when required to manage risk, information is shared lawfully and efficiently, they work to time frames and actions are completed. Survivor, victim and respondent needs must also to be considered in core group practice and acknowledged in the guidance.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* Casework • *Lead:* Deputy Director Casework		✔	
	7	To develop an information sharing agreement between employers of lay or ordained ministers who hold the Bishop's Licence, such as self-sustaining ministers or part-time stipends. To extend the scope of the Information Sharing Agreement project, responsible for IICSA recommendations five and six, to include the implementation of an information sharing agreement between the organisations who employ Church of England chaplains (lay such as ALMs or LLMs or ordained ministers, sea scouts etc.) and the dioceses who grant the the chaplains the Bishop's Licence.	• *Responsible organisation:* National Safeguarding Team and Dioceses • *Responsible department:* Regional Model/Audit Project (IICSA recommendations 1&8) • *Lead:* Deputy Director Development and Diocesan Bishops			✔
Managing risk (continued)	**8**	Dioceses to review their current Information Sharing Agreements (ISAs) within their local partnership arrangements and update them where required. The ISAs should be robust, withstand legal scrutiny and cover all key and statutory partners.	• *Responsible organisation:* Diocese • *Responsible department:* Safeguarding • *Lead:* Diocesan Safeguarding Advisors		✔	

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Theme	Recommendations		Implementation of the recommendation:	Keep doing well	Do more effectively and consistently	Must improve
Case management	**9**	Dioceses, cathedrals and the National Safeguarding Team to support the implementation of a national safeguarding case management system to enable standardised recording and effective case management.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* National Casework Management System Project • *Lead:* Deputy Director Partnerships and Engagement	✔		
Managing information	**10**	All Church bodies should maintain good records and must adhere to the legal standards set out in the UK General Data Protection Regulations (GDPR). Diocesan Safeguarding Advisory Panels with the Diocesan Safeguarding Advisors are encouraged to implement information management approaches that make sure information is retained and shared lawfully. As with all Church bodies, the approach should be proportionate.	• *Responsible organisation:* Dioceses and all church bodies • *Responsible department:* Information Governance and Safeguarding • *Lead:* Diocesan Bishops		✔	
	11	Diocesan bishops to be satisfied that there are appropriate and robust arrangements in place for the management and control of all blue clergy files and which are conducted in line with existing policy and guidelines to ensure that safeguarding issues are correctly identified, recorded and referred onwards.	• *Responsible organisation:* Dioceses • *Responsible department:* Diocesan Bishops • *Lead:* Diocesan bishops		✔	

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Theme	Recommendations		Implementation of the recommendation:	Keep doing well	Do more effectively and consistently	Must improve
Safeguarding teams	**12**	Dioceses to review safeguarding resources to ensure these are sufficient, prioritised and in place to deliver the required standard of safeguarding, including training, prevention and support for survivors and victims, risk assessment and management of safeguarding caseloads. This may also apply to cathedrals who do not have arrangements with their diocese.	• *Responsible organisation:* Dioceses (and cathedrals) • *Responsible department:* Diocesan Board of Finance • *Lead:* Diocesan Bishop		✔	
	13	The role of diocesan safeguarding teams to be clearly defined and understood, including line management and supervision, in line with future planned arrangements contained within IICSA recommendation 1 'Introducing diocesan safeguarding officers in the Church of England'.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* Regional Model/Audit (IICSA recommendations 1&8) • *Lead:* Deputy Director Development		✔	
Safer recruitment	**14**	Dioceses and all church bodies to comply with the House of Bishops' '*Safer Recruitment and People Management Guidance',* (issued by House of Bishops came into effect on 4 January 2022) including clergy, parochial and extra-parochial, and also PTOs, church officers, lay ministers and volunteers. DBS renewals to also be consistent and effective and recorded on file.	• *Responsible organisation:* Dioceses and all church bodies. • *Responsible department:* Human Resources • Lead: Diocesan Bishop or accountable officer		✔	
	15	Diocesan bishops to be satisfied that all relevant clergy and church officers fully comply with the Clergy Current Status Letter (CCSL) policy ensuring that any safeguarding risks or concerns are highlighted as part of the process.	• *Responsible organisation:* Dioceses • *Responsible department:* Bishop's Office • *Lead:* Diocesan Bishop		✔	

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Theme	Recommendations		Implementation of the recommendation:	Keep doing well	Do more effectively and consistently	Must improve
Support and accountability	**16**	The National Safeguarding Team to provide guidance on the reflective conversations that should be considered when safeguarding situations are explored during Ministerial Development Reviews (MDRs).	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* Regional Model/Audit (IICSA recommendations 1&8) • *Lead:* Deputy Director Development			✔
	17	Dioceses to ensure that parish safeguarding officers (PSOs) are provided with the correct training and support to enable them to perform their role effectively.	• *Responsible organisation:* Dioceses • *Responsible department:* Safeguarding • *Lead:* Diocesan Safeguarding Advisory Panel Chair		✔	
Learning and Development	**18**	Dioceses to share their lessons learned reviews with the National Safeguarding Team to enable it to ensure the enactment of the existing process to include lessons learned recommendations in the national plan and share learning lessons review outcomes with relevant governing bodies. Ensuring the impact of this strategic work further influences improvements in safeguarding practice.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* National Safeguarding Team • *Lead:* Director		✔	
	19	The National Safeguarding Team to continue to develop effective ways of ensuring that contemporary societal safeguarding issues are incorporated into safeguarding learning, policy and guidance.	• *Responsible organisation:* National Safeguarding Team • *Responsible Department:* Learning and Development • *Lead:* Deputy Director Development		✔	

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Theme	Recommendations		Implementation of the recommendation:	Keep doing well	Do more effectively and consistently	Must improve
Learning and Development (continued)	**20**	The National Safeguarding Team to continue to develop an accredited national safeguarding training programme for all Diocesan Safeguarding Team staff covering induction and a centrally coordinated and structured Continuous Professional Development (CPD) process.	• *Responsible organisation:* National Safeguarding Team • *Responsible Department:* Learning and Development • *Lead:* Deputy Director Development		✔	
	21	The National Safeguarding Team and dioceses to ensure all training that is available to diocesan safeguarding advisors, their teams, parish safeguarding officers, members of clergy and other church officers is underpinned by a robust communications plan which provides the information using a variety of methods and platforms ensuring all relevant stakeholders know what is available, how it can be accessed and what skills and knowledge it will provide.	• *Responsible organisation:* National Safeguarding Team • *Responsible Department:* Learning and Development • *Lead:* Deputy Director Development		✔	
Strategy, Leadership and Governance	**22**	Diocesan Safeguarding Advisory Panels to ensure they review their terms of reference and membership. They should include an independent chair and survivor representation, with a range of independent statutory and voluntary partners that is appropriate to the diocese.	• *Responsible organisation:* Dioceses • *Responsible department:* Safeguarding • *Lead:* Diocesan Safeguarding Advisory Panel Chair	✔		
	23	The Church of England to continue to set in place a strategic objective to undertake regular independent external auditing of its safeguarding policies and procedures, as well as the effectiveness of safeguarding practice in dioceses and cathedrals.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* Safeguarding • *Lead:* National Director		✔	

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Theme	Recommendations		Implementation of the recommendation:	Keep doing well	Do more effectively and consistently	Must improve
Strategy, Leadership and Governance (continued)	**24**	Diocesan Safeguarding Advisory Panel Chairs along with the appropriate persons responsible for vocations and ministry to reach out to TEIs and other church bodies to ensure a whole system approach to safeguarding and adherence to best practices.	• *Responsible organisation:* Dioceses • *Responsible department:* Safeguarding • *Lead:* Diocesan Safeguarding Panel Chairs		✔	
Culture	**25**	Bullying is not defined as a safeguarding issue, but is a significant concern. All church bodies requested to ensure that identified incidents of bullying within the Church are recognised, recorded and dealt with effectively, and in accordance with relevant HR policies or as a safeguarding concern if a threshold is met.	• *Responsible organisation:* All church bodies • *Responsible department:* Leadership teams in each church body • *Lead:* Appropriate responsible person with identified leadership accountability.		✔	
	26	All church bodies to raise awareness of domestic abuse, including the understanding of the harmful impact of domestic abuse on children.	• *Responsible organisation:* National Safeguarding Team • *Responsible department:* National Safeguarding Team • *Lead:* Director			✔

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Implementing the recommendations

Planning for implementation

The National Safeguarding Steering Group (NSSG) is committed to ensuring that the recommendations contained in this report are delivered in full. Nevertheless the NSSG is aware that there will be significant work for the National Safeguarding Team (NST), dioceses and all other church bodies to put in place robust implementation and delivery plans for these.

The planning for implementation should be collaborative and where appropriate involve a range of stakeholders (including survivors and victims) in a defined process. In this way the NSSG can be assured that delivery of change is realistic, and the risk of duplicative efforts is avoided and that where work is already underway it is provided with further evidence to support its purpose.

Accountability and monitoring mechanisms

The NSSG will also establish the required accountability and monitoring mechanisms required to ensure that it is able to continue to publish regular updates on; a) progress towards each recommendation and b) the evidenced impact of the recommendation and the benefits achieved once it has been delivered.

These mechanisms will range from:

- a request to respond in writing by various church bodies to a timetabled request relating to specific recommendations;
- inclusion in the NST annual plan
- review via designed audits on an ongoing basis.

Communications

The NSSG will be supported in communicating the implementation of the recommendations through the National Church Institutions' communications expertise. This will ensure that there is a strategy in place for ongoing publicising of outcomes, impact and benefits to show the improvements, changes and continue to keep at the forefront the awareness of safeguarding and the experience of survivors and victims.

Bishop Jonathan Gibbs
Lead Safeguarding Bishop and Chair
of the National Safeguarding Steering Group

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Safe Spaces

Safe Spaces is a free and independent support service, providing a confidential, personal and safe space for anyone who has been abused by someone in the Church or as a result of their relationship with the Church of England, the Catholic Church in England and Wales or the Church in Wales.

Although the churches have funded the service, it is run independently by the charity Victim Support, who are one of the leading charities providing specialist support to survivors of abuse in England and Wales.

If you have been affected, however long ago, Safe Spaces can provide you with support. You do not have to have told the police or the church authorities, and you do not have to still be involved with the Church. Your information will not be shared without your consent unless you or someone else is in immediate danger.

General enquiries
0300 303 1056
www.safespacesenglandandwales.org.uk

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THE CHURCH OF ENGLAND

OCTOBER 2022