GENERAL SYNOD

Safeguarding Code of Practice: Safeguarding Practice Reviews

Summary

This paper presents the first Safeguarding Code of Practice on Safeguarding Practice Reviews. The document is attached at Appendix 1.

This paper sets out the new process for agreeing Safeguarding Codes of Practice, the reason why this particular document has been produced, and details of the consultation and development which were undertaken.

1. Status of this document

1.1. The *Safeguarding Practice Review* Code of Practice attached at Appendix 1 is the first to be published as Safeguarding Code under *Section 5A of the Safeguarding and Clergy Discipline Measure (2016).* Section 5A replaces the former rules under which safeguarding guidance has been issued. These Codes of Practice must be approved by General Synod. Section 5A differs in two important respects from the former rules. First, it replaces the former 'duty to have due regard' with a 'duty to comply' with the requirements of the Code. This was a recommendation arising from the Independent Inquiry into Child Sexual Abuse (IICSA).[1] Secondly, it extends the list of 'relevant persons' to whom this Code applies.

1.2. All Code documents contain both **requirements**, which are mandatory, and **good practice advice,** which is advisory. All requirements are clearly marked as such and are in a blue box.

1.3. The good practice advice explains how to deliver some of the requirements, sets out some good practice examples, and explains why some requirements are necessary. In other words, it explains "why and how" to deliver the requirements.

1.4. The programme for bringing forward all existing safeguarding guidance to become Safeguarding Code is set out below.

[1] Recommendation 2: amendment of Canon 30. anglican-church-case-studies-chichester-peter-ball-investigation-report-may-2019.pdf

Title	NSSG	Synod
Safeguarding Practice Reviews	March/May 2023	July 2023
Managing Allegations	November 2023	February 2024
Religious Communities	November 2023	July 2024
Learning & Development Framework	January 2024	July 2024
Safer Recruitment and People Management	November 2024	February 2025
Roles and Responsibilities	November 2024	February 2025
Safeguarding Children, Young People and Vulnerable Adults	November 2025	February 2026

2. Reasons why this Code is required

2.1. Under the current House of Bishops' *Responding to, assessing and managing safeguarding concerns and allegations against church officers practice guidance* (2017), advice regarding carrying out a Lessons Learnt Case Review comprises just two pages, including a footnote which states that further guidance on carrying out these reviews would be published by the NST in 2018. The principles this guidance sets out, that any review is independent, transparent, and has SMART outcomes are not incorrect, but are not in any way detailed enough to provide clear and consistent parameters and guidance about how to conduct such a review in order to achieve the best learning outcome.

2.2. The existing guidance also does not take account of good practice from other sectors, such as health and social care, where learning reviews after serious incidents are a common and well-established practice. There are particular similarities between what we now propose to call a Safeguarding Practice Review (SPR) and Child Safeguarding Practice Reviews and Safeguarding Adults Reviews which occur in the statutory sector.

2.3. It has also become increasingly important to distinguish the purposes of the different processes that exist in respect of safeguarding, so that people are clear what to expect from each.

- First, there is the process for responding to, assessing and managing safeguarding concerns about Church officers. This process is about the identification and management of risk through the core group process.

- Secondly, there are the processes which focus on responsibility and accountability for actions, including the establishment of guilt. These processes include criminal investigation and prosecution, disciplinary processes for those with contracts of employment, and complaints under the Clergy Discipline Measure (CDM) for those who are ordained.

- The third process, “learning lessons”, is about taking a step back to try to understand **why** the events happened in the way they did, and what were any underlying organisational and contextual issues which contributed to them. Answering the “why” question enables an organisation to learn and make improvements that will keep people safe in the future. Without these underlying issues being identified and addressed, there remains a risk that unsafe practice and organisational factors continue.

These distinctions are crucial. Safeguarding Practice Reviews are not judicial processes designed to establish guilt. If people think they are, they will inevitably be disappointed and frustrated, therefore it is important to prevent that by providing absolute clarity about their purpose.

2.4. Finally, although it is important to emphasise learning lessons as a discrete process from managing allegations and accountability processes, it is also important to locate it within the wider context of culture change in safeguarding. Safeguarding Code of Practice is being written in a way which encourages and facilitates a change in behaviour and attitudes and moves safeguarding beyond compliance into it being part of the Church’s DNA. Taken with all other workstreams, this Code and its promotion of reflective learning helps create a Church which is safe for all.

The Church’s Safeguarding Learning and Development Framework is based on dialogue and self-reflexivity, and therefore it was important to provide this

additional suite of resources which facilitate these discussions and learning in practice, according to the particular context.

3. What has changed

3.1. The principles set out in the current *Responding to, assessing and managing concerns or allegations against church officers practice guidance* are all sound and all remain in place. The key changes are around the focus of the Review and the details, good practice advice and templates we have provided in order to assist people to plan and manage the process to provide the most useful learning:

- We have provided information on the context of reflective learning, and within that been very clear about what a Review is designed to achieve, and what it will not.
- By setting these clear parameters, this will hopefully encourage participation from within the organisation itself, as well as providing a clear purpose for victims/survivors.
- We have provided good practice advice around the timescale for completing Reviews and the number of recommendations for a Review. This is to promote timely focus on the most critical areas where improvement is needed and at the point the organisation is most open to the changes needed.
- We have threaded the engagement of victims and survivors throughout the process.
- There is clear guidance (and Requirements) around thresholds, publication and implementation, none of which were provided previously.
- Templates have been provided for the Terms of Reference, quality assurance and exercises in the Appendix.
- GDPR is covered in comprehensive detail and a data pack is included.

4. Development and Consultation Process

4.1. Section 5B of the Safeguarding and Clergy Discipline Measure 2016, states that before issuing the code, the House of Bishops must be satisfied that:

sufficient and appropriate consultation has been carried out.

In deciding whether it is satisfied, the House of Bishops must, in particular, assess whether and, if so, to what extent it would be appropriate to consult the following—

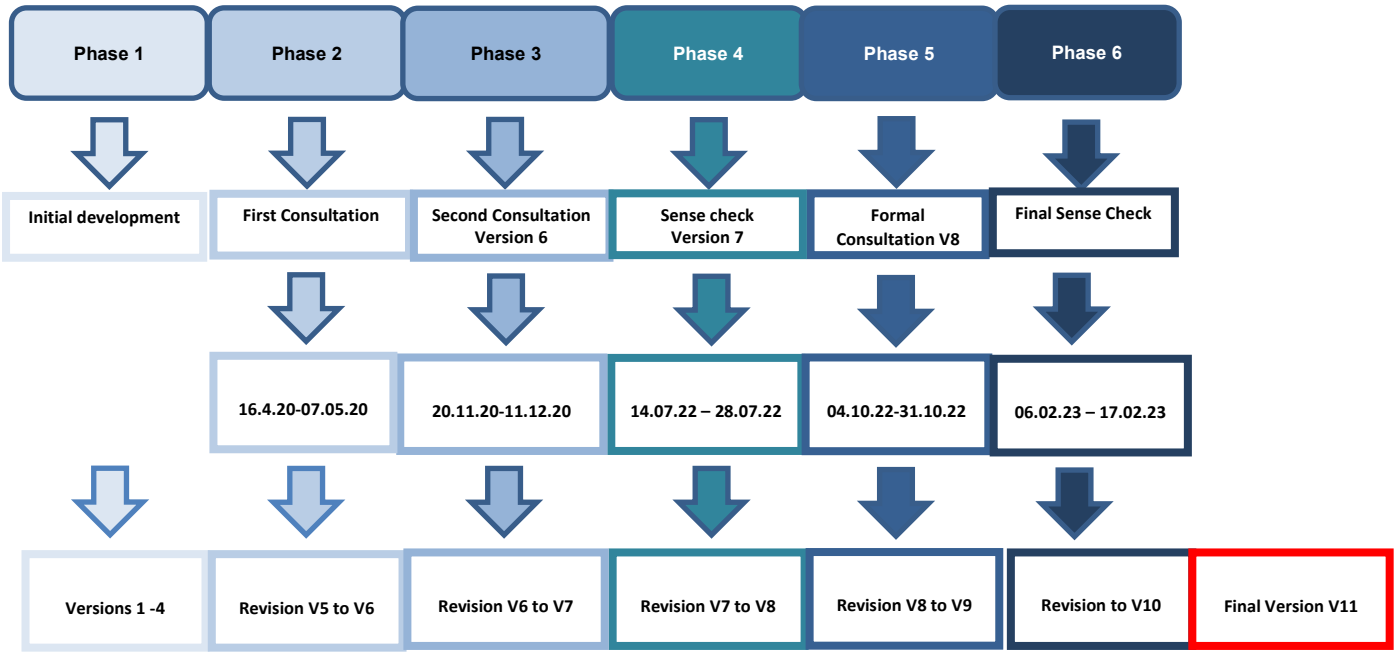
(a)persons, or groups of persons, who have suffered violence, abuse, neglect or exploitation in a setting or relationship to which the code applies;

(b)the president or deputy president of tribunals;

(c)the Standing Committee of the House of Clergy;

(d)the Standing Committee of the House of Laity

4.2. In order to comply with this requirement, we set out below the full details of the consultation and development activities undertaken in producing this new Code.



4.3. This section focuses on the main consultation carried out as Phase 4 towards the end of 2022, outlining how we undertook it, the key feedback points and how we have amended the document in light of them. There is also a separate section on the consultation with the National Safeguarding Panel (NSP).

4.4. The main consultation took place between 4th and 31st October 2022 (with reminders being sent on 26th October). This included victims and survivors. A second opportunity for survivors to provide feedback ran from 21st November to 5th December 2022. All NST consultations are circulated via email to the following groups:

- Bishops
- Diocesan Secretaries
- DSAs / CSAs
- Deans
- Cathedral Administrators
- DSAP Chairs
- Archdeacons
- Cathedral Safeguarding Leads
- Independent Safeguarding Board

In addition, as part of the requirements of the Code, we also circulated the document to:

- Standing Committee, House of Laity
- Standing Committee, House of Clergy
- House of Bishops

To consult with victims/survivors, we used our existing survivor engagement network to publicise the consultation, and additionally a small number of victim/survivors contacted us directly. Feedback was via the same template form, but 1-2-1 conversations were also offered. We also consulted internally with colleagues in the legal and data protection departments and externally with the Charity Commission and the National Safeguarding Panel.

4.5. Key feedback from the consultation focussed on the following topics. We asked four specific questions, the results of which are detailed in paras 4.3.1 to 4.3.4. The remaining points (4.4.1 – 4.4.6) were raised as “other feedback”. We have summarised both the points that a number of people made as well as points that,

though not necessarily made by several people, did have a material impact on the current version.

4.3.1 Question 1: What new term should be used to describe this process?

The majority of responses (19) indicated that *Safeguarding Practice Review* was the preferred term, and this is reflected in the latest version. Other terms suggested had three or less responses.

4.3.2 Question 2: Are any further measures needed in respecting the confidentiality of the respondent?

The majority of responses (14) indicated that enough had been done. Other responses (maximum of two respondents each) were generally focussed on practical points which have been added, or were focussed on victim/survivor confidentiality, which we have also added.

4.3.3 Question 3: Do we need further examples of "complex" and "significant" in relation to Section 2?

15 responses said yes, 11 said no. We have therefore added some examples of this, which we asked further questions on in the final sense check. We also amended the wording to take account of the sensitivities of using terms like "significant" and "harm", in specific response to feedback from survivors.

4.3.4 Question 4: What are the potential barriers?

The most commonly cited barrier was cost/lack of resources (23 responses), with the next most frequent being potential lack of engagement in the process (10 responses). There will of course be a cost when conducting a Review. It is hoped that this more detailed guidance will help to make them as efficient as possible. We have also provided additional steps to ensure that it is clear what resources are required. The best way to avoid costs is prevention: these Reviews should not be regular events for individual Church bodies if they are fulfilling their safeguarding responsibilities to an adequate standard. In terms of lack of engagement, this is understandable, but the intention is that by providing clear guidance and good practice on how to carry out Reviews – and

in particular by being clear about their purpose - people will be encouraged to engage because they will be contributing to keeping people safe in the future.

4.4 Other feedback

4.4.1 Holding people to account

Some concern was expressed that these Reviews would not hold people to account for what they had done and they would not establish guilt. We have tried to be very clear that the purpose of **this** process is not about managing allegations or about findings of guilt/responsibility. It is about understanding the reasons why events have happened so that an organisation can learn and improve its safeguarding. As explained in 1.3 above, there are other processes for holding individuals to account.

4.4.2 Time-scales for completion of Reviews

The draft consulted on in October 2022 included the following statement: "The expectation is that the whole LLCR process should take no more than **six months** from the decision to undertake the review until publication (commencing once the planning and data protection considerations have been completed)". This was not stated as a requirement but as good practice advice. The original two-page section in *Responding to, assessing and managing safeguarding concerns or allegations against church officers* did not provide a time-scale, and this can mean that the learning opportunity is lost. This is not a mechanism to curtail or do a less thorough job. By way of context, Safeguarding Adult Reviews in Rapid Time are completed in roughly 5 weeks.

There were several reasons this time-scale was given:

- if there are significant safeguarding issues in a Church body that need to be identified and addressed, then this needs to be done as soon as possible to keep people safe;
- if a review takes too long, the organisation's impetus for change might be reduced as they face other challenges and settle back into a "business as usual" frame of mind;

- review processes can be stressful for all concerned and shorter time-scales will serve to reduce peoples' stress.

However, the concern was expressed that by putting in this advice, Reviews that really did need longer to be completed, would not now take place.

To provide reassurance that this is not the intention, the text for this section has now been revised. It now states that the six-month timescale runs until the point the report is signed-off, rather than publication. It also states more explicitly that there may be exceptional circumstances where the timescale needs to be longer.

4.4.3. Number of recommendations

The October 2022 draft stated, in respect of the Reviewer's recommendations, that "These should usually be limited to no more than six recommendations which are outcome focussed and SMART". This was included because, potentially, a Review can come up with a high number of recommendations of varying degrees of significance. The danger with this (and this is certainly the experience in the statutory sector), is that the organisation's energies and resources might get dissipated across too many recommendations, when what might be needed is to focus on a smaller number, but to implement them in depth to a very high standard so that genuine change results.

This was included as good practice advice rather than a requirement. However, concern was expressed that this might prevent important recommendations being made in particularly complex cases. Accordingly, the wording has been changed to now state: "These should be focussed on a small number of high priority, outcome focussed, SMART recommendations, normally between six and ten in number". We have also made it clear that the Review Group can reject any report that does not produce SMART recommendations.

4.4.4 Engaging in the process

Concern was expressed that there would be no point in engaging in the process as previous LLCRs and PCR2 have not been implemented. We agree this could be a disincentive if people feel this, although there is a clear plan to take forward the recommendations arising from PCR2 and many recommendations from previous Reviews have been implemented. We have therefore made it a Requirement that if there are any previous Lessons Learnt Case Reviews or PCR2 recommendations which are applicable to the current case, these must be given to the Reviewer, and the Reviewer must consider them. The monitoring of the implementation plan by the Diocesan Safeguarding Advisory Panel will ensure that the learning is implemented in a timely manner.

4.4.5 Can cases be considered together?

We had not considered this, but we can envisage situations where a number of cases, which of themselves do not meet the threshold but represent a trend or pattern that warrants independent review. We have added this provision and provided guidance around it's use.

4.4.6 Promoting a Safer Church

The question was asked as to whether Reviewer recommendations should be linked with the six principles in Promoting a Safer Church**.** We had not considered this, and can understand the suggestion. However, we have decided to link the recommendations instead to the forthcoming Safeguarding Quality Standards. This is because church bodies will be focusing on implementing these, and they will form the basis of external audit, so this will provide another way of making sure the recommendations of reviews are implemented.

5. Feedback from the National Safeguarding Panel

5.1. This section briefly outlines some of the main feedback received from members of the NSP who joined a consultation meeting which is in addition to that mentioned above, and our response.

Feedback	Response
Sound piece of work – because it aligns with other types of review	
Six month time-scale – the publication stage can take quite a while; - in other sectors the time period can be 3-6 months. - language needs softening	We have made the changes outlined above.
Review the use of acronyms – reduce the number or take our completely.	Some reduction and glossary added.
"Core group" Use this term rather than the term it might be changed to, indicating it might change.	Change made
Consistency of terms – both "adult" and "vulnerable adult" used.	All references now to "vulnerable adults".
Other processes – need to spell out the other processes that will hold people to account. Though don't like the phrase "What Reviews are not"	This has been done. We have kept this is to aid clarity of purpose.
Chronology This needs to be in the body of the Review report, not alongside it.	Change made
Key Lines of Enquiry Need to make reference to the key lines of enquiry i.e. the specific things the review should look at.	Included
Rapid Review option – has there been discussion with SCIE about this?	Yes, and a number of members of the NST are currently undergoing the training provided by SCIE on this approach.
Quality assurance / Quality Markers How will they be quality assured?	We have developed Quality Assurance markers.

Publishing • Publish on national website rather than diocesan to help protect anonymity. • How long are Reviews published for i.e. how long do they stay on websites? • Should be sent to NST when published to hold archive of all Reviews. • How to ensure consistency in decision-making about what situations result in a Review?	We have covered all these points in the current version.
Templates Produce templates for the final report, Terms of Reference etc – this will help to draw out themes across different reports.	We have produced templates for the ToR, the structure of the report is clearly set out in the Good Practice Advice.
Purpose Emphasise that Reviews are about understanding the **why** not just the **what**.	This has been clarified.
Research The lines of enquiry should include reference to research findings and whether there is relevant previous learning – whether it finds things that were already found by previous Reviews.	This has been included.
Sign-off process Needs to be clear how final report is signed-off	This has been added.

6. Implementation

6.1 This Code will go live on the 31sy July 2023. It may take some time before any church body needs to undertake a Safeguarding Practice Review, and there is therefore time to become familiar with the Code. In the unlikely event of a Safeguarding Practice Review being required immediately after approval, the NST will be able to offer support.

6.2 The NST will provide workshops and other resources on the Code to support implementation, this will include GDPR templates and checklists in consultation with the Information Governance office. These will also cover the reflective learning exercises in Appendix A to the Code, as these will be the events that happen with much greater frequency, and where the opportunity to capture learning is greatest. Much of these are built on work that is already being undertaken and developed around reflective practices, including reflective supervision and risk assessment, and therefore tie in with ongoing workstreams.

6.3 The reflective exercises we suggest are exactly that: they are suggestions to help people find the way that works best for them and for their organisation to learn from safeguarding events in a variety of circumstances. The key thing is the move away from focussing only on what is wrong with individual practice or processes, into what is hampering or enabling good safeguarding practice at an organisational level. We will continue to work on developing tools and resources to help this.

6.4 In terms of the Safeguarding Practice Reviews as described in the Code, the NST will establish an archive in which a copy of every review will be stored. Each year the NST will complete an overview report setting out the main themes arising from Reviews completed across the Church in that year. This will be presented to the NSSG and the learning used to drive improvement.

Alex Kubeyinje, National Director of Safeguarding

July 2023

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Safeguarding Practice Reviews

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Contents

Introduction

The Church of England's policy statement 'Promoting a Safer Church' sets out the Church's commitment to the safeguarding of children and adults. One way the Church meets this goal is by ensuring that safeguarding activity is appropriately reviewed so that the learning which emerges is used to drive improved safeguarding behaviours and outcomes.

Learning from reflection on safeguarding behaviours and activity should be happening all the time, at all levels, as part of our routine way of working. However, some situations require a more formal review, known as a Safeguarding Practice Review, previously referred to as a Lessons Learnt Case Review (LLCR).

This Code outlines the Church's requirements for conducting Safeguarding Practice Reviews (SPR(s)).

The status of this document

This document is a safeguarding Code of Practice issued under s. 5A of the Safeguarding and Clergy Discipline Measure 2016, as amended by the Safeguarding (Code of Practice) Measure 2021, which came into effect on 1 March 2022.

Section 5A replaces the former rules under which safeguarding guidance has been issued. Section 5A differs in two important respects from the former rules. First, it replaces the former 'duty to have due regard' with a 'duty to comply' with the requirements of the Code. Secondly, it extends the list of 'relevant persons' to whom this Code applies.

This Code applies to people who have safeguarding responsibilities within the Church, including all authorised clergy, bishops, archdeacons, licensed readers and lay workers, churchwardens, parochial church councils and cathedral chapters. The full list of relevant people is set out below. In practice, safeguarding policy uses the terms Church bodies[1] and Church officers[2] to cover relevant people.

This Code contains both **requirements,** which are mandatory, and **good practice advice**, which is advisory. The **good practice advice** explains, for example, how to deliver some of

[1] Church bodies includes PCCs, diocesan bodies, cathedrals, religious communities, and the National Church Institutions. This policy will apply to the whole of the provinces of Canterbury and York (including the Diocese in Europe subject to local variations/modifications). There is also an expectation that the policy will apply to the Channel Islands and Sodor and Man unless there is specific local legislation in a jurisdiction that would prevent adoption.

[2] 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.

the requirements, sets out some good practice examples, and explains why some requirements are necessary. In other words, it explains "why and how" to deliver the requirements. Whilst the case examples and other associated advice should be considered as best practice which should be followed, the duty to comply does not apply to them. For clarity, in this Code, all **requirements** are clearly marked as such and are in a blue box.

Failure by a member of the clergy to comply with a **requirement** is an act or omission which may constitute misconduct under the Clergy Discipline Measure 2003 ('CDM'). Failure by a Reader or lay worker to comply with a **requirement** would be grounds for the revocation of that Reader's or lay worker's licence by the bishop, and failure by a churchwarden, parochial church council or cathedral chapter could result in an investigation being conducted by the Charity Commission and the person being disqualified as a charity trustee.

Who is a relevant person?

Each of the following is a relevant person:

(a) a clerk in Holy Orders who is authorised to officiate in accordance with the Canons;

(b) an archbishop;

(c) a diocesan, suffragan or assistant bishop;

(d) an archdeacon;

(e) a person who is licensed to exercise the office of reader or serve as a lay worker;

(f) a churchwarden;

(g) a parochial church council;

(h) the Chapter of a cathedral;

(i) the Diocesan Board of Education for a diocese (see subsection (8));

(j) the Diocesan Board of Finance for a diocese;

(k) any other diocesan body as defined by section 19(1) of the Dioceses, Pastoral and Mission Measure 2007;

(l) a body established to carry out a mission initiative as defined by section 80(1) of the Mission and Pastoral Measure 2011;

(m) a person who is an officer or member of staff of the Archbishops' Council, or who provides services to the Archbishops' Council, and whose work to any extent relates to safeguarding children and vulnerable adults;

(n) a person who works (on any basis) in a diocese or parish, or at a cathedral or for the purposes of a mission initiative, and whose work to any extent relates to safeguarding children and vulnerable adults.

Terminology Checker

SPR – Safeguarding Practice Review: Formerly known as a Lessons Learnt Case Review, a process of learning in order to improve safeguarding activity.

DSA – Diocesan Safeguarding Advisor: A professional employed by the diocese to support and manage safeguarding activity in the diocese.

CSA – Cathedral Safeguarding Advisor: A professional employed by the cathedral (or provided under a Service Level Agreement with the Diocese) to support and manage safeguarding activity in the cathedral.

CDM – Clergy Discipline Measure: The Clergy Discipline Measure sets out a legal process for handling serious misconduct cases against clergy[3], and sets out specific provisions in respect of safeguarding allegations, which were inserted by the Safeguarding and Clergy Discipline Measure 2016.

ToR – Terms of Reference: These set out the detailed parameters which the Review needs to fulfil, including what is to be reviewed, how and when.

SMART – Specific, Measurable, Achievable, Realistic, Time-bound: A standard way of ensuring that the recommendations/goals from any process are clear, well defined and impactful.

ISA – Information Sharing Agreement: A legal document that allows two or more parties to share, receive and use certain confidential information.

NST – National Safeguarding Team:[4] The Church of England's central safeguarding provision, supporting policy development, training, major projects and investigating cases against senior clergy (e.g. bishops and deans), and cases where there is a high degree of interest or complexity.

DSAP – Diocesan Safeguarding Advisory Panel: An advisory body offering external oversight and scrutiny to the diocese with regard to safeguarding.

ISB - Independent Safeguarding Board: The Board charged with independent oversight and scrutiny of the NST.

PCR/PCR2 – Past Case Reviews: PCR was a review of the handling of child protection cases carried out between 2007 and 2009. However, there were concerns about it as a process. As

[3] For further information, please see the Clergy Discipline page on the Church of England website
[4] For further information on specific responsibilities, please see Key Roles and Responsibilities of Church Office Holders and Bodies Practice Guidance.pdf (churchofengland.org)

a result, PCR2 was undertaken to independently review all concerns, allegations or convictions in relation to abusive behaviour by a living member of clergy or church officer. This was published in May 2022.

For the purposes of this document:

Victim/Survivor: This term is used to mean the person who suffered the abuse which led to the core group process. We appreciate there are a number of terms which are used by those who suffer abuse, but victim/survivor is used as shorthand throughout the report.

Respondent: This term is used to refer to the person about whom the allegation was made and who was the subject of the core group.

Section 1: Overview

1.1 The reflective organisation

Human organisations are complex systems working to achieve certain goals. Because they are complex, comprising a range of knowns and unknowns, predictable and unpredictable moving parts, things will inevitably go wrong at times or not achieve the desired goals and standards.

A healthy and effective organisation will be aware of this, and will know that it needs to be constantly reflecting on, and challenging, what it does and how it does it. This is how the organisation learns, both at an individual level and whole-organisation level. It is not just about learning from what goes wrong; a reflective organisation will be able to identify what is working well and build on that.

This "business as usual" approach to reflective learning by Church bodies in respect of safeguarding can take different forms. For example, in one-to-one reflective supervision sessions for safeguarding professionals such as Diocesan Safeguarding Advisors (DSAs)[5] and Cathedral Safeguarding Advisors (CSAs), or group reflection by the core group[6] during and at the end of work together on a case. Appendix A contains examples of other forms of reflective exercise.

When a situation demands a more formal approach with an independent dimension, a SPR will be commissioned. It is expected these cases will be in the minority.

1.2 What a Safeguarding Practice Review is and what it is not

The main features of an SPR are that:

- It is a planned process of reflective learning by a Church body designed to improve the quality and impact of that Church's body's safeguarding activity.
- The aim is to identify a limited number of key themes which, if implemented, will result in improved outcomes for victim(s)/survivor(s) and respondent(s).
- The Reviewer is a safeguarding expert who is independent of the case/situation in question and not directly employed by the Church body – this is explained further in Section 4.

[5] Following the approval of Amending Canon 42 in February 2023, and subject to Royal Assent and Licence, the term Diocesan Safeguarding Advisor will become Diocesan Safeguarding Officer at some point in the future.

[6] As part of the revision of the *Responding to, assessing and managing concerns or allegations against church officers practice guidance*, the term "core group" will be replaced with one which better reflects its purpose, for example, Safeguarding Case Management Group

- The SPR is governed by Terms of Reference – this is explained in Section 4.2.

It therefore follows that an SPR is **not:**

- An 'investigation' or 'inquiry' into an individual, the Church body or the NST, or focussed on the practice of any one individual.
- A legal or disciplinary process in relation to personal and professional conduct that seeks to establish blame or guilt and/or recommend sanctions – this is further explained in Section 1.6.
- A redress process that seeks to recommend restorative actions that should be taken in respect of specific individuals.

It is important to distinguish the purposes of the different processes that exist in respect of safeguarding in the Church context, so that people are clear what to expect from each.

- First, there is the process for responding to, assessing and managing safeguarding concerns about Church officers. This process is about the identification and management of risk through the core group process.

- Secondly, there are the processes which focus on responsibility and accountability for actions, including the establishment of guilt. These processes include criminal investigation and prosecution, disciplinary processes for those with contracts of employment, and complaints under the Clergy Discipline Measure (CDM) for those who are ordained.

- The third process, "learning lessons", is about taking a step back to try to understand **why** the events happened in the way they did, and what were any underlying organisational and contextual issues which contributed to them. Answering the "why" question enables an organisation to learn and make improvements that will keep people safe in the future. Without these underlying issues being identified and addressed, there remains a risk that unsafe practice and organisational factors continue.

These distinctions are crucial. Safeguarding Practice Reviews are not judicial processes designed to establish guilt. If people think they are, they will inevitably be disappointed and frustrated, therefore it is important to prevent that by providing absolute clarity about their purpose.

The approach taken in this Code reflects good practice in the statutory sector, in particular, Child Safeguarding Practice Reviews commissioned by Local Safeguarding Children Partnerships as set out in the government guidance Working Together to Safeguard Children, and Safeguarding Adults Reviews commissioned by Safeguarding Adults Boards, as set out in the Care Act 2014. It is important for the Church to mirror what is recognised as good practice standards for prevention and practice improvement in the wider safeguarding sector.

For victims and survivors of abuse, because the SPR's focus is on learning and improvement and not the establishment of guilt, the SPR might not deliver some of the answers and outcomes they are looking for in response to the abuse experienced. This is why it is important to be clear about the parameters of a SPR. Most of the answers and outcomes victims and survivors are looking will need to come from the two other safeguarding processes described above. In addition, victims and survivors must receive the support they need and are entitled to, which is set out in *Responding Well to Victims and Survivors of Abuse.* This includes the option to apply to the Interim Support Scheme and, in time, the Redress Scheme.

This is especially pertinent when the case involves abuse which happened some time ago. Policies, processes and personnel will have changed in the intervening time, and whilst the allegation must still be responded to as if it were current[7], i.e., the victim(s)/survivors(s) must be responded to and supported appropriately, the remaining risk assessed through the managing allegations process and any criminal investigations initiated, the learning outcomes of a SPR may be more limited. They are, however, none the less valid.

1.3 The outcomes of SPRs

SPRs should seek to achieve the following outcomes:

- The identification of systemic and organisational factors or failings which impacted on what happened. This should include any issues of organisational culture, the nature and quality of human relationships, resourcing and governance, and any inappropriate use of power within the Church body.
- An evaluation of the quality of decision-making and actions by Church Officers and their impact, highlighting both poor and positive practice.
- The identification of any strengths, good practice and what has worked well.

[7] Further information on how to respond well to historic allegations will be in the forthcoming Managing Allegations Guidance

- An evaluation of how well victims and survivors were heard with their concerns taken seriously, responded to, and supported throughout the process from the point of initial disclosure, including the impact of that response and support on victims and survivors.
- An evaluation of how well respondents were treated throughout the process of the case, including the provision of pastoral support, and how well risk was managed.
- An evaluation of interagency working with statutory services (where necessary).
- A set of priority, Specific, Measurable, Achievable, Realistic, Time-bound (SMART), evidence-based recommendations designed to improve safeguarding arrangements, practice and outcomes in respect of the Church body concerned and at whole Church level, specifically focussing on **what these recommendations will achieve.**

1.4 Timing and timescales for a SPR

The central objective of a SPR is the identification of learning to improve safeguarding practice and this should inform the timing of when Church bodies or the National Safeguarding Team (NST) commission them. The Church of England is committed to learning and improving practice. This means that the decision to hold a SPR should be made as soon as is practicable so that Church bodies can ensure that learning is current and can be quickly adopted in practice.

The general expectation is that in the majority of cases, the SPR process should aim to be completed in six months. This commences once the planning and data protection considerations have been completed and ends at the point at which the report is signed off (rather than published). It is appreciated that the representation and publication processes may take some time; however, the learning will be available once the report is complete. There may be exceptional circumstances where the timescale needs to be longer. However, this needs to be balanced against the risk that extending the timescale for a longer period increases the chance that the Church body loses focus on the issues and the impetus for change is reduced as the organisation reverts to its previous ways of working. In addition, review processes can be stressful for all concerned and shorter timescales will serve to reduce peoples' stress. Where delays or extensions occur, this must be communicated to the victim, survivor and respondent in good time along with a reason and the expected revised timescale.

1.5 Victims', survivors' and respondents' engagement

SPRs occur against the background of many inquiry findings about denial and cover up of abuse by clergy and others in Church-related roles. While the Church has expressed a desire to change, victims and survivors have experienced failings in the Church's responses when

clergy abuse is disclosed. This has created mistrust about Church safeguarding processes and the commitment to safe practice. Furthermore, the subjects of SPRs will usually be alive and the re-opening of the circumstances of their abuse can re-traumatise and re-abuse them. The Review process should seek to minimise these harms through a trauma-informed approach. This means placing victim and survivors' needs at the centre of the process, ensuring that they are fully supported, and involved at key SPR decision-points.

To this end, there is no separate "Victim/Survivor Engagement" section in this Code. Rather this is the "Golden Thread" that runs throughout the process, and sections contain a separate green box outlining the key considerations and means by which victims and survivors should be involved in each part of the process, where this is **in addition** to the blue box Requirements both in this Code and the *Responding Well to Victims and Survivors of Abuse Guidance*.

It is also important that respondents are able to engage fully in the process and given the necessary support to be able to do so. This includes ensuring they are treated with the same dignity and respect throughout the Review and that their personal data is subject to the same legal protections as others.

1.6 Relationship to other processes

The Review is not a disciplinary investigation and cannot recommend sanctions in respect of individuals. The Review should, however, identify where there are concerns about the safeguarding practice or behaviour of individuals, including their responses to victims or survivors. The Terms of Reference should clarify how, to whom, and when the Reviewer should report their concerns about individuals to the Review Group. The Chair of the Review Group should refer these concerns onto the person who is best placed to assess them for potential further action. This could be the line manager in respect of employees or the archdeacon for clergy.

It may be that a SPR identifies elements of an individual Church Officer's practice which, whilst not at the level of serious misconduct, nevertheless fall short of a reasonable standard of practice or behaviour. In ideal circumstances, these elements will have been identified by the Church Officer themselves through an iterative process of reflection and discussion. However, it is part of the Reviewer's role to help bring those individuals to this place during the process, it should not need to wait until the report is published. Where the Reviewer identifies evidence of poor practice, behaviour, and especially of any misconduct or any breach of House of Bishops' safeguarding guidance or Safeguarding Code, they must notify the Review Group at the earliest opportunity. This should not wait until the Review is

published. The decision regarding further investigation of professional capability or disciplinary issues rests with the appropriate senior officer in the Church body involved.

In some instances, a safeguarding incident may lead to criminal investigations, legal proceedings or it may trigger a review by statutory agencies. In these situations, the Church body should discuss with statutory partners its intention to conduct a SPR and document their advice. If it is advised by statutory services that the SPR should wait until the completion of these parallel process, then the Church body should consider this. However, the Church body can also decide that there are ways to conduct the SPR which will not adversely impact on these processes, and that the benefits of a speedy SPR outweigh the disadvantages of waiting. In addition, as outlined in Appendix A, there are other mechanisms which can be used in quick time to ensure that the opportunity to learn and to develop is not lost. The planning stage of the process needs to evaluate the capacity for the victims and survivors and respondents to participate in the Review within the suggested timescale, especially if statutory processes will run alongside.

Section 2: Thresholds for holding a Safeguarding Practice Review

Requirements

2. A SPR must be undertaken if serious harm has been caused to a child or vulnerable adult and one or more of the following factors are present:

2.1.1 There is evidence of systemic failures and/or vulnerabilities.

2.1.2 There is cause for concern as to the way in which Church Officers and/or different Church bodies, have worked together to safeguard children and/or vulnerable adults or treated victims and survivors.

2.1.3 There are challenging or complex factors present, for example, an indication that organised or multiple abuse may have taken place.

2.1.4 Initial assessment indicates that there is likely to be significant learning from the case, for example, that the case highlights the need for a significant change in diocesan or national safeguarding policy or practice.

2.1.5 The case is (or appears to be) high profile and has the potential to cause widespread loss of confidence in the Church's safeguarding practice.

Good Practice Advice

Each case is unique and different, but for a case to meet the threshold for an SPR it must meet criteria that can be summarised as relating to **harm**, **complexity, learning** and **profile**. This does not mean that the harm caused is greater than for other cases, but that there is more likelihood for learning to be achieved. Determining what constitutes "serious harm" is always going to be a professional judgement call, and it is accepted that for every victim and survivor, the harm they have suffered is serious and significant. This definition does not seek to minimise their harm, but to ensure that SPRs are reserved for the highest category of harm. A sound starting point might be if the harm would constitute a crime, for example, coercive and controlling behaviour, or physical, emotional or sexual assault.

Even if a case does not meet the threshold for a SPR, another form of reflective process should nonetheless be carried out, and victims, survivors, respondents and other Church

officers should be asked for their feedback on the management of the case. See Appendix A for further details.

It may be the situation that a non-recent case does meet all the criteria for a SPR. However, it is likely that learning from these cases may be more limited due to the passage of time. It is therefore important to acknowledge this fact and scope the Terms of Reference proportionately.

There is no hard and fast definition of "complex factors" in a church context, but examples of these include:

- Abuse by multiple perpetrators/suggestion of organised abuse.
- Perpetrators who work in various roles across a number of bodies and are therefore subject to different regulations/supervision etc.
- Multiple victims and survivors across multiple Church bodies.
- Continued reluctance from the victims, survivors or respondents to engage with the case.
- The magnitude and type or risk presented and how well or badly this was managed.
- Previous involvement or lack of engagement of statutory services.

In cases which come to light after the respondent has died, there can still be benefit in carrying out an SPR in order to determine if any learning can be elicited. This will, however, depend to a degree on how long ago the incidents took place. The SPR process to be followed needs to be proportionate and needs to account for the fact that the respondent's perspective, and the organisational and contextual situation which existed at the time, will be harder to capture. The revised *Responding to, assessing and managing concerns and allegations against church officers* guidance will provide guidance on how cases involving deceased respondents should be handled, including any criminal or HR procedures to be followed.

One final consideration is around thematic SPRs. This may be, for example, where a number of allegations around safer recruitment have come to light, which in and of themselves do not meet the threshold criteria, but due to the volume and emerging pattern, a case can be made that this is an area which requires further examination.

Section 3: Decision making process for commissioning Safeguarding Practice Reviews

Requirements

3.1 SPRs will be commissioned and governed by the Church body that took the lead role in the case itself (e.g. the cathedral or diocese). Therefore:

3.1.1 For casework in which a diocese has taken the lead role, the diocese will commission the Review, govern the process by which the review occurs, and receive the Review at the end of this process.

3.1.2 For casework in which another Church body, such as a cathedral or Religious Community, or where a Theological Educational Institution has taken the lead role, these responsibilities will be undertaken by this body.

3.1.3 For casework in which the NST takes the lead role, the NST will be responsible for commissioning the SPRs.

3.1.4 The decision to commission a SPR must be made by the DSAP Chair (or equivalent, see section 3.2 for other bodies and section 3.3 for NST) following recommendation by the core group.

3.1.5 The NST must be notified of all SPRs that are commissioned.

3.2 Victims and survivors must be consulted during the deliberations about commissioning of the Review and offered the support outlined in Responding Well to Victims and Survivors of Abuse Guidance during this period.

3.3 Respondents must be consulted during the deliberations about commissioning of the Review and offered the support they need to participate.

Good Practice Advice

3.1 The role of the Core Group

Responding to, assessing and managing safeguarding concerns or allegations against church officers states that Reviews need to be conducted after the end of every managing allegations process. At this point, the core group should also consider whether the thresholds in Section 2 apply and if there is the need for a formal (independent) SPR. If the core group does not believe that this is a straight-forward decision or it is unable to reach a decision, then it should seek advice from the NST or from its local statutory partners.

It is recognised that there are many different organisational structures within the Church of England, and this means that under this Code, any person within the leadership of the Church body can suggest that a SPR should be held. In some dioceses, diocesan secretaries, directors of human resources or archdeacons may chair core groups and in this role, they can recommend that the Church body should have a SPR. Bishops (or deans, where applicable) should not be involved in the operational details of safeguarding. However, they can make a recommendation to the core group to consider a SPR, if they believe from the information they have that the SPR is needed because it will lead to improvement in practice.

The victims and survivors involved in the case may also request that a SPR is undertaken. Their request must show that the case meets the criteria set out in the Section 2 Requirements. Any such request will be assessed by the core group using the criteria in Section 2. Should the core group determine that the threshold is not met, an appeal can be made to the Diocesan Safeguarding Advisory Panel (DSAP) Chair[8], whose decision is final.

The respondent may also request an SPR is carried out.

In all of these instances, it is the responsibility of the core group to consider the issues and decide whether the threshold for a SPR has been met. If it considers that the criteria have been met, it should then make a recommendation to the DSAP Chair that a SPR be held.

For cases which the core group considers that the SPR threshold is **not** met, the core group should conduct another form of case reflection and identify any relevant learning. For further information on the different forms of reflection, see Appendix A.

3.2 Role of the DSAP[9] Chair

The decision about whether to commission an SPR rests with the DSAP Chair, based on the information provided by the core group. This will include, as a minimum, a chronology of events and the reason why the core group considers this to be appropriate for an SPR.

Where the DSAP Chair decides that a case does **not** meet the SPR criteria, but the core group believe it does, the Chair must write[10] to the core group Chair to explain their reasons. If there have been any requests from external individuals or organisations for a Review, or an expression of concern that is the equivalent to such a request, the DSAP Chair must write to those individuals or organisations with an explanation for their decision.

[8] Or equivalent, see section 3.2 and 3.3

[9] Where another body, such as a Cathedral, TEI or Religious Community has their own independent safeguarding scrutiny governance arrangements, it will be the Chair of this group which will make the decision and carries out the role ascribed here to the DSAP Chair. Where they do not, it will revert to the DSAP chair. See Section 3.3 for cases involving the NST.

[10] For the avoidance of doubt, this includes email.

Where the DSAP Chair decides that a case **meets** the SPR criteria, they must write to the relevant lead (dean, bishop or archbishop) as well as the DSAP, the core group Chair, and the DSA[11] with an explanation. Assuming the DSA is the one who will have permission to do so, the DSA will communicate the result to the Church officer(s) and the victim(s)/survivor(s). Where the referral was made by an external partner, good practice requires the DSAP Chair to inform the referrer.

3.3 Cases involving the NST

Where the NST has led the work in a particular case which meets the SPR threshold, the NST will take the lead on the Review.

In the circumstances where the NST is leading on the Review, the Archbishops' Council is the data controller. There needs to be clarity from the beginning, particularly in cases with multiple Church bodies, what the data protection responsibilities are for each body.

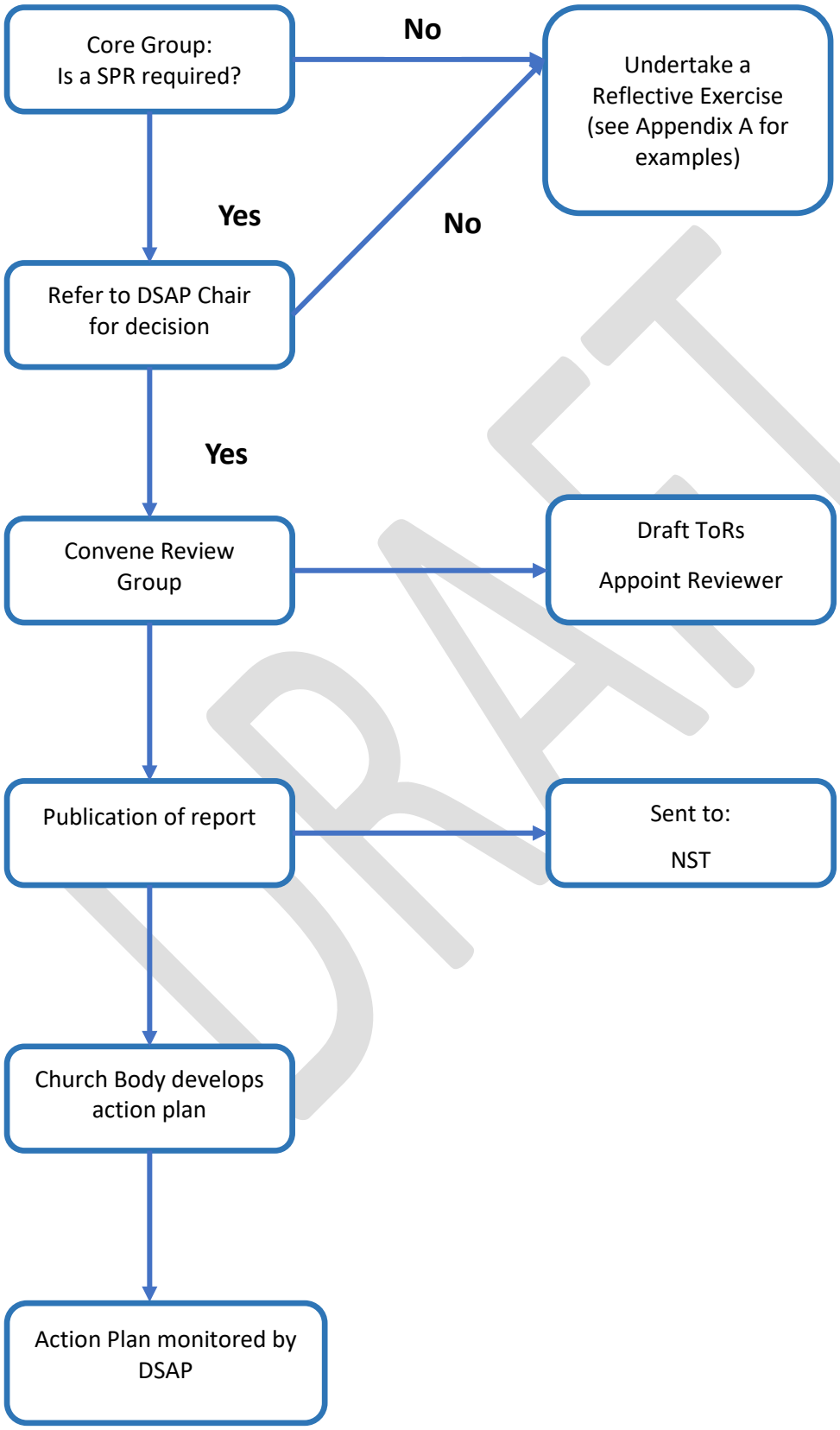
If the National Director of Safeguarding believes that a case has met the threshold for a SPR, the recommendation will go to a sub-group of three members of the National Safeguarding Steering Group (NSSG), one of whom will be a lead safeguarding bishop with no prior involvement with the case or the individuals concerned. In the unlikely event that all three lead safeguarding bishops are conflicted, another bishop from the NSSG will join the group.

An appeal against the recommendation of the National Director of Safeguarding to not conduct a SPR can be made to the lead safeguarding Bishop. The lead Safeguarding Bishop will convene a sub-group of three members of the NSSG to determine the appeal.

Victims and survivors may request that an SPR is undertaken in a particular case, and the core group will use the criteria in Section 2 to determine whether the case reaches the threshold or not. Victims and survivors can appeal against this decision to the DSAP Chair, who will use the same criteria, and whose decision is final.
Victims and survivors can be assured that, even if an SPR is not going to take place, there will always be a process of reflection in all cases which reach the core group, and that the main learning points will be shared with them, but what that process looks like will differ, depending on the circumstances of each case.

[11] Or CSA or equivalent Safeguarding Lead in the responsible body

3.4 Decision making Flowchart 1



Section 4: Managing Safeguarding Practice Reviews

4.1 Establishing the Review Group

Requirements

4.1.1 When the SPR threshold is met, the Church body must establish a Review Group to manage the process of establishing, coordinating and responding to the Review. The Review Group will remain in place for the duration of the SPR process. The role of the Review Group includes:

- Setting the Terms of Reference (ToR) and initial Key Lines of Enquiry (KLOE), including whether there are any previous Lessons Learnt Case Reviews where the recommendations have not been implemented.
- Completing the data protection arrangements with the Reviewer.
- Specifying the resources required for the Review to occur, including administrative support. In some cases, more than one Reviewer will be required.
- Selecting the Reviewer/s.
- Engaging with the victims, survivors and respondents to identify how they want to be involved in the process and what support they require in order to participate.
- Agreeing on the methodology and participants for the Review.
- Devising a plan for the implementation and evaluation of the SPR recommendations.
- Providing support to the Reviewer and ensuring the timetable is adhered to, including what governance processes the report will need to go through and planning for these in the overall timetable.
- Quality assuring the final report.

4.1.2 Chairing arrangements must be agreed on a case-by-case basis, but they are likely to be the DSAP Chair (in dioceses or cathedrals), Director/Deputy Directors or Safeguarding Lead bishops[12] if the SPR is commissioned by the NST, bearing in mind the data protection requirements which will apply.

[12] Safeguarding Lead Bishops would not be able to Chair any SPR which involved their own dioceses, or any other body (e.g. Religious Community, TEI) with which they have a connection

Good practice advice

The Chair will determine membership of the group. The size will be determined by the complexity of the case and the available resources but is likely to be four to five people. This is not intended to add an additional layer of bureaucracy, but to administer and manage the Review process. This will include who will be the point of contact for the Reviewer, the victims and survivors or their family and the respondent. The Chair has discretion to appoint other members with relevant expertise, if required.

The Group is likely to involve the following roles, but it will depend on the case and the resources:

- A member of clergy e.g. chaplain, archdeacon.
- A HR officer if the Church Officer is employed or a volunteer in a lay role.
- A member of the safeguarding team, if there is a member who **was not** involved in the original case.
- An individual who can make commitments about resources.
- An independent member e.g. from statutory services or the DSAP.

Where the case is likely to be very high profile, either locally or nationally, consideration should be given to having an additional independent person on the Review Group.

Given the resource implications of a SPR, consideration should be given to whether there should be someone on the group who can give those commitments. Alternatively, the Group needs to clarify how those decisions will be made. Other professionals may need to advise the Review Group depending on the circumstances of the case. The victims, survivors and Church officers/respondents need to be made aware of who is on the Review Group.

The Review Group is responsible for signing off the final report. See section 4.6 for further details.

The Review Group is not a legal entity from a data protection perspective, and the data controller will therefore be the relevant members who make the decisions about the processing of personal data by the Review Group. The Review Group should put in place a document which sets up and governs the management of the Group, and sets out which individual(s) manage the Group on behalf of its members and are likely to act as the controller, or the members of the Group act as joint controllers.

As the data controller, the Review Group are responsible for complying with the UK GDPR, including being able to demonstrate compliance with data protection principles, and taking

appropriate technical and organisational measures to ensure processing is carried out in line with the UK GDPR. The members of the Review Group may, however, be exempt from paying the data protection fee under the not-for-profit exemption. The Review Group should undertake the ICO self-assessment to check if this applies.

4.2 Setting the Terms of Reference (ToR) for the Safeguarding Practice Review

Requirements

4.2.1 The Review Group is responsible for setting the ToR for the SPR, which must be completed before the Reviewer is appointed. Once finalised, the ToR should be published, appropriately anonymised, unless there is compelling reason not to.

4.2.2 The ToR must include:

- Key Lines of Enquiry (KLOE).
- Timescales for the SPR.
- Governance arrangements for the SPR.
- The specific tasks that the Reviewer must undertake as part of the SPR.
- The Reviewer's responsibility for ensuring anonymity and preventing jigsaw identification of all victims and survivors and overseeing the representation process.
- The necessity for outcome-based recommendations.
- The proposed methodology for conducting the SPR.
- Who will be responsible for providing pastoral support to all those involved who may request it.
- Who will carry out any necessary representation process.
- The appropriate Information Sharing Agreements and Privacy Notices. This applies to all personal data used during the course of the Review. All interviews and evidence-gathering sessions must be carried out within the terms of this Privacy Notice.

4.2.3 Victims and survivors must be given the opportunity to suggest questions and areas of concentration that are personally important to them, the answers to which may contribute to their recovery. If these suggestions are not accepted, the reason must be given.

4.2.4 Respondents must be given the opportunity to suggest specific questions and areas of concentration that are personally important to them. If their suggestions are not accepted, the reason must be given.

4.2.5 The views of statutory partners on the ToR must also be sought if the Review Group believes this will assist the SPR.

Good Practice Advice

A template checklist for producing the Terms of Reference is available at Appendix B.

The ToR set out how the Review will be conducted and will start with the Key Lines of Enquiry (KLOE). Defining the KLOE helps to ensure that the Review is focussed. Exactly what the KLOE will be will vary from case to case and will be based on the initial areas of concern that have been identified by the core group. For example, the quality of relationships between people, organisational culture, adequacy of resources, arrangements for oversight of safeguarding activity. One important KLOE, although not applicable in all cases, will be the extent to which learning from previous Lessons Learnt Case Reviews, including Past Case Reviews (PCR and PCR2), has been implemented or not, as the case maybe. Where these exist, the Reviewer must be given access to them. Additional KLOE might emerge in the course of the Review process.

The Review Group will set specific and clear timescales by with the Church Body must provide the relevant documentation which is required for the Review.

There will be specific tasks which the Review Group requires the Reviewer to undertake. For example, a review of recent research relevant to the case in question, reference to any further documents, whether the Reviewer will be required to periodically meet the Review Group and/or any other performance indicators, and whether the Reviewer is responsible for contacting victims and survivors, respondents, other Church officers or the police and other statutory partners as part of the SPR.

The ToR will also inform the Data Processing Agreement (DPA) which is the instruction to the Reviewer about what processing activities they must undertake, if the Reviewer is a data processor. If the Reviewer is a data controller in their own right, then a joint data controller agreement should be put in place with the Review Group, and the responsible church body. There will be a number of different actions/responsibilities for the reviewer, therefore it needs to be made clear this may not be simply a data processing agreement.

The views of victims and survivors on the ToR

Listening to the perspectives and experiences of victims and survivors and in some cases their families is essential to maximising the organisational learning from an SPR. It is the foundation of all safeguarding work in the Church of England that survivors of abuse have a vital and unique perspective. They are the only ones who can see the situation in which they were abused from their viewpoint.

Determining how victim/survivor-centred the response of the Church body and Church Officers was might involve including:

- *Was the disclosure treated seriously?*
- *Was the disclosure treated with empathy and compassion?*
- *What attempts were made to establish the validity of the disclosure?*
- *What support was provided to victims and survivors and how effective was it?*
- *How involved were victims and survivors in the management of the case and how could this have been enhanced?*
- *What options for reconciliation, restoration and restitution were explored with the victims/survivors and how effective were they?*

The consultation with victims and survivors about the ToR and any follow up communication and explanation relating to the final version of the ToR can be done by a member of the Review Group, providing the required information sharing agreements are in place.

Structure of the report

Whilst every Review will be unique, and **the report is not the main product of the process**, nonetheless, there are some key themes which should be addressed. These include:

- A section outlining the **independence and qualification** of the Reviewer.
- A **chronology** of the case.
- Consideration of previous reviews/repeat learning and current research.
- Reporting on the KLOE will form the central body of the report. This needs to be not just a description but an analysis of what happened in respect of each KLOE – providing the **"why"** answer in respect of the **"what"** description. For example, **what** descriptions might include:
    - How victim/survivor-centred the responses of the Church and Church Officers were from disclosure onwards;

- Whether Church safeguarding guidance at the time of the events in question was followed;
- The quality of safeguarding arrangements and practice – both strengths and deficits.

Why answers might include;

- Whether any 'contextual factors' impacted on the case and in what way, for example:
  - Availability of adequate guidance;
  - Resourcing of safeguarding/workloads/staffing levels;
  - Training/supervision/support for relevant Church Officers;
  - Organisational culture and relationships;
  - Personal constraints (e.g. excessive or onerous responsibilities);

- The Reviewer's **conclusions**: what are the key lessons and changes required of specific Church Bodies and/or the whole Church system?

- The Reviewer's **recommendations:**
  1. These should be focussed on a small number of high priority, outcome focussed, SMART recommendations, normally between six and ten in number. The aim is to have a smaller number of achievable, impactive recommendations, rather than a large number of recommendations which are not impactive.
  2. Recommendations need to be aligned to the Safeguarding Standards[13]:
     - Prevention
     - Culture, Leadership and Capacity
     - Recognising, Assessing and Managing Risk
     - Victims and Survivors
     - Learning, Supervision and Support
  3. Within this, recommendations should be grouped under the following headings:
     - Strategic: Recommendations relevant to the whole Church system.
     - Local/operational: Recommendations relevant to the specific Church Bodies involved in the case. This must include whether further action is needed to manage on-going risk, and whether consideration of further investigatory action should be undertaken by Church Bodies

[13] Link to these when they are available

within their capability and disciplinary frameworks (These latter would not be published.)

4. In making recommendations, Reviews must:
   - focus on the most pressing and priority issues, rather than presenting a high number of minor points.
   - state the outcome each recommendation is intended to achieve.
   - provide an evidence base for why and how the recommendation will achieve the outcome required.
   - address issues of organisational culture and relationships as well as process.

Outcome-based recommendations

SPRs which take a long time to come to fruition and generate an excessive amount of high-level recommendations which may or not be realistic in terms of implementation do not adequately fulfil the purpose of creating opportunities for learning and improvement. Therefore, the focus should be on a smaller number of recommendations, which clearly evidence **what the outcome of that recommendation will be** and adhere to SMART objectives (Specific, Measurable, Achievable, Realistic, Timeline). At a simple level, this is the difference between saying:

"Recruitment and selection processes relating to members of the clergy should be the subject of review" and

"Recruitment and selection processes relating to members of the clergy should be reviewed so that they are in line with the Requirements of the Safer Recruitment and People Management guidance, including making sure that all those involved in the process have undertaken the Safer Recruitment and People Management Training. A phased timetable should be implemented so that both these issues have been addressed within 12 months.

Outcome: *All those involved in the recruitment of clergy have undertaken their SRPM training and are evidencing its use in their practice by this time next year. This will ensure that all the required checks as outlined in the SRPM guidance are being followed in respect of clergy appointments, which will mean that any safeguarding risks are identified and dealt with at the earliest possible stage.*

4.3 Tone and Methodology

The way in which the SPR is conducted should form part of the ToRs, and needs to be completed before a Reviewer can be appointed. However, there needs to be scope to amend

the detail of the ToR once the Reviewer is appointed, as they should be advising on the best way to conduct the Review.

Learning does not start and end with the SPR, and the purpose of the exercise is not to produce a report. The SPR is merely one part of the process designed to facilitate discussions to produce learning and improvement.

Adopting an appropriate tone and methodology is essential if the Review process is going to help to deliver learning which results in actual change. This is particularly the case if change in beliefs, values, behaviours and culture are needed.

An approach which:

- treats all involved (that is victims, survivors, respondents, clergy and staff, volunteers) with empathy, respect and compassion as valuable and complex human beings who matter;
- is dialogical, seeing all those involved as partners in the development of understanding and solution finding;
- is marked by genuine curiosity and transparency;
- is marked by creative ways of exploring issues relevant to the circumstances;
- prepares those who will be involved to address anxieties and fears,

is more likely to help bring about genuine change than one marked by fear, threat, fixed and strongly held positions, and inflexibility.

This also applies to informal reviews, where the opportunity to be more creative in approach is much greater.

This might mean that as well as the more "formal" aspects of the Review such as the chronology and meeting with those who were involved, there may be more informal aspects which might help the Reviewer to "get inside" the organisation to really understand **why** things happened the way they did. This might include things like attending particular services or observing meetings to fully understand the dynamics involved or convening groups of relevant people and facilitating a reflective dialogue.

The consultation with respondents about the ToR and any follow up communication and explanation relating to the final version of the ToR can be done by a member of the Review Group, providing the required information sharing agreements are in place.

Two examples of specific methodologies which could be adopted are below. **The Learning Together model by the Social Care Institute of Excellence** focuses on how organisations

can improve their practice by learning about the causes of the safeguarding incidents, taking the wider context of other 'systems' that they interact with. It specifically focusses on:

- using systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture;
- building internal capacity by having staff trained and accredited in the Learning Together approach to reviewing;
- undertaking rigorous case reviews and audits using a core set of principles and analytic tools;
- building on the experience and findings of previous reviews

The website contains helpful advice for organisations about commissioning reviews, deciding on the skills of the Reviewer suitable for their purposes, and quality assurance.

Practice Review Framework – developed in Wales and suitable for reviewing both children and adults' safeguarding failures, this model emphasises speedy completion of reviews to ensure quick implementation of learning. This has been compared favourably to more traditional approaches to reviews in the study **'Comparing Safeguarding Review Methodologies'**.

4.4 Selecting and appointing the Independent Reviewer

Requirements

4.4.1 The Reviewer must be independent of, and must not have had any prior involvement in, the case and be suitably qualified to undertake the Review in question.

4.4.2 The Reviewer must not have a professional or personal relationship with any individual connected to the case being reviewed.

4.4.3 The Reviewer must not have professional or personal involvement in any church, parish, diocese or cathedral or other Church Body that is part of the review.

4.4.4 The Reviewer must have significant professional experience relevant to the specific features of the case in question.

4.4.5 The Reviewer must demonstrate experience and ability to collaborate with victims and survivors of abuse, demonstrating empathy and compassion.

4.4.6 In the majority of cases, the Reviewer will be a data controller. Therefore, they must be registered with the ICO and evidence their knowledge of, and ability to comply with, data protection legislation, including the UK GDPR; the implications of this legislation for the Review, how these will be managed, and evidence sufficient IT skills to be able to do so.

Good Practice Advice

Final responsibility for the selection and appointment of the Reviewer rests with the Review Group.

To ensure that victims and survivors have confidence in the Reviewer, their views should be sought on the specific experience that a Reviewer should be able to demonstrate, for example, someone with specific experience in domestic abuse, spiritual abuse etc.

Where any stated requests cannot be met, for example, where no potential Reviewer matches all the criteria, or is not available in a reasonable time scale, the alternatives should be discussed with victims and survivors.

It will be essential to good practice and a victim/survivor-centred approach for the Reviewer to meet the victims and survivors whose abuse led to the Review, as soon as possible after their appointment.

Independence of the Reviewer

'Independence' does not require a Reviewer to have no connection whatsoever with the wider Church of England. For instance, a Reviewer's independence may not be undermined if they attend a church in another diocese, or another cathedral, or they led previous safeguarding work in the Church. However, there may be cases where the Review Group and victims and survivors agree that a Reviewer must be entirely independent of the Church of England.

Reviewers may come from a variety of backgrounds and are likely to be identified via professional networks. These might include:

- someone who has completed a review before;
- a recommendation from DSAP members;
- a recommendation from statutory or third sector services.

It is important to note that just because someone is recommended, that does not automatically mean they will be appointed. The Review Group will still need to satisfy themselves that the individual meets all the desired criteria.

Experience of the Reviewer

In addition to the requirement for independence, all Reviewers will have the relevant personal qualities and professional experience to conduct the Review:

- The Reviewer should possess the inter-personal skills and experience to engage sensitively with victims and survivors, respondents and other Church officers. Being able to evidence the soft skills required to hold detailed and painful conversations with people (both individually and in groups) is of as much importance as their experience. Ideally, they should have experience of successfully involving survivors in case reviews.
- The Reviewer should have the relevant skills and experience for the matter being reviewed. This would normally consist of experience derived from employment in social work, police, probation, law, but may also, depending upon the case, include other professional backgrounds such as psychiatry or psychology. '*Relevant'* here means 'specifically relating to' rather than just in the same general field. For instance, a retired senior police officer with an extensive experience in fraud investigations would not be an appropriate person to review a case involving child sexual abuse.
- The Reviewer would normally be expected to have held 'senior management responsibility' as part of this experience. '*Senior management*' means responsibility for leadership and management of an organisation which included leadership of organisational change, improvement and quality assurance. They need to demonstrate

understanding of how organisational systems work, how change happens and the significance of organisational culture. They need to have a good understanding of the requirements of data protection law in the operational context.

- The Reviewer should have proven analytical skills, experience of quality assurance and service improvement in safeguarding. This experience may include formal, structured reviews of complex casework, for instance, Serious Case Review, Serious Further Offence Review or Domestic Homicide Review work, and have had these reports published.
- The Reviewer will also need experience of organisational culture and change, and experience of being able to "get inside" of an organisation, in order to fully understand the challenges and dynamics, and see beyond the surface. A key skill will be the ability to ask the right question, of the right person, at the right time to unlock the capacity for learning and improvement. It will be an advantage if this has been previously carried out in a Church context, as an understanding of the workings of the Church will be needed. Where they do not, the Review Group will need to ensure that the Reviewer has adequate access to material, briefings and individuals who will help them understand any relevant issues. It is for this reason that the Reviewer will need to contribute to the methodology section of the ToR – they should have the experience to be able to provide advice on what methodologies are best suited to achieve the outcomes needed from the Review.
- In high profile cases, it may be appropriate to consider a Reviewer with experience in managing media and public scrutiny.
- The Reviewer will need to confirm they can commit sufficient time to conclude the Review within the time parameters set.
- The Reviewer must be able to demonstrate the ability to properly anonymise data and carry out representation processes.

It is expected that a published[14] SPR will include a section outlining how the Reviewer meets the above criteria and an 'Independence Statement' showing their separation from the matters being reviewed. The Reviewer needs to be made aware of this in advance and it must be included in the Privacy Notice.

After the appointment of the Reviewer, the Review Group must give the Reviewer any specific instructions as to the conduct of the Review. These might include[15]:

[14] See section 6 for what we mean by "published"

[15] The exact instructions will depend on whether the Reviewer or the Church Body is the data controller.

- That the victims and survivors should be asked what they wish to contribute, and what support they might need to do so. They should also be asked if any of the information they have already provided as part of the case can be used if they do not want to give it twice.

- That the Reviewer must, as part of the process of interviews of respondents and other Church officers, put any potential criticism or judgement to them so that they have a right to reply before the report is written.

- The Reviewer must also take notes of interviews and send them for approval to interviewees, to mitigate the risk of challenge at the representations stage.

- The Review Group will also supply the Reviewer with a detailed chronology of the case, which will be published within the final report, subject to anonymity considerations.

- The Reviewer must work closely with the Church body's legal and data protection lead throughout the SPR.

4.5 Other issues

Requirements

4.5.1 When commencing the Review, all data subjects whose data will be used in the Review must be provided with the Privacy Notice setting out how their personal data is to be processed. The Privacy Notice will also need to be issued to any data subject who is contacted by the Reviewer, or who contacts the Reviewer, during the Review.

4.5.2 The Reviewer must actively engage with victims and survivors throughout the process.

4.5.3 A victim-centred approach means that victims and survivors must be kept informed during the Review.

4.5.4 The respondent must be kept informed during the Review.

When inviting victims and survivors to be involved in the SPR process, great care must be taken to ensure they are sufficiently supported at the earliest part of the process, as set out in Responding Well to Victims and Survivors of Abuse Guidance. By revisiting the circumstances of the victims and survivors abuse, SPRs carry the risk of re-traumatisation. Victims and survivors should be asked if they want to provide anything they wish, however it is advised that victims and survivors should not be asked to repeat information that they have already disclosed to other professionals and is readily available from other sources.

Good practice requires that exploring with victims and survivors how the Review process and its conclusions can bring a degree of healing should be an essential part of the process. Victims and survivors should not be made to feel as if they are being asked to contribute to the SPR only for the Church's benefit; they are also key stakeholders in the SPR.

The Reviewer will need to consider how this can be most effectively achieved. It is good practice to establish how contact will be maintained throughout the duration of the Review, agreeing with the victim(s)/survivor(s) when they would like to be contacted, by whom, by what method, frequency of contact and so on.

The support provided to the victim(s)/survivor(s) as required in the Responding Well to Victims and Survivors Guidance needs to remain in place during the Review process. This

includes the provision of a Support Person, therapeutic support for emotional and psychological needs; theological, spiritual and pastoral care; signposting to other services such as Safe Spaces, and other support available through the central Church.
The survivor has the right to give a written or verbal 'impact statement' which can inform the work of the SPR. This must be discussed with the victim/survivor and they should be given a choice which meets their needs.
High standards of professional practice must underpin the conduct of the SPR to minimise adverse impact on the victim/survivor. These include speedy decision-making, transparent internal processes and communication with the victim/survivor about their involvement. The Review Group must also explain how confidentiality applies in the process.

Continuous / real time feedback loop and dialogue

The SPR must be a time-limited, dynamic process. As key aspects of good practice or areas for improvement are identified, they should be fed back to the Review Group during the process of the Review as a continuous dialogue. Any progress made during the course of the Review should be included in the final report. Because the SPR process focuses on organisational learning, there may be a limited number of cases where it has to proceed without the involvement of the victim/survivor and respondent if they choose not to participate.

Involvement of Children

The framework outlined here also applies to children in terms of giving them the opportunity to be engaged, however additional care should be taken to ensure that they are not harmed by their involvement. Children and their parents (where appropriate) must be asked what support they might want and if the offer of a Support Person has been taken up, they will be required to identify children's 'circle of support', for example parents, guardians and any professional network, to assist with the work. Given that cases will already have been subject to a core group, it is expected that the additional data protection considerations which apply when processing children's data will be in place, along with what information will be shared with the parents. If there are no such arrangements in place, these do need to be implemented before the Review commences.

Involvement of the respondent

SPRs will also have an impact on respondents and potentially their families, and therefore they will need appropriate support, to be treated with respect and care and have their needs taken into account. The continued support of the Link Person may help provide this.

Involvement of families

There may be circumstances, e.g., with children or deceased clergy, where the involvement of families is required. This will be subject to all the same requirements and data protection that apply to victims, survivors and respondents as applicable, including the provision of appropriate support.

4.6 Quality Assurance and signing off the report

The Review Group is responsible for "signing off" the Report (i.e. it has fulfilled the brief given in the ToR to the required standard). The Review Group should not feel they need to sign off any report which does not meet the ToR to the required standard. This is one of the reasons why the ToR need to be very clear about what is expected, and regular check-ins with the Reviewer will help keep this on track. In order to sign off a report, the Group will need to be satisfied that the report has:

- Addressed the Key Lines of Enquiry, and any additional lines of enquiry which arose during the process.
- Delivered SMART recommendations.
- Been reviewed by legal and data protection colleagues with regard to confidentiality issues.
- Met any other criteria specified in the Terms of Reference.
- Has been properly anonymised, and any instructions from data protection and/or legal colleagues have been followed.

The Quality Markers template at Annex C provides two markers, number nine and ten, in relation to the report and publication, which may be a helpful starting point to review the report by.

The remainder of the Quality Markers can help the Review Group understand how well the Review has been carried out, and feedback from the victims, survivors, respondents and other Church Officers will need to be sought. This feedback will also help the NST understand what is working well in terms of these Reviews.

5. Publishing Safeguarding Practice Reviews Reports

Requirements

5.1 Victims and survivors must be given the opportunity to comment on their contribution to the report before publication.

5.2 Church Officers whose practice is scrutinised in the report must be given sufficient time to comment on that section of the draft. The Review Group has discretion on how much time is allocated to this stage of the process and the Reviewer must ensure that this feedback is reflected in the final report.

5.3 The Church body's legal and data protection leads must review the report before publication. They must be fully consulted on all decisions about publication and the Reviewer must follow advice which is given prior to publication.

5.4 The SPR report (or an Executive Summary in exceptional circumstances such as those described in the good practice advice below) must be published on relevant Church of England websites.

5.5 The anonymity of victims, survivors, and all other data subjects must be protected.

Good Practice Advice

What do we mean by "publication" and why is it important?

The reason that an SPR is being carried out is to identify any areas of learning that are required of a Church body in order to improve their safeguarding response. Therefore, the key output from the Review will be the Reviewer's recommendations. Historically these, along with the full report, have been made public on the Church of England websites (both diocesan and national as appropriate) and this practice will continue. This is what we mean by a report being "published". A hard copy can be made available to victims, survivors and respondents if that is their preferred way of receiving it.

In order to make sense of the recommendations, and to be transparent about past failures (or current strengths), it is necessary for the report to provide some degree of narrative as to what happened and why. However, this needs to be written in such a way that the victims and survivors (and other data subjects) cannot be identified. This goes further than making sure they are not named, it covers any identifying features, context and quotes which may

contribute to identifying someone through "jigsaw identification".[16] This is not an easy process, and it is advised that expert advice and Information Commissioner's Office (ICO) guidance is followed. It is understood that there may be reports where the degree of information which would need to be removed makes the narrative unhelpful, and in these cases, an Executive Summary outlining the recommendations/action plan is the only thing which can be published. In some cases, an option would be to publish the report on the main Church of England webpage, rather than on diocesan websites, as this will make it harder to use local context to identify victims, survivors and other data subjects. Reports should stay on the website until the action plan has been completed, at which point they can be moved to an archive.

Representation Process

Respondents and others who may be criticised

Previously known as "Maxwellisation", this is the process by which those who will be criticised in a report are given an opportunity to respond to these criticisms. Responses should be invited under two broad headings**:** *Fact* and *Emphasis*. This process of fact and emphasis checking should meet the requirements of fairness but also the goals of timeliness and cost effectiveness. The Reviewer would normally undertake this process[17], and should provide early opportunities for Church Officers and others who may be scrutinised in the report to respond before the publication stage. The Reviewer can therefore impose a relatively swift deadline for responses to the draft report and explain the timeline for finalising it so that respondents know the intended publication date. It is the Reviewer's responsibility to make these arrangements.

The Reviewer should also make it clear that he or she will have the discretion as to how to respond to any representations and is not obliged to publish them as part of or alongside the report. This is particularly relevant if the report relates to a senior figure within the Church Body as there will be no real means to anonymise their identity.

Victims and Survivors

Victims and survivors must also be given the opportunity to submit representations based on fact and evidence. It is the Reviewer's responsibility to provide the opportunity and ensure

[16] Jigsaw identification' is the ability to identify an individual by using two or more different pieces of information from two or more sources even when that individual is not explicitly named. Other sources of data may be easily or publicly available, and individuals may have prior knowledge.

[17] The Reviewer can only undertake the complete process, e.g. deciding what changes may be necessary in the report, if they are the data controller, this must be made clear in the Terms of Reference.

support is available for them to do so, and again, the Reviewer should also make it clear that he or she will have the discretion as to how to respond to any representations.

Further considerations

The timing of publication should, where possible, be agreed with all involved. This is to avoid any particular times of sensitivity for victims and survivors.

Victims and survivors might react in different ways when they receive feedback about the Review. They may feel relieved and vindicated whilst at the same time be reminded of traumatic experiences. Appropriate support should be available to victims and survivors and, if necessary, family members. This support should be offered proactively, survivors should not be left with the responsibility to approach the Church and ask for it.

It is also important that the needs of respondents and/or their families are considered, and if appropriate, support is offered to them also. Respondents' roles within the diocese are such that they will be easily identifiable even if they are not explicitly named. Again, the purpose of the Review is to focus on the lessons learned, particularly any systemic learning, as opposed to concentrating on individuals. This should be made very clear in the ToR that the review does not seek to apportion individual blame or culpability.

Who needs copies

In addition to those already mentioned in this section, the following people may need to be provided either with whole, redacted or sections of the reports:

- The National Safeguarding Steering Group (NSSG) must be sent any recommendations which require a national response or a change to policy, practice or training.
- The NST must be sent a copy of all completed SPR reports.
- Further to the IICSA[18] recommendation, reports are required to be shared with the Child Safeguarding Practice Review Panel. This will be done by the NST.
- Any external body which has requested the Review, e.g. the Charity Commission, must be sent a copy of the report.

[18] Recommendation 5 of the 2019 report: The Anglican Church Case Studies: Chichester/Peter Ball Report

6. Implementation and Evaluation of SPRs

Requirements

6.1 The Church body(ies) directly involved in the case and any other bodies in respect of which the Review makes recommendations, must produce a formal response to the Review's recommendations, within two months. This will include details of which recommendations will be taken forward and, where recommendations are not accepted, provide reasons and any additional actions.

6.2 Where applicable, no later than three months after the publication of the Report, the Review Group must publish a composite action plan bringing together the individual action plans from each Church body to whom recommendations apply.

6.3 For each recommendation, the action plan will state what outcome the recommendation is expected to achieve, how the desired outcome will be measured, timescale for delivery, specific actions required and who owns the actions.

6.4 The Church bodies implementing the Review recommendations must establish a mechanism for over-seeing and reporting on the implementation of their action plan (e.g. a specific implementation group, or the DSAP).

6.5 The progress and impact of the action plans must be formally reviewed after 12 months of the production of the action plan and reported to relevant governance bodies.

6.6 The Review Group must decide on, and action, the most effective way of sharing messages about good practice that have Church-wide relevance.

6.7 The final role of the Review Group will be to evaluate the quality and impact of the review process against the Terms of Reference.

Good Practice Advice

Where the report identifies **good practice,** this should be highlighted and the report should outline whether and how this practice should form the basis for practice improvements elsewhere.

It is acknowledged that there may be governance processes that reports, responses and action plans may need to go through, and this may extend the three months deadline in some cases. However, as noted in Requirement 4.1.1, these should be identified at the start of the process and provision made for these to be scheduled.

Disseminating learning

The Church Bodies involved in the case under review should give consideration at the earliest possible point as to how the learning from the Review will be shared and disseminated, first and foremost with those who contributed to the Review and also more widely within their local context to promote learning. In terms of wider learning, the production of an executive summary of the report will assist. Other processes might include a letter from the Bishop to their diocese (or equivalent), an article within a newsletter or an overview of the learning within an annual report.

On a wider scale, the NST will have a role in reviewing the themes that are emerging from all the Reviews carried out. This will feed back into the NST's planning cycle for learning and development thus closing the learning loop. Linking the recommendations to the Safeguarding Standards also allows for them to be included in any further external audits, again ensuring that the learning is captured and implemented.

Appendix A: Types of Reflective exercises

The following section gives examples of other ways in which learning can be identified from safeguarding situations, where they do not meet the threshold of an SPR. Church bodies are free to use some, all, or none of these, as long as they can evidence that an exercise to capture learning has taken place. This section will be added to as further tools and resources become available.

1. Self-reflexivity and feedback

One of the marks of a healthy organisational culture is when the individuals who comprise the organisation are personally self-reflexive and welcome feedback from others. Self-reflexivity is different from just self-reflection because it contains the idea of turning self-reflection in to actual action that brings about change.

For all Church officers involved with safeguarding matters, taking time for personal self-reflection and identifying what they will do differently as a result is a powerful change mechanism. This is enhanced if, as part of the self-reflexivity, the individual encourages feedback from others.

2. Reflective supervision

For safeguarding professionals such as DSAs and CSAs, the opportunity for reflective professional supervision is essential. This will be the model adopted when the Diocesan Safeguarding Advisor role becomes the Diocesan Safeguarding Officer role. Both supervisees and supervisors will require training in the supervision model to be used to maximise impact.

3. Reflective exercise by the core group

At the end of every piece of work managed by a core group, group members should take time to reflect on the case / issue and its own role to determine relevant learning. This might take less than an hour in some cases whilst in others it will be a more extensive conversation. Some such conversations can then be shared with the DSAP and/or senior leadership team of the relevant Church body if it will promote wider organisational learning. A sample checklist/agenda template is in Appendix A1, but in essence, the group should seek to address three key points:

1) What is our reflection on how well we did as a core group?

2) What does this case tell us about how well we are doing in relation to the Church's National Safeguarding Standards in terms of:

i) our systems and processes;

ii) our culture, organisation and context.

3) What worked well in terms of managing risk and what hindered us, in terms of:

i) our systems and processes;

ii) our culture, organisation and context.

4. Learning event

A learning event workshop is a good way to gather relevant individuals together to review the way a case has been handled. Such workshops:

- can happen quickly, with learning available immediately
- will need facilitation by someone with the skills to ask the right questions, to hold any tensions and to make the situation safe
- need all participants to be able to reflect on their own behaviour and identify strengths and shortcomings, as well as strengths and shortcomings of the organisation, and as such have the capacity to become powerful effectors of change

Templates are available in Appendix A2-A4.

Appendix A1 – Core Group Reflective Discussion Template

Issue	Objective	Notes/Actions
1. Decide: • who will chair the meeting • who will take the notes • who these will be circulated and to whom • how the actions will be followed up	Members are clear who is responsible for what, and what is going to happen following the meeting.	
2. Confirm this discussion operates under the same confidentiality as the core group meeting	Whilst this discussion should not really focus on case findings, it is useful to recap these and therefor the same rules will apply.	
3. Reflect on how the core group processes worked		
4. Agree **what** the key features of the case were, e.g. processes were not followed, was risk not correctly identified. Specifically relate these to the Safeguarding Standards.	Recap of the key points of **what** happened ensures everyone is agreed on that, especially if the discussion occurs sometime after the close of the case. Identify two or three key issues to focus on, rather than multiple smaller ones.	
5. In the experience of the group members, are these issues confined to the individual/individual church body or are they replicated elsewhere?	This helps establish whether, for example, risk is not being well identified anywhere, and ensures that any solution, (eg in this case additional training), is targeted. At this stage, we are still establishing how to improve on the **what.**	
6. Discuss the **why** relating to the two or three key issues, and the management of risk, for example: • **Why** is there an issue with training being completed?	This moves beyond the **what** into the **why**, into the systems findings which are the focus of this approach. It might be that only a few things are able to be identified to start with, the important thing is to engage	

• **Why** are safer recruitment processes not being followed? • **Why** is risk not being identified?	and to start tyring to move beyond the **what.**	
7. Capture the key actions (both the **what** and the **why**)	Be clear about who is doing what.	
8. Is any additional support/supervision needed for members of the group?		
9. Closing reflections – what are peoples closing thoughts on the discussion?	This allows some closure for the members of the core group.	

Appendix A2 – Learning Event Template

Add logo

Learning Event

<DATE> 2022

xx:xx-xx:xx

Via Microsoft Teams - joining instructions within the calendar invite

Or venue location

AGENDA	
Time	➢ Welcome ➢ Purpose of the event ➢ 'Ground rules'- confidentiality, behaviour, listening
Time	➢ Explore the case, clarifying what happened and why. Participants can jot down any points that occur to them which time restrictions may prevent them raising during the learning event. Email to be sent to the facillitator at the conclusion of the event.
Time	➢ Tea/coffee/comfort break (time of break subject to change and potentially be held earlier)
Time	➢ Participants asked to identify the key learning themes emerging from the case. Attendees also asked to push themselves to identify any underlying issues which have contributed to these. ➢ Participants should also identify what went well and what is helpful
Time	➢ Quick tea/coffee/comfort break (time of break subject to change and potentially be held earlier or later)
Time	➢ Participants asked to identify what needs to change in order to prevent this happening in the future, drafting of action plan
Time	➢ Closure of the event. Summarise next steps including how the action points will be communciated and monitred ➢ Space for reflection, processing and evlauation

Appendix A3- Learning Event Checklist

Learning Event Checklist

Learning events are useful ways of eliciting learning, whether as part of a formal Safeguarding Practice Review (SPR) or as part of other learning processes. For them to be effective, it is important that they are planned and facilitated well.

If happening as part of a SPR, the Independent Reviewer (IR) should have the skills to do this.

If happening as part of an internal process, consideration should be given to who the best person is to facilitate the event – it may be that someone from outside needs to be brought in to deliver this, purely based on skills and capacity.

Issue for Discussion	**Commentary**	**Action/Resolution agreed**
Identifying the person with the correct skills and capacity to plan, facilitate and record the session.	This will be the IR for all SPRs. This person will also need the skills to ensure the meeting is productive, even if there are strongly held different opinions in the room.	
Identifying the right people to attend	The IR or the core group should draw up a list of who they want to involve and why. These must be the people who can best contribute to the learning.	
Communication, support and briefing pre and post the learning event	The IR or a designated member of the core group need to ensure that people are clear as to purpose, timescales, outcomes etc.	
Setting the right tone	Needs to be agreed how conflict, emotions and differences will be handled. This needs to be reiterated at the start of the meeting, and the person facilitating the group **must** be prepared to challenge and step in where this does not happen. It may be the case that additional support will need to be provided to participants on the day, and this needs to be put in place	
Venue	Venues can make a significant difference to the productivity of the meeting. There are benefits in this being an off-site location where possible, as well as being accessible, comfortable, and with access to refreshments.	
Pre-event administration and recording the event itself	Organising an event takes time, administrative support will be needed. There may be a timeline	

	or other information to be collated or produced before the event. It needs to be agreed how the outcome will be recorded – are minutes needed or just action points? How will these be captured and communicated?	
Timing	If an event is part of a SPR, the IR will need to determine when it is most beneficial for the meeting to take place.	
How the victim's/survivor's voice will be present in the room	Within the bounds of confidentiality, the event must remain victim/survivor focused.	
How will the respondent's voice be present in the room	The perspective of the person who has been subject to the allegation needs to be understood – what helped or hindered them in the process?	
De-brief process	Space needs to be left at the end of the event for people to reflect on and process the events. Support may be required at this stage	
Outcomes/action points	It must be clearly agreed and accurately captured what the outcome and specifically the learning/action points arising from the event have been, along with who is responsible for them and timescales. These also need to be in a SMART format.	
What if key people are missing?	There are always people who cannot attend, have left/moved on. It is possible to try to seek their views via other means prior to the event and bring this into the room on their behalf, should they wish to engage.	

Appendix A4 – Learning Event Invite Letter

Dear

Learning Event in respect of xx

Date: xxx 2022 via Microsoft Teams/Venue

You are being invited to participate in a Learning Event in respect of the above case. This is being run to collectively reflect on, and learn from, what has happened in order to improve safeguarding practice in the future.

You are being invited as a key individual who will have learning to share. This event will be held **on xxx 2022** starting at **xx:xx via Microsoft Teams.**

The event will explore and seek to understand **why** things in the case happened the way they did and based on this reflection and understanding, how safeguarding can be improved in the future. The event will be led by xxx and facilitated by xxx who will structure the event to help participants reflect, think, and learn together in a safe environment. A pre-read document also accompanies this letter that xx has prepared for you to read before the event.

Preparation for the event
Along with reading the document that xxx has prepared, it would be helpful if you could give some thought to your involvement in the case, thinking specifically about:

- Decision making
- Actions
- Contributing factors
- Interaction with other professionals and services/ and information sharing
- Areas of good practice
- Areas where there could be some improvements

(Prior to the video call, it would also greatly assist if you could consider the necessity to ensure that the call remains strictly confidential. Please: -

- Participate in the video call from a location where you can't be overheard.
- If necessary, use headphones to ensure that other members of the call are not heard by any individuals in your vicinity.
- Make sure that no other applications are open on your screen which might result in personal, confidential, or sensitive information being inadvertently shared with other attendees)

We very much look forward to working with you at the learning event and hope you find this approach constructive and helpful. In the meantime, if you have any queries or need further clarification, please do not hesitate to contact me.
Yours sincerely

Appendix B – Template Terms of Reference

SAFEGUARDING PRACTICE REVIEW

TERMS OF REFERENCE CHECKLIST

Section	Considerations	Action/Notes
Key Lines of Enquiry (KLOE)[19]	• What are the key issues that the SPR needs to focus on? What will happen if further KLOE emerge during the process?	
Timescales	The Good Practice Advice advises six months from the resolution of GDPR and planning, up to the point of sign-off • Can the Review be done in these timescales? If not, what are the reasons and what is a reasonable timescale? • What currently known external processes/staff absences/ other factors might put the timescale at risk? • How will delays be communicated and by whom?	
Resources	• What funding has been identified for the Review? • What staffing resources, eg administrative support is needed? • What support is required for victim(s)/survivor(s), respondents and where appropriate their families, to actively participate? • What other resources are needed, e.g. translators, office space,	
Governance	• How often will the Reviewer meet with or report to the Review Group? • Is a written update required or will verbal suffice? • Are there key milestones which must be met dictated by other processes/needs? • What are the mediation/escalation processes for the Reviewer and the Review Group to follow in case of disagreement? • What governance processes (meetings) need to be scheduled?	

[19] Key lines of enquiry for healthcare services - Care Quality Commission (cqc.org.uk); Disclosure Manual: Chapter 5 - Reasonable Lines of Enquiry and Third Parties | The Crown Prosecution Service (cps.gov.uk)

Role of the Reviewer	Are there specific instructions for the Reviewer before they commence. This might be: • Will they contact victim(s)/survivor(s) directly? • Will they be the data controller? • Are they responsible for the representation process? Are there particular individuals that need to be spoken to, specific things they need to observe, for example team meetings, services, robing procedures, governance groups? • Any specific documents they need to read and referenced, including past reviews and relevant research [20]?	
Outcome based recommendations	The recommendations must be SMART, based on the National Safeguarding Standards and between 6 and 10.	
Proposed Methodology		
Pastoral Support	• Who will be offering this and to whom? For example, will the Support Person continue to provide support to victim/survivor, will the Link Person provide support to the respondent, what about other Church officers who might be involved? • Will more than one person be required?	
Data protection arrangements	• Who will be responsible for these?[21] • Who is the data controller?	
Publication of report	• Who will be advising on publication from a data protection/legal perspective? • How will viewing the report (by victims, survivors, respondents, Church officers who are criticised) be managed? • What sensitivities are there around the timing of the publication? • Is it clear to everyone involved exactly what will be published, for example, the full report, a summary, redacted versions, recommendations only?	

[20] This is particular important where there have been previous similar Lessons Learned Reviews, but the learning has not been implemented

[21] These **must** be drawn up with input from data protection/legal colleagues, or specialist contractors where these roles do not exist

Views of victim(s)/survivors(s) on ToRs	• Who will carry this out and how? • What is the timescale? • How will disagreements be recorded?	
Views of respondents	• Who will carry this out and how? • What is the timescale? • How will disagreements be recorded?	
Views of statutory partners (where this is deemed necessary)	• Who will carry this out and how? • What is the timescale? • How will disagreements be recorded?	

Appendix C – Quality Markers

Quality markers for Safeguarding Practice Reviews (SPRs)

(Space for logos etc –Hyper links to specific requirements to be done when uploaded)

This document contains 11 Quality Markers for Safeguarding Practice Reviews (SPRs). Covering the whole process, the Quality Markers help provide for a consistent and robust approach to SPRs. The SPR Quality Markers draw heavily on SCIE's work developing Quality Markers for statutory multi-agency safeguarding reviews both related to children and to adults.[22] The SCIE Quality Markers are based on established principles of effective reviews. The SPR Quality Makers include adaptations to reflect the SPR guidance.

The SPR Quality Markers can be used during the process to support the Review to achieve good practice standards. They can also be used by the DSAP on the conclusion of the process. This template is not designed to be exhaustive, it can be adapted/expanded to suite each particular SPR. The responsible person is an indication, it is likely that the work will need to be collaborative in practice. This document sets out some key markers, why they are important, what evidence can demonstrate if a SPR process is on track to achieve or has achieved them. In this way, the SPR Quality Markers are a tool to support continual self-assessment and improvement in SPRs conducted.

Quality Marker 1: Referral		
Quality statement: The case is referred for Safeguarding Practice Review (SPR) consideration with an appropriate rationale and in a timely manner (DSA)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• The closer to the event, the more the decisions and events will be in the forefront of people's minds. • The more current the behaviours, cultures and processes being reviewed, the more applicable the learning.	• The rationale for referral is clear and attempts to explain how the case meets the thresholds in Requirement 2. • The referral is made at the earliest opportunity following the conclusion of the core group risk assessment process.	

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• The quicker the learning can be identified, the bigger the benefit and the lesser the risk of it re-occurring. • SPRs require resource, and are not suitable for all types of learning. The suggested reasons why this particular case or group of cases require an SPR needs to be made clear.		
Quality Marker 2: Decision-making		
Quality statement: The decision about whether to conduct a SPR takes into account factors related to the case and the local context as well as views of the victim(s)/survivor(s) who must be consulted during deliberations. The rationale for these decisions is clear, defensible and reached in a timely fashion (DSAP Chair)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• The decision needs to be justifiable to all involved in the case. • The decision needs to be based on the ability to produce learning, and meeting the criteria set out in Requirement 2.	• The decision is linked to the criteria in Requirement 2, with sound evidence. • The evidence relates to current learning needs of the Church locally and/or nationally. • The rationale includes the evidence of seeking the views of the victim(s)/survivors(s) and respondent(s), and their responses if given. • The decision is made in a timely manner.	
Quality Marker 3: Informing all relevant people		
Quality statement: All those who had a role in the case, including the victim(s)/survivor(s) and the respondent, and where relevant their families and other Church Officers, are told what the SPR is for, how it will work, what the parameters and are treated with compassion and respect. Options and expectations for their engagement in the SPR and support to be provided them are clarified, as well as what the data protection considerations are.		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**

• All those involved in the SPR because they had a role in the case, need to be informed at an early a point as possible, that a decision has been made to progress a SPR. • The outcome of decision making about whether to progress a SPR will likely raise a range of expectations and anxieties for all involved, and care needs to be taken in communications. • Working in an open, honest and collaborative way is the best way to make improvements. • The difference between an SPR and other processes may be confusing. Clear, early communication will help provide clear parameters as to what the SPR can and cannot deliver and help avoid misunderstandings.	• Evidence (emails/phone calls) that the information has been communicated at the earliest opportunity. • Those involved can report they understood the processes involved and felt communication had been conducted with suitable clarity and sensitivity.	
Quality Marker 4: Clarity of purpose and Terms of Reference		
Quality Statement: The Church body is clear and transparent, from the outset, that the purpose of the SPR is organisational learning and improvement, acknowledges any factors that may compromise this, and the Review Group produces clear Terms of Reference (Church body/Review Group)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• The purpose of SPRs is organisational learning and improvement and, where relevant, the prevention of the reoccurrence of similar incidents. • However, the SPR should identify where there are concerns about the safeguarding practice or behaviour of individuals, including their responses to victims or survivors, in order that these can be	• Feedback from the Independent Reviewer confirms commitment to the learning purpose from those commissioning the SPR. • Evidence of courageous leadership in articulating any tensions and challenges, and willingness to discuss these if they are proving problematic for participants. • Use of suggested ToRs template, focusses on how best to identify the learning, and	

addressed through the most appropriate route. • Being open and transparent about any tensions or complications that exist in relation to the goal of learning in a particular SPR, helps avoid claims that purpose is learning from ringing hollow to those involved and/or potential frustration that other forms of accountability are being avoided.	acknowledging anything which may compromise this. • The tone of communications promotes open collaboration for the purposes of learning. • Feedback from those who have participated evidences that any complications have been dealt with, with the requisite sophistication and sensitivity.	
Quality Marker 5: Governance		
Quality Statement: The SPR runs to time, budget and achieves the ToRs, with participants escalating and addressing any obstacles encountered in a timely and effective manner. (Review Group).		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• There are real advantages in Reviews being completed in a relatively short timescale. The closer the review is to the event, the fresher it will be in people's minds, and the loss of organisational history due to people moving on will be mitigated. • Learning will be easier to apply and have a greater impact the closer to the event it is implemented. • Competing priorities for participants and organisations that pull against the learning and improvement purpose of a SPR may lead to a lack of engagement or openness, requiring clear governance arrangements that are robustly overseen.	• All aspects of the ToR are achieved • Sufficient resource has been allocated. • Any barriers to progress of the SPRC are escalated appropriately with robust efforts made to address them.	

Quality Marker 6: Collating information		
Quality Statement: The SPR gains sufficient information to underpin an analysis of what happened in the context of normal working practices and relevant organisational factors (Review Group/Independent Reviewer)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• To elicit learning, it is essential to know **why** something happened, not just **what** happened, in order to identify on-going systemic weaknesses that made and will continue to make poor responses more likely. • This requires more than just a Review of relevant documentation. It also requires conversations, observations, exploration of culture, relationships and behaviours, as well as review of safeguarding processes, arrangements and resourcing to determine what some of the contributory factors were and their current relevance.	• All relevant sources of data are identified. The Reviewer shows flexibility in not excluding those with a genuine desire to engage because they have relevant information to share. • Information from the time of the case, as well as information from the present is sought. • The ToR makes clear the kind of data to be sought from the different sources. They are reflected in the content of the report. • Any evidence gaps are identified in the report with a defensible rationale. • The Reviewer demonstrates sufficient curiosity about the cultural and organisational context of practice and decision making.	
Quality Marker 7: Positive Involvement for victims and survivors		
Quality statement: The SPR is conducted in a way that keeps the victim(s) / survivor(s) at the centre of the process, fully supported and involved. The process and conclusions are responsive to the victim/survivor's views of how the SPR can help bring them healing and move forward rather than exacerbating negative impacts of abuse and/or responses. (Independent Reviewer)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• Many victims and survivors have experiences failings in the Church's responses when abuse by clergy or people in Church related roles is disclosed. Church	• Victim(s)/survivor(s) feedback reflects an experience of being kept at the heart of the process and recognises efforts to minimise	

responses are often experienced as re-abusive. Re-opening both the circumstances of the abuse and the responses they experienced through a SPR can compound harm already experienced. • This requires that victim and survivors' needs are kept at the centre of the SPR process, and they are fully supported and meaningfully involved throughout the process. • There may be a minority of cases where the victim/survivor does not wish to be engaged in the process, and this will need to be reflected.	re-traumatisation and re-abuse through the SPR process • Victim(s)/survivor(s) feedback evidences that their views about what might help to bring them healing have been taken seriously and acted on. • All communications demonstrates suitable clarity about the sequence, outcomes of activity/meetings and next steps. • Appropriate type and quantity of support is sourced.	
Quality Marker 8: Positive involvement for the respondent and other church officers		
Quality statement: The way the SPR is conducted enables respondents, their families if applicable and other church officers who were involved have a constructive experience of taking part in the review, one which helps them acknowledge any mistakes and learn from them, rather than blaming and creating fear. (Independent Reviewer)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• Everyone involved in the SPR needs to be treated with compassion and dignity. • SPRs should not create a culture of "name and shame" or fear, as this is counter-productive to creating safe, healthy cultures. • Identify and accepting mistakes or poor practice where they occurred, is a necessary step in the learning process both for individuals and organisationally in order to identify systemic issues making similar mistakes and poor practice more likely.	• Mistakes or poor practice in reducing risk, responding to disclosures and supporting victims/survivors are clearly communicated to the relevant respondents and church officers. • Mistakes or poor practice identified in the SPR are acknowledged by the relevant respondents and church officers. • Feedback from those involved in the process reflects efforts to enable a constructive experience and the extent to which this was achieved.	

• Demonstrating an acceptance of one's own mistakes or poor practice, where you may fear public shaming, can be difficult and mean support is required. • Everyone who was impacted will have feedback to give, and should be given that opportunity.	• All communications demonstrates suitable clarity about the sequence, outcomes of activity/meetings and next steps. • Appropriate type and quantity of support is sourced. Everyone who was impacted is able to give feedback	
Quality Marker 9: Analysis		
Quality Statement: The SPR analysis is transparent and rigorous. It evaluates and explains what happened and why, shedding light on cultural and organisational issues that increase the chances of poor safeguarding responses. It focuses on optimising organisational learning and improvement and does not investigate, reporting concerns about individual behaviour and/or safeguarding practice appropriately so they can be addressed separately to the SPR. (Independent Reviewer)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• The purpose of SPRs is to support improvements in safeguarding practice. • This means it is not sufficient to describe activity in a case or to identify elements of practice that were problematic, without analysing why they occurred. • The analysis needs to identify what has led to and sustained the kind of practice problems that the case reveals, so as to focus improvement efforts. • Where concerns about the safeguarding practice or behaviour of individuals, are identified, including their responses to victims or survivors, this needs to be reported as agreed at the start, in order that further action in separate processes can be taken as necessary.	• The review has been undertaken in such a way as to establish the contributory factors in the case and the underlying systemic issues still at play (see QM 6.) • The report is clearly written to establish these generalisable issues, with recommendations which relate to the National Safeguarding Standards. • Mistakes or poor practice in managing risk, responding to disclosures and supporting victims/survivors are clearly identified in the SPR and clearly communicated to the relevant respondents and church officers. • Any concerns are shared in a timely way with the Review Group and then acted on accordingly.	

Quality Marker 10: The Report		
Quality Standard: The report clearly identifies the analysis and findings of the SPR that are key to making improvements, detailing cultural and organisational issues identified that increase the chances of poor safeguarding responses and focussing on evidence based SMART recommendations relating to the National Safeguarding Standards. (Independent Reviewer)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• The report needs to show enough of the working out to allow confidence in the process and learning outcomes, while maintaining anonymity as necessary. • The main function of the report is to make accessible the SPR analysis, in order that it can support necessary improvement work. • Reports producing numerous, unclear, low level recommendations do not help improvement or drive change.	• The case specific analysis is easy to distinguish in the report from the wider systemic learning to be drawn from the case. • The recommendations are in line with the criteria in Section 4.2. • They are based on the evidence collated in the review. • They are SMART, with clear outcomes which will deliver change.	
Quality Marker 11: Publication		
Quality Statement: Publication plans foster active responsibility for addressing barriers identified to good safeguarding practice and responding well to victims and survivors. Decisions about what, when and how to publish the SPR report are made with sensitive consideration of the impact, and with the aim of protecting the identity of the victim(s)/survivors(s), and where feasible, the respondent or others who may be criticised. (Independent Reviewer)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• Publication of SPRs is a key means of sharing the learning and (re)building trust. • It is a key mechanism for allowing transparency for the learning and improvement identified as needed. • The identification of victim(s)/survivors(s) must be prevented at all costs, this may	• Publication plans reflect genuine openness to share the learning. • The identities of those involved are treated appropriately. • Discussion around publication impact with the victim/survivor is evidenced.	

mean only an Executive Summary can be published. • The dignity of respondents and others who may be criticised must be preserved as far as possible, acknowledging that this is not always feasible.	• Discussion around publication with others involved is evidenced. • Feedback from the victim/survivor reflects evidence of the appropriateness of publication plans. • The report clearly identifies the analysis and findings that are key to making. improvements, while keeping personal details to a minimum.	
Quality Marker 12: Improvement Plan		
Quality Statement: The Improvement Plan sets suitably ambitious goals and is completed to standard and in the required time, with monitoring and evaluation arrangements in place. (Church body)		
Why is this important?	**How might we know?**	**Evidence Found/Areas for Improvement**
• How the recommendations are going to translate into action and improvements are as important as the Review itself. • This may require robust discussion within and amongst Church bodies to achieve real improvement. • Evaluation benefits from being planned from the start, with a clarity about underpinning causal assumptions.	• The improvement actions get to the heart of the barriers identified. • The right range of people are involved in determining the improvement actions. • It is clear how the improvement action is expected to lead to the intended outcome. • Criteria in Section 7 are complied with. • Clear monitoring and evaluation arrangements been established.	