DIOCESE OF LONDON

Past Cases Review 2

Independent Review Report

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Date: Final report agreed by the DSSG 30 September 2021

3rd October 2022 - Final version prepared for publication

It should be noted that all data and names contained in this report were accurate as at 30 September 2021, representing the work that had been completed by the independent reviewer team.

Acknowledgments

The Past Cases Review 2 has been an important and significant undertaking for the Diocese of London and which, for the most part, took place during the challenges we all faced due to the Covid-19 pandemic and restrictions. The review could not have happened without the support and assistance of many people. The contributions of the following individuals are particularly acknowledged:

- To those survivors who were courageous in coming forward for the greater good, to share their personal stories about the abuse and harm they suffered, and for holding on to hope about learning, change and improvement by the Church of England.

- The Bishop of London, the Bishop of Willesden, the Bishop of Stepney, the Bishop of Kensington, the Bishop of Edmonton and the Bishop of Fulham for their support and contributions to the project.

- Ailsa Reid-Crawford, the Diocese PCR2 independent Project Manager, for her clear thinking, tenacity, and commitment to keeping the review on track throughout the entire life of the project.

- Tim Bishop, Independent Chair of the PCR2 Reference Group Chair, and all members of the PCR2 Reference Group for their time and commitment.

- All members of the Diocese Safeguarding Team and the Director of Human Resources & Safeguarding.

Glossary

Appendix A	The template devised to collect information from parishes where there may be concerns of a safeguarding nature about individuals.
Appendix D	The template devised to collect information from Bishop area file reviews where there may be concerns of a safeguarding nature about individuals.
Bishop's Mission Order	An Order made by a Bishop which endorses and authorises the mission initiative it covers to promote or further the mission of the Church through fostering or developing a distinctive Christian community.
CPS	Crown Prosecution Service.
Core Group	Every safeguarding concern or allegation involving a church officer should be managed by a defined core group, convened for the specific situation. The purpose of the core group is to oversee and manage the response to a safeguarding concern or allegation in line with House of Bishops' policy and practice guidance, ensuring that the rights of the victim/survivor and the respondent to a fair and thorough investigation can be preserved.
Clergy Discipline Measure	Provides for a range of penalties to be imposed in cases of clergy misconduct.
Diocese of London	The Church of England Diocese covering the geographical area north of the River Thames, and divided into five geographical episcopal areas – Willesden, Kensington, Stepney, Edmonton, and Two Cities – each with an area Bishop.
Diocesan Safeguarding Adviser	The Diocesan Safeguarding Adviser (DSA) is a member of the Diocesan Safeguarding Team (DST) and they manage and coordinate the day-to-day operational mechanisms for safeguarding practice across the Diocese. This is achieved by the provision of advice on safeguarding concerns, support

	for parishes in managing concerns, overseeing safeguarding training and monitoring safeguarding issues in parishes.
Diocesan Safeguarding Team (DST)	A Team of professionals that have been established to develop and improve safeguarding in the Diocese; manage the Disclosure and Barring Service applications, carrying out risk assessments when these are blemished; ensure that safeguarding issues are managed effectively; coordinate safeguarding across the Episcopal Areas; coordinate safeguarding training across the Diocese and monitor and review safeguarding cases.
Diocesan Safeguarding Steering Group (DSSG)	Responsible to the Bishop of London for ensuring that the Diocese has: adequate policy and procedures for safeguarding children, young people and vulnerable adults; mechanisms for monitoring, auditing and reviewing the implementation of safeguarding; monitoring and reviewing safeguarding training and sharing relevant learning from case management.
Episcopal area	A part of the Diocese, comprising a number of boroughs, overseen by a Bishop through delegated authority under the Diocese of London Area Scheme.
General Secretary	The principal administrative officer of the London Diocesan Fund.
House of Bishops	The House of Bishops is one of three Houses that make up the General Synod, all members of the House of Bishops are members of the General Synod. They meet separately to talk about issues such as episcopal ministry, mission and national issues that affect the Church.
IICSA	Independent Inquiry into Child Sexual Abuse
Known Cases List	A term used by the Church of England National Safeguarding Team to describe a list of individuals who have been assessed, or judged, as presenting some degree of risk or have caused harm to children or adults.
London Diocesan Fund (LDF)	The LDF is a registered charity through which the affairs of the 'Diocese of London' are conducted.
MAPPA	Multi-Agency Public Protection Arrangements
NST	National Safeguarding Team for the Church of England.
National Church	Shorthand reference to bodies, collectively known as the National Church Institutions (NCIs), which undertake work for the Church of England. Its purpose is to support the mission and ministries of the Church by working with those who serve in parishes, Dioceses, schools and other ministries, and with partners at a national and international level.
Ordinand	Someone who is training to be ordained as a priest or minister.
Past Cases Review 2	An exercise commissioned by the House of Bishops in 2019 to identify both good and institutional failings in relation to how allegations of abuse have been handled, and provide recommendations to the Church of England that will lead to improvements.
Past Cases Review 1	An exercise conducted from 2007 – 2009 commissioned by the House of Bishops reviewing the handling by the Church of child protection cases over many years.
Safebase	The electronic data base used by the Diocese of London, which acts as an information storage facility.
SCIE	Social Care Institute for Excellence.
Suffragan Bishop	A Bishop subordinate to a metropolitan Bishop or Diocesan Bishop. He or she may be assigned to an area which does not have a cathedral of its own.

Joint Foreword by the Bishop of London & the General Secretary of the London Diocesan Fund

Thank you to all those who have thoughtfully contributed to the past cases review process within the Diocese of London. It has for many been a difficult, heartfelt and painful task, involving a core team of independent reviewers, a project management team, bishops and their administrative staff, survivors and victims, safeguarding advisors and members of the PCR2 Reference Group (from within the Diocese, as well as from statutory services and survivor organisations).

In 2019, the Church of England set out to ensure through the past cases review process that every diocese and church institution would carry out independent review work, within both the letter and the spirit of the protocol and practice guidance agreed by the House of Bishops. During the course of this review, the independent reviewer team within the Diocese of London has examined over 5000 files to identify any information regarding a concern, allegation or conviction in relation to abusive behaviour by a living member of the clergy or church officer, (whether still in that position or not). Each parish has also submitted a return of all their known cases, whether or not these had previously been shared with the Diocesan Safeguarding Team.

This review marks the conclusion of that process, identifying where our actions and those of our predecessors have fallen short, where further work regarding specific concerns or allegations is required, and where the needs of known victims require further consideration, as well as summarising areas for practice improvement. We apologise unreservedly to every victim and survivor of abuse and, while we realise apologies alone cannot be enough, we are focused on taking action and working towards lasting change.

The past cases review process has been a major investment of time and resource by the Diocese. With additional resource in the Diocesan Safeguarding Team, they continue to respond to the additional cases that have been identified and to take forward the significant commitments that we are making as part of a safeguarding improvement plan. As part of that work, we will be looking at how we can strengthen the governance of safeguarding in the Diocese. We will also be looking at how we will ensure that those who are victims and survivors, and those who are the subject of complaints or allegations, receive a timely and appropriate response and support.

We welcome the PCR2 report and are working through the recommendations as part of the overall improvement plan to address the issues raised.

We remain absolutely committed to ensuring that the findings of this review and our subsequent actions all contribute to making the Diocese of London a safer place for everyone.

Executive summary

1. The Past Cases Review 2 (PCR2) has been a national exercise commissioned by the Church of England, with an intention that every Diocese undertakes a review of any file that may contain information about a concern, allegation or conviction in relation to members of the clergy or church officers. The Diocese of London completed their PCR2 between February 2020 and September 2021, mostly during the Covid-19 pandemic.

2. The Diocese used three Independent Reviewers, an independent Project Manager and a dedicated Reference Group to support and oversee the project. A comprehensive and systematic methodological approach was used throughout. The review benefitted from a high level of independent input throughout the process, as well as the contributions of senior members of clergy, representatives from a survivor group, statutory agencies and the London Diocesan Fund. The review has also greatly valued the contributions of survivors that have had direct contact and experience with the Diocese of London and, who's insights, have helped shape learning and recommendations.

3. Over 5000 files and documents relating to members of the clergy or church officers were reviewed. From this, 273 cases were identified that warranted further enquiry or investigation due to actual or potential risk factors being identified. Of these 273 cases, 166 cases were not previously known to the Diocesan Safeguarding Team (DST). A high number of these were non-recent, and some related to information that was decades old, and which had been archived, but nonetheless has, or will, require further detailed and sensitive work to rule out any ongoing risk to children or adults. However, cases were also identified which indicated concerns about more recent practice, including how well those disclosing abuse and those that have survived abuse, are responded to. From these 273 cases, no cases were judged as needing immediate action based on an assessment of risk. In addition to the 273 cases detailed above, a separate exercise was conducted with a targeted request to all parishes about concerns they may have. This request yielded a further 241 concerns, of which 172 specifically related to a church officer role and 113 which met the criteria set by the PCR2 guidance. From this 113, 43 cases were not known to the DST. In line with the methodology agreed by the Diocese of London for undertaking the PCR2, where any concerns were identified requiring further work, these were passed to the DST and any ongoing actions have been, or will be, incorporated into their work schedule. The majority of all the cases have, or will, need a measured and systematic approach to evaluating needs and risks. Due to the considerable implications for the Team's workload, further planning and resourcing will be needed in order to effectively manage the work but also any identified risk, whilst continuing to respond well to new concerns that will inevitably be referred.

4. The review also examined the quality and effectiveness of the work of the DST. As well as identifying some areas of good practice, findings have been captured which indicate the need to strengthen a number of practice, management and leadership areas. Given the persisting and critical nature of some findings, improvement activity will need to be considered at a strategic level from within the Diocese without delay, so as to strengthen and improve the work undertaken by the DST.

5. The review has concluded with recommendations and areas for consideration for the Diocese of London but also the national Church, and it is hoped that these will be used to drive improvement action and strengthen arrangements for safeguarding.

1. Introduction & synopsis of Past Cases Review 2 in the Diocese of London

1.1. The Past Cases Review 2 is a national exercise commissioned by the Church of England, with an intention that every Diocese undertakes an *'… independent review … of any file that could contain information regarding a concern, allegation or conviction in relation to abusive behaviour by a living member of the clergy or church officer, (whether still in that position or not) …'*[1] (see sections 5.14 – 5.16). This report provides an account of the Past Cases Review 2 conducted by the Diocese of London, setting out how it was approached, managed, and governed, as well as findings, learning and recommendations. It has examined not only past cases, but also and in line with expectations, those cases that were referred to the Diocese Safeguarding Team (DST).

1.2. The Past Cases Review 2 in the Diocese of London entailed reviewing over 5000 files and documents relating to members of clergy and other church officer roles. Based on guidance issued by the national Church at the time, early financial planning for the review began in March 2019 with review activity formally beginning in February 2020. Due to restrictions imposed as a result of the Covid-19 pandemic, the timeframe for completion was extended by the national Church, with the project ultimately concluding in September 2021. Notwithstanding these restriction's, momentum was maintained throughout, as best as possible.

1.3. The review benefitted from three Independent Reviewers, an independent Project Manager and administrative support. A dedicated Reference Group was established to provide governance and oversight. This group met monthly throughout the duration of the project and comprised of an Independent Chair, senior members of clergy, representatives from a survivor group, statutory agencies and the London Diocesan Fund[2].

1.4. From over 5000 files and documents reviewed including clergy blue files, files associated with safeguarding or Clergy Discipline Measures, 273 cases were identified that warranted further enquiry or investigation due to actual or potential risk factors being identified. From these 273 cases, 166 were not known to the DST. A high number of these were non-recent, and some related to information that was decades old, and which had been archived, but nonetheless required further work to rule out any ongoing risk to children or adults. However, cases were identified which indicated concerns about more recent practice, including how well those disclosing abuse and those that have survived abuse are responded to. In addition to the 273 cases detailed above, a further 241 concerns were shared from parishes through a targeted request for information. From this, 43 cases were not known to the DST and were related to church officer roles. In line with the agreed methodology for the Diocese of London, where concerns were identified requiring further work, these were passed to the DST and any ongoing actions will be incorporated into their work schedule.

1.5. The review also examined the quality and effectiveness of the work of the DST. As well as identifying some areas of good practice, findings have been captured which indicate the need to strengthen a number of practice, management and leadership areas. Given the persisting and critical nature of some findings, improvement activity will need to be considered at a strategic level from within the Diocese without delay, so as to strengthen and improve the work undertaken by the DST.

[1] Wording and descriptions used in the Background and Overview guidance, July 2019, Church of England.

[2] The London Diocesan Fund exists to support the mission of the Church of England in London; hence its strategy is nested entirely within the wider objectives of the Diocese's Capital Vision 2020.

2. Overview of the Past Cases Review 2

2.1. Background to the Past Cases Review 2

2.1.1. In 2007 the Church of England conducted a significant review[3] of past safeguarding cases which aimed to scrutinise clergy and church officer personnel files. The focus was specifically on children with the purpose being to examine how it had handled child protection cases and to identify any on-going risks to children and where there had been no appropriate action taken. In April 2018 an Independent Scrutiny Team, commissioned by the Church of England's National Safeguarding Steering Group, reported on significant shortcomings of this 2007 past cases review (PCR). Recommendations[4] in 2018 by the Independent Scrutiny Team included the need to revisit the areas where shortfalls were identified. These recommendations were accepted by the Archbishops' Council and, as such, the Past Cases Review 2 (PCR2) project was initiated by the Church of England's National Safeguarding Team in 2019. The overall purpose of the PCR2 review has been stated *'… to identify both good practice and institutional failings in relation to how allegations of abuse have been handled, and to provide recommendations to the Church of England that will lead to improvements in its response to allegations of abuse and in its overall safeguarding working practices; thereby ensuring a safer environment for all …'*[5]

2.2. Governance and ownership of PCR 2

2.2.1. All 42 Dioceses across England have been required to participate in the PCR2 with seven, plus one episcopal area from within the Diocese of London, needing to repeat the whole exercise because of shortcomings in the original review process in 2007. Governance of the project at a national level, sat with the PCR2 Project Management Board, which is a sub-group of the Church of England's National Safeguarding Steering Group. The expected time frame for concluding the review in all Dioceses was originally December 2020 however due to Covid-19 the deadline was extended into the Spring of 2021, and then further extended to December 2021.

2.2.2. Direct governance and ownership of the PCR2 in the Diocese of London has been achieved with a PCR2 Reference Group[6] which was established for the specific task of supporting the project, managing any issues that emerge from the review along with ensuring the smooth and timely completion of the project. This group met monthly between January 2020 and September 2021. Membership is set out below in Table 1.

[3] Past Cases Review, 2007, Church of England.

[4] Report of the independent scrutiny team into the adequacy of the Church of England's past cases review 2008-2009, Sir Roger Singleton, Amanda Lamb, Donald Findlater, June 2018.

[5] Protocol and practice guidance, July 2019, Church of England.

[6] As required based on the guidance issued; Protocol and practice guidance, July 2019, Church of England.

Table 1: Diocese of London PCR2 Reference Group membership	
Name	**Role**
Tim Bishop	Independent Chair of the PCR2 Reference Group
The Rt Revd Dr Joanne Woolway Grenfell	Bishop of Stepney, Lead Bishop for Safeguarding
The Ven John Hawkins	Archdeacon of Hampstead
Kim Bond	Fundraising Manager, National Association for People Abused in Childhood (NAPAC); appointed survivor lead for the Reference Group
Dan Setter	Detective Chief Inspector, Central Specialised Crime, Metropolitan Police (until October 2020)
Simon Morley	Detective Chief Inspector, Operation Winter Key Metropolitan Police (from November 2020)
Caroline Birkett	Head of Service for Victims & Witnesses at Victim Support
Nigel Chapman	Operational Director, Children's Services, London Borough of Brent
Suzie Long	Director of Human Resources & Safeguarding
Aileen Stamate	Diocese Safeguarding Manager (January 2020 – October 2020)
Ailsa Reid-Crawford	Independent Project Manager
Kevin Ball	Lead Independent Reviewer
Esther Stewart	Communications & Digital Content Manager
Susie Barber	PCR2 Project Administrator & Assistant

2.2.3. The PCR2 Reference Group in the Diocese of London has reported to the Diocesan Safeguarding Steering Group (DSSG). The DSSG is responsible for the strategic monitoring and development of safeguarding in the Diocese and has taken a lead in commissioning the arrangements for the PCR2; it is independently chaired. The Reference Group, for the purposes of the PCR2 project has been accountable to the DSSG and the Bishop of London who is the project sponsor, who in turn, is accountable to the national PCR2 Project Board. This report has been endorsed by PCR2 Reference Group. It has also been shared with the Bishop of London and General Secretary of the London Diocesan Fund, and the DSSG – all of whom have been given the opportunity to comment.

2.3. The organisational structure of PCR 2

2.3.1. The governance and ownership of the Diocese of London PCR2 has been set out above. Responsibility for the day-to-day management of the project was provided by an independent Project Manager, recruited solely for the purposes of completing the Diocesan PCR2. The Project Manager and the Independent Reviewers reported to the Director of Human Resources & Safeguarding within the London Diocesan Fund, who in turn reported to both the General Secretary and the Bishop of London. Further details about the organisation and operationalisation of the project are set out below in the methodology section.

2.4. Commissioning of Independent Reviewers

2.4.1. An important aspect of this PCR2 was the appointment and use of Independent Reviewers to conduct the review of files[7]. The Diocese of London appointed Kevin Ball as the lead Independent Reviewer; he is the author of this report.

2.4.2. Given the size of the task two more Independent Reviewers were appointed, Adenike (Nicky) Sobamiwa and Yvonne Brown. All three Independent Reviewers brought significant and relevant professional knowledge and experience to the PCR2 and were from different professional backgrounds – children's safeguarding, adult safeguarding, policing/public protection.

2.4.3. All three Independent Reviewers were independent of the Diocese of London in that they had not been previously employed by the Diocese, had not held any role within the Church and were commissioned for this task as independent consultants rather than being on the London Diocesan Fund payroll; as such, there was no conflict of interest. A brief biography for each reviewer can be found at Appendix 1.

3. Purpose & parameters of the review

3.1. Purpose and objectives of PCR 2

3.1.1. Guidance issued by the Church of England[8] in 2019 states that it is the aspiration of the Archbishops' Council that *'… By the end of the PCR 2 process, independent review work will have been carried out in every diocese and church institution within both the letter and the spirit of the protocol and practice guidance. Any file that could contain information regarding a concern, allegation, or conviction in relation to abusive behaviour by a living member of the clergy or church officer, (whether still in that position or not) will have been identified, read, and analysed by independent safeguarding professionals. At the completion of the review process, it will be possible to state that: all known safeguarding cases have been appropriately managed and reported to statutory agencies or the police where appropriate; that the needs of any known victims have been considered and that sources of support have been identified and offered where this is appropriate; that all identified risks have been assessed and mitigated as far as is reasonably possible'* (see sections 5.14 – 5.16).

3.1.2. Further guidance issued by the PCR2 Management Board[9] in 2019 set out specific objectives:

- To identify all information held within parishes, cathedrals, dioceses, or other church bodies, which may contain allegations of abuse or neglect where the alleged perpetrator is a clergy person or other church officer and ensure these cases have been independently reviewed.
- To ensure all allegations of abuse of children, especially those that have been recorded since the original PCR, have been handled appropriately and proportionately to the level of risk identified and with the paramountcy principle evidenced within decision making.

[7] Protocol and practice guidance, July 2019, Church of England.

[8] Background and overview, Past Cases Review 2 (PCR), July 2019, Church of England.

[9] Background and overview: Past Cases Review 2, July 2019 & Protocol and practice guidance, July 2019, Church of England.

- To ensure that recorded incidents or allegations of abuse of an adult (including domestic abuse) have been handled appropriately demonstrating the principles of adult safeguarding.
- To ensure that the support needs of known survivors have been considered.
- To ensure that all safeguarding allegations have been referred to the Diocesan Safeguarding Advisers and are being/have been responded to in line with current safeguarding practice guidance.
- To ensure that cases meeting the relevant thresholds have been referred to statutory agencies.

3.2. Parameters of the review

3.2.1. A review by an Independent Scrutiny Team in June 2018[10] recommended that seven Diocesan areas needed to repeat the original PCR due to several shortcomings being identified. In addition to these seven areas the Willesden episcopal area, from within the Diocese of London, was also confirmed as needing to repeat the exercise on the basis that the Bishop of Willesden had conducted the review himself, thereby calling in to question the level of independence and impartiality.

3.2.2. On that basis, all files held by the Bishop of Willesden were reviewed, including those of deceased clergy which contained information pre-1945 (which was the timeframe for the original PCR exercise). Guidance[11] issued for PCR2 sets out the parameters for the review *'… every living clergy person and all living church officers whether or not they are engaged in ministry or in paid or voluntary work at the time of the review. Those who are not in ordained or licensed ministry become subject to review where their church role brings them into direct contact with children or with adults at risk of abuse … There is no expectation that files held in parishes will be reviewed but parishes will be asked to contribute to this PCR2 process …'*. To achieve consistency, as well as wanting to conduct a robust and thorough review, a decision was taken by the Diocesan PCR2 Reference Group that all files, in all other London episcopal areas would be reviewed, not just the Willesden episcopal area; this included reviewing all files going back as far as possible. In practice, this meant that the Independent Reviewers did not stop reviewing a file simply because it contained historical information that pre-dated the original PCR which had been conducted in 2007.

[10] Report of the independent scrutiny team into the adequacy of the Church of England's past cases review 2008-2009, Sir Roger Singleton, Amanda Lamb, Donald Findlater, June 2018.

[11] Background and overview: Past Cases Review 2, July 2019 & Protocol and practice guidance, July 2019, Church of England.

3.3. Files which were in scope and reviewed

3.3.1. Table 2 below shows the church institutions that were considered as in scope, and which were reviewed:

Table 2: Church institutions in scope & reviewed					
Category	Reviewed		Category	Reviewed	
	Yes	No		Yes	No
Military Chaplains *NB		√	Overseas exchange programmes	√	
Royal Peculiars *NB		√	Centre for spiritual direction	√	
University Chaplains	√		Centre for Reconciliation and Peace	√	
Prison Chaplains	√		The centre for Church planting and growth	√	
Hospital Chaplains	√		The Centre for Theology and Community	√	
Retreats	√		Police Chaplaincy	√	
Cathedrals	√		Airport Chaplaincy	√	
Training Colleges (TEI's)	√		Church affiliated Schools (inc' Academy Trusts)	√	
Religious communities (inc' Priories)	√		-	-	
Diocese of London Deaf Church	√		-	-	

***NB:** It was agreed at the outset that military Chaplains and Royal Peculiars would be reviewed by the National Safeguarding Team.

3.3.2. Table 3 shows the roles that were considered as in scope, and which were reviewed:

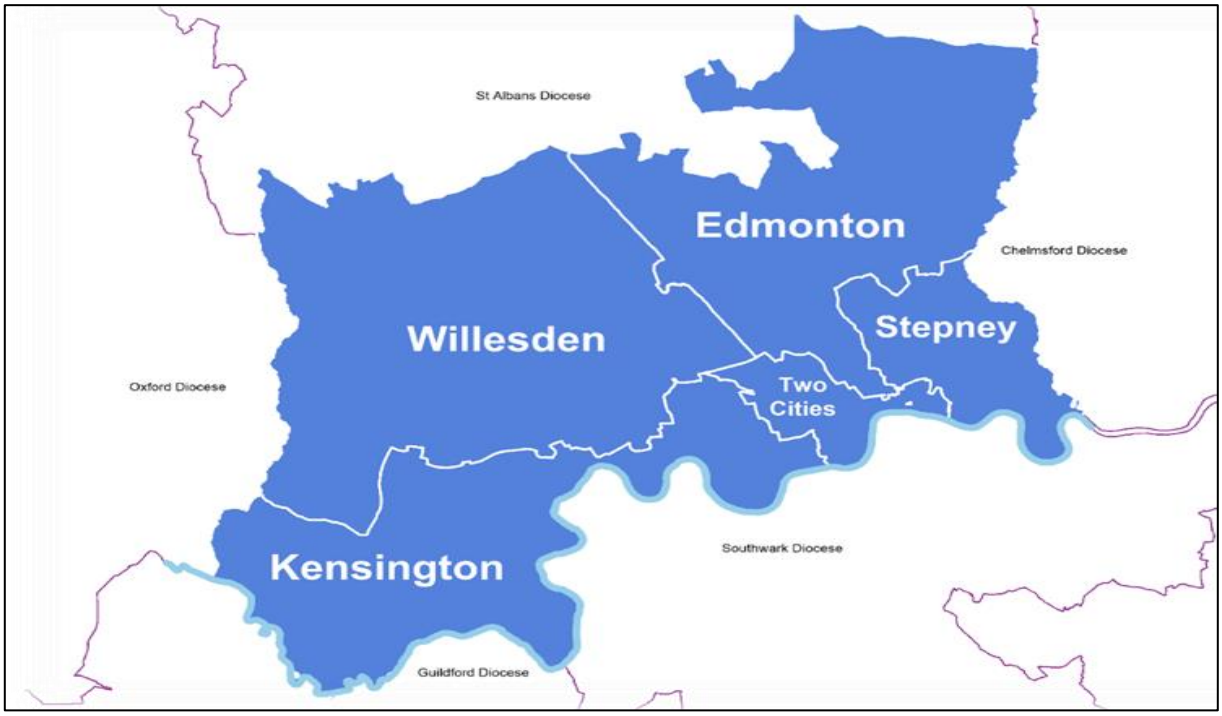
Table 3: Roles in scope & reviewed					
Category	Reviewed		Category	Reviewed	
	Yes	No		Yes	No
Assistant Chaplain	√		Hall/facilities manager	√	
Archdeacons	√		Honorary Assistant Priest	√	
Associate Vicar	√		Honorary Assistant Bishop	√	
Authorised preacher/worship leader	√		Hospital chaplain	√	
Associate Rector	√		Key office holders	√	
Bell ringers	√		Licensed Lay Ministry (LLM)	√	
Bishops	√		Leaders/assistants: religious communities	√	
Bishops Chaplains	√		Licenced lay workers	√	
Bishops PA	√		Ordinands	√	
Bishop's Secretaries	√		Organist/Director of music	√	
Church Safeguarding Officer	√		Parish Administrator	√	
Commissioned Children's Worker	√		Pastoral Assistant	√	
Choir Master	√		PCC Secretary	√	
Church Appointed School Governors	√		PCC Treasurer	√	
Church Wardens	√		Principals of theological colleges	√	
Clergy	√		Chaplains in the institutions above	√	
Curate	√		PTO – Permission to officiate	√	
Deans of Cathedrals	√		Deceased clergy *** NB**	√	
Eucharistic Ministers	√		Scoutmasters (where relevant)	√	
Team Vicar	√		Team Rector	√	
Youth workers	√		Volunteers - Children and adults	√	
Relevant religious community members	√		-	-	

*** NB:** The national Project Manager for the PCR2 confirmed that deceased clergy were out of scope for PCR2. Based on the need to review all files from the Willesden area all files presented to the Independent Reviewer were examined. This included files where people were deceased; often it was not apparent that someone was deceased until halfway through a file review. On this basis, a decision was taken that all files in the Diocese of London – whether they related to a deceased person or not – would be reviewed.

4. Brief profile of the Diocese of London

4.1. Geographically, the Diocese of London covers 277 square miles of Greater London north of the Thames from Staines in the west to the Isle of Dogs in the east and as far north as Enfield. It comprises the Cities of London and Westminster and the London boroughs of Brent, Harrow, Ealing, Hillingdon, Barnet, Camden, Enfield, Haringey, Hackney, Islington, Tower Hamlets, Hounslow, Kensington & Chelsea, Hammersmith & Fulham, Spelthorne, and part of Richmond-upon-Thames, including several famous religious sites e.g., St Paul's Cathedral and St Martin-in-the-Fields, which attract many clergy from outside the Diocese.

Image 1: Geographical outline of Diocese 1



4.2. The Diocese of London has over 500 worshipping communities, 1,000 clergy and ministers, 200 men and women in training for ministry, 150 church schools, over 150 chaplaincies in schools, colleges, hospitals, the Metropolitan Police, Heathrow airport, railways, prisons, theatres, the armed forces, football clubs, companies, shops, and City institutions. The Diocese also includes several other institutions including Royal Peculiars, extra Diocesan Churches and partner organisations such as St Mellitus theological college and Oak Hill college, the Bishop of London's Mission Fund, the Royal Foundation of St Katharine, and the Centre for Theology & Community.

4.3. The Diocese is overseen by the Bishop of London, the Rt Reverend & Rt Honourable Dame Sarah Mullally DBE, who was appointed the 133rd Bishop of London in May 2018. The Diocese consists of six areas. Each of the areas has its own Area Bishop, who looks after that geographical area, as well as having wider responsibilities across the whole diocese. The Bishops of London, Willesden, Kensington, Stepney, Edmonton,

and Fulham operate together as the London College of Bishops. Administration of the Diocese is provided by the staff of the London Diocesan Fund. The Cathedral for the Diocese is St Paul's.

4.4. The episcopal areas, and their Suffragan Bishops are:

- Two Cities: The Bishop of London, the Rt Reverend & Rt Honourable Dame Sarah Mullally, DBE appointed in May 2018.
- Willesden: The Bishop of Willesden, the Rt Reverend Pete Broadbent, appointed in 2001.
- Stepney: The Bishop of Stepney, the Rt Reverend Dr Joanne Woolway Grenfell, appointed in July 2019.
- Kensington: The Bishop of Kensington, the Rt Reverend Graham Tomlin, appointed in September 2015.
- Edmonton: The Bishop of Edmonton, the Rt Reverend Rob Wickham, appointed in September 2015.
- The See of Fulham[12], the Bishop of Fulham, the Rt Reverend Jonathan Baker, appointed in March 2013.

4.5. The role and expectations placed on each of the Bishops in terms of safeguarding children and adults, is set out in a policy statement issued by the Church of England[13], in as much as they must have 'due regard' to safeguarding matters. As Bishops they each have additional responsibilities to lead, influence, promote and embed a positive safeguarding culture in their respective episcopal areas.

4.6. In terms of keeping people safe in the area and the worshipping communities, the Diocesan website sets out its commitment *'… to safeguarding children, young people and vulnerable adults to worship and grow in Christ safely …'*[14]. Policies, procedures, and structures exist at a strategic and operational level to support this commitment and spread from a local parish level with Church Safeguarding Officers (CSOs) and clergy through to Parochial Church Councils (PCCs), Area Bishops and Archdeacons and a centrally based Diocesan Safeguarding Team. The Diocesan Safeguarding Steering Group, as noted above, has responsibility for monitoring and development of safeguarding in the Diocese and reporting 'to' the Bishop of London.

4.7. The Diocesan Safeguarding Team (DST) has a pivotal role in providing training, advice, support, and the overall management of safeguarding concerns. At the beginning of the project (January 2020) the Team consisted of:

- Safeguarding Manager (full time)
- Diocesan Safeguarding Adviser (full time)
- Diocesan Safeguarding Adviser (0.8 – 4 days per week)
- Diocesan Safeguarding Adviser (0.6 – 3 days per week)

[12] The Bishop of Fulham, under the London Plan, takes care of parishes in London Diocese (and Southwark Diocese) which have passed a Declaration under the legislation about women's ministry in the Church of England from a Traditional Catholic position – i.e., are unable to receive the sacramental ministry of women priests and bishops. Those parishes will all be in an episcopal Area of the Diocese of London, belonging to local deaneries and often relating well to their Area Bishop, Archdeacon, and other Area staff. However, they will look to the Bishop of Fulham for their oversight. The Bishop holds their clergy records.

[13] Promoting a safer church, 2017, Church of England states that under *'… section 5 of the Safeguarding and Clergy Discipline Measure 2016, all authorised clergy, bishops, archdeacons, licensed readers and lay workers, churchwardens and PCCs must have 'due regard' to safeguarding guidance issued by the House of Bishops (this will include both policy and practice guidance).* A duty to have 'due regard' to guidance means that the person under the duty is not free to disregard it but is required to follow it unless there are cogent reasons for not doing so. ('Cogent' for this purpose means clear, logical and convincing.) Failure by clergy to comply with the duty imposed by the 2016 Measure may result in disciplinary action …'.*

[14] Diocese of London: Safeguarding

- Safeguarding Assistant (full time)
- Out of hours advice and support can be sought from Thirtyone:eight[15], an independent charity that works in close partnership with the Diocesan Safeguarding Team.

4.8. Over the course of the project and up until its conclusion (September 2021) there were a number of personnel changes in the DST which greatly impacted capacity; these changes occurred alongside the national restrictions imposed due to Covid-19 meaning that routine case working, and management were additionally tested. Changes included staff leaving (Manager and Adviser) which resulted in two key vacancies for over eight months, staff sickness and absence, existing staff taking on additional responsibilities, and temporary staff being brought in to fill vacant posts. In parallel to these challenges, workload increased significantly due to the identification of issues relating to the PCR2 but also the need for the team to devote time to one particular case which required considerable input.

4.9. In summary, the Diocese of London covers a considerable geographical area comprising a large and ethnically diverse population. The Diocese has an equally great and diverse number of individuals and roles undertaking a range of functions and tasks, offering practical support and spiritual guidance within, and across the worshipping community. On this basis it has been important for the PCR2 to cast a wide net when attempting to capture and review, as best as practicably possible, all information that may indicate a concern about an individual's behaviour or conduct, and which may place a child or adult at risk.

5. Methodology used for the Diocese of London Past Cases Review 2

5.1. Given the aspiration of the Archbishops' Council for the PCR2, the Diocese of London completed an in-depth scoping exercise using a project management approach[16]. This was necessary to plan, fund and execute the work within the original timescales set by the Church of England. A project management model was maintained throughout the PCR2 timeframe with an independent Project Manager being appointed and driving the work plan forward, which ultimately proved critical to the successful delivery of the whole project.

5.2. Based on the guidance[17] and framework issued by the Church of England National Safeguarding Team the PCR2 was to be viewed as having five phases. In practical terms some of these phases ran concurrently for most of the time; however, for the purposes of reporting and ease of reading, the methodology detailed below reflects the five phases outlined in the guidance.

Phase 1: Diocese of London PCR2 Project initiation, governance & scope:

5.3. Phase 1 established the arrangements for the governance, funding and preparatory stages of the review including the recruitment of the Independent Reviewers, project management team, agreement about relevant procedural pathways i.e., escalation, referrals & risk management, information sharing and reporting.

[15] Thirtyone:eight an independent Christian charity which helps individuals, organisations, charities, faith and community groups to protect vulnerable people from abuse.

[16] Diocese of London PCR2 Project Initiation Document, March & August 2019.

[17] Background and overview: Past Cases Review 2, July 2019 & Protocol and practice guidance, July 2019, Church of England.

Phase 2: Creating an extended Known Case List for children & adults:

5.4. At the point of commissioning the PCR2 the Diocesan Safeguarding Team held a list of known cases where there were safeguarding concerns i.e., cases that were known about (see paragraph 10.2.3. for comments about the ambiguity around for the term 'known'). This list, in part, was created as a result of the original PCR exercise completed in 2007 but also included cases that had subsequently emerged as needing oversight and management during the intervening years. However, on closer review it became apparent that the quality and reliability of this original Known Case List (KCL) was highly questionable. As part of the purpose of the PCR2 exercise there was a requirement to examine whether the existing list of known cases (i.e., the original KCL generated from PCR1) needed extending. Ultimately, this shifted the approach taken by the Diocese of London requiring a KCL to be created at the conclusion of the process rather than at the beginning.

5.5. As well as the activity outlined in phase 3 below, a separate and distinct exercise was undertaken seeking information from parishes and religious institutions in each episcopal area, in line with the expectations set out in the PCR2 guidance thereby informing the Known Case List. To achieve this, the following steps were taken:

- The Bishops of Two Cities, Stepney, Willesden, Kensington, Edmonton, and Fulham sent letters in February 2020 to their respective parish areas in their episcopal areas. The letter requested each parish to complete a record, known as an Appendix A (based on the PCR2 guidance) which captured information about any individual where the parish had concerns, whether information had been referred, whether the parish was satisfied with the response from the DST and if there were any current risks.
- To support and assist the completion of Appendix A in those episcopal areas, briefing sessions were offered. The project team ran four briefing sessions during March 2020 with 25 people attending. Two more sessions were scheduled but these had to be cancelled due to the Covid-19 restrictions[18]. Briefing session FAQs (frequently asked questions) and guidance were published on the PCR2 area of the Diocesan website.
- Returned Appendix As were scrutinised initially by the Project Team to assess the quality of returns, filtering and cross referencing with the current Known Case List, Safebase and other records, where necessary. Once completed across all areas, this formed the basis for two separate lists: a Known Case List for children and a Known Case List for adults; and which would ultimately also include individual names generated from phase 3. These were then scrutinised and reviewed by the Independent Reviewers to confirm that they met the threshold criteria.
- Given the self-assessment process of local areas identifying and reporting safeguarding risks and survivor support, but also the original desire of the PCR2 to improve overall safeguarding practices across the Church, it was agreed that randomly selecting some returns would offer an opportunity for scrutiny and testing of thresholds at a parish level. Given that this was outside of scope of the PCR2 project, it was agreed by the PCR2 Reference Group in November 2020 that a random sampling audit

[18] UK Government guidance issued 23rd March 2020: Covid-19 Staying at home & away from others

of parish returns would be incorporated into the workload of the DST going forward and which would not form part of the PCR2. Responsibility for oversight of this audit work will rest with the DSSG.

Phase 3: Review of all blue clergy files held in the Diocese of London:

5.6. All current clergy have a blue file[19] connected to them[20]; this is meant to follow them throughout their ministry with the Church of England and acts in a similar way a Human Resources personnel file might in an employing organisation. The PCR2 guidance requires all blue files that were not reviewed in the original PCR to be examined, plus all blue files that were not reviewed previously with a focus on identifying incidents of abuse of adults, including domestic abuse and spiritual abuse. In practice, this meant that all blue files needed to be reviewed to gain the best assurance that any issues had been identified and responded to.

5.7. To support preparations for each area to have files and information reviewed, the Bishop of Willesden wrote to each of the area Bishops' offices in November 2019 with guidance notes advising that files were to be complete, up to date, well ordered, and ready for scrutiny by the Independent Reviewers. The Bishop of Willesden helpfully completed this task because he had been originally involved in the 2007 PCR exercise and had some experience to draw on. The guidance notes issued by the Bishop of Willesden can be found at Appendix 1. This included a request for each area to provide a list of all current clergy, plus other role categories, which would then form the basis for the work of the Independent Reviewers. These lists were cross referenced by the Project Team prior to an area review to identify clergy that were under the pastoral care of the Bishop of Fulham (as provided for under the London Plan). They also identified those already known to the DST and those who had been reported as a concern from the parish returns. This cross referencing strengthened the overall structuring of the review scope and scheduling.

5.8. The Independent Reviewers examined all known blue files provided in all five episcopal areas, including those held by the Bishop of Fulham's office. This activity took place between February 2020 and May 2021. To confirm a review had taken place, a signed and dated document was placed at the front of the blue file, on yellow paper titled *'Past Case Review 2 – Independent Reviewer case file summary'*.

5.9. Where information examined on a blue file indicated that a) there may be concerns about the safety and welfare of children or adults (either current or historical), and/or b) where there was no evidence that these concerns were either recognised or were being managed, and/or c) where it was judged that further enquiry was needed in order to rule out the possibility of ongoing risk or harm, information was passed to the DSA on an Appendix D note (as taken from PCR2 guidance and developed). When any immediate issues or concerns were identified, these were referred to the DST immediately.

5.10. Given the overall size of the Diocese, the high number of files reviewed, and concerns logged it was, proportionately (time and financially), not realistic or viable for the Independent Reviewers to make all necessary enquiries in each case. As agreed by the PCR2 Reference Group, the follow-through work would be handed over to the DST. Invariably, the details added to the Appendix D at the initial stage of it being received required the DST to undertake further enquires, either internally with the involvement of the relevant Bishops' office, or more procedurally using multi-agency safeguarding procedures. The completed Appendix Ds formed

[19] Personal files relating to clergy: Policy for Bishops and their staff, approved by the House of Bishops May 2018.

[20] The blue file system only came in during the 1980s. Prior to that, personnel records of clergy consisted of gathered correspondence and file notes, not systematically arranged.

the basis for further consideration about whether individuals' names should be added to the extended Known Case List (children or adults) as required by the guidance[21]. All were checked by the Project Team against current known cases to see if any case work had already been undertaken or if there were any records held. In all cases where an Appendix D had been completed by the Independent Reviewers it was brought to the attention of the PCR2 Reference Group; this allowed further impartial scrutiny and oversight.

5.11. Given the number of Appendix Ds completed by the three Independent Reviewers and handed over to the DST, the stretched capacity of the DST but also the need for further information to be gathered to better assess levels of risk on each case, a RAG rating system (Red-high/Amber-high/Amber-low/Green-low[22]) was applied by the lead Independent Reviewer to help prioritise risk and workload. Importantly, the use of a RAG rating system marked a point in time and was used in February 2021 to help with risk management and workload. Risk rating shifted over time, given enquiries and investigations completed against cases as they were examined – and responsibility for ongoing risk evaluation and risk management rested with the DST. Risk, workload, and capacity were discussed, not only by the PCR2 Reference Group monthly, but also by the lead Independent Reviewer, the Independent Project Manager, and the Director of HR & Safeguarding on a regular basis from November 2020 onwards at the point the episcopal area reviews began to close, and the emphasis shifted from the identification of possible, or actual risk, to risk assessment and risk management. Ensuring a smooth and effective transition of work, but also risk management, from the Independent Reviewers/Project Team to the DST has been an important consideration.

5.12. Once all episcopal area file reviews had been completed in May 2021 the three Independent Reviewers, a representative from the DST and the independent Project Manager conducted a moderation exercise reviewing all the Appendix Ds. This allowed a further opportunity to examine each case, consider a shared understanding about risk or harm against the threshold criteria (set out in the guidance), sample for quality and bias, and reach consensus about which names should go forward to be included in the extended Known Case List and which names would not. For those individuals', that warranted an Appendix D to be completed a note was made on the Independent Reviewer Case File Summary sheet placed at the front of each blue file to flag that further action had been required. This will need to be followed up, post the PCR2 project, by the DST ensuring a copy of the Appendix D is also placed on file. For those where an Appendix Ds was not created, a judgement was made that they did not warrant inclusion on the KCL, due to the issues identified not meeting the threshold following moderation, and also because there was no substantiated risk identified. Although not added to the KCL, actions may still be required to give full assurance that issues identified have been properly dealt with. This, combined with the steps outlined in 5.10 – 5.12 ensured a robust filtering exercise which formed the basis for the extended Known Case List.

5.13. Once all files had been reviewed in an episcopal area, an action plan was created by the Independent Reviewers and passed to the respective Bishop and the DSA for follow-up. This included all names where an

[21] Background and overview: Past Cases Review 2, July 2019 & Protocol and practice guidance, July 2019, Church of England.

[22] The terms Red-high, Amber-high, Amber-low, Green – low, were created in order to provide a more meaningful differentiation for those cases where it was judged to be a medium level of risk. The larger proportion of concerns identified were placed in the Amber category, and a split category was judged to be helpful in terms of the DST managing the workload. Please refer to Appendix 8 for a full explanation of these descriptors, with examples. This matrix should be read in conjunction with the PCR2 threshold criteria set out in paragraph 5.15 & 5.16.

Appendix D had been created and which required action as well as other actions identified as a result of the overall file review.

5.14. The threshold criteria used for examining all cases – whether from the return of Appendix As from parishes or blue clergy file reviews and completing an Appendix D is set out in guidance[23], was:

5.15. In respect of children:

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

5.16. In respect of adults:

- Behaviour which has harmed, may have harmed or is likely to harm a vulnerable adult.
- Behaviour which could be a relevant criminal offence against an adult/vulnerable adult.
- Behaviour which indicates that the person is unsuitable to work with vulnerable adults.
- More than one low level concern which would not, taken individually, meet the threshold for referral but taken together would justify further exploration.
- Allegations of abuse which have not led to a prosecution or caution.
- Allegations that indicate a church officer was seen as being in a position of responsibility or authority, where they were trusted by others and used this position to groom or exploit adults who are vulnerable.
- Any cases where victims have reported abuse but where, following investigation, there has been insufficient evidence to substantiate the claim or report. This should be clearly stated on the KCL (Adults).

5.17. The PCR2 guidance allowed for exemptions to be made in cases where evidence might be produced by the DSA to demonstrate that risk management, based on existing and recent independent review had been undertaken; and that survivor support (where necessary) was in place and that any safeguarding issues were being appropriately managed. No exemptions were sought by the Diocese of London.

<u>Phase 4: Review of all cases known & those being managed by the Diocese Safeguarding Team:</u>

5.18. Phase 4 provided an opportunity for the Independent Reviewer to gain assurance about the quality and effectiveness of safeguarding practice and management arrangements by the DST for each open and active case; closed cases were however also reviewed. In practice, this included some cases where an Appendix D

[23] Protocol and Practice Guidance, July 2019, Church of England. It is worth noting that no reference was made in this Protocol & Practice to categories of abuse, as specifically stated in either statutory guidance i.e., Working together to safeguard children or the Care and support statutory guidance for the Care Act 2014, or the Church of England's own guidance, Practice Guidance: Responding to Safeguarding Concerns or Allegations that relate to Children, Young People and Vulnerable Adults.

had already been completed by the Independent Reviewer because other papers had been found in an episcopal area which contained new, or not previously assessed information. This involved reviewing information held in the electronic database used by the DST, Safebase, and the internal drive where documents were stored.

5.19. An audit tool was developed and was based on Church of England guidance[24]. Broadly, the criteria covered the following areas: 1. First response, 2. Information sharing, 3. Initial assessment & management of concerns/allegations, 4. Investigation, 5. Risk assessment & management, 6. Ongoing risk management, 7. Outcomes, 8. Recording keeping. A full audit template for this can be found at Appendix 3.

Phase 5: Collation of information, analysis & reporting:

5.20. The Project Team undertook a significant amount of cross referencing and triangulation of information from across all area reviews, and parish returns. The culmination of activity from phases 2, 3 & 4 made it possible to then create an extended Known Case List. In turn, this will form ongoing work for each of the episcopal area Bishops, the DST and the Diocesan Safeguarding Steering Group.

5.21. This report, and information collated, using Appendix E (children) and F (adults) was then presented to the Diocesan PCR2 Reference Group. In turn, it was then shared with the Bishop of London and the Diocesan Safeguarding Steering Group before being submitted to the national PCR2 Project Management Board.

Additional methodological considerations:

5.22. Victims & survivors: The involvement of victims and survivors has been important for the Diocese when conducting this review. On that basis, the following steps were taken:

- Representatives from Victim Support and the National Association for People Abused in Childhood (NAPAC) were co-opted onto the PCR2 Reference Group to ensure the voice of survivors featured in the overall governance of the review.
- During the lifetime of the PCR2 project the Diocese formulated a Survivor Strategy and pathway that was not only intended to meet the needs of those survivors and victims' that might come forward to directly contribute to the PCR2, but also make provision the Diocese's intentions and commitments in the longer term. The strategy was heavily influenced and shaped by the contributions of the representatives from Victim Support and NAPAC. Diocese of London Survivor Strategy weblink
- An anonymous survey, using Survey Monkey, was created, and made accessible to victims and survivors for the purpose of seeking learning.
- The lead Independent Reviewer spoke with two survivors who wished to contribute directly to the PCR2.
- A leaflet for survivors was developed which explained the PCR2 as well as opportunities for survivors to speak with someone, should they wish to come forward. Diocese of London: Survivor leaflet

5.23. Interviews: Four members of the DST were spoken with by the Independent Reviewer in order to gain their views and perspectives of the quality and effectiveness of safeguarding work in the Diocese.

[24] Practice Guidance: Responding to, assessing & managing safeguarding concerns or allegations against church officers, Church of England, 2017

5.24. Covid-19: Due to the Covid-19 restrictions in place which covered most of the review time fame, adaptations were needed to keep the review moving. These mostly related to the Independent Reviewers needing to work off-site i.e., not in the Bishops' offices where files were held, and having files securely couriered to their working locations. Files were then held securely by each Independent Reviewer. The PCR2 Reference Group is grateful to all parishes that returned their Appendix As despite many of the restrictions in place at the time as a 100% compliance was achieved.

6. Limitations of the Past Cases Review 2 in the Diocese of London

6. 1. The completion of Appendix A was reliant on the time, skill and local knowledge of incumbents, ministers of parishes, chaplaincies, Bishops Mission Orders and parish Safeguarding Officers. By asking individuals at a local parish level to complete this information it resulted in a self-assessment exercise by people who will have differing levels of knowledge, experience, and confidence in safeguarding issues. The ambiguity of the national protocol, guidance and templates issued did not help this.

6.2. Although this was a review examining files held in the Diocese of London, its specific focus was to examine for information which related to the PCR2 threshold criteria. The review was not an audit of file management compliance against guidance[25]. However inevitably, when reviewing over 5000 files, issues were noted and where helpful to do so, these have been commented on.

6.3. Whilst this review has examined the quality and effectiveness of the DST from a case work perspective, the project was not formed to undertake a whole safeguarding system review; as such, any data and findings made in this report have not been triangulated with other sources of information i.e., formally gathering the views of key stakeholders such as Bishops, Archdeacons, parish Safeguarding Officers, statutory agencies, or reviewing the effectiveness of the Diocesan Safeguarding Steering Group. These may be areas that the Diocese wish to examine in due course alongside reviewing the accountability arrangements between the Diocese Safeguarding Steering Group, the Bishop of London and General Secretary.

7. Findings & analysis by episcopal area & as a Diocese

The following sections provides details about review activity and findings in each episcopal area.

7.1. Willesden episcopal area:

7.1.1. The Willesden episcopal area is the responsibility of the Bishop of Willesden, the Rt Reverend Pete Broadbent. He is supported by the Archdeacon of Northolt, the Venerable Catherine Pickford. The Willesden area includes Brent, Harrow, Ealing, and Hillingdon in North West London. Brent, Ealing, and Harrow are home to some of the largest minority ethnic communities in London. It has an estimated worshipping population of 12,300 people. In addition, the presence of London Heathrow Airport means numbers of refugees and asylum seekers in the area are high. There are 20 Church of England voluntary aided schools in the area, 18 primary and two secondaries. There are 14 hospitals in the area. The area consists of 115 parishes and 105 churches.

7.1.2. Given the findings from the original 2007 – 2009 PCR that the Willesden area review had been conducted by the Bishop of Willesden himself rather than someone independent, the Willesden episcopal area was chosen as the first area to review in the Diocese of London PCR2 and to incorporate a review of all files

[25] Personal files relating to clergy: Policy for Bishops and their staff, approved by the House of Bishops May 2018.

considered as part of PCR1. The current Bishop of Willesden is the same person who was the Bishop during the original 2007 – 2009 PCR.

Review activity:

7.1.3. In February 2020 files were reviewed from the Bishop of Willesden's office. Table 4 below shows the number and type of file reviewed as well as whether any safeguarding issues were identified that were of relevance to the PCR2. In addition to these files, the Known Case List for Willesden that was generated in the 2007 PCR was examined to examine current circumstances as required by the PCR2 national guidance issued.

Table 4: Summary of review activity & findings from the Willesden area review

Episcopal Area Willesden	No. of Files reviewed at the Bishops Office	No. of concerns (Appendix D's) as result of this review	No. of those concerns already known to DST *	No. of concerns not previously referred to DST (including not known)
Current Clergy	148	3	3	0
LLM	71	0	0	0
PTO	57	0	0	0
Ordinand	59	0	0	0
Archive	242	3	2	1
Parish files	141	21	10	11
Area total	718	27	15	12

*** NB:** Files identified that were on Safebase or the Safeguarding V drive.

Summary of findings:

7.1.4. *Review of the original PCR 2007 - 2009 Known Case List for Willesden:* this contained 26 names, highlighted a range of issues which are further discussed in sections 8 and 10. In summary, these relate to:

- In many cases there were no further records found on the DST Safebase database, despite the fact that the original KCL, with supporting documentation had been passed to the DST at the time of the original PCR1 exercise. In practice this meant that for cases where a previously identified concern as a result of the national review, there was no record of how the case had been investigated, managed or concluded. This is not something the Bishop of Willesden can be held accountable for.
- For a small number of cases, it was unclear why a person's name had been added to the KCL; for example, in three cases it seemed to be because of minor offences disclosed on the criminal records check which were not necessarily of a safeguarding related matter. In a small number of cases unsubstantiated allegations also seem to have been included.

7.1.5. *PCR2 related review activity:* in addition to achieving the core aim of reviewing all relevant files and identifying any issues that met the threshold criteria as set out in the PCR2 Practice Guidance, the following good practice features were noted as a result of reviewing files held by the Bishop of Willesden:

- Current blue files were well maintained, securely stored in an office area within a private residence, and systematically organised in filing cabinets. They were only accessible to those with authorised

access. The Bishop and his Personal Assistant had a very good working knowledge of where files were located and individual members of clergy.
- Information on active blue files demonstrated that the Bishop had been actively engaged in communicating with the individuals thereby providing a sense of oversight and management.

7.1.6. The following areas for development were noted:

- The clergy file management/front sheet in a significant number of clergy files were incomplete (both recent and historic).
- There was some inconsistency in terms of Disclosure & Barring Service criminal records checks being held on the blue files.
- Although a temporary arrangement to facilitate the PCR2 exercise, archived files were held by the Bishop in a spare room, stored in open cardboard boxes. Once the review was complete, it was reported that the files were returned to secure location in the same building.
- Of note more generally when reviewing all files, a high proportion of documents or letters from various sources were not signed (mostly historical in nature).
- Where issues or concerns had been raised, whether it be of a safeguarding nature or regarding conduct, compliance, or disagreement, often outcome or closure statements were not on file (both recent and historic).
- It was not always clear nor apparent if, and how, victims and survivors had been offered support.
- Ministerial Development Reviews not designed or used to consider safeguarding related matters.

7.2. The See of Fulham:

7.2.1. The Bishop of Fulham has specific pastoral oversight for parishes and members of the clergy that do not accept the ordination of women into the priesthood on grounds of theological conviction; this role covers the dioceses of London, Southwark and, until 2014/2015 Rochester. This is outlined in the London Plan which *'… provides a framework within which those who hold sharply defined differences about the ministerial priesthood can live together in simplicity, reciprocity and mutuality. We believe that the diversity of church tradition of the Diocese is part of our strength, and in it we find unity …'* [26].

Review activity:

7.2.2. From March to April 2020 files were reviewed from the Bishop of Fulham's office. Given the restrictions imposed due Covid-19 the review of files required a combination of on, and off-site, activity.

7.2.3. Table 5 below shows the number and type of file that was reviewed as well as whether any safeguarding issues were identified that were of relevance to the PCR2.

[26] The London Plan - Diocese of London

Table 5: Summary of review activity & findings from the See of Fulham area review				
Episcopal Area See of Fulham	**No. of Files reviewed at the Bishops Office**	**No. of concerns (Appendix D's) as result of this review**	**No. of those concerns already known to DST ***	**No. of concerns not previously referred to DST (including not known)**
Current Clergy	57	15	9	6
LLM	0	0	0	0
PTO	0	0	0	0
Ordinand	18	0	0	0
Archive	183	14	4	10
Parish files	105	2	0	2
Area total	363	31	13	18
***NB:** Files identified that were on Safebase or the Safeguarding V drive.				

Summary of findings:

7.2.4. In addition to achieving the core aim of reviewing all relevant files and identifying any issues that met the threshold criteria as set out in the PCR2 Practice Guidance, the following good practice features were noted as a result of reviewing files held by the Bishop of Fulham:

- Files were held securely in locked filing cabinets in an office area within a private residence, accessible to only those with authorised access.

7.2.5. The following areas for development were noted:

- Overall, the file management systems appeared limited, and some files had not been examined by the current Bishop or his Personal Assistant since taking up post; a considerable amount of documentation had been inherited from the previous Bishop and there had been no internal review or audit of what might be contained in files. This was confirmed by the current Bishop, who expressed having greater confidence about the quality and effectiveness of managing any safeguarding issues which had arisen during his time in post, as opposed to being much less certain about anything that was historical or had a legacy from the previous Bishop.
- The clergy file management/front sheet in many clergy files was incomplete (both recent and historic).
- Inconsistency of Disclosure & Barring Service criminal records checks being held on the blue files.
- Some information was held electronically however the filing and management of this information was haphazard and did not necessarily correlate with what was held on any paper files.
- It was not clear if, or how, victims or survivors had been offered support.
- Ministerial Development Reviews not designed or used to consider safeguarding related matters.

7.2.6. The Independent Reviewer reviewed a small number of documents that had been removed from blue files. The author was advised that an experienced and recommended independent consultant, with significant clergy administration experience, had been commissioned by the Bishop of Fulham in June 2019 and then commenced October 2019 to undertake some overdue file management work i.e., consider GDPR and file management compliance; it was the independent consultant that had removed these documents from the blue files. This exercise was completed prior to the PCR2 exercise beginning and prior to guidance being issued by the Bishop of Willesden. These documents had been put aside for destroying. When reviewing these

documents, in one case information was found which gave specific details about a member of the clergy's sexual behaviours. There were no specific references to this anywhere else in the member of clergy's blue file; effectively, the details had been removed and the only wording remaining in the blue file was one reference to alleged 'sexual conduct' in a document. It is reported that the relevant guidance (Personal Files relating to the Clergy: Policy for Bishops and their Staff' issued in May 2018) was followed during this exercise. The issues were not directly of a safeguarding nature and were probably about sexuality, however allegations were clearly made. Importantly, the absence of any corroborating information on the blue file and only leaving a mention of 'sexual conduct' left uncertainty and raised questions about what this might relate to.

7.2.7. Also noted were attempts at redaction by the independent consultant, of some statements in documents with a black marker pen. Without too much effort it was possible to read what was underneath the black marker pen; the method used was therefore inadequate and ineffective. Most redactions reviewed related to a third-party name that might reasonably not need to appear in the incumbent's personal file. However, in a small number of cases redactions were inconsistently applied, and in one case the redaction did conceal information that could be interpreted as of a safeguarding nature until otherwise disproved or discounted.

7.2.8. Clearly these were worrying findings especially in the context of findings from previous high-profile investigations and reviews by the Church of England[27] It has been important for the Independent Reviewers to approach the PCR2 task with a level of curiosity and healthy scepticism when reviewing documents and files. Whilst the original request by the Bishop to examine GDPR and file management compliance in October 2019 was likely made with good intent the activities and findings, as outlined above, provoke only one thing - increased alertness and scepticism that can be interpreted different ways.

7.2.9. Combined, the removal of papers and redaction of statements, led to the Independent Reviewer escalating this finding to the Bishop of Fulham, the Safeguarding Manager, the Director of Human Resources & Safeguarding and the PCR2 Reference Group. This resulted in a formal response by the Bishop of Fulham being requested to account for the removal and redactions. In addition to this, at the time of the early findings being made and the initial escalation a formal message from the Bishop of Stepney, with lead responsibility for safeguarding in the Diocese, was issued advising that the removal or redaction by any person currently commissioned to tidy files, should not happen in any circumstances.

7.2.10. The Diocese Safeguarding Manager considered the removals and redactions with the Bishop of Fulham and his Personal Assistant, and a full report was provided to the Independent Reviewer with four findings:

- The independent consultant had been commissioned in October 2019 to review the files for GDPR and file management purposes and had been expressly instructed not to remove information of a safeguarding nature.
- Due to staffing issues, the Bishop of Fulham's office delayed introducing revised blue file management in May 2018; thus, in the intervening months, very limited administrative support was provided and not at a sufficiently competent level to oversee the introduction of a new system of blue file management; this task was explicitly left to the potential full-time successor. Once in post, some changes and preparations were achieved, but not all; as such, preparations for the PCR2 were not as effective as hoped for.

[27] The Anglican Church, Investigation Report, October 2020, Independent Inquiry Child Sexual Abuse, IICSA report

- Knowledge of GDPR expectations was not strong enough, and consequently weakened administrative practice.
- There was no evidence to indicate that removal or redaction of papers from files was a deliberate attempt to divert or hide information from the PCR2.

7.3. Stepney episcopal area:

7.3.1. The Stepney episcopal area is the responsibility of the Bishop of Stepney, the Rt Reverend Dr Joanne Woolway Grenfell. She is supported by the Archdeacon of Hackney, the Revd Liz Adekunle. The Stepney area covers the London boroughs of Hackney, Islington, and Tower Hamlets. Like much of London the area spans great social and economic contrasts. The three boroughs contain some of the most deprived wards in the country alongside neighbouring districts of expensive housing – as in the south of Islington and Hackney and the rapidly growing businesses in the Docklands in Tower Hamlets. All three boroughs are home to large minority ethnic communities. There are 29 Church of England voluntary aided schools in the area, 26 primary and three secondaries. There are also three universities in the area. There are five hospitals and one prison in the area. The area consists of 76 parishes and 87 churches.

Review activity:

7.3.2. From August to October 2020 files were reviewed from the Bishop of Stepney's office. The majority of this review activity took place on site.

7.3.3. Table 6 below shows the number and type of file that was reviewed as well as whether any safeguarding issues were identified that were of relevance to the PCR2.

Table 6: Summary of review activity & findings from the Stepney area review

Episcopal Area Stepney	No. of Files reviewed at the Bishops Office	No. of concerns (Appendix D's) as result of this review	No. of those concerns already known to DST *	No. of concerns not previously referred to DST (including not known)
Current Clergy	127	12	4	8
LLM	53	1	0	1
PTO	28	2	1	1
Ordinand	38	1	0	1
Archive	115	27	8	19
Parish files	135	9	1	8
Area total	496	52	14	38
*** NB:** Files identified that were on Safebase or the Safeguarding V drive.				

Summary of findings:

7.3.4. In addition to achieving the core aim of reviewing all relevant files and identifying any issues that met the threshold criteria as set out in the PCR2 Practice Guidance, the following good practice features were noted as a result of reviewing files held by the Bishop of Stepney:

- Appropriate planning for the PCR2 project was demonstrated with file preparation evident ahead of the Independent Reviewer arriving.
- File management front sheets were evident on each file, although some gaps in information on some was noted.
- Files were stored in a systematic and secure way, in an office area within a private residence, with information being easily accessible to those with authorised access.
- Information being stored on file in accordance with the practice guidance[28].
- Where Clergy Discipline Measures had been used, there was good evidence found on those files.
- Good evidence of the current and previous Bishop of Stepney recording on clergy, PTO and archived files.

7.3.5. The following areas for development were noted:

- It was not always clear if, and how, victims or survivors had been offered support.
- Ministerial Development Reviews not designed or used to consider safeguarding related matters.

7.4. Kensington episcopal area:

7.4.1. The Kensington episcopal area is the responsibility of the Bishop of Kensington, the Rt Reverend Dr Graham Tomlin. He is supported by the Archdeacon of Middlesex, the Venerable Richard Frank. The Kensington area includes the west London Boroughs of Hammersmith and Fulham, Hounslow, Kensington and Chelsea, the borough of Richmond north of the Thames, and the Surrey Borough of Spelthorne. Spanning from Knightsbridge to the bridge that crosses the Thames into Staines, the parishes of the Kensington area serve hugely diverse communities. There are 38 Church of England schools, 12 hospitals, one prison. It is also home for theological training, with St Mellitus College training over 100 Ordinands (and many hundreds of other students). The area consists of 98 parishes and 118 churches.

Review activity:

7.4.2. Between September and December 2020 files were reviewed from the Bishop of Kensington's office. The majority of this review activity took place on site.

7.4.3. Table 7 below shows the number and type of file that was reviewed as well as whether any safeguarding issues were identified that were of relevance to the PCR2.

[28] Personal Files relating to clergy: Policy for Bishops and their staff, May 2018.

Table 7: Summary of review activity & findings from the Kensington area review				
Episcopal Area Kensington	**No. of Files reviewed at the Bishops Office**	**No. of concerns (Appendix D's) as result of this review**	**No. of those concerns already known to DST ***	**No. of concerns not previously referred to DST (including not known)**
Current Clergy	233	6	3	3
LLM	56	0	0	0
PTO	68	1	0	1
Ordinand	85	2	1	1
Archive	402	17	3	14
Parish files	127	11	1	10
Area total	971	37	8	29
***** **NB:** Files identified that were on Safebase or the Safeguarding V drive.				

Summary of findings:

7.4.4. In addition to achieving the core aim of reviewing all relevant files and identifying any issues that met the threshold criteria as set out in the PCR2 Practice Guidance, the following good practice features were noted as a result of reviewing the files held by the Bishop of Kensington:

- The files were stored securely in an office area within a private residence, and only accessible to those with authorised access.
- Files for Ordinands and Licenced Lay Ministers was better organised with clearer expectations about how long information might be retained under GDPR guidance.

7.4.5. The following areas for development were noted:

- The clergy file management/front sheet was incomplete in a significant number of clergy files, and many contained incorrect dates of birth (both recent and historic).
- A notable number of documents relating to members of the clergy, which should have been filed in the respective blue file, were filed elsewhere in plastic wallets. Some of these documents contained relevant information which indicated risk and which needed further examination and investigation.
- Information about members of the clergy was also held electronically or only electronically and cross referencing between the two was inconsistent.
- Parish files contained duplicate documents, and some parishes had more than one file; file/documents management was haphazard. Some parish information was incorrectly filed in the wrong parish folder, and identification numbers were not consistently applied. Some parish folders contained information about individuals such as copies of passports, DBS applications and other identification.
- Many historic files did not have clearly recorded outcomes following investigations; more recent issues managed by the current Bishop of Kensington were clearly stated and documented.
- Many letters, from the previous Bishops of Kensington, were unsigned, as were letters to the Bishop from other members of the clergy; more recently, improvements on this were noted.
- Uncertainty about whether, and how, victims or survivors had been offered support.
- Ministerial Development Reviews not designed or used to consider safeguarding related matters.

7.5. Edmonton episcopal area:

7.5.1. The Edmonton episcopal area is the responsibility of the Bishop of Edmonton, the Rt Reverend Rob Wickham. He is supported by the Archdeacon of Hampstead, the Venerable John Hawkins. The Edmonton area covers the four north London Boroughs of Barnet, Camden, Enfield, and Haringey. There are 60 Church of England primary schools and 11 secondaries in the area. The area consists of 115 parishes and 119 churches.

Review activity:

7.5.2. Between August and November 2020 files were reviewed from the Bishop of Edmonton's office. The majority of this review activity took place on site.

7.5.3. Table 8 below shows the number and type of file that was reviewed as well as whether any safeguarding issues were identified that were of relevance to the PCR2.

Table 8: Summary of review activity & findings from the Edmonton area review

Episcopal Area Edmonton	No. of Files reviewed at the Bishops Office	No. of concerns (Appendix D's) as result of this review	No. of those concerns already known to DST *	No. of concerns not previously referred to DST (including not known)
Current Clergy	188	4	3	1
LLM	88	2	1	1
PTO	75	1	1	0
Ordinand	49	1	0	1
Archive	194	20	7	13
Parish files	183	2	2	0
Area total	777	30	14	16
*** NB:** Files identified that were on Safebase or the Safeguarding V drive.				

Summary of findings:

7.5.4. In addition to achieving the core aim of reviewing all relevant files and identifying any issues that met the threshold criteria as set out in the PCR2 Practice Guidance, the following good practice features were noted as a result of reviewing files held by the Bishop of Edmonton:

- Files were stored securely in locked cabinets in an office area within a private residence and only accessible to those with authorised access.
- Appropriate planning for the PCR2 project was demonstrated with file preparation evident ahead of the Independent Reviewer arriving.

7.5.5. The following areas for development were noted:

- A recurring issue of information missing from files; missing historical information on new files that had been set up, minutes of meetings, substantial gaps in history, self-declarations, Disclosure & Barring checks, letters that might be viewed as relevant to be on a file, were not present including records of communication with relevant authorities.

- Inadequate file management systems including filing errors, information found in other non-blue files relating to individual members of clergy, information of concern relating to more than one member of clergy not being cross referenced on other files where it would be relevant to do so.
- Illegible handwritten notes, often on what appear to be scrap pieces of paper, as opposed to formal document templates and which have no explanation about what they might relate to. One example included a handwritten bullet point made by a former Bishop 'safeguarding issues' that was followed by other indecipherable notes.
- Confidential notes held by the Bishop about issues such as complaints, risk management, HR matters. On review, these could have been held on the respective member of clergy's blue file, or at very least (if a confidential file is to be kept by the Bishop) for the blue file to refer to other confidential papers being held. Some confidential notes held were electronic and password protected; in one case the password had been forgotten.
- For those members of clergy that held positions in other countries there was a lack of references or criminal records checks.
- A general lack of information about Licenced Lay Ministers in terms of safer recruitment i.e., the application process, references, education, and employment history.
- A lack of information about whether victims, informants or survivors were offered support.
- Ministerial Development Reviews not designed or used to consider safeguarding related matters.

7.6. Two Cities episcopal area:

7.6.1. The Two Cities episcopal area is the responsibility of the Bishop of London, the Rt Reverend & Rt Honourable Dame Sarah Mullally, DBE. She is supported by the Archdeacon of London, the Venerable Luke Miller. The Two Cities area includes Paddington, St Marylebone, St Margaret's (Westminster) and the City of London. There are 34 Church of England schools in the area, 21 Primary and 13 secondaries. There are nine hospitals, 75 parishes and 88 churches.

Review activity:

7.6.2. Between September 2020 and April 2021 files were reviewed from the Bishop of London's office covering the Two Cities area. Given the restrictions imposed due Covid-19 all file reviews were completed off site and some restrictions delayed the completion of file reviews any earlier.

7.6.3. Table 9 below shows the number and type of file that was reviewed as well as whether any safeguarding issues were identified that were of relevance to the PCR2.

Table 9: Summary of review activity & findings from the Two Cities area review				
Episcopal Area Two Cities	**No. of Files reviewed at the Bishops Office**	**No. of concerns (Appendix D's) as result of this review**	**No. of those concerns already known to DST ***	**No. of concerns not previously referred to DST (including not known)**
Current Clergy^	189	7	7	0
LLM	0	0	0	0
PTO	92	4	3	1
Ordinand	54	1	1	0
Archive	1114	64	27	37
Parish files	134	20	5	15
Area total	1583	96	43	53
*** NB:** Files identified that were on Safebase or the Safeguarding V drive. **^ NB:** includes senior clergy, suffragan bishops and honorary bishops.				

Summary of findings:

7.6.4. In addition to achieving the core aim of reviewing all relevant files and identifying any issues that met the threshold criteria as set out in the PCR2 Practice Guidance, the following good practice features were noted as a result of reviewing files held by the Bishop of London:

- Files were securely stored in an office area within a private residence, systematically organised, and kept in a well-ordered manner, and the Bishops Personal Assistant had a good knowledge of what files were kept in the different drawers. Files were accessible to only those with authorised access.
- Individual files, overall, were well maintained.

7.6.5. The following areas for development were noted:

- The Bishop's office held a number of papers/files relating to members of the clergy who had been through, or were going through, Clergy Discipline Measures. Some papers where these processes had concluded still needed to be reunited with the individual blue file so that all information would be held in one place.
- A high number (over 1100) archived files were held by the Bishop of London; many related to former clergy that had spent their life with the Church of England however the size of the file did not reflect this with their often being just a few pieces of paper held on file. It would be reasonable to conclude that a high number of these files had been reviewed and contents removed in the past. Neither the Bishop of London or her Personal Assistant were aware of when, or why, this would have been done and were clear that this happened before either of them coming into their role.
- The clergy file management/front sheet in a significant number of clergy files were incomplete (both recent and historic).
- Where issues or concerns had been raised, whether it be of a safeguarding nature or regarding conduct, compliance or disagreement, outcome or closure statements were often not found.
- It not being clear if, and how, victims or survivors had been offered support.
- Ministerial Development Reviews not designed or used to consider safeguarding related matters.

7.7. Summary of activity & findings from episcopal area file reviews

7.7.1. Review of the data set out in Table 10 below, shows that in 271 cases, information was identified which raised concerns for the three Independent Reviewers and which, in their view, justified further enquiries or investigations to either discount current risk, or confirm arrangements for responding to and managing risk. In all cases where this threshold had been met, the PCR2 Reference Group validated the Independent Reviewers findings and recommended actions. No challenges were received about the threshold which had been applied.

7.7.2. Over the course of the review, it has become apparent that the reliability of file lists held by the Bishops offices was not always trustworthy; in some cases individual files could not be located, despite records held on a central database or other lists kept, indicating that the file was held in one of the episcopal areas. This required a considerable amount of tracking and triangulating to locate some files. Each episcopal area now has a tracking sheet containing all files in their area for future reference; ensuring this is kept up to date and information about movements across the Diocese are logged will be important to avoid unreliable lists being re-created.

Table 10: Summary of total review activity & findings across all area reviews

Diocese of London	**No. of Files reviewed at the Bishops Office**	**No. of Concerns (Appendix D's) as result of this review**	**No. of those concerns already known to DST ***	**No. of concerns not previously referred to DST (including not known)**
Edmonton	777	30	14	16
Fulham	363	31	13	18
Kensington	971	37	8	29
Stepney	496	52	14	38
Two Cities	1583	96	43	53
Willesden	718	27	15	12
Total	4908	273	107	166

*** NB:** Files identified that were on Safebase or the Safeguarding V drive.

7.7.3. In 166 cases, it was confirmed that the DST had not previously known about the information identified by the Independent Reviewers because information had been found on archived files which, most likely, had not been accessed by either the current Bishop, their administrators or indeed anyone else. A high proportion of these pre-dated the requirement by Dioceses to have any structures, arrangements[29], or dedicated roles[30] in relation to safeguarding responsibilities i.e., before 2013 and then 2017. Given the archived nature of these cases, the introduction of more formal safeguarding arrangements and expectations more clearly set out

[29] Since 2013, Government guidance or legislation (Working together to safeguard children, 2013 & the Care Act 2014) has explicitly stated that like other organisations and agencies who work with children and adults, faith organisations should have appropriate arrangements in place to safeguard and protect them from harm.

[30] The introduction of Diocesan Safeguarding Advisers became a requirement from 01/01/2017 under the Diocesan Safeguarding Advisers Regulations 2016.

about record keeping from 2016, this finding is unsurprising. However, for some of these archived cases, information related to concerns that was decades old and which, seemingly, had neither been examined by the original PCR in 2007 - 2009 or anyone with any safeguarding expertise to consider risk, harm, or abuse. Given that the Diocese did not have full information about what review activity was undertaken in the original PCR exercise it is impossible to confidently comment on whether these cases were, or were not reviewed, but the absence of any documentary evidence (as has been found in other files that were clearly reviewed) is a concern. A major contributory factor to this happening can be linked to records being created in the names of either/or the victim/survivor or the alleged perpetrator; as such, there may have been records created in the name of the victim/survivor, but which failed to obviously flag who the alleged perpetrator was. Inadequate file naming conventions, poor recording practices and the use of two different recording locations (Safebase and an internal drive) all contributed to this. Further action will be needed to address these findings.

7.7.4. It is noted that proportionately, there is a discrepancy in the number of concerns captured (based on an Appendix D being completed) in the See of Fulham area compared to the other episcopal areas and the number of files reviewed. Given the importance of clergy, ordinands and licensed staff in how parish areas operate further work is needed to better understand the reasons for this.

7.7.5. The following overall themes and patterns have been captured from review of files from all areas:

Recording, record keeping and records management:

7.7.6. Practice relating to recording, record keeping, and records management varied considerably. Whilst information security was considered good (with the exception of archived boxes held in the Bishop of Willesden's residence), there is learning about the quality and effectiveness of recording, record keeping and records management. Some of these issues relate to the practice of individuals (current but mostly historic) i.e., a) incoming Bishops reviewing all documents/files held in their episcopal area when first entering role, nor knowing what is contained in files to gain assurance about hidden risks or risks that appear not to have been examined, and b) filing documents incorrectly, c) illegible handwritten notes, and unsigned letters on file. These can be corrected by improved management and oversight. However, other issues also relate to practices and processes which can be strengthened at a more systemic level and may require a more coordinated approach i.e., the inconsistent use clergy file front sheets, self-declarations.

7.7.7. The storage of archived files was inconsistent. In the Bishop of Willesden's case, archived files were stored in large open boxes held in a spare room in his residence, where-as in the Bishop of London's office archived files were stored in filing cabinets, albeit in the Bishop's residence but in the office area. To some extent, the holding of clergy files in personal residences limits access. The Bishop of Willesden helpfully produced a document titled 'policy on archiving the files of dead clergy' dated 29/10/2009. This document refers to waiting to hear from the Church Commissioners about a list of deceased London clergy, but also the London Metropolitan Archive for advice. It is not clear what the outcome of these enquiries were, however based on the findings from the Independent Reviewers it seems clear that matters never progressed to a satisfactory conclusion.

7.7.8. Some episcopal areas used electronic filing systems, and used them more effectively, than others. In some instances, relevant information was held about individuals that was of interest to the Independent Reviewers, which was not found on paper blue files. Conversely, some information was found in paper blue files on individuals that was not held electronically. Many organisations strive to work in a paperless way, and

there is a persuasive argument about the benefits of this ambition. Findings by the Independent Reviewers about the inconsistency of whether paper versus electronic records are kept, as well as the variable quality of records, reflect an overall uncertainty about which to use, which to embrace and how to manage a transition from paper to paperless. It is beyond the remit of this PCR2 to make a recommendation about whether the Church of England should make a policy decision on such matters, however, the issue in question concerns the effective use of information to assess and manage risk. If information is stored in different locations in local episcopal area offices, accessible by only a select few, not efficiently duplicated in either recording format, and also not effectively shared with the DST who could act as a central repository of relevant information, this, in itself, creates additional risk. Pockets of potentially important information held in different locations, not shared, and not joined together is a well-researched and verified risk factor and hampers effective multi-agency working and effective public protection[31]. It makes it harder to access potentially important information in a timely way and prevents the ability to build a picture about behaviour or conduct over time. Statutory guidance[32], which is relevant to all faith-based organisations, states *'… Effective sharing of information between practitioners and local organisations and agencies is essential for early identification, assessment and service provision to keep children safe. Serious case reviews have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children …'*. Current House of Bishops guidance[33] states '… [regarding format] *… It is for the Bishop, as the data controller for the purposes of the GDPR, to determine how information about his clergy is held and managed. In practice, this is likely to involve a combination of paper-based and computer records …* [regarding location] *… the guiding principle … is that all personal information about clergy must be held together in one place … should not keep separate files … and where this is the case a note should be placed on the file to indicate that material is held elsewhere and to explain how it may be accessed. Such working papers should be transferred periodically to the main file: each diocese should have in place a policy to ensure that this happens regularly and systematically …* [regarding updating & retention] *… any material which relates to safeguarding allegations and/or concerns: how such issues were dealt with and the ultimate outcome of any investigations must be retained in the file until 70 years after the cleric's death. Where a cleric moves diocese and the personal file is passed to the receiving bishop, a copy of all safeguarding matters, … must be included in the personal file sent to the new diocese. The originals must be retained for the same period in the diocese which dealt with the allegation or complaint, so that the bishop of his/her successor can provide evidence of how a particular matter was handled if necessary …'*

7.7.9. Whilst it is acknowledged that the House of Bishops guidance is somewhat contradictory and ambiguous i.e., allowing local discretion by Bishops in how they hold and manage data, stating that information must be held together in one place but also stating it can be held in more than one location and by more than one person, it does provide a framework. It is also recognised that in a significant number of cases, relevant information found by the Independent Reviewers pre-dates the above guidance, however, due to more recent relevant information being found by the Independent Reviewers on some cases, and the variable practice

[31] a) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 – 2014, 2016, University of Warwick & University of East Anglia, HM Government b) Complexity and challenge: a triennial analysis of serious case reviews 2014 – 2017, March 2020, University of East Anglia, HM Government, c) Domestic Homicide Reviews: Key finding from analysis of Domestic Homicide Reviews, 2016, HM Government.

[32] Working together to safeguard children, p.18, 2018, HM Government.

[33] Personal files relating to clergy: policy for Bishops and their staff, May 2018.

across the Diocese, the Independent Reviewers did not have confidence in how effectively the guidance was being followed on a day-to-day basis. It is an area where further guidance or expectations are needed in order to reduce the likelihood of important information not becoming lost, mis-filed or forgotten.

Lack of outcomes on files:

7.7.10. Heavily linked to the above comments on recording, record keeping and records management, the Independent Reviewers found a very strong theme of there being no recorded outcome on files relating to complaints, allegations, or investigations. A significant number of actions added to local area action plans related to needing to confirm that a complaint, allegation, or indication of risk/harm that had been raised and known about, had been drawn to a conclusion. In the majority of cases, Independent Reviewers were left wondering, or concerned, what the outcome was and whether risk had been appropriately assessed. In some instances, there was no information available to use and triangulate from, for example the DST records which would provide assurance, leaving the Independent Reviewers further concerned about whether the DST had known about the issues in the first place, whether the assessment and outcome had just not been recorded, or whether other information was held elsewhere and how effective overall tracking of the issue was. The use of a chronology template, held at the front of every paper file (or on an electronic database), and a policy decision by the Diocese (but also nationally) to use such a template would greatly assist in recording outcomes and avoid later confusion or uncertainty. The chronology should be used to record the following: 1) Clergy movements i.e., from one role/post to another or to another Diocese, 2) Any safeguarding issues/allegations, 3) Complaints/use of the Clergy Discipline Measures. The template should consist of three columns - date, event, outcome.

File transfers:

7.7.11. In all Bishops offices, current or open files were noted to be held securely in locked cabinets. Files held in the London Diocesan House were also held securely. However, in two cases it was not possible to locate files which were believed to have previously been transferred from the Bishops Office to London Diocesan House with neither side able to confirm its location. A clear and secure file transfer protocol needs to be in place by the DST which also logs which files are kept in London Diocesan House.

Failure to follow safeguarding procedures:

7.7.12. In a small, but nonetheless significant, number of cases there appeared to be evidence of *'… negligence, 'cover up' or poor allegations management by senior clergy or other church officers …'*[34]. It is important to note that these were all historical in nature and did not relate to current incumbents. Whilst some of the issues identified, it may be argued related to incidents or events decades old and safeguarding knowledge, policies, procedures, and practices would not have been as sophisticated as they are now, the issues identified were clearly unacceptable at the time; as such, any defence of a failure to consider them is weak. Given some of the findings, it would not be appropriate to comment any further on these issues in this report and where appropriate to do so, these have been passed to the Church of England National Safeguarding Team. Nonetheless, given that this PCR2 exercise has examined all files held by the Diocese, the findings of the Independent Reviewers on these issues concur, when placed alongside the findings of the IICSA report about culture and past failings in the Church. The National Safeguarding Team will wish to ensure that a there is a

[34] Wording and description used in the Protocol and practice guidance, July 2019, Church of England.

systematic and coordinated policy but also approach to responding to cases of concern which may span more than one Diocese across the Church.

Ministerial Development Reviews:

7.7.13. The review of each area noted that Ministerial Development Reviews were not designed or used to consider safeguarding related matters, whether this be individual learning about case examples, training or the impact on the individual incumbent. There is no national template for conducting these Reviews. The current Diocesan system of Ministerial Development Reviews, which follows a reflective practice model, has no expectation within it of assessing the performance of individual clergy in relation to the handling of safeguarding matters, and therefore reference is rarely made to safeguarding practice issues or training needs unless the clergy themselves bring these up. These reviews are undertaken by experienced clergy and lay volunteers, who have no access to clergy blue files and no knowledge of any issues that might be safeguarding or disciplinary related (except for the respective Bishop). They also do not know what training clergy have done, and whether this includes compulsory safeguarding training. Bishops may see only a summary of the Ministerial Development Review conversation and then may write to or see the clergy in rotation every few years. Therefore, under the current system, the Review will never address safeguarding or safeguarding training matters. Parish files kept in the Bishop's or Archdeacon's office contain some material about parish safeguarding, with safeguarding matters sometimes being picked up in Archdeacons' visitation reports, but the level of detail in reporting is variable. This is a missed opportunity at three levels. Firstly, it does not lend itself well to Bishops being responsible for safeguarding in their respective areas and acquiring an oversight about the overall quality and effectiveness of safeguarding practice. Secondly, at parish level it does not provide a mechanism to consider the individual member of clergy's holistic development, learning or accountability in respect of safeguarding related matters. Thirdly, it is a missed opportunity to support culture change across the Church, by not providing a systemic mechanism which places safeguarding at the heart of the clergy role and for it to be considered in a more open and transparent manner. Whilst it is understood that a national working group is currently examining Ministerial Development Reviews, the Diocese is piloting a revised approach which includes the following questions, a) How have you developed further a healthy safeguarding culture? b) Is your and your Parochial Church Council safeguarding training and DBS checks up to date? c) Are there any safeguarding matters in the parish or chaplaincy, which you would like to reflect on further? Further evaluation of this pilot is likely to be needed to ascertain whether the revised approach achieves its intentions of firstly, understanding how a positive safeguarding culture can be developed or maintained, secondly, allows some form of measure of compliance, and finally, promotes critical reflection and self-evaluation about individual practice.

Case examples to illustrate attitudes to risk, abuse & harm but also supporting people:

7.7.14. In their final investigation report, IICSA[35], refer to clericalism, tribalism, naivety, reputation, and sexuality as emergent characteristics in the Church of England which were of concern. The following small

[35] IICSA – Independent Inquiry Child Sexual Abuse, The Anglican Church, Investigation report, October 2020: p 80 - 81,

Clericalism: Power was vested chiefly in the clergy, without accountability to external or independent agencies or individuals. A culture of clericalism existed in which the moral authority of clergy was widely perceived as beyond reproach. They benefited from deferential treatment so that their conduct was not questioned, enabling some to abuse children and vulnerable adults.

selection of case examples illustrate some of these characteristics were found by the Independent Reviewers when reviewing file. Many of these had no evidence of being examined in the original PCR and although reflecting practice, culture and to a degree, societal attitude some decades ago, remain relevant and highlight valuable learning, but also help us reflect on how far the Church may have moved over time in terms of safeguarding. More recent examples have intentionally not been used given the higher likelihood of needing further enquiry, and possible investigations.

Case example 1. In a letter between two people holding positions of authority and influence in the 1970's an individual makes several complaints about a church officer. No explicit references are made about any safeguarding concerns at-all, more about his general approach to the role and his apparent lack of commitment; however, the letter concludes *'… I very much hope that eventually there might be some country parish for which he might care without doing too much harm, but I cannot honestly advise you to appoint him to a living in the patronage of the Crown, as I feel it might involve the Crown in unfortunate and undesirable criticism …'.* The lack of specific detail, but intimation of concern, is worrying - saying something without really naming it. The discourse reflects an uncomfortable attitude to risk or the safety of others.

Case example 2. A letter sent by a Bishop from another Diocese to a former Bishop of London pre-1960, requesting whether a particular church officer was 'safe to receive'[36] the response was, *'… I was afraid you were going to ask me about X. I honestly think it ought to be all right. There has been a sorrow and indeed a sin: he committed adultery with a* [vulnerable female in an institution*] … I think there was almost no scandal about it and the fact that, although some of the top people in the* [institution] *knew about it, he is yet recommended for another post in* [another institution*] … I have seen the man and I do believe he is sincerely penitent. I don't think you need have any grave anxiety about receiving him. The woman concerned is having a baby, but she has been entirely promiscuous, and I gather there is no danger of her bringing any action against X for maintenance …'*. This letter was found on a very thin file that contained no other information about the matter at-all and reflects tribalism, naivety, clericalism, and greater concern about reputational risk. Based purely on the content of the letter.

- The situation was known about by senior institution staff – no action taken, and the matter appears to have been brushed aside and a further position given to the church officer.

Tribalism: Within the Church, there was disproportionate loyalty to members of one's own 'tribe' (a group within an institution, based upon close personal ties and shared beliefs). This extended inappropriately to safeguarding practice, with the protection of some accused of child sexual abuse. Perpetrators were defended by their peers, who also sought to reintegrate them into Church life without consideration of the welfare or protection of children and vulnerable adults.
Naivety: There was and is a view amongst some parishioners and clergy that their religious practices and adherence to a moral code made sexual abuse of children very unlikely or indeed impossible. Reports of abuse were on occasions dismissed without investigation.
Reputation: The primary concern of many senior clergy was to uphold the Church's reputation, which was prioritised over victims and survivors. Senior clergy often declined to report allegations to statutory agencies, preferring to manage those accused internally for as long as possible. This hindered criminal investigations and enabled some abusers to escape justice.
Sexuality: There was a culture of fear and secrecy within the Church about sexuality. Some members of the Church also wrongly conflated homosexuality with the sexual abuse of children and vulnerable adults. There was a lack of transparency, open dialogue, and candour about sexual matters, together with an awkwardness about investigating such matters. This made it difficult to challenge sexual behaviour.

[36] Safe to receive seems to be a colloquialism used in the Church involving a communication between Bishops about an individual when moving into another Diocese. There appears to be no set format or structure to these communications, and - based on the findings by the Independent Reviewers - the quality seems to vary and may contain language or a narrative that disguises or fails to name certain behaviours that could present a risk. No guidance, or policy, can be found on the use of this term. This has now been replaced with a Clergy Current Status Letter (approved by the House of Bishop in July 2018).

- Individually, the Bishops' have not recognised the situation for what has happened, minimised it and blamed the woman for being promiscuous. No action was taken.
- No recognition about the woman being a vulnerable adult; no concern for the baby.
- The individual appears to have been 'forgiven' without investigation.
- More worry about scandal and paying maintenance than any abuse or abuse of his position of power.

Case example 3. Adopting an apologetic tone about highlighting risk, an example being a letter to all Bishops in England, Wales, and Scotland from Lambeth Palace in the 1980s *'… I am sorry to have to write this kind of letter again to you, but I have received information about Y … which necessitated me asking you not to give him permission to officiate in your diocese under any circumstances …'*. The underlying tone somewhat reflects a sympathy bias and regret at having to raise the issues.

Case example 4. In a letter to a former Bishop of London in the 1940s one church officer wrote *'… X has been to see me and in view of the information he has given me I feel that you may find the enclosed correspondence of some value. I do not think he should see it. … I am fully acquainted with his history, and I think I know his failings, but I would have no hesitation in giving him work among youths as I am convinced that his indiscretions were not the result of any conscious impropriety, though I am quite prepared to admit the possibility of a sub-conscious movement towards a very dangerous relationship, the recognition of which has put him on guard. If his spiritual life is as genuine as I believe it to be there is no risk that that which resulted from ignorance of motivation will happen again …'*. A later letter noted *'… I am prepared to give X the opportunity of a new start on conditions which I consider necessary in order to safeguard parochial as well as his own interests … that he should be prepared to give an undertaking not to entertain young men and boys …'*. The discourse reflects tribalism, naivety, and attitudes about sexuality.

Case example 5. In a series of letters exchanged between a former Bishop and a former Archbishop pre 1970 regarding a church officer *'… X has done excellent work. In all other respects I can speak most highly of him; but unfortunately, he is a man of homosexual tendencies, and there have come to my knowledge incidents in his parish of behaviours with boys which might, if pressed, lead to criminal charges. Information has been given by parents of the boys, who did not wish to make any public charges against him, out of regard for him personally and his ministry. It is possible that if they had done so, and prosecution had followed, this would only have led to his being bound over – unless in fact other cases emerged about which I do not know: but there is no doubt of his tendency to unwise conduct with boys … he did not wish to deny the charge … Personally I would judge, from what I know at the moment, that after a period at* [location] *he would be perfectly fit to go and assist in another parish … The question is whether he should be put on the List now, or whether I might keep in touch with you about his future employment without this. The latter course would only be fair if I could get an assurance from him (which I am sure he would be ready to give) that he would not seek employment anywhere without reference to me in the first instance …'*. A later letter then refers *'… to safeguard him, and to avoid the possibility of scandal, I got him to resign …', following by a further letter ' … Though not on the List, he is under discipline in as much as he cannot be employed except by arrangement between the Bishops concerns; but I can honestly recommend him for full-time parish work … there is no danger of scandal arising out of his resignation, but I am quite sure that he must be quite definitely under the guidance and direction on another priest …'*. A final letter states *'… I do not think, with someone else there in charge, there would be any danger (owing to the proximity of choirboys etc) …'*. This example highlights tribalism, naivety, bias, and

concern about reputation, as well attitudes about sexuality by conflating the issue of homosexuality with paedophilia and risk.

Case example 6: A letter from the 1950s about an individual member of the clergy which states *'… you wrote … asking what should be done with him. …* [his*] trouble was of a homosexual kind, and it looks as though he may be an incurable homosexual. The Bishop says of him that he has expressed himself willing to undergo any form of discipline or psychiatric treatment; but there has been some kind of psychiatric report out there which seems to show that his condition is serious and obstinate …*'.

Case example 7: In another more recent example pre-2005, a file note reveals a limited appreciation about the impact on children of living in a household where there is parental hostility and abuse. The note refers to some anticipated potential physical and verbal conflicts, but that the oldest male child *'… being around for the whole weekend to ensure that there is no problem with violence or abuse …'*; this placed an undue level of responsibility on the child and offers no consideration about a possible need to refer the concerns to Social Services. At this time, the general understanding about domestic abuse, plus the impact of it on children, was not as developed as it is in 2021. It is important to use this example as a learning point to inform future practice.

7.7.15. These examples reflect attitudes and culture at the time; review of more recent information where similar issues have arisen still raise some concerns but generally reflect less tribalistic behaviour, less deference, less naivety or concern about reputational risk. The greater lack of progress seems be around understanding about sexuality and risk.

7.8. Summary of Parish returns and those meeting the PCR2 threshold:

7.8.1. As part of the PCR2, parishes were asked to provide information where they had safeguarding concerns. This activity took place in addition to the review of clergy blue files. Table 11 below summarises Appendix A returns from parishes.

Table 11: Summary of all area Parish returns

Diocese of London	Total Number of Returns	Those parishes submitting a nil return		Those parishes submitting concerns		Total number of concerns reported	Total concerns pertaining to a church officer	Of those pertaining to a church officer, the number meeting the PCR2 criteria	Those meeting PCR2 criteria that were known to the DST*	Those meeting PCR2 criteria that were not known to the DST*
		No.	%	No.	%					
Edmonton	110	80	73%	30	27%	78	42	28	18	10
Kensington	116	100	86%	16	14%	28	22	15	7	8
Stepney	79	59	75%	20	25%	32	22	13	10	3
Two Cities	77	63	82%	14	18%	45	42	26	18	8
Willesden	106	74	70%	32	30%	58	44	31	17	14
Total	488	376	77%	112	23%	241	172	113	70	43

*** NB:** Files identified that were on Safebase or the Safeguarding V drive.

7.8.2. As stated earlier, information submitted by parishes was based on a self-assessment, using a template provided via the national guidance which was ambiguous and left room for interpretation and bias i.e., asking lay people to form a view about whether something constitutes a safeguarding concern, form a judgement about how well risk is being managed. Although each submission was reviewed by the Project Team and Independent Reviewer the quality of returns was variable. The DST may wish to undertake a random sampling of case information submitted in order to gauge knowledge and understanding of safeguarding related matters, thresholds for referral, as well as identify any training needs.

7.8.3. As noted in Table 11 parish returns included 69 cases that did not relate to a church officer; evidencing that some parishes used this exercise as an opportunity to share information which might not have otherwise been shared. This may indicate a specific learning and development need for some parishes around reporting and understanding thresholds.

7.9. Known Case List and further actions required:

7.9.1. Table 12 below details the final Known Case List for the Diocese of London as of the 14th September 2021. In total, there were 403 names under consideration to go onto the Known Case List. These were comprised from the original PCR1 entries, parish concerns and those concerns identified by the independent reviewers, as well as any cases known to the DST that did not already fall into one of these categories. From the 403 cases, 94 cases have been investigated and identified as requiring to go onto the KCL (10 relate to

both child & adult concerns = 104), 159 have been investigated and judged that there was insufficient evidence for them to be reported on the KCL, and 150 cases remain pending and require further investigation. As noted in paragraph 5.11. all cases were RAG rated to assist with risk prioritisation and workload management in February 2021; from that date, risk management became an operational issue for the DST and risk rating has been a dynamic process outside of the remit of the PCR2 project.

7.9.2. It is therefore recommended that the Known Case List is submitted to the National Safeguarding Team alongside this Independent Reviewer report, acknowledging that this marks a point in time and that a further submission, once all cases have been investigated, will be needed. Table 12 does not therefore show the complete and final detail of the Known Case List and the distribution across the episcopal areas is likely to shift. The timeframe for completing this outstanding work will need to be set by the Diocese Safeguarding Steering Group.

Table 12: Known Case List for the Diocese of London (as of 14th September 2021)

Diocese of London	**Number of concerns going onto the Known Case List (KCL)**		
	Child Related	Adult Related	Total
Edmonton	10	11	21
Fulham	2	2	4
Kensington	8	9	17
Stepney	10	2	12
Two Cities	21	16	37
Willesden	9	4	13
Total	60	44	104

***NB:** 10 cases pertained to both children and adults and so they have been counted in both categories

7.9.3. A detailed action plan has been created for each episcopal area where areas for improvement in the files were found or where case files indicated actual, or potential harm and where actions were required. Actions were designated as either the responsibility of the respective Bishop's office to complete or the DST, and in several cases require joint actions. Actions ranged from:

- Undertaking further enquiries and research about a particular individual to rule out any concern,
- Collate and triangulate information held in various locations to gain a more comprehensive and holistic view about levels of risk or need,
- Seek up to date information to gain assurance about the effectiveness of oversight and case management, and,
- Administrative tasks to ensure files/records were accurate or up to date.
- Ensure there is adequate, yet robust oversight of progress made on each action plan, with clear and transparent reporting and governance from the Bishops offices, through to the DST and the Diocesan Safeguarding Steering Group. In turn, this should include ensuring the Bishop of London and General

Secretary are kept informed of progress so that they can, respectively, be held to account of overall arrangements[37], progress and improvement.

7.9.4. The content of the action plan remains confidential given it contains information about individuals. Monitoring of progress and completion of these action plans will be the responsibility of the respective Bishop, the DST, and the Diocesan Safeguarding Steering Group.

7.9.5. Due to the volume of individual cases where information has been identified which indicate either current potential risk, or historical information requiring further enquiries, it has not been possible for the Independent Reviewer to endorse all actions taken; simply because the DST has not had the opportunity to work their way through all cases before the PCR2 project concludes. As noted in section 5 a risk rating was applied to all cases where information had been identified to assist the DST prioritise case work and risk management.

7.9.6. Separate communications have occurred with the relevant Bishop where information provided from the Appendix A (parish returns) has been necessary. Similarly, the DST will be responsible for working through the concerns raised via the parish returns, in collaboration with the relevant incumbent, Bishop and statutory agencies where necessary to do so.

8. The quality & effectiveness of safeguarding practice by the Diocese Safeguarding Team

8.1. The PCR2 has allowed an opportunity to examine the quality and effectiveness of cases known to the DST and which might be subject to active case management. The PCR2 guidance states as one of its objectives *'… to ensure that all safeguarding allegations have been referred to the Diocese Safeguarding Adviser and are/have been responded to in line with current safeguarding practice guidance …'.* As noted in section 5 an audit tool based on the Church of England Practice Guidance[38] was developed to examine the work of the DST. The approach used by the Diocese has gone beyond the requirements of the PCR2 guidance. The audit tool examined the following core practice areas: 1. First response, 2. Information sharing, 3. Initial assessment & management of concerns/allegations, 4. Investigation, 5. Risk assessment & management, 6. Ongoing risk management, 7. Outcomes, 8. Recording keeping. In each of these core practice areas there are sub-set which have been audited. A rating system was used to evaluate practice with a rating scale being used; that being a score of 1-2 (poor) and 3-4 (good). This can be found at Appendix 3.

8.2. Table 12 shows the number of cases audited by the Independent Reviewer that were known to the Diocesan Safeguarding Team. These reflect records held since the Team was established and the role of DSA became a formal requirement, but also since the electronic record keeping system was established. Identifying the cohort of cases to audit was not without challenges; mostly because the electronic recording system (Safebase) has been used to record not only members of clergy and those having a church officer role, but also victims and survivors and anyone else who might have had contact with the Team. Given the focus of the PCR2

[37] Practice Guidance: Responding to, assessing and managing safeguarding concerns or allegations against church officers, Church of England, 2017.

[38] Practice Guidance: Responding to, assessing & managing safeguarding concerns or allegations against church officers, Church of England, 2017.

exercise on clergy and church officer roles extracting a list of names to audit was far from straight-forward. This report considers Safebase later in paragraphs 8.25 – 8.27.

Table 13: Number of Safebase records reviewed by year						
2016	**2017**	**2018**	**2019**	**2020***	**App A**	**Total**
53	38	69	48	30	8	**246**
***NB:** The file review cut off was 1st April 2020 so there is only 3 months of activity for 2020						

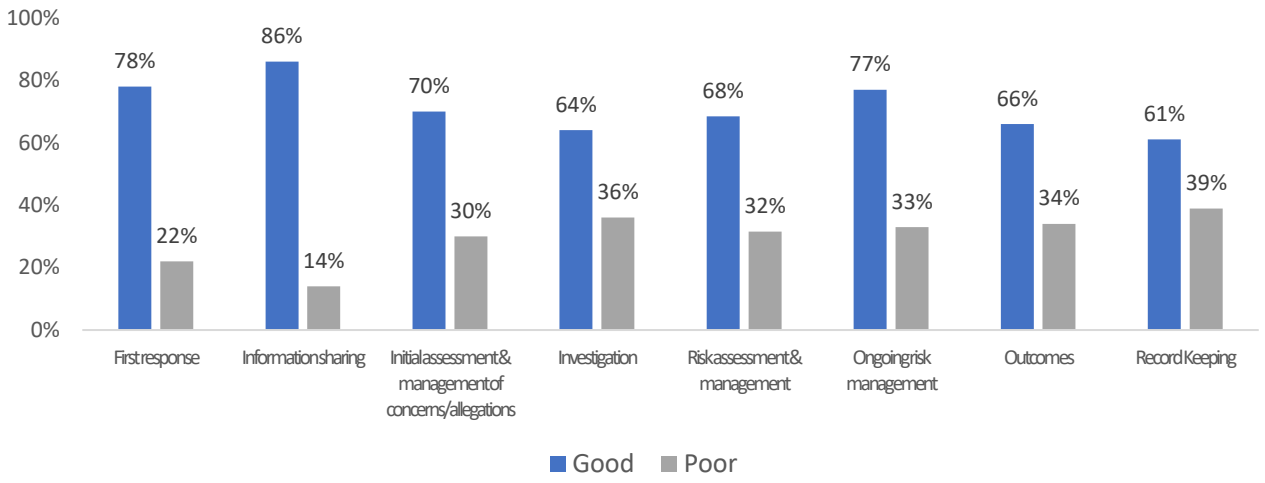
8.3. The audit tool was developed to provide a deeper layer of analysis beyond the identification of harm, abuse or inappropriate behaviour used to benchmark all other files reviewed across the Diocese. It was based on a slightly adapted version of an audit tool originally developed by the Diocesan Safeguarding Manager in post at the beginning of the PCR2. As such, this has allowed the Independent Reviewers to gather learning which goes beyond the remit of the PCR2 protocol, helping to shape and provide direction for future DST activity and the development of best practice. The audit tool did not differentiate between safeguarding adults or children as the Practice Guidance does not make a clear distinction in terms of procedure to follow.

8.4. Although the final audit tool was not an exact fit with the circumstances of each case that needed to be examined it was viewed, on balance, to be a suitable tool to adequately identify emerging themes about the quality and effectiveness of the work of the DST. A further challenge was the adequacy of the case management and information storage systems used by the DST to hold specific case related information, i.e., Safebase, and the use of a secure internal drive on the network. In the majority of cases where a specific issue was rated as 'not applicable' it would generally mean that the criteria was not relevant to that specific case. Therefore, issues rated as 'not applicable' have been excluded from the analysis. However, in cases where the information could not be found to judge the performance, this would generally be scored as such, meaning that the criteria was not met or evidenced; this was the case in a high number of cases. Given these limitations but also the unreliable nature of the data/records on which the audit was working with, some caution should be exercised about over-interpreting the detailed results of the audit.

8.5. Graph 1 below shows data collected from the audit of DST case work spanning from 2016 to 2020. Additional audit data is also available to the DST which has not been included in this report which reports on practice areas that have been benchmarked practice against Church of England's Practice Guidance. For the purpose of this report, a selection of findings is shown below.

8.6. First response: Data shows that overall, 78% of cases audited were rated as good when in terms of first response to receiving information which may indicate a safeguarding concern. First response might include whether the referral was received by the DST within 24 hours and there being a timely response, whether appropriate consents were sought and shared and wishes recorded i.e., from victims, survivors and offenders, whether the victim disclosing/person or child had been appropriately advised about the next steps, whether there was evidence that statutory agencies have been informed within 24 hours by the DST, and where the allegation related to a church officer that has a role with children or vulnerable adults the DSA convened a core group within 48 hours of becoming aware of the concern or allegation. This headline data can be interrogated further by examining specific criteria under first response; for example, there was recorded evidence that the victim or survivor had been appropriately advised about next steps in 83% of cases, however in 20% of the cases there was no evidence that statutory agencies had been informed within 24 hours by the DST, or evidence that a decision had been recorded not to refer to statutory agencies.

Graph 1: Overview of Audit Scores for each of the main audit areas



8.7. Information sharing: Findings indicate that in 86% of cases audited using data from across a five-year period, practice was rated as good in relation to information sharing; this specifically highlights that information had been shared in line with Government guidance on information sharing & other protocols.

8.8. Initial assessment & management: Findings from data taken from across a five-year period, indicate that in 70% of cases audited the initial assessment and management of concerns/allegations was rated as good. This might include ensuring there is due regard paid to the quality of the core group and minutes i.e. chair & note-taker appointed, and minutes being distributed to attendees, but also that the respondent had been informed/supported in line with guidance, an Initial Case Summary had been provided to help core group members judge the level of risk, an Interim Safeguarding Agreement[39] had been developed (where necessary), it had been signed by the respondent and there was evidence of regular review, and there was evidence of the DST working with parishes and others, who may be affected by the concerns/allegations. However, in just 56% of cases the quality of core group records was judged as good, and in just 44% of cases, there was good evidence of when an Interim Safeguarding Agreement had been developed, it had been signed by the respondent and there was evidence of regular review. This meant that in 56% of cases practice had been rated as poor about the use of Interim Safeguarding Agreements. In 74% of cases, there was evidence of good practice by the DST working with parishes and others who may be affected by the concern/allegations. These findings indicate improvement activity is needed; it is also recommended that further review of the data generated by the audit is undertaken by the incoming Head of Safeguarding to gain a better understanding of which areas to target improvement.

8.9. Investigation: Findings from data across a five-year period indicate that in 64% of cases audited the overall quality of investigation was rated as good. Two sub-sets were contained in this overall category; firstly, evidence of an investigation summary report on the case file, and secondly, that the investigation report reached a conclusion (of either substantiated/unsubstantiated/unfounded/malicious/false) or with indication that there were ongoing concerns and actions required. Looking more closely at one sub-set, in just 48% of

[39] The purpose of an Interim Safeguarding Agreement is primarily to safeguard children, young people and/or vulnerable adults, and manage the risks identified but it should also include support for the respondent.

cases audited there was evidence of an investigation summary on file; this is an area that needs further improvement action.

8.10. Risk assessment & management: Findings from data across a five-year period indicate that in 68% of cases audited risk assessment and management was rated as good. Examples of this would be that risk has been assessed and a risk plan put in place at each stage of the process, plus an independent assessment had been recommended, was commissioned appropriately and due process had been followed. It could also indicate that some victims/survivors had been kept up to date with decisions. Additionally, in 68% of cases there was evidence that risk had been assessed and a risk plan put in place at each stage of the process. However, the qualitative information reviewed highlighted variable quality.

8.11. On-going risk management: Findings from data across a five-year period indicate that in 77% of cases audited there was evidence of on-going risk management and monitoring and parallel processes i.e., referrals to Disclosure & Barring Service, Bishop's list, Clergy Discipline Measures & MAPPA[40], and there was evidence that a link person was supporting the respondent throughout the whole process. As above, further analysis is required to fully understand the quality, effectiveness and evidencing of on-going risk management.

8.12. Outcomes: Findings from data across a five-year period indicate that in 66% of cases audited there was a recorded outcome i.e., no further action needed, police investigation discontinued/ CPS discontinued/conviction/ bailed, and that there was evidence of management oversight from within the DST throughout the case management process; therefore in 34% there was no recorded outcome. This may be an under-report given the deficits noted above in terms of investigation, risk assessment and risk management – all of which are clearly linked to the quality of outcome. As above, further analysis is recommended for this area. The audit conducted by the Social Care Institute for Excellence (SCIE) in 2016[41], in relation to the response to allegations, noted *'… The recording of the case work meant it was difficult at times to understand the outcome of actions or whether a case was closed or not ... As a result, the evidence for good case work was patchy …'.* In 65% of these cases there was evidence of management oversight and monitoring from within the DST; therefore in 35% there was no evidence. Again, the quality of management oversight and monitoring is an area that cannot be confidently reported on given the limitations of Safebase, stretched capacity and workload.

8.13. Record keeping: Findings from data across a five-year period indicate that in 61% of cases audited record keeping was judged to be good across the period. This was evidenced by case records being up to date, contact details, closure forms and outcomes recorded as well as any support or communication needs an individual may have also being recorded. However, it is clear that there is variability across this period.

8.14. Table 14 below shows more detailed ratings from the DST audit by year from 2016 to 2020. The following findings are of interest:

- 2017 and 2020 saw a noticeable a spike in first response practice rated as good.
- Across the period, the range of practice rated as good is between 50 - 95% with a significant cluster between 55 – 65%; the implication being there being plenty of scope for improvement.

[40] MAPPA – Multi Agency Public Protection Arrangements: The process for the Police, Probation and Prison Services working together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.

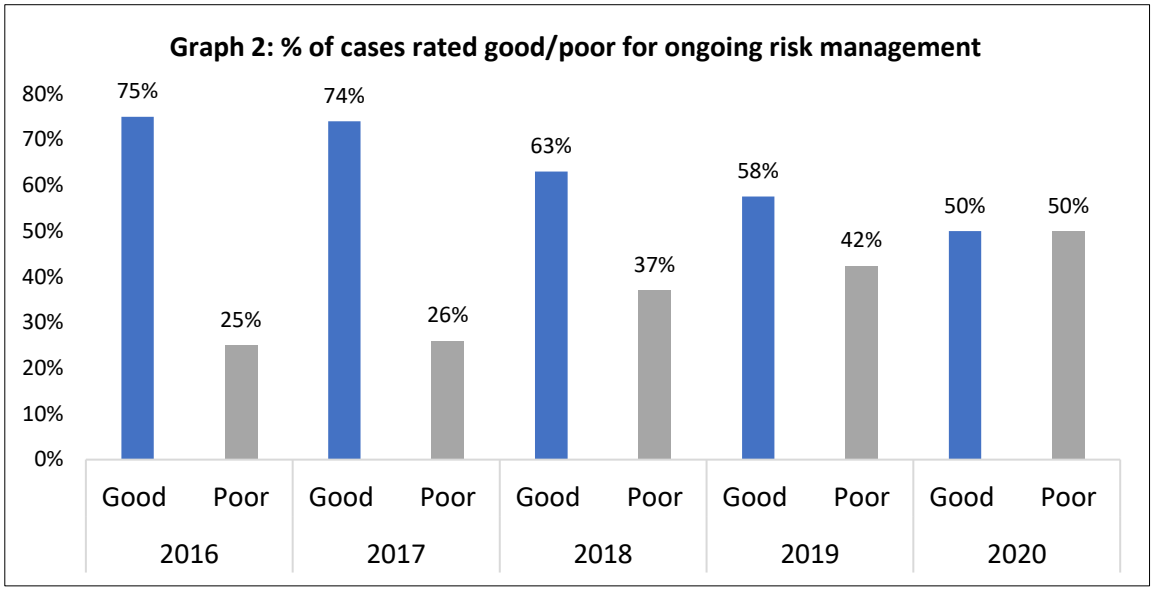
[41] SCIE, London Diocese Independent Safeguarding Audit, p.15, March 2016.

- The quality and effectiveness of information sharing practice, overall, has remained consistently good; again with 2017 and 2020 spiking with improved practice.
- Initial assessment and management of concerns/allegations has fluctuated with a noticeable dip in performance in 2018.
- The quality of investigation is variable, never rising above 79% in the last three years of cases audited.
- The quality of risk assessment and management does fluctuate somewhat but does show some pattern of consistency ranging between 59 – 81% across the time frame; 2019 appears to have been a better year although it is a concern that risk assessment/management is so variable.
- The quality and effectiveness of ongoing risk management does fluctuate but the data indicates a downward trajectory of performance. This is a concern.
- Recorded outcomes are also variable highlighting further improvement is needed in this area.
- Although the data from a five-year period, set out above, found 61% of cases audited good record keeping was noted, the picture across the timeframe indicates greater fluctuations and inconsistency.
- Reasons for these fluctuations may be due to staffing capacity changing, efforts by the Safeguarding Manager to improve practice when first into post and then stalling due to workload and systemic problems with the recording mechanism in place at the time.

Table 14: Ratings awarded to cases audited across the 5-year period

	2016		2017		2018		2019		2020	
	Good	Poor	Good	Poor	Good	Poor	Good	Poor	Good	Poor
First response	69%	31%	87%	13%	83%	17%	71%	29%	93%	7%
Information sharing	78%	22%	95%	5%	81%	19%	88%	12%	94%	6%
Initial assessment & management of concern/allegation	66%	34%	79%	21%	62%	38%	75%	25%	79%	21%
Investigation	58%	43%	77%	23%	52%	48%	76%	24%	57%	43%
Risk assessment & management	59%	41%	62%	38%	65%	35%	81%	19%	70%	30%
Ongoing risk management	75%	25%	74%	26%	63%	37%	58%	42%	50%	50%
Outcomes	55%	45%	68%	32%	65%	35%	79%	21%	59%	41%
Record Keeping	59%	41%	61%	39%	56%	44%	71%	29%	58%	42%

8.15. Graph 2 below illustrates the percentage of cases rated good or poor for ongoing risk management over the five-year period. It highlights an increasing number where cases have been rated as poor; something the Diocese will need to examine in further detail to prevent a worsening picture.



8.16. Other, more qualitative, information gathered by the Independent Reviewer over the course of conducting the audit of DST cases, but also interviews with four members of the Team, includes:

- There being limited information held in the 'contacts' section of Safebase.
- Extensive evidence of files being stored in a haphazard way making it difficult and more time consuming to find information i.e., often more information held in a folder but not on Safebase.
- Records being created sometimes using the victim/survivors name and at other times using the alleged perpetrator/offenders name, with no standardised approach.
- Evidence of the same names being spelled differently in Safebase, which complicates using the search function.
- Challenges in linking cases of concern where there may be two or more victims or perpetrators.
- Evidence of over-due Safeguarding Agreements.
- The rationale for decisions made not always clearly recorded or apparent.
- Delays in progressing risk management measures.
- Cases closed with no management oversight.
- Granting Permission to Officiate (PTO) to church officers despite previous convictions relating to harm against children.
- Challenges associated with information sharing across geographical borders/other Diocese and with the National Safeguarding Team, often resulting in there being gaps in information.
- At the initial stages of the PCR2 project the professional background of members of the DST was mixed, including those from Police, social work (adult & children) and probation. At the conclusion of the project, it was mostly former Police officers.
- The DST can sometimes be pulled into multiple work streams i.e., case work, training, complaints – which can sometimes divert efforts away from the core task.
- Positive feedback from training can be better used to support forward planning i.e., targeting parishes where greater support or intervention might be needed.
- The use of Practice Guidance to benchmark, evidence or guide practice is not consistent.

- The use of internal and external formal supervision for members of the DST, during the concluding stages of the PCR2 has been inconsistent.
- Appraisals were reported as over-due, and more self-directed; further work is needed to create a system that is useful to individuals but also the Team as a whole.
- Challenges remain for the DST in working with members of the clergy to help them understand safeguarding.
- The findings by HM Coroner[42] in July 2021, in respect of an Inquest conducted into the tragic death of Alan Griffin in November 2020, resonate with findings made by the review of the quality and effectiveness of the DST audit. This has resulted in a Prevention of Future Deaths report being issued to the Archbishop of Canterbury.

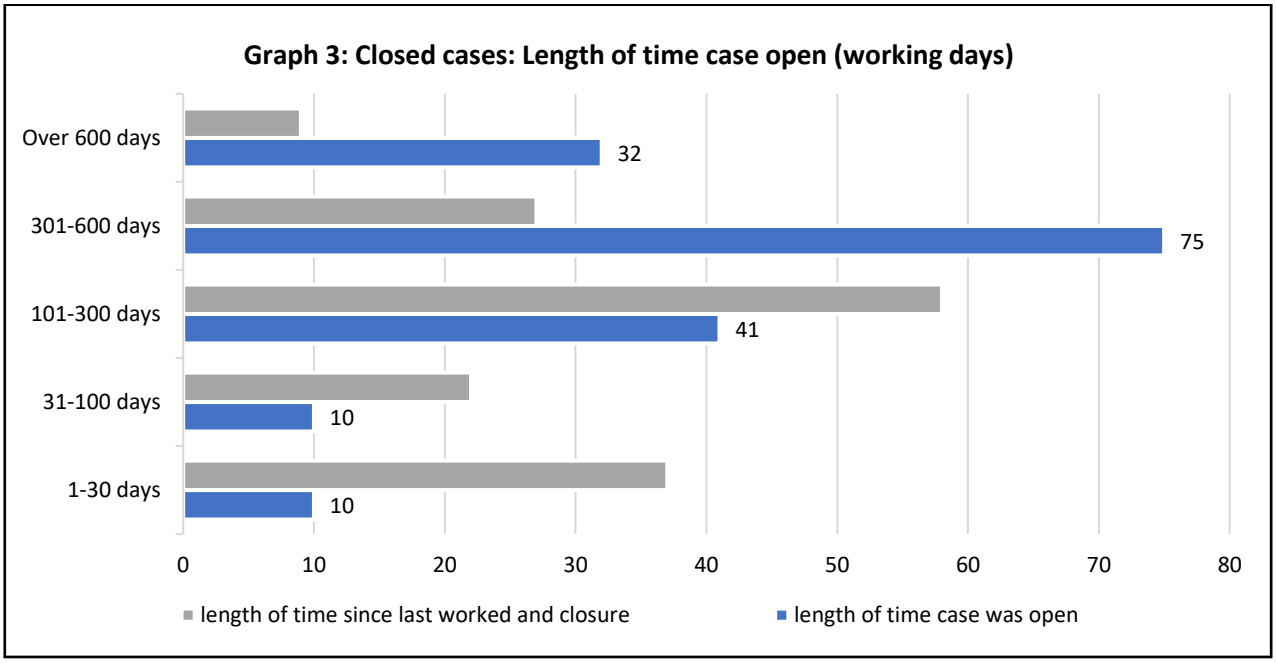
8.17. Overall, having reviewed and analysed the findings and data from the DST audit over a five-year period there is a consistent theme of practice being variable and inconsistent across a range of core practice areas, which also includes findings about the assessment and management of risk. Our judgement is that there needs to be improvement activity that not only raises the standard of practice in these core areas as a high priority, but also seeks to embed higher expectations that withstand the test of time.

8.18. Through the audit of DST case work the Independent Reviewer gained a sense of some drift with case work. To test the hypothesis about drift, further interrogation of data was undertaken. An analysis on open and closed cases was conducted on a sample of cases from 2016-2018, 185 in total and to look at how long the case had been left without any recorded evidence of contact or involvement by the DST.

8.19. 168 closed cases were analysed. Of the 168 closed cases examined, there was no evidence of management sign off in 39 cases (23%) – which is clearly not acceptable. In at least 21 cases (12.5%) there was a clear lack of recorded outcome or information to indicate how the case had been worked on or progressed to closure, or management decisions to close the case. For the remainder of the cases, closure was based on a range of outcomes and included, a successful prosecution following a Police investigation resulting in, for example, imprisonment, effective monitoring arrangements being in place as a way of managing any identified risk, victims/survivors not wishing to pursue their complaint/allegation any further and there being no basis to maintain any DST involvement, advice or training provided which resolved the issue, and/or the successful use of the Clergy Discipline Measure to deal with the issues raised.

8.20. Graph 3 below shows that out of the 168 closed cases, 116 were open for between 101 – 600 days. A case being open for a period within this range may be justified, for example, the need for ongoing risk management and safety planning through the use of Safeguarding Agreements and Core Groups, and/or complex Police investigations which may then culminate in legal processes. However, case data suggests there are other reasons for some cases being open for such a significant period. Data has been calculated using working days, which clearly does not reflect the total number of days endured by a victim or survivor in waiting for action or offers of support.

[42] Courts & Tribunals Judiciary, 9th July 2021, https://www.judiciary.uk/publications/alan-griffin/



8.21. Table 15 below shows that 94 cases (56%) in the sample used to obtain this date (of 168 cases) the gap from last being worked to closure was longer than 100 days, potentially signifying delays, or drift with case management and/or formal closure processes. 148 (88%) out of 168 that were open for longer than 100 days had no explicit rationale or clear chronological information which reflected ongoing and active case management or management oversight. 32 cases examined had been open for over 600 days. Of those 32 cases, 9 had not been worked on for over 600 days. This suggests a small number of cases are left without any meaningful case management or oversight for a significant amount of time, and that there has been no management scrutiny of case work management and recording systems or processes. This is very worrying not only from a risk assessment/risk management perspective but also from a duty of care point of view (towards both victim/survivor but also alleged perpetrator).

Table 15: Closed cases	
Day range	Length of time since last worked & closure (due to data anomalies with 15 cases total does not match 168)
1 -30	37
31 - 100	22
101 – 300	58
301 – 600	27
600 +	9

8.22. A sample of 17 open cases was examined. Table 16 below shows that of those 17 cases the period in which there was a recorded contact or intervention for 14 cases was more than 31 days. Again, this may signify drift or lack of active case management.

Table 16: Open cases	
Day range	Length of time since last worked
1 – 30	3
31 – 100	2
101 – 300	7
301 – 600	5
600 +	0

8.23. Review of Safebase, the electronic recording system used by the DST, leads to our judgement that it is not fit for purpose, and which, can be argued, has generated a culture of poor recording practices emerging. It was noted that in the independent audit conducted in 2016 by SCIE[43] commented on case recording as an area that needed improvement *'… Case recording is an acknowledged problem in terms of what is recorded and how. The auditors were told that a new system had been purchased and was going live the week following the audit. It is anticipated that this will make it easier to store and access relevant information. The auditors observed on the system that was in place at the time that the recording of case information needs to improve so as to provide a summary of key data, consistent identification of individuals by name and role, decisions taken, action taken, outcomes and a closing summary* ... [p.4] *… The format for case recording seems to have been developed without reference to the typical recording formats in standard databases available in social care* … [p.11] … *It may be that the Diocese will be judged more harshly than it deserves in the future because case recording does not give the whole story and, ideally, steps would be taken to redress some of the balance while key people are still in post* … [p.16]*'.*

8.24. Safebase, the system that was introduced in 2016, acts as a storage facility for information. Review of its usage as well as discussion with members of the DST highlighted the following factors, many of which are likely not to have helped the effective management of individual cases or promote high standards:

- Information is not necessarily stored in chronological order.
- The different tabs i.e., documents, case over-view, journal, often results in information/documents being stored in duplicate.
- Option to record information using drop-down menus i.e., type of allegation or type of concern, is limited. The watchlist option which seems to offer a risk rating scale of low, medium, high, has no guidance to inform a risk judgement.
- Information can be stored, or uploaded, in different formats which does not help ease of access to records. In turn, retrieving information to use for any purpose is problematic.
- Some documents are password protected, with no obvious or intuitive record of where a password might be kept.
- The quality of some information inputted is poor.
- There being no workflow or alerting process, which may allow drift to affect case management.
- Information about individuals is stored in two locations: Safebase and an internal drive. This makes oversight and case management considerably more challenging, time consuming and less efficient. The internal drive is used in a completely haphazard way with an idiosyncratic approach to folder and document naming/conventions. Only very recently, has an attempt been made to tidy it, however it has not addressed the root problem regarding the lack of an effective recording database, but also individual idiosyncratic recording practices and culture which has gone unchallenged. These issues will be heightened by staff on short term contracts plugging vacancy gaps resulting in variable recording practices.
- Aspects of Safebase functionality which do not allow reliable data extraction and reporting for the purpose of performance management, or any kind of management oversight.
- Entries and records can be made using only the name of the alleged offender/perpetrator or the victim/survivor; therefore, the search function cannot, for example extract information about work

[43] SCIE, London Diocese Independent Safeguarding Audit, p. 4 & 11.

with survivors, nor does it allow cases to be cross references – instead relying on the person manually inputting information to specifically name anyone else that might be connected or have associations.

8.25. To support good and effective case management practices, a user friendly and systematic case management system is fundamental; one which allows for workflow, alerting and greater management oversight in terms of authorisation and monitoring of caseloads. Many more recent case management systems have a dashboard of activity being undertaken for the manager to supervise as well as make it easier for the worker to view their individual caseload and activity. This should be a high priority for the Diocese, alongside it being accompanied by good quality training and guidance being provided, recording expectations being set, management scrutiny and regular performance monitoring.

8.26. The findings of the audit indicate that the DST demonstrate strong practice in relation to the receipt and initial processing of new enquiries or new referrals which identify a concern. Findings also highlight inconsistent practice across several critical areas. This highlights that further work is needed to improve and strengthen practice in the following areas:

1. The overall quality and effectiveness of individual case management needs closer inspection to gain assurance that risk is being systematically and proportionately managed (and recorded as being managed) from initial assessment and planning phases through to intervention and evaluation activity. Evidence from the DST audit, members of the DST interviewed, and other stakeholders that have contributed to the PCR2 i.e., Bishops, suggests the quality and effectiveness of practice is inconsistent across a range of core case work functions.
2. In parallel to the above, the importance of good case work being supported by good quality supervision, training and guidance, and targeted management support. Information and views obtained from those members of the DST interviewed, as well as data generated by the DST audit, indicates that this is inconsistent.
3. The need for stronger and more effective and proactive strategic management input i.e., monitoring and scrutiny of core practice areas, improvement activity and performance management.
4. The need to review and replace the case management recording systems and processes and implement a robust case management recording system that supports good recording practices and monitors case progression.
5. Finally, and potentially of greatest priority, given the significant changes in staffing over the last 12 months, there is a need to achieve stability within the DST, with a mix of skills (including management and leadership skills) and with people from different practice backgrounds. The DST leadership then needs to concentrate on sustainable improvement and development that will have a lasting impact. Given the significant increase in workload generated by the PCR2, DST resource, skill and capacity needs to match the level of overall demand to provide an effective and good quality service to Bishops, other members of the clergy, but more importantly to victims and survivors, and the worshiping community in the Diocese of London.

9. The contributions of victims & survivors to the Past Cases Review 2

9.1. Prior to the PCR2 project starting the Diocese of London had an intention to create and implement a Survivor Strategy. Over the course of the PCR2 project being undertaken a Survivor Strategy was developed, ratified by the PCR2 Reference Group, and published on the Diocesan website. It provides details about

context, pathways those coming forward may take if support is needed, as well as setting out longer term intentions by the Diocese. It is too early to comment on whether this strategy has had any impact, and how well it has been embedded into the day-to-day practice of the DST; evaluation will be needed in due course.

9.2. Over the course of conducting the file reviews, examples were found which provide some insight into how victims and survivors have been helped and supported by the Diocese.

9.3. These more positive examples are outweighed however, with examples of survivors that did not receive a good response. In one case, the complainant (i.e., the survivor) detailed the poor treatment received by a former Bishop of London, receiving a cold response from an initial disclosure and request for support but that also, there was never any follow through following these initial attempts. A much later attempt was more successful. A more recent example, as a result of the PCR2, has highlighted a survivor getting an initial positive response to a disclosure of non-recent abuse, but then experiencing a considerable delay in getting any update, despite numerous requests and escalation.

9.4. As part of the PCR2 methodology, an on-line and anonymised survey was created to seek the views of any victims or survivors from within the Diocese. This was developed in collaboration with NAPAC (National Association of people abused in childhood) and Victim Support. It was published on the Diocesan website and opened in January 2021 and at the point that this report was completed there had been just one response. The limited response may indicate the need to consider alternative communication strategies for raising awareness about the opportunity to contribute, as well as consider other options should victims or survivors wish to come forward and seek support. In hindsight, greater involvement by the Communications Department from within the Diocese, and more regular review of the Communications Strategy (Appendix 4) might have strengthened the response to the survey. Nevertheless, the one person that did contribute has highlighted a number of relevant learning points, which can be learnt from.

9.5. When asked why they decided to participate they responded with *'… I want others to be protected from the pain I suffered … and ensure perpetrators can no longer perpetrate, and for me to be able to die at peace I did my best …*'.

9.6. When asked how easy it was to contact someone who could assist, their response was *'… Not at all easy … [it was a] … complex process, different perpetrators, different police forces, no clear instructions …*'. When specially asked about the experience of working with the Diocesan Safeguarding Team they responded with '… [the] *Diocesan Team in London were excellent …*'. They expanded on this by then confirming that no support plan was provided. Their response to whether they received support services was contradictory with it not clear whether they received services provided by the Diocese or via their GP, however, it was confirmed that some form of group and talking therapy support was eventually sourced.

9.7. Some uncertainty was reported about the outcome of the process that had been initiated as a result of the survivor making a disclosure, but it seems receiving an apology from two perpetrators was a positive experience for this particular survivor; they had been hoping for an apology and some compensation to spend on therapy. Being given the opportunity to share their experience and feeling like their voice had been heard was the most helpful aspect of the whole process.

9.8. Learning from this includes; a) acknowledging that those who have experienced abuse and harm, are likely to suffer with varying levels of emotional and mental turmoil and that any response needs to be sensitively,

yet confidently, handled; b) recognising that the process of disclosure and then responding to offers of support, potentially alongside, having to assist with an investigation, will be challenging for the survivor; c) providing clarity about what support can be offered, possibly through a written plan, may be helpful to many and being listened to is a really important aspect of learning to live with the abuse and harm.

9.9. Two other known survivors came forward, in response to a request that was sent out, requesting to speak directly with the Independent Reviewer. Both recounted their experiences of dealing with the Diocese of London through conversation and email exchange, highlighting learning for the Church to take forward. Their accounts, which are considerably more recent than those discussed in section 7.7.13, are outlined below:

Survivor 1:

One male survivor spoke about being groomed during adolescence by a member of the clergy, which resulted in sexual abuse. The abuse had stopped before the age of consent however a relationship between the abuser and survivor was maintained for a number of decades; the survivor spoke about how maintaining his connection seemed the natural thing to do. The insight and thoughts of the survivor, who came forward and disclosed abuse when in his fifties, has highlighted several important lessons for the Diocese and Church of England to consider.

a) The initial disclosure: Whilst accepting that procedures and protocols do exist for reporting abuse and they can be helpful, there is a need to ensure appropriate support is in place at the point of someone making a disclosure, above what might be viewed as the immediate priority of involving the Police. The experience of having the Police called by those the survivor initially disclosed to, prior to any support being considered, was seen by the survivor as too reactive and went on to seriously damage the individual's mental health. The concern expressed about this type of response, by the survivor, was that a one-off incident may be abusive and cause harm but the effect of sustained sexual abuse taking place over a longer period is highly likely to also cause psychological harm and result in greater vulnerability. In this case the survivor described not having the psychological capacity to deal with the sudden exposure of the issues; something that children or other adult survivors of abuse may also lack, and which may cause more harm. Ensuring a procedural response that can flex with the individual circumstances of each case is important.

b) The initial response: Having been given a choice about whether a plain clothes or uniformed Police officer would take a statement, and a choice about either a male or female officer, the reality was the opposite of that which the survivor requested for both issues.

c) During the process of investigation & proceedings: The swift move to the Police investigation and Court action was a very positive experience; in part due to a supporting witness and a guilty plea by the perpetrator resulting in there being no trial. Being given the opportunity to speak about the abuse, using a personal impact statement in Court was important and helpful to this survivor. Being given the choice to do so, was even more important. The survivor described *'… the justice system is not about the victim … but being able to speak as a victim is a really powerful tonic … this worked well for me as I had been in denial for so many years …and I wanted the world to know …'.* Due to the way the abuse was disclosed, information was not shared with the DSA resulting in them being bypassed. Knowledge of the case only reached them at the point the case was initially heard in Court, and at that point did not include any details about how to contact the survivor. There is learning from this episode for the Police, but all agencies involved about gaining consent to share

information as well as timely information sharing. Initially, the Diocese did not respond well and caused the survivor more distress, by publicly stating that support was being offered when in fact it was not. Following various communications between the survivor and the DSA (some of which were more thoughtful and sensitive in tone than others) appropriate support was eventually provided in the form of therapy. The survivor was very grateful for this, however, was acutely aware that there were many people he knew about that had survived abuse but had not received any support and were not well resourced to seek their own. By achieving that earlier engagement by all parties, it would have avoided the need to repair any mistakes that appeared as a result of a failure to share information, but also plan better for those survivors that are less well-resourced to gain the support they need, at the best time. Whilst the abuse was taking place the survivor was aware that the perpetrator had been given the support of a Confessor from outside of the Church of England – which in effect removed any responsibility on the Confessor to report any concerns. This did not provide any comfort or instil any confidence in the process for the survivor, leaving them feeling that it helped maintain a degree of secrecy.

d) On reflection the survivor felt that, overall, the contributions of the Diocese were weak, and that there was a sense of *'… towing the party line rather than standing up to it …'*. The conclusion of the criminal process resulted in, not only a conviction, but also an apology from the Church of England. However, to use an analogy, the survivor described the tone of the apology sounding like a child being told off for doing something wrong, the child saying sorry, but not really meaning it but knowing that making an apology, was the right thing to do.

Survivor 2:

One survivor spoke about how a member of the clergy's initial offers of emotional support to her, when she was 15 years old and had caring responsibilities, turned into opportunities for him to manipulate, groom and then go on to sexually abuse her. The behaviour and abuse by the member of clergy, was shared by the survivor at the time with two trusted adults in the church but it was not clear what action was taken at the time; the behaviour by the member of clergy did however stop because the survivor removed herself from the situation, in part due to a sense of shame and guilt rather than a sense of injury or danger. The survivor came forward because of the increasing publicity about other abuse that had happened in the Church, and a concern about whether her abuser was still practicing and causing harm to others.

a) The initial disclosure: The handling of the initial disclosure by the DSA, although taken seriously, was described as unhelpful due to being told that she would need to report the abuse to the Police. I remember thinking at the time *'…I didn't want anyone else to be a victim … I wasn't gunning for a prosecution … so I hadn't considered the involvement of the Police … if other people had come forward, I would stand with them, but not on my own …'*.

b) The initial response: The survivor described her first contact with the Police as the most upsetting part of the whole experience. A young, male, uniformed officer visited the survivor at her home, was asked to take his shoes off when entering the home but insisted he could not, and *'… then proceeded to ask quite forensic and intimate questions which felt totally inappropriate …'* at such an early stage. There is learning to be gained from this experience about the style and sensitivity of initial approach by all agencies when working with survivors of abuse.

c) During the process of being responded to: Once the survivor found out that she was the only person that had come forward it shifted her view to not wanting to take the matter any further, knowing that the matter would be addressed by the Clergy Discipline Measures and wanting to see how it panned out. However, the offender was interviewed by the Police and did confess but as the survivor did not want to proceed with a prosecution the matter never went to Court. The issue was ultimately dealt with through the use of the Clergy Discipline Measures and a three-year prohibition from office, by consent, admitting to 'conduct unbecoming or appropriate to the office and work of a clerk in Holy Orders'. At the time, the survivor felt like the response did not convey the Church of England lighting the way forward by really demonstrating their commitment to rectifying past mistakes. Although the DSA took the initial concerns seriously, there were considerable delays and periods of silence when there was no communication or update; this was not helpful or empowering and most updates were given when the survivor sought them herself. Positively, the survivor was provided with funding to access counselling support. Given the outcome, and notwithstanding the early difficulties with the initial disclosure, the survivor spoke about feeling like she was *'…really listened to and it really did have an effect … feeling startled by the power I held …'.*

d) The survivor is no longer involved with the Church but did speak about missing it; this led her to wonder how the Church reaches out to, and welcomes back, those that have had adverse experiences with the Church.

9.10. The contributions set out above reflect some of the issues identified through the audit of DST cases, supporting the view that there are pockets of good practice as well as areas that need developing and strengthening so as to provide a consistently helpful response to survivors of abuse.

10. Learning identified from the PCR2

10.1. Learning identified for the Diocese of London from the PCR2

10.1.1. Information and data set out above highlights a number, and range of, issues for the Diocese and national Church to learn from. In summary the following good practice features have been noted on which the Diocese of London can learn from, and consolidate:

- The security and storage of sensitive and personal information by Bishops is mostly good.
- Whist data indicates variable practice standards across a number of core practice domains, there is evidence that higher practice standards can be achieved by the DST when there is more consistent management oversight, stability and the right resourcing levels in the team.

10.1.2. In summary, the following learning for improvement and development activity has also been captured:

- The critical role leadership and management has in setting standards, monitoring case work, as well as providing scrutiny and challenge in safeguarding related matters.
- The central importance of recording, record keeping and records management to supporting good quality safeguarding work. In a large and complex institution such as the Diocese of London, the need for efficient case management systems that support good quality case work and case management has been shown to be critical. This not only includes reporting on outcomes of allegations, complaints, investigations or reviews and placing the outcome on record in order to demonstrate a robust, fair and thorough process has been achieved, but also management performance reporting.

- The central importance of working with, and supporting, victims and survivors of abuse – treating them with respect and ensuring they remain at the centre of any activity undertaken and the outcomes they wish for, are kept in mind and achieved, where-ever possible.
- The clear need for there to be rapid change and enduring improvement in how the DST approach and undertake their work in regard to a number of core practice areas, to avoid further harm occurring to those that are either victims/survivors of abuse, or are subject to allegations of abuse (including first response, information sharing, initial assessment & management of concerns/allegations, investigation, risk assessment & management, ongoing risk management, outcomes, record keeping). Resourcing and senior leadership support needs to be part of the change and improvement needed.
- The necessity to ensure personal and sensitive data is securely stored, handled and safely transferred.
- The importance of understanding, following and abiding by agreed policy and procedure, in order to avoid later problems or a poor response to victims and survivors of abuse.
- Whether there is scope to broaden the expectations and use of the Ministerial Development Reviews as a tool for exploring an incumbent's developmental needs concerning safeguarding related matters.

10.1.3. An independent audit[44] conducted by the Churches Child Protection Advisory Service (now 31:8) in February 2015, commissioned by the then Diocese Safeguarding Advisor, states *'… In some ways, the greatest concern regarding this review of the previous past cases review was that there was no evidence on file of the previous review in 2009/10. This is concerning as … there can be less confidence that all matters have been appropriately addressed … it is recommended that the diocese identifies an appropriate independent method by which this incomplete picture can be remedied …'*. Further to this, an internal audit[45] completed in April 2018, commissioned by a different Diocese Safeguarding Advisor, noted the following comments*: '… there were no parameters or terms of reference set for this review; it is being undertaken on the basis of concerns that arose during December 2017, in the process of reviewing our Past Case Reviews and in particular that cases that were marked as requiring action had not been progressed. The Past Case Review* [review of outcomes of the original PCR] *completed in 2019 included 31 cases that apparently had actions to be undertaken. From the information gained from reviewing these cases it would appear that actions were not documented as being followed through or indeed actions were not processed appropriately. … Similarly, the Deceased Clergy Review undertaken by the Diocese in 2015 includes both deceased and not deceased cases, this apparently being due to certain files having been identified as requiring further review … This review has identified cases that required/require further action. Of concern is that both reports detail the cases as needing action, but the 2009 review did not identify what the action was or who should undertake these actions. The 2015 review referred to some actions, but it seems that no particular person was identified to follow the actions up; they appear to have been left with no one taking responsibility …'.*

10.1.4. As no parameters or terms of reference were set for the April 2018 internal audit mentioned above, there is limited structure and focus however it does highlight two learning points for the Diocese. Firstly, the importance and need for effective audit trails to be established to avoid the need to continually look back at cases that may, or may not, have been audited and any risk or support needs resolved. Secondly, the importance of consistent management oversight, scrutiny and monitoring that can follow through action plans

[44] Churches Child Protection Advisory Service (CCPAS), Report of the Independent Audit of Clergy Files in the Diocese area of Willesden, February 2015.

[45] Diocese of London, Review of 2009 PCRs and 2015 deceased PCRs, April 2018.

that may arise as a result of audits and reviews, which support the embedding of learning and improvement activity.

10.1.5. Data from the DST audit, plus anecdotal information gathered through the PCR2 process, suggests that the problematic issues highlighted in the 2015, 2016 and 2018 audits/reviews persist; inconsistent case management practices, limited use of case closure summaries, variable information uploaded and available on which to judge risk and the quality and effectiveness of practice, and an overall sense of uncertainty about how confidently and effectively the Diocese safeguarding system assesses and manages risk. Examples of this can be seen through information captured by the Independent Reviewers when reviewing files, often which did not contain full information about relatively recent concerns which were known to exist in another episcopal area within the Diocese, but which had not been triangulated or recorded, but which would have helped inform a bigger picture about levels of risk. The systematic, effective, and intelligent use of information about safeguarding related issues within the Diocese does appear to be a persisting problem which the Diocese does need to learn from in order to avoid continued false starts to new safeguarding initiatives.

10.1.6. Previous audits and reviews by the Diocese (internal, Churches Child Protection Advisory Service, and SCIE) indicate a need to strengthen systems and processes around not only the quality and effectiveness of case work, but also case management and management systems and processes. Over the lifetime of the PCR2 there was an eight-month gap for the key role of Safeguarding Manager (now Head of Safeguarding). Going forward, a high emphasis has been placed on the incoming Head of Safeguarding (due to begin in August 2021) to tackle and resolve many of the issues captured locally, especially in relation to the work of the DST. Whilst it is undeniable that the postholder will have a critical role, data and the findings from previous audits which have spanned former post-holders indicate that the problems require the efforts and investment of more than one person. A safeguarding system that operates within such a large and complex institution as the Diocese of London (and then the larger and equally complex institution of the Church of England) cannot function purely based on the efforts on one person; it must be a whole system approach, with every part of the system contributing. In this case, it includes the direct contributions, investment, and explicit commitment of a number of people such as senior leaders (within the Diocese of London Fund & Bishops), the Diocesan Safeguarding Steering Group, as well as individuals at a local parish level. Consideration should be given to undertaking a more focused diagnostic assessment that identifies and assists with unlocking any organisational barriers that may impact on achieving sustainable change and embedding high expectations.

10.1.7. By applying the system thinking concept of emergence to the findings that have been captured through the PCR2 it is possible to understand, to some extent, why events have occurred as they have. Emergence[46] is a key property of complex systems – of which the DST and its network is one. The strength of a complex and self-organising system can often be tested against its ability to respond to emerging issues which cannot be controlled, predicted, or easily managed. Emergence as a concept is therefore relevant as it allows us, often with the benefit of hindsight, to better examine system weaknesses – rather than purely concentrating on the efforts, or errors, of individual practitioners. There are a number of factors which are relevant and contributory and help us understand the current situation. These include:

[46] Emergence in organisations, Seel, R., 2006 & Caffrey, L., and Munro, E., 2017, A systems approach to policy evaluation, LSE Research Online.

- Inadequate data and record keeping systems and processes resulting in the emergence of some extremely unhelpful recording practices, thereby allowing unconscious drift and expectations, unwittingly, being reduced.
- Cultural problems in the Church around reporting concerns and responding to survivors[47].
- Staff changes over time in the DST, for a variety of reasons, but which has resulted in the emergence of practice gaps, coupled with insufficient management oversight.

10.2. Learning identified for the Church of England from the PCR2 project

10.2.1. The PCR2 is a large-scale national project directed and endorsed by the Archbishops Council; it was based on needing to rectify the inadequacy and shortcomings of the original PCR conducted in 2007 – 2009 and will have been a costly exercise – in terms of money and time. Guidance was issued for the PCR2 by the National Safeguarding Team of the Church of England in July 2019. The Protocol & Practice Guidance refers to 'careful consultation with sample diocese' in producing the guidance. However, the Independent Reviewer is not aware of any pilot being conducted by the National Safeguarding Team to test the strength of the guidance, assess the rigour of the proposed methodology or to capture any learning about process prior to it being issued to all Dioceses. Considerable ambiguity has been found in the guidance whilst conducting the review in the Diocese of London and which has needed either interpretation of further clarification from members of the national project team during the closing stages of the project. As such, nationally, there has been inconsistency in approach, differing interpretation of the guidance issued, and localised approaches i.e., the use of numerous different recording sheets for files. This was a missed opportunity that could have been used to strengthen the expectations and conduct of a national project, and which would have supported a consistent approach across all Dioceses. In turn this would likely have strengthened the reputation of the Church of England's desire to achieve its commitments[48] to safeguarding. In practice, this has meant that for at least the first half of the PCR2 project there has been limited direction and guidance from the National Safeguarding Team. Examples of this include;

a) a final report template only being issued in November 2020 some 16 months after the guidance was issued, after some Diocese's had submitted their report, and which shifted the focus from the PCR2 being a review of files and statistical return, to something more akin a whole safeguarding system review for each Diocese,

b) the templates issued in the original protocol were unclear and often ambiguous i.e., relating to the review of deceased clergy or not,

c) guidance about General Data Protection Regulations (GDPR) needing to be chased over a series of months, and,

d) delays in receiving a list of cases that have been/were being reviewed by the national team.

10.2.2. Attempting to resolve these issues generated additional work and challenges for the Diocesan project team. Whilst the support and time of dedicated staff at a national level to assist Dioceses was welcomed and

[47] a) IICSA – Independent Inquiry Child Sexual Abuse, The Anglican Church, Investigation report, October 2020, b) SCIE – Final overview report of the independent diocesan safeguarding audits and additional work on improving responses to survivors of abuse, The Church of England, March 2019.

[48] Church of England Safeguarding Overview, 2018

useful, this resource arrived too late and by the time of their arrival the Diocese of London had established a methodology and completed over 70% of file review activity. The national Church body needs to learn from this to avoid further similar missed opportunities.

10.2.3. The use of the term 'known cases list', is flawed. The definition provided in the original PCR guidance[49] was very loose *'… All known child protection cases should be listed including all recent or current cases as well as those that are 'past' cases, which are sometimes called 'historic cases' … the Child Protection Adviser will compile and maintain the Known Cases List …'*. The more recent PCR2 guidance issued at the beginning of the project perpetuates this definition, coupled with unclear and misleading footnotes which offer no greater clarity or definition. Verbal guidance provided towards the end of the project has suggested that names should only be added to the KCL if concerns or risk has been substantiated i.e., a finding has been made through due process of investigation. The issuing of such clarification, although intended to be helpful, came late and further reflects the need for piloting the methodology. The concept of a KCL is based on a list of names, known, at any given moment in time. It suggests a static list that is somehow held in perpetuity, and which does not reflect the often-shifting nature of risk and uncertainty. Other institutions responsible for managing caseloads and working in the fields of health, social welfare or public protection operate 'open/closed' or 'active/inactive' cases, or a 'risk register' which more accurately reflect the status of any service involvement or shifting risk factors. For those other institutions, judging or evaluating performance when working with open or active cases is through performance management frameworks, regular audit, and review. Closed or inactive cases are rarely examined until a new issue emerges and requires activity. It is right and proper that past failings, behaviour, and conduct is reviewed to either seek redress and provide support for those that have survived abuse or learn lessons. However, the use of backwards looking phrases such as Known Cases List and the prospect of a further national review looking at deceased clergy does not help. By supporting the implementation of a sensible performance framework at a local level that then feeds into national reporting, there is scope to avoid static known case lists, and have a more dynamic and relevant picture of how well the Church is moving forwards to eliminate past failings.

11. Conclusion

11.1. The Past Cases Review 2 was commissioned as a result of shortcomings that had been identified with an original Past Cases Review that took place in 2007. The national objectives of the PCR2 were set to identify both good practice and areas for improvement in relation to how allegations of abuse have been handled that will ultimately help the Church of England to strengthen their overall safeguarding practices.

11.2. In order to achieve this goal and fulfil its obligations in the Diocese of London all clergy and relevant church officer files were reviewed by Independent Reviewers. The Reviewers were supported by a dedicated Project Manager and benefitted from a Reference Group to provide governance, quality assurance and scrutiny throughout the project.

11.3. Over 5000 files and documents were reviewed. From this, a total of 273 concerns were identified; 107 of which were already known about by the DST, and 166 which were not previously known about. A further 241 concerns were identified and shared by parishes, of which 172 related to church officer roles and 113 of which met the criteria for consideration under the PCR2 guidance; of this 113, 43 cases were not previously known about by the DST. This exercise has laid a baseline foundation in the Diocese which may mean they do

[49] Review of Past Child Protection Cases: A House of Bishops Protocol, December 2007.

not need to repeat costly, time consuming and all-encompassing reviews of past cases, instead focus on specific case reviews where there is new learning to gain as well as build an improved case management and case performance culture which will result in a greater focus on practice in the here-and-now.

11.4. Findings have been captured from the review of files which highlight the importance of good quality recording practices, good record keeping and effective records management systems; this includes ensuring outcome statements or documents are placed on files which provide sufficient assurance that there are no outstanding safeguarding issues to be dealt with. Past failures to following safeguarding policy and procedure have also been captured highlighting a clear need to rectify deficits.

11.5. Findings from reviewing the quality and effectiveness of the DST have also been captured. These include pockets of good practice about their first response to concerns raised, information sharing and initial assessment and management of concerns. However, worrying findings have been made which over-shadow positives and indicate concerning current, but also less recent, practice; these reflect both acute (i.e., more immediate) but also chronic (more entrenched) problems. They cover a number of core practice areas where improvements need to be made swiftly in order to provide a consistently good response but also which reduce the likelihood of predictable and preventable situations arising for victims, survivors and those individuals who are subject to allegations occurring. This is likely to need associated funding to support and sustain improvements. Contributions from survivors of abuse that have come forward to this review support the findings made by the Independent Reviewers.

11.6. Action plans have been created in order to respond to the issues identified; responsibility for over-seeing the progress of these plans rests with the respective Bishop, the DST and the Diocesan Safeguarding Steering Group. A series of recommendations has been made for the Diocese and national Church to consider. These are intended to strengthen practice and promote higher safeguarding standards.

12. Recommendations & considerations

Recommendations are made where the Independent Reviewers consider it essential that changes are made to strengthen and improve safeguarding practice in the Diocese of London. Considerations are offered where the Independent Reviewers wish to highlight a particular area that need further critical reflection, which in turn, may also strengthen and improve the quality of arrangements.

12.1. Recommendations for the Diocese of London

1. The Lead Independent Reviewer made a commitment to the two individual survivors who gave their time to the review that they would be given advance notice, via email, of the intention by the Diocese to publish this report. It is recommended that this commitment is followed through by the DSA, which includes a further expression of gratitude to them for coming forward to share their story for the greater benefit of all, but also an additional offer of support should it be needed as a result of any trauma which may have resurfaced.

2. The handover of oversight for the PCR2 project, the monitoring of any outstanding risks recorded on the risk register, disseminating learning across the wider Diocese, and overall continued governance, should transition to the Diocesan Safeguarding Steering Group and Bishop of London by September 2021 once the final report has been agreed by all relevant parties.

3. The Director of Human Resources & Safeguarding, in collaboration with the Diocesan Safeguarding Steering Group should create an action and implementation plan, which addresses the learning and recommendations from the PCR2 project. This should fit with the development of a Diocesan Strategic Safeguarding Plan that, not only considers an annual set of targets and ambitions, but clearly articulates and maps a longer-term vision i.e., a 5-year plan.

4. In undertaking further work on those cases where the Independent Reviewers have identified a concern, and logged this on either an Appendix D or the Known Cases List, the starting point for all work on individual cases, should be for the DSA to retrieve the relevant files to see the same information that the Independent Reviewers had access to; the DSA and Team should not solely rely on the summary of information contained in either Appendix Ds or spreadsheets generated by the Project Team.

5. Given the persisting nature of some of the findings about the work of the DST, the General Secretary, the Bishop of London and the Director of Human Resources & Safeguarding should undertake a review to better understand any organisational or systemic barriers that prevent, or limit the likelihood, of implementing successful change and improvement on safeguarding related matters.

6. The Diocesan Safeguarding Steering Group should provide monitoring, scrutiny, and oversight of progress of each episcopal area PCR2 action plan, plus the overall action and implementation plan; it should also hold the Bishop of London and General Secretary to account for progress on recommendations. The Head of Safeguarding should take a lead role in maintaining the operational momentum from the PCR2 exercise in laying a benchmark from which a strong foundation can be built that sees the emergence of strong, effective, and sound safeguarding practice across the entire Diocese.

7. As a priority, the General Secretary, the Bishop of London and the Director of Human Resources & Safeguarding should review the capacity and resourcing of the DST to ensure that it can provide consistently good quality case management advice and initial response, then dependable case management support, assessment and monitoring going forward. It should also ensure good quality management overview and leadership. Achieving stability in the Team should be a high priority. Ensuring there is a healthy skill and experience mix in the team, with professionals from different professional backgrounds will be important to ensure a range of professional perspectives are available to interpreting thresholds for intervention and support.

8. As a further priority, the Diocese should invest in a recognised electronic case management software package, of the sort, that is used in social care settings. The investment should be accompanied by training, guidance, and an implementation plan.

9. The Diocese should review the policy and practice for archiving clergy or officer files to enable all archived files to be held centrally and securely, rather than in individual Bishop's offices/personal residences. Consideration should be given to the national policy as a starting point. The revised policy should also include guidance about file retention and information destruction.

10. Given the considerable inconsistency with which it has been used, the Diocese should review the purpose and use of the File Front Sheet that goes in clergy blue files. A system, whether it be paper or electronic, should be applied that will be useful to those accessing files in Bishop's offices and anyone reviewing the file.

11. Based on the assumption that blue files will remain in use, the DSA should consult with each area Bishop (who retain their responsibility as the data controller) to recommend the introduction of a file chronology template; such a step should not pose any conflict with any guidance set out in the document '*Personal files relating to Clergy, Policy for Bishops and their staff, May 2018*'. A chronology should be placed at the front of every Blue File which aims to provide a chronological summary of three simple issues: 1) Clergy movements i.e., from one role/post to another or to another Diocese, 2) Any safeguarding issues/allegations, 3) Complaints/use of the Clergy Discipline Measures. The template should consist of three columns - date, event, outcome.

12. The Head of Safeguarding should introduce a transparent policy, procedure, and schedule for performance management for members of the Safeguarding Team as a mechanism to promote standards and expectations.

13. The Director of Human Resources & Safeguarding should review the audit tool used for auditing DST cases and develop something that can be used internally as a management tool, on a regular basis to benchmark practice standards against the Church of England's Practice Guidance. The Diocesan Safeguarding Steering Group should establish a sub-group which reports to the DSSG, and which should commission and conduct audits and reviews on a regular basis (e.g., thematic i.e., core groups, timeline i.e., new referrals or case closures in a six-month period, location i.e., episcopal or parish area, etc).

14. The General Secretary, the Bishop of London and the Director of Human Resources & Safeguarding should review the level of support, supervision, and training available to members of the Safeguarding Team to ensure they are suitably equipped to deal with the challenges of the work. This should also include a review, by the General Secretary and the Bishop of London, of the support available to the Director of Human Resources & Safeguarding given the different skill-sets needed to cover both human resource issues as well as safeguarding related matters.

15. To test and further strengthen the quality of case work and case management, as well as demonstrate an openness for scrutiny, the Head of Safeguarding should consider the use of focused independent external audits on either case work, or theme-based topics, on a regular basis i.e., every 12 - 18 months. Audits and reviews should become embedded into action plans and be seen as a healthy mechanism for the safeguarding system to gain learning and feedback. This should specifically include a random sampling of parish returns for the PCR2 and could extend into an audit of the quality of referrals from parishes which, in turn, may help identify any training or threshold issues which may need attending to.

16. The Director of Human Resources & Safeguarding should review, on a twice-yearly basis, the effectiveness of the Survivor Strategy as a mechanism to improve practice. This review should include examining the effectiveness of any communications strategy with victims and survivors, the frequency with which survivors come forward and any potential barriers, their experiences of interacting with the DST, the levels of support made available and accessed by survivors, and their satisfaction with the support offered.

17. All members of the Diocesan Safeguarding Team should be provided with training, and guidance, about working with disclosures, and supporting victims and survivors of abuse.

18. To assist with bringing about culture change, disseminate learning from the PCR2 and improving the recognition and reporting of harm, abuse, maltreatment or other worries, the Diocesan Safeguarding Steering

Group should devise a dissemination strategy that aims to share learning across the whole Diocese; this should be more than simply publishing documents on the website but involve face to face interaction at a parish level.

19. Where information captured by the Independent Reviewers indicates that former Bishops in the Diocese, or wider, have not responded well or appropriately to concerns, allegations or complaints, the Head of Safeguarding should take responsibility for systematically collating this information, passing it to the National Safeguarding Team for further advice or action. The current Bishop of London and the Head of Safeguarding should expect regular update on progress made by the National Safeguarding Team, and where this is not forthcoming the matter should be logged and escalated.

20. The DSA should ensure that a copy of the Appendix D completed by the Independent Reviewer is printed (on yellow paper) and placed on the file of the individual to which it relates to physically show that information had been captured as a result of the PCR2 and that further enquiries or investigations were needed.

21. The Director of Human Resources & Safeguarding should review the policy document on archiving the files of dead clergy, dated 29/10/2009 and provided by the Bishop of Willesden, and work to achieve a better solution to the storage of archived clergy files across the Diocese (not just deceased) that avoids the need for individual Bishops to retain them in their own residences.

22. The Director of Human Resources & Safeguarding should consult with the area Bishops in London to agree a policy decision about the use of electronic records by Bishops and their staff, notably in relation to safeguarding issues, and how to avoid relevant information becoming either lost, mis-filed or forgotten.

23. The Director of Human Resources & Safeguarding should work with the Bishops and the relevant person in the London Diocesan Fund who has expertise on information security and information sharing, to agree an effective protocol for the exchange, and recording, of paper files between Bishops Offices and the DST. Given the number of blue files that will be exchanged in the coming weeks that need further review, this should be a priority.

24. Given the variation across the country of PCR2 concluding for other Dioceses, and the possibility of additional files being sent to the Diocese of London PCR2 having not been independently reviewed, the Head of Safeguarding should ensure that any clergy files received from other Diocese's, are independently reviewed using the PCR2 criteria. This may entail some negotiation with the Diocese sending the file and a request that they review it, prior to it being sent.

25. Further exploration is needed to better understand the reasons behind the discrepancy in the total number of concerns captured (based on an Appendix D being completed) in the See of Fulham area compared to the other episcopal areas.

26. Given the current pilot taking place in the Diocese on Ministerial Development Reviews, the Director of Human Resources & Safeguarding should work with the Bishops to ensure that, going forward, there is an appropriate mechanism to encourage incumbent members of clergy the opportunity to critically reflect on their confidence and competence about how to identify and respond to, safeguarding related matters, and any training or development needs.

27. The Director of Human Resources & Safeguarding and Head of Safeguarding should work with the Bishops to review whether Archdeacons' three yearly visitations can examine the quality and effectiveness of

safeguarding practice (adult and child) in the parish. Support and training should be provided to Archdeacons to implement any changes and a feedback loop with the Diocese Safeguarding Team should be established in order to promote system change.

Considerations for the senior leadership team in the Diocese of London

The following considerations should form part of the Diocese of London's overall improvement plan, and provoke critically reflective conversations, actions and improvement activity.

a) How can the senior leadership team in the Diocese best use the learning from this PCR2 to strengthen their own approach to safeguarding children and vulnerable adults? How best can the whole organisational system in the Diocese change to enable both successes and past failures be used as opportunities to galvanise real and sustainable change?

b) Accountability is often something referred to when looking back, especially in the recent and current context the Church of England finds itself in given the high number of cases that have required review and shown past failings. Creating a 'safer church' is one of the three priorities in the Diocesan 2030 vision and strategy; what steps can the senior leadership team in the Diocese take to demonstrate this lead, shining the way forward, in shaping a safeguarding culture that is seen as the highest priority and where there is greater forward-looking accountability?

c) Using the findings of the PCR2 and information captured about the quality and effectiveness of the DST, the Diocese may wish to consider commissioning an independent review of the effectiveness of the Diocesan Safeguarding Steering Group. This should include are review about lines of accountability between the Group, all area Bishops, the Bishop of London and General Secretary, consideration of a whole safeguarding system review i.e., triangulating information from other sources i.e., involving key stakeholders such as Bishops, Archdeacons, parish Safeguarding Officers, statutory agencies, and how the Group can act as a critical friend to senior leaders in the Diocese to strengthen and promote safeguarding arrangements.

12.2. Recommendations for the national Church

It is recognised that the national Church, through the National Safeguarding Team, and National Safeguarding Steering Group have, and are, actively taking steps to remedy past failings and strengthen safeguarding arrangements in the Church of England. It is hoped that the following recommendations can be usefully considered alongside current work plans.

1. When planning for national projects that involve every Diocese, the methodological approach should always be piloted with learning used to refine any issues that arise i.e., test for ambiguity or lack of clarity. Any guidance issued should also be consulted on and stress tested before being issued nationally.

2. The use of the term 'Known Cases List' should cease to be used at the earliest opportunity.

3. Based on the assumption that clergy blue files will remain in use, the national Church should consider amending the current document *'Personal files relating to Clergy, Policy for Bishops and their staff, May 2018'*, by adding an explicit recommendation that all files contain a chronology template. A chronology should be placed at the front of every Blue File which aims to provide a chronological summary of three simple issues: 1) Clergy movements i.e., from one role/post to another or to another Diocese, 2) a concise record of any

safeguarding issues/allegations, 3) A concise record of any complaints/Clergy Discipline Measures. The landscape template should consist of three columns - date, event, outcome.

4. In the light of the findings and analysis from the PCR2 from all Dioceses the national Church should review, and strengthen, the guidance issued to Bishops about managing personal files relating to clergy to ensure it provides clear guidance about the potential pitfalls with storing some information electronically and the risk of it being lost, mis-filed or forgotten.

5. Consider best practice and guidance in relation to Ministerial Development Reviews which include explicit reference to safeguarding practice issues, safeguarding training needs and responding to victims and survivors of abuse.

6. Develop a standard case audit template, based on Practice Guidance, for use in Dioceses; this will allow improved benchmarking data to be produced, learning to be shared and improvement activity to be targeted.

<u>Considerations for the national Church</u>

a) Members of clergy frequently deal with other people's pain, suffering and loss. The impact of this may need attending to so as to support emotional and mental health and allow individuals to continue their work. Some cases examined in this review showed little evidence of support being offered to members of clergy. How can the Church provide support for members of the clergy to assist them with critical reflection, avoid vicarious trauma and a safe space (yet within the bounds of needing to share information which may indicate someone is at risk of harm) to talk through issues which may affect judgements and their own safeguarding thresholds? What support mechanisms are already in place, how effective are these, and how would the Diocese know that as an institution it is caring well for its workforce? The Methodist Church has a policy and set of practice documents which may provide a good starting point for the Church of England to consider.

END

Appendices

Appendix 1: Brief biography of the Independent Reviewers

Kevin Ball: Kevin was appointed as the Lead Independent Reviewer for the Diocese of London PCR2. He has over 30 years of experience working across children's services ranging from statutory social work and management to inspection, Government Adviser, NSPCC, and independent consultant; having worked for a local authority in both operational, management and strategic roles, the Commission for Social Care Inspection/Ofsted as a Regulatory Inspector, central Government as an Allegations Management Adviser, and the NSPCC as a Senior Consultant. He also has extensive experience of working in residential childcare. He has been the lead Consultant on two national Department for Education projects (2014 & 2016) aimed at improving the quality of statutory children's Serious Case Reviews. He has worked with the Foreign & Commonwealth Office and provided consultancy to the Department for Justice as well as the Government of Brunei. Kevin has extensive experience of delivering consultancy and has worked with over 40 Local Safeguarding Children Boards/Partnerships in a consultancy or advisory capacity. More recently he was the interim Independent Strategic Scrutineer for Berkshire West Safeguarding Children Partnership. He has worked with a range of charities and independent sector organisations undertaking safeguarding audits, thematic reviews or providing advice and support. He has conducted, or been involved with, over fifty Serious Case Reviews/Child Safeguarding Practice Reviews, as well as being a Chair/author of Domestic Homicide Reviews. He is currently appointed as specialist Panel member (children's safeguarding) to the Church of England National Safeguarding Panel. He is registered with Social Work England, a member of the British Association of Social Workers and an active member of the Association of Child Protection Professionals.

Adenike (Nicky) Sobamiwa: Nicky obtained her first degree in Linguistic studies from the Nigeria's Premier University in 1991. She became qualified as a social worker in 2005. Prior to her social work degree, she worked as an unqualified social worker with the inner London Boroughs including Tower Hamlets, Croydon and Westminster Adult Social Services teams. Following her Social Work Degree, she worked as a Qualified Social Worker for several London and suburban local authorities including Hounslow, Surrey County Council, Southwark, Croydon, Islington, Portsmouth, and Wokingham Social Services. Adenike has been working as an independent social worker since January 2010. Her work includes adult social and health care review projects, various integrated Health and Social Care Projects such as enablement, discharge to assess, and including NHS/Continuing Health Care services. She continues to provide independent social and health care services. Adenike worked as senior social worker/ deputy Team manager in social services teams in her last appointment. She obtained a Master's Degree (LLM) in Law from Birkbeck, University of London in 2017.

Yvonne Brown: Yvonne has 30 years' experience as an investigator in the Metropolitan Police Service, working in areas of child protection, domestic abuse, and serious sexual assaults. In her final four years on Trident Central Gang Command, she led teams in reducing Serious Youth Violence and Gang Exploitation in London. At Detective Chief Inspector rank she was the responsible officer in developing a victim focused strategy, adopting innovative prevention tactics to combat county lines and child criminal exploitation by organised criminal networks in London and county police forces. Yvonne trained in specialist sexual investigative techniques and achieving best evidence from children and vulnerable witnesses. She is also a trained counsellor.

Appendix 2a: Letter to incumbents from the Bishop of London

19th February 2020

Dear Incumbents and PCC Secretaries in the Two Cities Area,

Past Cases Review 2 (PCR 2)

You will know that I as Bishop, and the Diocese of London as a whole, take the issue of safeguarding and the abuse of children and vulnerable adults very seriously. The National Church has agreed that all Dioceses in the Church of England should undertake a second review of all past cases, and we write to you to request your help on this. In the Diocese of London, we are undertaking this exercise in each episcopal area where we will be conducting the review to pick up where PCR1 left off in 2007, in line with the House of Bishops approved practice guidance. The House of Bishops wishes to ensure that our churches and church related activities are as safe as possible for children and vulnerable adults.

We're reminded by St John the Evangelist that *"the Light shines in the darkness and the darkness has not overcome it." [John 1.5]* John uses the imagery of light and darkness, where darkness represents concealment and shame, whereas light represents the revelation of truth. Darkness hides things that are forgotten, uncomfortable or broken and have been "put out of the way" in cellars or behind closed doors. They may be things that are inconvenient or of which we are ashamed or afraid. In darkness they lie where we can forget about them, but Christ is the Light of the World and brings to light things now hidden in darkness. He brings to light those deeds that have been concealed and the victims of sins who have been silenced or kept from view. The Light shines for those who need justice and healing and upon those misdeeds that have injured them.

Allowing light to shine on what has been hidden is a first step towards healing, not only for those who have been abused, but for those whose consciences are, or ought to be, troubled by those sins they have buried away beyond the sight of others. Sometimes it will take an external prompting for those things to be opened to the light of day and to the light of Christ, but with such prompting may begin the path to penitence and forgiveness, the path to healing of long-hidden wounds.

Through PCR2, we are asking you to help shine a revealing light on any instances of abuse that have occurred in your parish (or chaplaincy or BMO) and to help us to ensure that everything that ought to be brought into the light has been. Shining a light on what has hurt or frightened someone is a matter of justice for those who have been victims; sometimes it may also prevent further harm and sometimes it may be the first step towards healing. We are asking clergy and PCCs (as the Trustees of the parish) to do three things, please.

1. **To disclose any known historic cases since 2007**

A full PCR1 was undertaken across the Diocese of London in 2007-9 which covered all cases up until 2007. PCR2 therefore, is concerned with what has happened in your parish since 2007.

What we do ask is that you consult your parish files and those in the parish with long memories (and, where appropriate, your predecessor(s) if you are in touch with them) and note on the attached schedule (Appendix A) the details of any known cases involving clergy in the parish or lay church officers that have not to your knowledge been previously reported. In the spirit of the Gospel, we all want to protect and care for our children and the vulnerable. At a time when the Church's safeguarding policies and practices are under close scrutiny, you will recognise the importance of being as sure as possible that all known instances of concern have been addressed.

Experience has shown that there have been some cases of alleged abuse to people over 16 who have later said that they consented. The legal status of such abuse has changed over the years. For the avoidance of doubt, any such cases should be included even though prosecution or cautioning has not taken place.

If you become aware of matters that you believe may never have been reported to the Diocesan Safeguarding Team (DST), then you should, as well as noting them on the schedule, immediately report them directly to the DST.

2. To check any files or records you may hold on church officers, employees and volunteers

Information is being sought on persons who have or have had a role in the Church where their role brings them into contact with children or with adults at risk of abuse. Information is not being requested on worshippers and those attending church activities who do not hold a role in the Church. You do not need to provide details of people subject to safeguarding agreements. Protective measures should have been installed in such cases. The advice of the DST should be sought in any instances of doubt, as well as advice on whether a particular circumstance should be reported.

The footnote below outlines some of the roles that fall under the remit of the PCR2 however a full list of roles is included at the end of this letter.

Where there are concerns, please enter them on Appendix A. We recognise that this is a difficult task. You are being asked to ensure that everything that is relevant and currently known has been passed to the DST and that further information which may emerge in future is promptly notified to them.

3. To complete the Schedule at Appendix A and sign it on behalf of the PCC

Because the PCC are the responsible body as Trustees, you will need to ensure that they are aware of this exercise. We are asking you as incumbent to sign this off (even if you are sending in a nil return), but they need to know what is being done in their name (though you shouldn't share details of historic and current matters with the entire PCC!). When you have signed it off, please return it to pcr2@london.anglican.org. A proper signature is required, please, then the paperwork can be scanned in and sent by email.

We need your returns in by 30th April 2020 at the very latest. This is something that is vital to the life of our Church, and we very much hope that you will take it extremely seriously and do your best to comply with what is being asked of you. There will be support in this process, briefing sessions have been arranged at the Diocese of London Offices for the 6th of March. Further details will follow.

Thank you for your co-operation and our partnership together for a safer Church.

Wishing you every blessing

+ Sarah London

The Rt Revd & Rt Hon Dame Sarah Mullally

Bishop of London

c.c. Parish Administrators

Appendix 2b: Notes to Bishops office on file preparation

Preparation for PCR2

Guidance Note to Area Bishops' Offices

You may know that The National Church has agreed that all Dioceses in the Church of England should undertake a second review of all past cases relating to safeguarding and the abuse of children and vulnerable adults – Past Cases Review 2 (PCR2). This will take place in 2020 and will involve independent reviewers scrutinising files held in Area Bishops' offices, as well as other files (such as those of Licensed Lay Ministers) for which the Area Bishop is responsible. The PCR2 protocol documentation calls for a broad remit of roles to be considered in addition to clergy files. A full list of roles is included at the bottom of this guidance note.

In November 2019 Bishop Pete wrote to make you all aware of the PCR2 and its requirements. This guidance spoke of the preparatory work which we requested that you do from November 2019, in order to enable PCR2 to go smoothly. This involves you ensuring that your Blue and other files are complete, up to date and ordered well, ready for scrutiny by the independent reviewers carrying out PCR2. This guidance has been updated to reflect our experiences in reviewing the Willesden files.

In addition, a separate letter is going out from Bishop Sarah and the Bishop of each episcopal area to incumbents asking them to review the files that they hold and to complete a form – Appendix A to record any allegations against staff members from 2007 to date.

What we need you to do

There are two tasks for Bishops PA's as part of the PCR2 process; the first is to assist in encouraging parishes in your area to complete Appendix A we require the form to be signed and returned as a nil return if there are no allegations or cause for concern. The second is to prepare the files in the Bishops office ready for our independent reviewers to go through them.

We will be contacting episcopal areas in the next couple of weeks to arrange a time for our independent reviewers to come to the offices and start reviewing files. The review period will commence early March and continue until the end of May 2020 (approximate end date). We will work around the demands of your offices where possible to minimise disruption, it is likely that one or more reviewers may be on site for several days during this review period. *Please be assured that we will not be scheduling any review work between the 5-14 April.*

How to prepare

The guidance below sets out a step-by-step process for you to follow. It will in any case help you order the Blue Files in your office!

1. Open MyDiocese and export the list of licensed and beneficed clergy for your Area into an Excel spreadsheet.
2. Print the spreadsheet and check that the list is up-to-date and that all beneficed and licensed clergy are on MyDiocese. Don't forget Chaplains and others not in a parish who hold a licence!
3. Where there are omissions or corrections to be made to MyDiocese, ask the Superuser in your Area (the person with editing rights on MyDiocese) to make the amendments.
4. Check that you have Blue Files for all those on the up-to-date list. Request Blue Files for any you haven't got (remember that +Fulham holds the Blue Files for his parishes).

5. Weed out all those Blue Files which relate to clergy not on the list and work out whether they have:
    - Moved to PTO
    - Retired and do not hold PTO
    - Died
    - Gone abroad (or to Scotland or Ireland)
    - Joined another Church (e.g. RC)
    - Left ministry completely
    - Moved to another Diocese (you can check this in Crockfords, which is about 75% accurate, though not entirely reliable!)
6. Send files on where they have gone to another CofE Diocese
7. Put PTO files together
8. Put other files for those not holding PTO and not in another diocese with Archive Files
9. Print out the PTO list for your Area (as per steps 1 & 2 above)
10. Check your PTO files against the list (you only need to worry about the PTOs issued from your office). Remember that sometimes the Blue File is held in another Diocese where the priest is licensed, and you will only have a "rump" PTO file, rather than a Blue File, for the priest.
11. Where there are omissions or corrections to be made to MyDiocese, make sure the amendments are made by an authorised database editor.
12. You should then be left with archived files of dead and alive clergy. Arrange them alphabetically and enter them into an Excel spreadsheet (Surname; First Name; Status). Using Excel will allow you to sort them more easily. Check the spreadsheet for completeness against the physical files you hold. Use the "Status" field to record if they are dead (you may not know!) or abroad or RC or out of ministry.
13. You should then have clergy files in 3 categories and lists that correspond to them – Beneficed/licensed; PTO; Archived. Congratulations if you already have all this in place.
14. PCR2 also requires us to review any files of LLMs and Commissioned Ministers/Pastoral Assistants. Please liaise with your ADTD/Warden of Readers/Warden of Licensed and Commissioned Ministers and get them to list the files they hold. If you have files in the Area Bishop's office, you will need to check your list against theirs.
15. Be mindful if you also hold any files electronically on shared drives, as these will need to be reviewed.
16. If your Archived files are off site please email the PCR2 project administrator to advise as to the location of files.

Appendix 3: Diocese Safeguarding Team case audit tool

PCR 2 Diocesan of London open case file audit tool

Name:	**Case file number:**
Person reviewing the file :	**Active case or closed:**
Care allocated to :	**Date opened to the DST:**
Audit date:	
Type of case i.e. harm to child or adult:	
Case referral date from Parish (within 24 hours):	
Referral received from:	
Parish:	

Scores to be applied: 1-2 = poor & 3-4 = Good

Areas of practice are based on: Practice Guidance: Responding to, assessing & managing safeguarding concerns or allegations against church officers, Church of England, 2017. *Please refer to for more details.*

Please provide a very brief summary of the case & provide your overall judgement about the quality and effectiveness of case management:

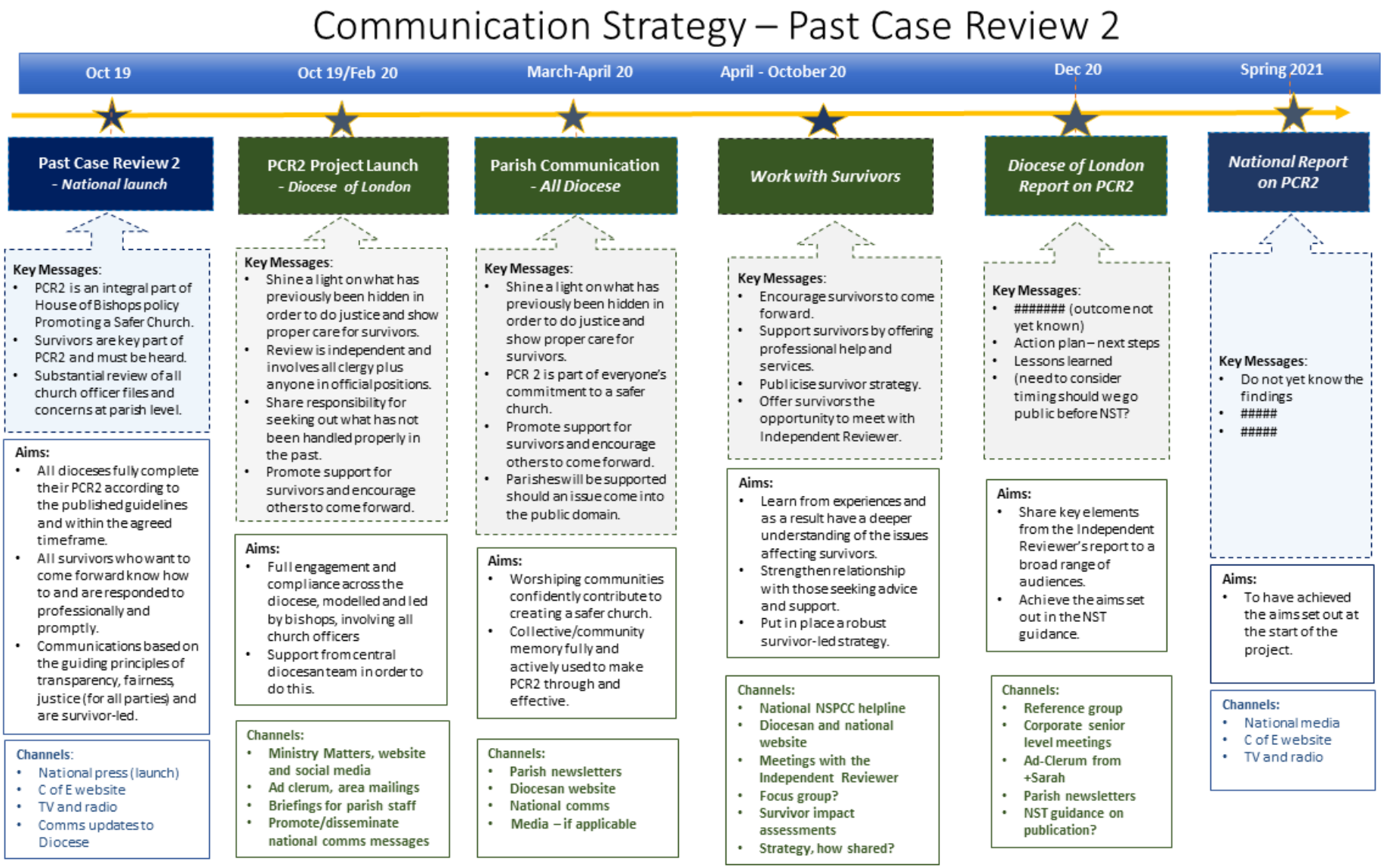
	Area of practice	Score	Comment on quality	Action	By who/when
	First response	**Score**	**Comment on quality**	**Action**	**By who/when**
1	Has the referral been received by the DST within 24 hours and was the response compliant with guidance? What is the quality of the referral? P. 25				
2	Have appropriate consents been sought and shared and wishes recorded i.e. from victims, survivors and offenders? P.25				

3	Has the victim disclosing/ person or child been appropriately advised about the next steps? P.25				
4	Is there evidence that the statutory agencies have been informed within 24 hours by the DST? Has the referrer been given written confirmation that this action has been taken? Has the decision not to refer to statutory agencies been recorded? P.26/28				
5	Where the allegation relates to a church officer that has a role with children or vulnerable adults has the DSA convened a core group within 48 hours of becoming aware of the concern or allegation? P.29				
6	If the respondent works for another organisation have they been informed? P.33				
	Information sharing	**Score**	**Comment on quality**	**Action**	**By who/when**
7	Has information been shared in line with Government guidance on information sharing & other protocols? P. 34				
	Initial assessment & management of concerns/allegations	**Score**	**Comment on quality**	**Action**	**By who/when**
8	What is the quality of the core group & minutes (P. 18/19) i.e. chair & note-taker appointed (P.40), minutes distributed to attendees (P.40).				
9	Has the respondent been informed/supported in line with guidance? When appropriate, has the support been extended to the respondent's family? P. 42/43				

10	Has an Initial Case Summary been provided to help core group members judge the level of risk? P. 43				
11	When an Interim Safeguarding Agreement has been developed, has it been signed by the respondent and is there evidence of regular review? P. 44				
12	Has suspension in this case been applied and is there evidence the bishop has consulted with the DSA and registrar? P. 45				
13	Is there evidence of the DSA working with parishes and others, who may be affected by the concerns/allegations? P. 46				
	Investigation	**Score**	**Comment on quality**	**Action**	**By who/when**
14	Is there evidence of an investigation summary report on the case file? P. 50				
15	Has the investigation report reached a conclusion of substantiated /unsubstantiated/unfounded/malicious/false or whether there are ongoing concerns and actions required? P. 50				
	Risk assessment & management	**Score**	**Comment on quality**	**Action**	**By who/when**
16	Has risk been assessed and risk plan in place at each stage of the process? P.54				
17	If an independent assessment has been recommended has the assessor been commissioned appropriately and due process been followed? P.58				
18	Have victims/survivors been kept up-to-date with decisions? P. 63				

	Ongoing risk management	Score	Comment on quality	Action	By who/when
19	Is there evidence of on-going risk management and monitoring and parallel processes i.e. referrals to Disclosure & Barring Service, Bishop's list, Clergy Disciplinary Measures & MAPPA? P. 44 & 66 & 68 & 69.				
20	Is there evidence that the link person is supporting the respondent throughout the whole process? P.15				
	Outcomes	**Score**	**Comment on quality**	**Action**	**By who/when**
21	Has the outcome off the case been recorded i.e. police investigation discontinued/ CPS discontinued/conviction/ bailed etc?				
22	Is there evidence of management oversight from within the DST throughout the case management process?				
	Recording keeping	**Score**	**Comment on quality**	**Action**	**By who/when**
23	Are there any support & communication needs that would ensure that the person participate in the concern process? (culture, age/development, language, disability, mental capacity etc)? Are these clearly recorded?				
24	Are the records up to date i.e. case closure form completed, outcomes recorded, contact details? What is the quality of recording?				

Appendix 4: Communications strategy



Appendix 5: Survivor support pathway

The Diocese of London Survivor Pathway

Introduction

The Past Cases Review 2 (PCR2) was commissioned following a report from the Independent Scrutiny Team led by Sir Roger Singleton in 2018. All national church institutions and dioceses are required to complete the review and all parishes, cathedrals and other church bodies are required to participate.

The PCR2 protocol and practice guidance has been approved by the House of Bishops. All dioceses and church bodies are required to have 'due regard' to this guidance in completing the review. It makes specific provision for the involvement of victims, survivors and those with a lived experience of abuse. We recognize that the welfare of children or adults at risk of abuse must be of paramount importance in the planning and delivery of the PCR2 and we want to ensure that we are using this as a framework for improvement for our ongoing work with victims and survivors.

The specific objectives of PCR2 are:

• To identify all information held within parishes, cathedrals, dioceses or other church bodies, which may contain allegations of abuse or neglect where the alleged perpetrator is a clergy person or other church officer and ensure these cases have been independently reviewed.

• To ensure all allegations of abuse of children, especially those that have been recorded since the original PCR, have been handled appropriately and proportionately to the level of risk identified and with the paramountcy principle evidenced within decision making.

- To ensure that recorded incidents or allegations of abuse of an adult (including domestic abuse) have been handled appropriately demonstrating the principles of adult safeguarding.

• To ensure that the support needs of known survivors have been considered.

• To ensure that all safeguarding allegations have been referred to the Diocesan Safeguarding Advisers and are being/have been responded to in line with current safeguarding practice guidance.

• To ensure that cases meeting the relevant thresholds have been referred to statutory agencies.

Appendix 3 sets out the checklist for implementing PCR2 guidance for survivors. This covers:

- Reference Group responsibilities
- Communications
- The involvement of victims, survivors and those with a lived experience of abuse
- Survivor engagement
- Survivor support plan

Each diocese is expected to put systems and services in place and to bring the appropriate agencies together to support victims and involve them in the programme, whether as contributors or as participants of the reference group. Both NAPAC and Victim Support are members of the Diocese of London PCR2 Reference Group and they are partnering us with the delivery of this pathway and our engagement with victims and survivors.

We have also reviewed the current literature to understand what is important to survivors (see Appendix 4).

As an institution, abuse has had a major impact on the churches' reputation and trust. Abuse can have a significant impact on people's lives, increasing the risk of poorer physical and mental health and poorer social, educational and criminal justice outcomes. Supporting someone who has been abused can be a complex and long-term intervention that needs

specialist skills and knowledge.

Often agencies who are funded to work with victims to improve their outcomes are health and social care professionals eg. Counsellors, therapists etc. Our duty towards victims of all abuse, not only that perpetrated by church officers, is to support them to disclose the abuse and help them to access appropriate support by signposting and referring to more specialist support as required.

In the past clergy and laity have often wanted to support people in their own congregation and while this can be appropriate in a general way, specialist support will need to be found outside of the local church community.

The role of the diocesan safeguarding team in relation to victims is important to set out, so that both the duties and the limitations of the team are clear.

To ensure people get the support they need the Church of England guidance requires each diocese to have listening services. These are intended as short-term support to provide victims and survivors of abuse within the church settings with support during the disclosure process.

To meet the needs of victims appropriately we have mapped a survivor pathway for the PCR2 review process in the Diocese of London, to ensure victims and survivors are well supported.

Mapping our development priorities

We have used the document called: STRATEGIC DIRECTION FOR SEXUAL ASSAULT AND ABUSE SERVICES: Lifelong care for victims and survivors: 2018 – 2023 [50] that sets out the strategy for NHS England[51] and represents a shared vision and focus for improvement in support for victims and survivors.

We have set out the PCR2 survivor pathway using this framework so that all the facets of this work are presented in a way they can be measured by the Past Case Review Reference Group (PCRRG). We will also use this as the foundation for the Diocese of London Survivor Strategy.

Based on the six core priorities identified in this NHS framework, we have identified the priorities for the Diocese of London as follows:

1. Building our Safer Churches Strategy to help prevent future abuse
2. Promoting safeguarding and the safety, protection and welfare of victims and survivors
3. Involving victims and survivors in the development and improvement of what we do
4. Developing key performance indicators to ensure timeliness of our response and the quality of what we do
5. Developing our partnerships with Napac, Victim Support and other service providers
6. Ensuring that our clergy, and all those involved in the life of our churches receive safeguarding training appropriate to their roles.

Appendix 1 - A map of the survivor pathway

Appendix 2 - The Survivor and Victim Framework Summary for 2020/2021

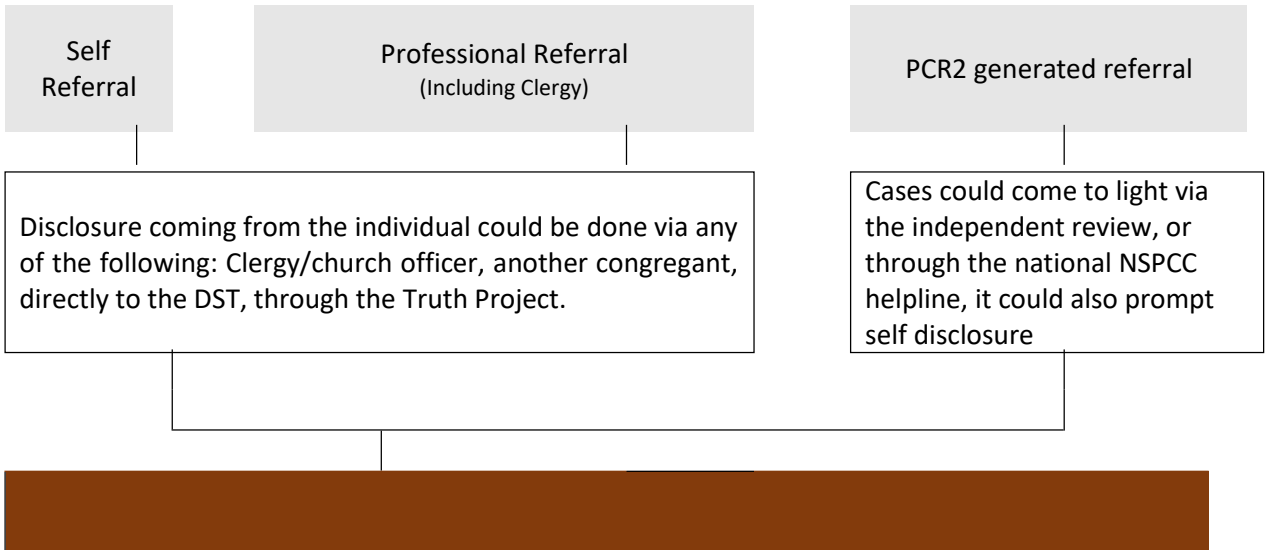
Appendix 3 - How the priority outcomes will be achieved.

Appendix 4 – what victims tell us

[50] https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf

[51] NHS England leads the National Health Service (NHS) in England

Appendix 1 of the Survivor Pathway – Map of Survivor Pathway



Initial Assessment of case and survivor services on offer:

If case doesn't meet criteria to launch investigation	Support on offer: Signposting to other relevant organisations, e.g. Mind or Napac, Victim Support.
Meets Criteria and investigation is launched	**Police support**: Victim Support **DST Support**: Individual Survivor support plan - could include Napac group service (12- week program), counselling, listening service etc
During investigation	Listening service
Post investigation	**Include EIG and how accessed as option and any other support still on offer**
PCR2 cases	NSPCC helpline, and In addition to any of the above - opportunity to meet with Independent Reviewer

Historic cases could appear for whole process or if case has already been acted-on, they could receive post investigation support.

Appendix 2 of the Survivor Pathway - Summary plan

The Survivor and Victim Framework Summary for 2020/2021

Vision	2030 Vision					
Priority outcomes	DOL is Strengthening its approach to prevention	Promoting safeguarding and the safety, protection and welfare of victims and survivors	Promoting safeguarding Involving victims and survivors in the development and improvement of services	DOL Introducing consistent quality standards	DOL is Driving collaboration and reducing fragmentation	Ensuring an appropriately trained volunteer and staff workforce
	Young people and adults are protected from harm and kept safe in our worshipping communities through safe practices. People seeking help from the church receive services and advice swiftly The church provides locally relevant information and advice about safeguarding support to enable choice and informed control	Everybody in our churches enjoys physical safety and feels secure People are free from harm in our churches Instances of abuse are investigated promptly and effectively Victims and survivors receive adequate support when making their disclosures People respect the dignity of the individuals and ensure support is sensitive and available to each individual circumstance People who are experiencing abuse are assisted with advice and support to help them maintain control over their situation	Responsible governance and partnership are in place Victims and survivors' are at the heart of what we do and their views are gathered to help services developments which we follow Survivors and victims' feel they are equal partners throughout any service change or design Survivor pathways are codesigned and impact assessments are used in commissioning	DOL Continue to improve the delivery of services and reliability of contractors through contract monitoring We ensure that clergy and church safeguarding officers have capacity and skills and expertise in safeguarding to deliver good services quality assurance frameworks for commissioning Risk Assessment for church officers	Use our learning from PCR to extend our networks and partnerships Have a diverse market in victim support services to offer choice and control for victims. Work with our partners in health to improve outcomes for victims and survivors of sexual/emotional abuse.	Everybody can access training to help them feel confident with their safeguarding duties People are protected as far as possible from avoidable harm by well trained safeguarding volunteers and members of clergy. Better identification and support to victims and survivors living in the London Diocese and to have a voice in the commissioning of training.
we aim to	work with Incumbents to gather historical cases of persons of interest to complete their returns Parish promote ways to report abuse and maintain safer recruitment practices To encourage incumbents and church communities to focus on prevention of abuse through the work of the DSSG and their PCC's Promote Leadership in safeguarding in parishes and encourage take up programmes	Ensure that people are free from harm in our churches through safer recruitment practices Ensure Instances of abuse are investigated promptly and effectively by appropriately trained personnel Victims and survivors receive adequate support through their disclosures and are offered support through the DST and church community where appropriate, work with independent advocates.	We aim to keep victims and survivors safe and support them to cope with the direct impacts of abuse when disclosing by working closely with agencies. Sign post victims who come to us to primary services to enable them to access where appropriate long-term recovery services to improve emotional wellbeing. CFPS recommendations are implemented to ensure effective survivor opportunity to influence governance and the way things are done around here	Review the case work within the DST to evaluate against practice standards and implement recommendations from the Independent Reviewers Feedback from training evaluations from face to face sessions is used ensure quality standards are maintained Introduce quality assurance framework for commissioning Risk Assessment for church officers	To work with police, social care and health to improve survivors and victims' experience when disclosing To provide access to justice for victims, and protect them when they are most vulnerable, we need to ensure they are supported before, during and after the criminal justice process, and that they are treated with kindness and consideration throughout Ensure we have enough capacity for victims to access our listening services. Improve collaboration with health services for victims to access lifelong services for victims and survivors through referral mechanisms	Ensure that clergy and church safeguarding officers have capacity and skills and expertise in safeguarding to respond well and they understand the complex needs of this client group. We aim to commission e learning and provide choices in relevant safeguarding to each episcopal area. Encourage volunteers in church settings to take responsibility for their own learning within and outside of the church.
Busine s suppo t	These priory outcomes are supported by					
	Operational plan 2020					

Appendix 3 of Survivor Pathway - Checklist PCRRG PCR2 guidance for survivors

Reference Group responsibilities

- ☐ The DSAP chair must nominate a member of the diocesan PCR reference group to lead for survivor support and engagement.
- ☐ The DSA, DSAP chair and diocesan bishop must agree survivor-care strategy at Phase One
- ☐ To regularly review the survivor-care strategy
- ☐ Local Adult and Children's Safeguarding Partnership Boards to be notified of PCR2 with a link to the guidance.
- ☐ To establish local partnerships (e.g. with Victim Support, Rape Crisis, local counselling providers etc.) are in place

Communications

- ☐ The diocesan safeguarding team is the point of contact for the review/survivors
- ☐ The NSPCC helpline number and how to contact with the DST must be promoted locally

The involvement of victims, survivors and those with a lived experience of abuse

- ☐ The DSA will liaise with lead for survivor engagement and IR when someone wants to make representations to PCR2
- ☐ Where safeguarding professionals or diocesan clergy are in **current contact** with victims and survivors, an invitation to be offered to engage with the IR

Survivor engagement

- ☐ Individual who we are working with should be invited to express their views to the IR
- ☐ Any survivor engaging with the PCR2 process will be assured of support and of anonymity
- ☐ Advocacy or carers for individuals who lack capacity or under 18 should be in place

Survivor support plan

- ☐ Any investigations should have a multiagency survivor support plan in place prior to contact.
- ☐ Pastoral care should be included in the survivor support plan if required
- ☐ If the IR identifies unmet support needs, they should pass to the DSA

Appendix 4 of Survivor Pathway

The needs of victims and survivors

Victims and survivors tell us that, both before and after disclosure, they frequently find it difficult to navigate a confusing and disjointed array of services at the time when they need them most and at times when they are often in crisis. They also tell us that their experience can be compounded both by difficulties in knowing which services to access to get the help and support that they need, and by inconsistencies in the quality of care that they receive once they do access services. This heightens the risk of compound trauma that can occur as a result of repetitive, prolonged and sustained abuse and/or re-traumatisation, which is the reminder of a past experience resulting in re-experiencing the initial trauma.

Heightening the risk further, disclosure and identification of sexual assault and abuse often takes place in a more formal setting rather than within an environment dedicated to the care and support of victims and survivors. This can often mean that, whilst support is available, there may be little emotional and physical support longer-term and over the individual's lifetime.

The Diocese of London have engaged the support of Victim Support and Napac with the intention of gaining their specialist insight and knowledge as we work to ensure the needs of victims and survivors are central to our past cases review. They will help us to ensure that joined up support for individuals, as well as for their families and carers and that victims and survivors are directed to the most appropriate service at the right time in their journey to recovery.

Appendix 6: Independent Reviewer file front sheet template & Appendix D template

Case ID:

Past Case Review 2 – Independent Reviewer Case file summary

DIOCESE OF LONDON

Name of clergy/officer:	DOB (DD/MM/YR):
Current role:	Date of file review:
File reviewed by:	Status of reviewer:

Is there information on file to suggest that the person has, or does, present a risk to children?	Yes/No
Is there information on file to suggest that the person has, or does, present a risk to adults?	Yes/No
Comments:	
If yes, has a PCR2 Appendix D been completed and placed on the file, and a referral made to the Diocese Safeguarding Adviser?	Yes/No
If not, why not?	
If no risks have been identified: Summary of observations or issues raised by review of the file & actions needed:	
Signature of reviewer:	

CONFIDENTIAL

APPENDIX D

INDEPENDENT REVIEWER'S RECORD OF CASES OF CONCERN

DIOCESE/PARISH: ……

INDEPENDENT REVIEWER: …….

Name of subject:	Known Cases List No:
Role of subject:	Gender:
Clergy/Lay/Religious:	
Name of alleged victim/s:	Gender:
Source of information:	

Concerns about child abuse:	**Concerns about adult abuse:**	
Physical	Physical	Neglect or acts of omission
Sexual	Sexual	Discriminatory
Emotional	Psychological/emotional abuse	Institutional
Neglect	Financial	Modern slavery
	Domestic violence	Self-neglect
Date when alleged abuse occurred (if known)		
Age of victim (s) when alleged abuse occurred		

1.Summary of allegations/concerns & relevant information, including statutory agencies involved/notified:
2. Wider safeguarding or conduct issues:
3. Current circumstances of person (s) harmed or affected:
4. Current circumstances of the person (s) of concern:
5. Actions taken by the Diocese & other agencies:
6. Any concerns from the Independent Reviewer about actions taken so far:
7. Any recommendations for further action:
8. Discussed with Diocesan Safeguarding Adviser (date):
9. Referred to Diocesan Safeguarding Advisory Panel (date):
10. Outcome of referral to Diocesan Safeguarding Advisory Panel (date):

Signed: Independent Reviewer Date:

Appendix 7: Survivor survey

Past Case Review 2 – Survivor Feedback Questionnaire

The Church of England is undertaking an important past case review of every safeguarding case since 2007. This involves reading the personal records file of every member of clergy and people who work in the church whether as an organist, volunteer youth worker or employee. A huge part of this project is to work with survivors to understand how the church can better respond and support them throughout the process and beyond.

The Diocese of London would really like your help in providing feedback about your experience of the safeguarding process and your journey from when you decided to make your disclosure right through to the outcome. To this end we have worked on producing this survey with two survivor services; Napac and Victim Support to help us create this survey.

Please be assured that all information that you provide will remain strictly confidential and will not be used in any way other than to help us improve our services. We are not asking you to provide your name. If after completing the questionnaire you feel that you would like some support, we do provide a listening service, group, and individual counselling all of which are provided by external survivor charities who are expertly placed to help you. Contact details for the Diocesan Safeguarding Team are at the end of the questionnaire so that they can discuss your needs with you.

What helped you decide to participate in PCR2? *(open text field)*

Thinking back to when you made your disclosure

What made you decide to take the first step to reporting the incident? *(open text field)*

How did you begin the process? *(open text field)*

What did you know about the process at the very beginning? (open text field)

Did you have a support network? (Family, friends, pastoral support) *(open text field)*

How easy it was to contact someone who could assist you?

Very easy Fairly easy Neither nor not very easy not at all easy Don't Know

If you have answered not very or not at all easy, could you tell us what made it difficult? *(Open text field)*

When you had made contact and were working with people who could help you;

What was your experience of the diocesan safeguarding team? (did you feel listened to, did you feel supported when making your disclosure and later when you had to contact them? For example) *(open text field)*

Were you informed by the diocese about the range of support services available to you? *(open text field)*

Did you have a support plan? *Yes/No/Don't know*

Did you access support services? *Yes/No/can't remember*

How easy was it to access services? (scale not very – very etc)

Very easy Fairly easy Neither nor not very easy not at all easy Don't Know

Were they provided by the diocese or did you source them yourself? Diocese/self/both/can't remember

What services did you receive? *(open text field)*

If you did not access services, why was this? *(for example: perhaps you felt that it wasn't right for you at the time or would have like to have had a support service but were unable to find childcare or it was too far to travel). (open text field)*

What support do/would you most value? *(open text field)*

Did/Do you have other informal support clergy pastoral /community support? Yes/No/Can't Remember

If yes, what informal support did you have? (open Text field)

How supportive was this for you? (open Text field)

Are you still receiving a service? Has the service ceased and was it your choice?
(open Text field)

Would you like to be engaged in services in the future? Yes/No/Don't know

Thinking about how your case progressed, and the outcome;

Were you made aware of the outcome of your case? Yes/No/Don't Remember

How do you feel about the outcome? (open text field)

When you began the process, did you know what you hoped for as an outcome? (open text field)

Has what you hoped for changed? (open text field)

What was the most helpful thing about the service/s you received? (open text field)

Did you have the opportunity to make a compliment or complaint? (open text field)

As we draw to the end of our reflection;

Has the process been as you expected? (open text field)

What was the most important part of the process for you? (open text field)

Has anything changed for you during the process? (open text field)

How are you feeling about the process now? (open text field)

We would like to thank you for taking the time to share your experiences with us. There is a range of support available to you should you feel that you need it. You can also speak with the Independent Reviewer who is an impartial professional who is meeting with survivors who wish to talk about their experience of disclosure and the case management process.

There will be a report published on the PCR2 nationally during 2021 which will use all the valuable feedback provided. The Diocese of London will also use the information to reach out to survivors and ensure that their journey in the future is well supported and that survivors feel safe.

Appendix 8: RAG rating matrix used for risk assessing concerns identified in February 2021

	Red	Amber high	Amber low	Green
Risk Level	Child/Adult appears to be at risk of immediate and/or serious harm.	Child/Adult at risk of harm, but not imminent and possibly less serious.	Child/Adult at risk of harm, but not imminent and possibly less serious.	Concerns about the wellbeing of child/adult which if not addressed, may lead to poor outcomes.
Links to London Continuum of Need Level	Level 4 Complex or acute	Level 3 High or complex	Level 3 High or complex	Level 2 Low to vulnerable
Examples relating to information captured through PCR2 file reviews	Information obtained indicates protective measures and risk management have not been recognised at-all, and an immediate intervention or safety plan is needed. Known information exists which strongly indicates immediate or serious harm may occur if there is no intervention. E.g. the situation is acute and needs a robust response in order to protect the immediate safety and welfare of the child/children/adult/adults.	Case may be complex but needs a planned approach in order to gain the best outcome in terms of any investigation by the DST, Social Services and/or Police. No known immediate threat to life/harm/safety E.g. Incumbent is still alive, still practicing but within another area and should be referred to another diocese. E.g. Information found is current/recent and explicitly refers to safeguarding/risk being a feature, the incumbent is still practicing and has access to children/vulnerable adults	Case is likely to need a systematic approach in order to examine and understand what safeguarding or risk issues might exist. This may involve input from other agencies i.e. Social Services/Police. No known immediate threat to life/harm/safety E.g. There is a lack of outcome on file to previously identified safeguarding or risk issues, or previously identified issues appear not to have been investigated. E.g. Information found on live files does not make explicit reference to safeguarding/risk but requires further investigation in order to confidently eliminate any safeguarding/risk.	Case details indicate less complexity, and may relate to deceased clergy and possible survivors, or the need to seek outcomes. No known threat to life/harm/safety E.g. The incumbent is deceased but information suggest possible survivors with outstanding needs. E.g. Historical information i.e. from archived files, explicitly refers to safeguarding/risk factors but there is no evidence of investigation or outcome on file.
DOL DST response time	Action needed within 24 – 48 hours with multi-agency working	48 hours to 5 working days and may involve multi-agency working	Longer than 5 working days but less than 4 weeks	As soon as possible, but within six months