thirtyone:eight

Creating safer places. Together.

Independent Review of Case TT commissioned by the Interim Commissioner for Independent Case Reviews

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Version	Final Version
Date:	15/07/2026

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Our Thanks

We express our deep gratitude to all those who have assisted in this review both by supplying documentary evidence and speaking with the Independent Reviewer. It would not have been possible to complete this review without your help.

Most importantly, we offer our sincerest thanks to TT and those who have supported her during the process of this review. We wish to honour the courage, determination and perseverance of TT and her willingness to revisit some dark places. She has done this in the hope that the findings and recommendations of this review will help to inform the ongoing discourse about making the Church of England a safer place for everyone and developing an appropriate trauma-informed approach to those who have been harmed by abuse within the church.

Section A: Introduction

This report is the final version of the independent review of case TT. It is a result of extensive Maxwellisation and replaces all earlier versions. We recognise that during this process there may have been progress made against some of the recommendations.

A.1. Independence of the Review

This Review has been conducted by individuals who are independent from the Church of England and the Archbishops' Council. The Reviewer and Thirtyone:eight have maintained independence from the Church of England. The Reviewer and those involved in supporting this Review have no previous connection to the issues which are the subject of this Review or with the Archbishops' Council.

A.2. The Terms of Reference and the Focus of the Review

A.2.1. The Terms of Reference

Thirtyone:eight were commissioned by the ICIR to provide an independent safeguarding case review that examines the case of TT, which involved allegations that they experienced abuse at the hands of two clergy youth officers/advisers, which included rape, sexual, and spiritual abuse. TT states that she first reported these to the relevant diocese in 2001, but no appropriate action was taken and the treatment she received caused further harm. In 2019, TT reported the allegations again, this time to the National Safeguarding Team who carried out their own investigation.

The main focus of this review is TT's concerns that investigations undertaken by the Church of England National Safeguarding Team into the Church's handling of the original allegations of rape, sexual and spiritual abuse were not sufficiently thorough. TT also maintained that the procedures followed by the NST were not sufficiently trauma-informed and caused her further harm.

A.2.2. The focus for the review

In completing this work, the role of the Reviewer was to review all associated documentation, interview those who were involved in the management of the case and the associated decisions, together with those impacted, who consented to meet with the Reviewer. They have taken account of the Survivor's view and experience, the manner in which the investigation process was carried out by the NST and the appropriateness of that process. With all these factors in mind, the Reviewer has sought to highlight any learning from the case and how it was managed, with findings, conclusions and recommendations being outlined in a final report.

A.2.3. The Survivor View

The views of TT have led to this Case Review.

2.3.1. In her statement for the ICIR, TT has stated she does not believe her experiences were adequately listened to by the Church at the time of their complaints/disclosures. TT was left feeling that there has been an absence of appropriate and consistent support for her as a victim/survivor during the investigation process.
2.3.2. TT is also of the view that the outcomes of the Church of England safeguarding processes are unreasonable and not consistent with best practice, resulting in no one being held to account for the perceived failures in the response to the case.

2.3.3. TT considers that the handling of the case has been unnecessarily traumatic, with poor communication; a lack of information or rationale offered for decisions and actions made; adversarial and legalistic responses; and a lack of trauma-informed practice.

2.3.4. TT also considers that it was difficult to raise concerns about safeguarding processes, being advised that complaints could only be raised against individual members of staff, rather than the levels of service provided by the National Safeguarding Team as a whole, meaning that they were powerless in seeking a response or remedy to their concerns through existing Church of England procedures.

A.2.4. Scope of the Review

The Reviewer was asked to produce a case review report covering the following **Key Lines of Inquiry:**

i. Whether the processes used by the National Safeguarding Team were just to all involved, timely, and done in line with best practice in the wider safeguarding environment.
ii. Whether the investigation in this case was thorough and properly conducted, including whether the National Safeguarding Team responded appropriately in the case of a deceased alleged perpetrator.
iii. Whether sufficient accountability has been demonstrated and consistent survivor support maintained.
iv. Highlight examples of good safeguarding practice and the factors that contributed to this.
v. Recommend improvements in policy, procedures, and practice where the Reviewer considers the evidence in this case shows that these are necessary.
vi. Make any recommendations that arise from this case to enable the Church of England to embed a proactive, preventative, safe culture.

A.3. Background to the Review

A.3.1. A recording made by TT and a transcript of that recording were shared with the Reviewer. In this statement, TT disclosed that she was a victim of interfamilial child sexual abuse (CSA) and teenage sexual exploitation. Following a review of the recording and transcript, the Reviewer met with TT who forwarded statements, emails and records of conversations, all of which supported the disclosures she was making. She reported that she became involved in the Church during her teenage years against this background and she regarded the Church as her 'safe place'. She became involved in the national youth work of the Church at the age of 18, as a result of involvement in youth activities in her home diocese. In this capacity TT met Rev A and Rev B, two ordained male youth officers/advisers. TT alleges that from

1979 and during the next 13 years she experienced abuse at the hands of both these clergy, which she stated included rape, sexual, and spiritual and psychological abuse.

A.3.2. TT states that with greater maturity and experience she came to understand the power dynamic that had been at work and enabled the abuse to take place. She first reported the allegations about Rev A to the relevant diocese, Southwark, in 2001, but reports that no appropriate action was taken. TT states that the treatment she received from senior clergy in Southwark at that time caused further trauma resulting in severe symptoms of post-traumatic stress disorder. Due to the impact on her physical and psychological health, TT ceased pursuing a just and compassionate response at that time. She left the church for a period and experienced a deep struggle with her Christian faith. The alleged abuse by Rev B did not take place in Southwark and had not been reported at that time.

A.3.3. Whilst listening to the Independent Inquiry into Child Sexual Abuse in the Church of England, TT felt encouraged to disclose her abuse again and she contacted the National Safeguarding Team (NST) in October 2019. TT has said that the reason for reporting to the NST was that by this time three dioceses would need to be involved due to clergy movement, and also her complaint involved two bishops whose responses had been re-traumatising to her. This resulted in an investigation by the NST which in TT's view resulted in further harm to herself.

A.3.4. TT referred this case to the Independent Safeguarding Board on the basis that she did not believe that the investigation undertaken by the NST, was sufficiently thorough and did not believe that her experiences had been sufficiently listened to and recorded appropriately. In addition, she did not feel the NST process followed best trauma-informed practice. A Reviewer was identified, and they met with TT in June 2023 and started the review at that meeting. A week later the ISB was disbanded by the Archbishops' Council (AC) without prior notice to any of the eleven victims and survivors of Church of England abuse and misconduct, who were pursuing complaints and reviews.

A.3.5. As stated above, Terms of Reference were agreed in October 2024 with a view to completing the report by the end of January 2025. This became subject to extension due to a number of challenges related mainly to the legal issues involved in sharing data.

Section B: Key Findings

B.1. Context of the Independent Review

B.1.1. TT came to the Church of England in her late teens. She had been a victim of both inter-familial childhood sexual abuse and teenage sexual exploitation, and she carried the shame and trauma of those experiences into early adult life. TT was looking for a safe place and initially the Church was that safe place. In 1978 TT became involved with national youth work across the church, thinking this too would be safe and a place where she could contribute and feel valued. It was in this context that she disclosed that she experienced further sexual abuse that continued, in one case into the 1990s. TT has provided a highly credible account of this alleged abuse by two ordained youth officers/advisors and the impact that this, together with the response of the church, has had on her, physically, mentally and spiritually, over

decades. These were men that, as a young adult, she had looked up to as spiritual leaders. Both alleged perpetrators denied the allegations whenever questioned and this is dealt with within this report.

B.1.2. Like many victims/survivors, TT kept her story hidden until years later. It was only in the late 1990's that TT first began to understand that her childhood and teenage experiences were abuse. During counselling she began to understand that her early adult experiences with these clergy were also abuse due to the power and control dynamic, and that the acts themselves had been coerced.

B.1.3. With the support of a professional colleague and mentor she reported the alleged abuse to the appropriate diocese, the Diocese of Southwark, in 2001, because that was where one alleged perpetrator had been in ministry.

B.2. Response from the Diocese of Southwark 2001

B.2.1. Whilst there were no adult safeguarding policies in place at that time, TT was looking for a compassionate and pastoral response and an appropriate investigation into clergy behaviour in which the perpetrator would be held to account. Instead, the treatment she received by senior clergy in the diocese was deeply shocking and fell far short of the standards expected of senior clergy. Some actions that she reports were highly inappropriate and had the potential to compromise any police investigation. This caused further distress and harm to TT.

B.2.2. There was consideration that, should the allegations be true, the perpetrator could be offered early retirement and documents read during this case review have indicated that this protectionism was part of the culture in Southwark at that time. There was considerable support for the alleged perpetrator, but a lack of any compassion towards TT. This was evidenced in letters that were exchanged between senior clergy.

B.3. The impact of Southwark's response on TT

TT stated this caused further harm to her physical and mental health and spiritual well-being and led to her leaving her job and the Church. For a time, she experienced repeated cycles of self-harm and attempted to take her own life. Although she has now received apologies from two of the current diocesan bishops, she has received no formal apology from the clergy concerned in 2001 or from an appropriate representative of the Church of England.

B.4. Referral to the NST 2019

B.4.1. In 2019, hearing the IICSA inquiry gave TT hope that cultures within the Church of England were at last changing. She attempted to report once more and went to the National Safeguarding Team as the two clergy and the original diocesan Bishop of Southwark were now in different dioceses. TT met with first one, and then a second caseworker at the NST. She felt that both meetings were very positive and entered the NST investigation very hopeful that this would be very different from the experience with Southwark in 2001-2002.

B.4.2. This was a complex case that involved three different dioceses due to the movement of the clergy involved. NST caseworkers worked hard over many months and were saddened both by TT's history and that there was not a more positive outcome for her. There were pockets of good and very good practice

both within the NST and the different dioceses. However, it is the opinion of the Reviewer that the investigation process was not sufficiently underpinned by consistent survivor-centred and trauma-informed practice, and this impacted on TT's physical and mental health and upon her family. This is explored fully in the body of the report.

B.5. Inadequate Handover Processes

Progress with the NST investigation was hindered by certain factors that could not have been foreseen at the outset, namely changes in staff and their roles and the impact of the restrictions in force from 26th March 2020 because of Covid 19. However, these additional challenges do not wholly account for the fact that, despite the best efforts of some individuals within the NST and the dioceses concerned, TT found the whole investigation process had been re-traumatising. The issues of staff turnover and role changes within the three dioceses as well as NST was a theme that was present throughout the investigation. Inadequate handover processes or at times the absence of handover processes added significantly to the stress and uncertainty experienced by TT.

B.6. Lack of clarity for the survivor about the NST Investigation Process

B.6.1. As the investigation progressed It became increasingly evident that there was an irreconcilable tension between the hopes and expectations of TT as an abuse survivor and the limitations of the NST investigation process. TT expected that the investigation would be carried out in a trauma-informed way and hoped for a recognition of the trauma she had experienced and an apology from the church. The NST process was narrowly focused on assessing current and future risk. The NST *affirmed 'this would have been explained to TT'* at the first meeting. TT refutes this assertion and says she did not fully comprehend this, and she did not receive a written record of the meeting, or of the advice given. There are no records of this meeting or of how much was explained to TT about the process itself to inform her decisions, highlighting the need for better record-keeping systems. She states she was advised that she might be disappointed, and she took that to mean she would not get a conviction, which she neither wanted nor expected. She understood that a key focus was risk but states it was not made clear this was the sole focus and that there would be no attempt to offer acknowledgement, apology, accountability or justice.

B.6.2. The NST acknowledged there was no written information for survivors to take away. That these limitations were only explained verbally but not set out in writing for the survivor raises a concern about the systems in place and the way information was shared with survivors. This was an action point from the Lessons Learned Review at the end of the NST Investigation. However, at the time of speaking with the NST as part of this case review, they stated that they were still awaiting the new Managing Allegations Policy before implementing this. The Reviewer notes that meanwhile work has been done in some dioceses to prepare appropriate written materials for abuse survivors. The draft Managing Allegations policy was completed and approved by the National Safeguarding Steering Group by the end of 2024 and approved by National Synod in February 2025.

B.7. Unnecessary delays hindered the investigation progress

It was known, at the start of the investigation that TT would be away from the UK from the end of November 2019 until April 2020. When the Core Group first met, they determined correctly that a police investigation was necessary. However, there was a delay of nearly seven weeks before the first Core

Group meeting whereas the Management of Allegations Guidance 20171 stated that the first Core Group should take place within 48 hours. By the time it took place it was too late for a police interview before TT left the UK. This had a significant impact on the progress of the investigation going forward.

B.8. The narrow focus on identifying and managing current and future risk

One of the limitations of the process was that the primary role of the NST investigation was to assess risk but not to make a finding of fact. Furthermore, there was no provision for a restorative justice process. As a survivor TT hoped for the validation that came from knowing that her full story had been heard and was believed, that there would be accountability for those she said had harmed her and that she would receive an apology from an appropriate representative of the Church of England. It became clear to TT that she would receive none of these, and that none of the caseworkers believed they could confirm they believed her account as this was not part of the process or within their remit. This had an extremely negative impact on her mental health. This highlights the need for a different framework for addressing the needs of survivors like TT, and a pathway to access a restorative justice process if this is appropriate.

B.9. Thoroughness of the Investigation

One of TT's concerns was that she felt the investigation was not sufficiently thorough. The Reviewer agrees that there were a number of strands in the investigation, relating to three different individuals, where this was the case. It was the Bishop of Oxford and the current Bishop of Southwark who both found ways to take matters further, once the NST investigation had reached its conclusion. In consultation with their safeguarding leads, they each demonstrated a willingness to take actions beyond the limitations of the NST investigation process, to consider what one bishop described as 'the right moral response' towards TT and to act on it. This was extremely helpful for the survivor, TT.

B.10. Inconsistent culture and practice across different dioceses

B.10.1. This review has highlighted that the development of strong safeguarding cultures where practice is survivor-centred and trauma-informed is not consistent across different dioceses. This is in part hindered by high staff turnover, and the recruitment and retention of high-quality Diocesan Safeguarding Advisers and Officers. The report demonstrates that both across and within dioceses, different DSAs took different approaches. This is an issue that needs to be addressed by the national Church.

B.11. The Role of Diocesan Bishops

B.11.1. Both the Makin Review and the report by Professor Alexis Jay CBE on the Future of Church Safeguarding in the Church of England recommend the establishment of a separate, wholly independent body who would be responsible for providing scrutiny and oversight of safeguarding, free from the influence of any senior church officers. This is also a finding of this review.

B.11.2. However, the role of the Diocesan Bishop in setting the safeguarding culture cannot be under-estimated. The best policies and guidance will not take effect while old cultures of protectionism remain. The report cites good practice in two dioceses where bishops worked closely with their safeguarding teams, taking their advice and supporting the development of strong survivor centred safeguarding cultures.

B.12. Clergy who now reside overseas

This review has highlighted the issue of clergy who have relocated overseas. By the time of the third Core Group Meeting on 28.9.20 the NST determined that no further action would be taken regarding a bishop, referred to as Bishop Y later in the report, as he was located outside the Church of England's jurisdiction and it was believed he was elderly and not engaged in active ministry. A report submitted to the Core Group by the caseworker recommended that a note should be placed on his file but that 'it was not proportionate to interview him.' This was deeply unsatisfactory for TT who felt that more could have been done. She would also have welcomed an attempt to explore whether some form of restorative justice was possible. This issue of church officers who have moved overseas was also addressed in the Makin Review which recommended that international reciprocal safeguarding procedures should be *established 'with other Anglican communion institutions and leaders where allegations are made against a person in a position of trust who relocates overseas'*. The lack of these reciprocal arrangements in that case had disastrous consequences for many more victims.

Section C: Methodology

The full details of the methodology used for this case review can be found in Appendix G.6. Some key considerations are highlighted here.

C.1. Trauma informed practice

As stated, one of TT's primary concerns was that in all her dealings with the Church of England she reported that she experienced the lack of a trauma-informed, survivor-centred approach. Whilst it was vital for the Reviewer to hold an independent position throughout the review, it was also essential to try and conduct the review in a way that was consistent with trauma-informed and survivor-centred practice. The Reviewer sought to embody the principles of trauma-informed practice. This included:

i. Understanding the impact upon TT's mental and physical well-being from both the trauma of abuse and the re-traumatisation that came from TT feeling she was not being heard.
ii. Developing a working relationship that would be as safe and trustworthy as possible for TT through early, unhurried, face-to-face as well as online meetings.
iii. Continuing to ensure that both online and in-person environments feel as safe as possible.
iv. Recognising that the review

process may be re-traumatising at different stages and to some extent the pace may need to be determined by the survivor.

v. Being sensitive to TT's needs and recognising when a conversation needs to be brought to a close.

vi. Listening carefully to TT's whole story and carefully reading all the documentation she provided to avoid asking her to go over the same ground repeatedly.
vii. Recognising the impact and consequences of power-imbalances.
viii. Regular online meetings with TT and her advocate from FearFree to check on her well-being and to provide updates on progress with the review.
ix. Providing notes that summarise the content of online meetings.
x. Ensuring there were good support systems in place to support TT.
xi. Ensuring personal trauma training was up to date.

C.2. History and Accuracy

The alleged abuse reported by TT dates to the period between 1979 and 1990. Significant time, 21 years, had passed between when the abuse first occurred and when TT first reported it in 2001. It was a further 18 years when she reported again in 2019 and asked for her case to be re-examined by the National Safeguarding Team. TT recognises herself that there may be some slight discrepancy in actual dates and details. Such discrepancies would be expected as a result of the passage of time. Those who work with abuse survivors, particularly when survivors are reporting abuse that happened a long time ago, recognise that some re-ordering of events in recounting the narrative does not in any way make the survivor's account any less credible.

C.3. Review of relevant literature

One of the challenges for the review was that the alleged abuse took place between 1979 and 1990 and was first reported in 2001. During this period, without any established policies and procedures in place for safeguarding adults in the Church of England, there were very different understandings of what constituted abuse, power dynamics and consent. It was therefore helpful to review some of the literature of that period. Further details are found in Appendix G.5.

C.4. Review of Documentary Evidence

This was a complex review that required scrutinising and cross-referencing documentation from a range of sources. These included documents submitted by the Survivor, the National Safeguarding Team and three different dioceses.

The Survivor, TT has retained emails, letters and personal reflections dating back to 2001. These records of what happened between 1979 and 1990 have been immensely thorough and present a highly credible account not just of the abuse but also of the physical and psychological consequences of the trauma suffered as a result. TT's accounts of the Church's response to her allegations are equally thorough. There are letters that provide a timeline and clearly document the response TT received when she first reported to the diocese of Southwark in 2001. These reflect the impact of the traumatisation due to what she feels

was the failure of senior clergy to afford her the dignity of listening and hearing her story, responding appropriately, or offering any appropriate pastoral care.

For the purpose of this review the dioceses of Southwark and Leeds have also shared many of these same letters and related documents, together with Reports, Minutes of Meetings and Correspondence. Full details of the documentation reviewed are found in Appendix G.6.

C.5. Interviews

Interviews were arranged with the following people:

i. TT
ii. Two advocates for TT
iii. Members of the National Safeguarding Casework Team
iv. DSA and senior clergy from the Diocese of Southwark
v. DSO and senior clergy from the Diocese of Oxford
vi. Former DSA from the Diocese of Leeds
vii. Former colleague and employer of TT

All individuals who agreed to meet with the Reviewer were sent the Privacy Notice and the Thirtyone:eight Information Sheet and Consent Form. Although they had already been sent the Terms of Reference for the review, these were included again in the Information Sheet. Where meetings took place online, they were recorded and a transcript was sent to the person interviewed for fact checking.

C.5.1. Interviews and meetings with TT

At the beginning of the case review in October 2024, TT supplied audio recordings and a transcript of her story. This began in early childhood and continued up until the end of the NST investigation and the referral of her case to the ISB. The Reviewer then spent a day with TT to hear her further reflections and to answer any questions about the process. Towards the end of the information gathering phase the Reviewer and TT spent a further day together.

In between these face-to-face meetings they met online as often as TT felt was helpful. This was to ensure TT was kept informed about progress with the review and, where there were delays, the reasons for this. In addition, TT was invited to monthly review meetings with the ICIR. Where appropriate the Reviewer sent notes from meetings to TT. TT's advocate was invited to all of the meetings.

At the report writing stage the Reviewer sent TT drafts of those sections of the report that contained her own contributions so that she could fact check these and offer any further comments or amendments. The Reviewer recognised that whilst this was important it could be difficult and trigger past trauma. It was important to ensure that TT's advocate was available to give support during this process.

C.5.2. Interviews and meetings NST

Securing meetings with NST personnel was a challenge for the Reviewer. Emails were not always answered promptly, and some individuals had to be contacted two or three times before a response was

received. Although some of those interviewed forwarded follow-up information as they had promised, the Reviewer at times did not receive a response to subsequent requests for further information or clarification. This was the case throughout the course of the review and may reflect the challenges of workload and staff changes.

C.6. Collation of Findings and Recommendations

C.6.1. Collation of information

Due to the complexity of this case, there has been a high level of documentation from four different bodies. The majority of these documents have been sent electronically. This has required considerable checking and cross-referencing to formulate clear and balanced findings and offer recommendations for future practice. In some cases, this part of the review has been made more difficult by poor filing systems and inaccurate or misleading labelling of some documents.

C.6.2. Presentation of information

For the purpose of this report, key individuals have been identified according to their roles as follows:

The two respondents to the allegations of sexual and spiritual abuse and rape:

Rev A: Formerly based in the Diocese of Southwark at the time of the allegations

Rev B: Formerly based in Bradford Diocese at the time of the allegations. (Bradford became part of the new Diocese of Leeds in 2014)

Bishop X: Former Diocesan Bishop in Diocese of Southwark

Bishop Y: Former Area Bishop in the Diocese of Southwark

AD: Former Archdeacon in the Diocese of Southwark

C.6.2.2. In presenting the findings, the Reviewer first examines the investigation process in relation to:

i. The survivor's original reporting of abuse in 2001-2002
ii. The survivors' experience of the NST Investigation in 2019 -2022
iii. Allegations relating to Rev A
iv. Allegations relating to Rev B
v. Allegations relating to Bishop X
vi. Allegations relating to Bishop Y
vii. Concerns relating to AD (Archdeacon)

C.6.2.3. The Reviewer responds to the questions contained in the Terms of Reference.

C.6.2.4. The Report concludes with the Reviewer's recommendations.

C.6.3. Requests for anonymity

The survivor TT requested that she remain anonymous during the case review process but reserved the right to make herself known publicly if she chooses to, once the review has been completed.

Amongst those who have contributed to this case review, some were happy for their names to be made known whilst others requested anonymity. As a result, none of the names of participants have been disclosed in this report. The Reviewer has spoken to a number of individuals who have various roles

within the National Safeguarding Team but due to some requests for anonymity, the report refers simply to the NST, members of the NST, NST caseworkers or a member of the NST where this is appropriate. In the same way, diocesan staff have not been referred to by name. Where appropriate senior clergy and church officers have been referred to by their role.

C.6.4. Terminology: Diocesan Safeguarding Adviser and Diocesan Safeguarding Officer.

Up to and including the time of the NST investigation the lead officer for Safeguarding in every diocese was referred to as the Diocesan Safeguarding Adviser (DSA). This was the term used in much of the documentation related to the NST Investigation including Core Group Minutes.

Following one of the recommendations of IICSA Report published in 2020, the General Synod in July 2023 voted to amend Church Law to rename the Lead Diocesan Safeguarding Advisers as Diocesan Safeguarding Officers (DSOs). These would be operationally independent of their diocesan bishops and would have responsibility for professional leadership on safeguarding matters. The change also makes provision for professional supervision and quality assurance by the NST. The changes have come into effect diocese by diocese upon certification by the Archbishops' Council. During the course of this case review the Reviewer has found that both terms have been in use, and this is reflected in some parts of the report.

The term DSO is used when referring to a Lead Safeguarding Officer in post during this case review and in the conclusions and recommendations of this report.

C.6.4. Recommendations

It has always been the intention of TT that this review should feed into the current discourse around safeguarding in the Church of England and particularly the response to the needs of survivors of church abuse. To this end the report has sought to highlight good practice and consider how this could inform best practice going forwards. Where practice has fallen short this has been identified and suggestions offered for improvement.

Section D: Disclosure to Diocese of Southwark 2001-2002

In order to review TT's case and the concerns raised about the National Safeguarding Team investigation that commenced in 2019, it is first important to understand the experience of TT when she first reported in Southwark diocese in 2001 and the impact that experience had on her.

D.1. Introduction

D.1.1. Previous abuse.

TT had been a victim of intra-familial child sexual abuse which continued into her teenage years. She was adopted as a baby and recalls growing up in an abusive environment in which her adoptive father was very controlling. She experienced sexual abuse from early childhood which continued until puberty. The

home was difficult for everyone, and TT quickly learned that '*it was better to be compliant'* and to please her adoptive father. She has reflected that one consequence of this was that as a vulnerable young adult, *her instinct was to be compliant in situations of unwanted sexual contact and assault.*

During her teenage years, TT was subjected to sado-masochistic acts by the brother of her then boyfriend and this brother then used her for the purposes of teenage sexual exploitation, in which she endured sexual assaults from multiple men. During both the child sexual abuse and the teenage sexual exploitation, TT learned to dissociate in order to survive the abuse. The impact was a deep sense of contamination and shame.

D.1.2. Early adult abuse

In the course of her involvement with the Church, TT became involved in national youth work. She says that she came to this carrying the weight and shame of her early child and adolescent experiences and that she needed a safe space in which she could contribute and feel valued. It was at this time that she met Rev A and Rev B, both of whom had significant roles in developing youth ministry within the Church of England. TT's disclosure of abuse centres on her complaint that both these men, whom she saw at the time as spiritual and pastoral leaders and examples, initiated unwanted sexual relations with her in 1978/9. Given the passage of time, it is unsurprising that the exact dates that this started is unclear in her mind. TT states that the alleged abuse initiated by Rev B ended when TT moved in 1980; the alleged abuse by Rev A continued until 1990 when TT moved away from him and took up a new job. Both individuals denied the allegations.

It was in this new role that she began to understand that her childhood and adolescent experiences had been abuse which she had felt powerless to prevent.

D.1.3. Framing past experiences as abuse

In 1997 TT was herself employed as a diocesan youth officer and began to write and deliver safeguarding training. This triggered PTSD from her childhood abuse and teenage sexual exploitation for which she sought counselling. During that counselling she came to believe that the 'relationships' with Rev A and Rev B had also been abusive. She had previously viewed what had taken place as being her fault, but now began to consider that in both cases there had been an abuse of power due to the power imbalance and her perception of their roles as spiritual leaders, men that she looked to for support and guidance. In both cases she realised that sex acts had been coerced, that though she had been compliant, she believed that this did not amount to consent, and therefore she now considered that both relationships included incidents of rape. In both cases TT states that she did not feel able to free herself from the power and control dynamic. Subsequently in around 1999, TT first disclosed the alleged abuse to a professional colleague who was her line manager.

D.1.4. 2001 Disclosing abuse in the diocese of Southwark

Evidence for this section of the report was taken from TT's own Chronological records and Statement transcripts together with copies of correspondence between TT and Senior Clergy in the diocese in 2001-2002.

In 2001 TT found the courage to report the alleged abuse by Rev A to the Diocesan Bishop, referred to in this report as Bishop X, in the diocese of Southwark, the diocese where much of the alleged abuse had taken place (she did not disclose the alleged abuse by Rev B at this time). TT understood that the police might be unable to progress the case due to the time lapse and lack of material evidence, but hoped that she might receive a compassionate response, support, an apology, and that the perpetrator would be held to account. TT had not been prepared for what followed and explained that experiencing such a lack of compassion or support from senior clergy constituted a further layer of abuse. It was as a result of this response from senior clergy that she describes losing her faith in God and the church. For a significant period, she experienced repeated cycles of self-harm, and on occasions attempted to take her own life. It was only during the IICSA inquiry in 2019 that she attempted to report again, this time to the National Safeguarding Team (NST).

D.1.5. Response from senior clergy in the diocese of Southwark

The Diocesan Bishop referred TT's complaints to the appropriate area Bishop, identified in this report as Bishop Y, and has stated this was normal practice at that time. The Reviewer has seen letters and emails that passed between Bishop X, Bishop Y, an archdeacon referred to as AD and correspondence with TT. Some of these were supplied by TT; these and other items of correspondence referenced are contained in the Southwark diocese case file. There was also significant correspondence between Bishop Y and the respondent, Rev A. The sequence of events and the content of these and other communications are summarised below.

D.2. Chronology and Timeline

The information contained in this chronology has been obtained from TT's own records and letters and those held by the NST and by the Diocese of Southwark.

Date	Correspondence between	Content
19.10.01	TT to Bishop X	TT reported the alleged abuse by Rev A to Bishop X. Bishop X replied that he would refer this to the area bishop and asked TT for permission to send her letter to Rev A with her accompanying statement in order to seek his reaction. TT subsequently gave consent for her statement to be shared with Rev A but on the condition that he was got given her address. TT did not consent for her letters to be given to Rev A.
22.10.01	Rev A's solicitors to TT	TT received a letter from Rev A's solicitors stating: *'Our client would like to place on record that what you say is quite untrue and that he has not been involved in any misconduct and that your allegations are an invention. We would strongly advise you to consider your legal position and that slander in this case is actionable per se as allegations are likely to damage our client in relationship to the office or profession carried by him.'*

23.10.01	TT to Bishop X	TT wrote to Bishop X and sought to clarify if Bishop X saw this as a pastoral or disciplinary matter and asking that her address was not disclosed to Rev A.
12.11.01	Bishop Y to TT	Bishop Y informed TT of Bishop Y's intention to see Rev A. The letters provide evidence that this meeting took place, but the Reviewer has not seen any records of the meeting. Quotations from the letters are evidence of the casual approach to TT's allegations.
8.12.01.	TT to Bishop Y following a conversation with him.	TT thanked Bishop Y for his time but declined Bishop Y's suggestion that she meet with Rev A. She said that if he acknowledged the sin and harm caused, she would prefer to receive a letter but did not want a face-to-face meeting. TT felt she had perhaps minimised what happened and re-iterated her statement that she had been *'groomed'* by Rev A. TT stated: '*Rev A raped me on the first occasion at a diocesan youth officers conference. At no time was this an adult consensual relationship. Rev A abused his power and his position of trust.'* She reflected that Rev A had 'groomed' her and that at no time did they have an adult consensual relationship and that he abused her spiritually as well as sexually. She highlighted that if he had been a teacher he would have been dismissed. TT highlighted the spiritual aspect of the abuse: *'He abused me spiritually as well as sexually. He explicitly told me that God wanted and blessed our relationship and other blasphemous statements which left me very confused and uncertain about the truth and ambivalent towards a God that wanted this. It was not my understanding of God previously, but this man was a priest so he must be right. For many years this was a barrier between me and God.'* TT also highlighted the long-term effects on her faith, work, health, family, friends and finances including nightmares and lack of trust in men or in God as father.
18.12.01.	Rev A wrote to Bishop Y following a meeting they had together the previous week.	He stated TT's allegations were exaggerated and bizarre and wrote: *'I feel this woman is trying to take over our lives and I want to stop her. I never did any of the things she claimed I did. I was stupid and wrong but nothing I did deserved this sort of vindictive abuse.'*
22.12.01	Rev A wrote to TT using a c/o address.	The letter contained repeated accusations that the allegations were lies, and TT was playing the victim. *'You seem to imply that you were an innocent little girl until you met me, Untrue!...You were sexually experienced from an early age…..I have no intention of apologising to you for something I have not done….I continue to take legal advice about your allegations.'*

02.01.02	Bishop Y to TT	Bishop Y reinforced his recommendation for a face-to-face meeting between TT and Rev A, her alleged abuser, saying, *'I put great store by Christians discussing and resolving their differences….I am disappointed that advice from various people has shifted you from your initial favourable response to my suggestion.'*
01.02.02	TT replied to Bishop Y	TT made Bishop Y aware of Rev A's letter and that she had taken legal advice. TT reiterated that she did not consider a face-to-face meeting with Rev A was the appropriate way to proceed and asked if this was being treated as a disciplinary matter and what procedure would be followed.
26.2.02	TT to Bishop Y	TT expressed her disappointment Bishop Y had not replied to the 01.02.02 letter. She had signposted Bishop Y to Australian abuse survivors' site and also to the work of Dr Thomas Plante relating to clergy sexual misconduct and to Margaret Kennedy and Christian Survivors of Sexual Abuse.
5.3.02	Bishop Y to TT	Bishop Y expressed regret TT would not meet Rev A. *'It is your word against his and it would be wrong for me to presume his guilt and act upon such presumption. Please let me know if you change your mind about this.'*
20.3.02	Southwark Diocese File Note: Cover Letter from Bishop Y to Bishop X updating him.	Enclosed with the cover letter were various pieces of correspondence stating that the area Bishop had not shared copies of his three letters to TT with Rev A but he has read them to him. Bishop Y ended letter saying: *'I have been careful not to break any confidences, but I gave Rev A the assurance that he would always know what I have written to TT. He does not have copies of my three letters to her, but I have read them to him. Please let me know if there is any further action I need to take.'*
25.3.02	TT's Line Manager and senior member of staff at X Theological College to Bishop Y.	TT's Line Manager wrote to Bishop Y in support of TT. He highlighted Rev A's priestly role, his responsibility to TT and his married status and the need for an investigation. He suggested that Bishop Y was treating this as a pastoral issue and not complaint.
27.3.02	Southwark Diocese File Note: Draft letter from Bishop Y in response to TT's Line Manager.	File contains a draft letter with handwritten note stating, '*not sent.*'
28.3.02	Extract of email from Archdeacon (AD) to Bishop X.	TT received a redacted copy of this email following her SAR to the Diocese of Southwark. This contained the Archdeacon's views about the case and made negative and accusatory speculation about TT's reasons for making the allegations with very inappropriate use of language about TT. *Dear Bp X* *I was surprised to hear the news about Rev A, yesterday. Several things strike me about this and other cases generally:*

		the woman who has made the complaint needs to "put up or shut up". What she has accused him of is a criminal offence and if she was at all serious, she would go to the police instead of writing to you and Bishiop Y. *e) My instinct tells me we have a gold-digger here who has read press reports of the RC's paying out millions in compensation and might like to get hold of some of that from us.* *f) She would be unlucky in that, if such a thing occurred, she was over 21 at the time, and Rev A was an employee.* *I must say I am unsettled by the fact this woman has been a close family friend to them, but they have known she is unreliable and not a little unstable for years. Sadly, this did not ring alarm bells for them at the time. Untangling what might be reasonable behaviour between close family friends, and someone intent on forcing an unwanted relationship upon another, is going to be very difficult to unscramble. Naturally we want to protect Rev A from hysterical and unreasonable accusations, but we don't want to go out on a limb only to find there was something nasty in the woodshed all along??* *This is not going to be easy. Rev A has two years to retirement and is not in the best of health. It may be that we could arrange for early retirement during this year as a way of snipping this Gordian knot?* This also raises the question of who had made the Archdeacon aware of confidential information regarding TT.
01.05.02	Bishop Y replied to TT's Line Manager nearly 3 months later.	*'Rape is a crime and therefore such an accusation should be brought to the attention of the authorities. If TT is minded to heed your advice, you may want to consider advising her along these lines.'*
29.5.02	Rev A's annual review 2002	No reference was made to TT's allegations in Rev A's annual review 2002, nor in the 2001 review.
7.6.02	TT to Bishop Y	TT expressed disappointment at Bishop Y's response. She did not wish to instigate criminal proceedings; she did want the complaint responded to appropriately and felt the response was inadequate. She aimed for a restorative process that involved recognition, repentance and recompense.
11.6.02	Bishop Y to TT	Bishop Y did not reply to the points TT had raised in her letter. He stated TT had refused his offer to arrange a meeting, *'instead you choose to add to your self-designated status of victim, the role of judge, jury and sentencer, telling me what you expect me to do. Please may I be excused participation in this particular production?'*
14.6.02	TT to Bishop X	Stated that Bishop Y's letter was inappropriate in tone and he was not dealing with the matter impartially. His expectation for her to meet with the alleged perpetrator took no account of the needs and vulnerability of the victim. TT requested an alternative way forward.
3.7.02	Bishop X to TT	Bishop X stated that the allegations were vehemently denied by Rev A. *'The matter you allege is extremely serious. Rape is a criminal offence. As such it should be properly investigated by the police…. It is very difficult for the church to investigate such an allegation when to do so might prejudice any*

		police inquiry. Indeed, the church might well be accused of trying to cover up a possible crime by such an action.'

D.3. Findings and Conclusions

D.3.1. The absence of safeguarding policies for adults

The two senior clergy (Bishop X and the Archdeacon) who were interviewed as part of the NST investigation acknowledged that they would act differently now and would pass anything on to the Diocesan Safeguarding Adviser/Officer. However, they qualified their statements and their responses in 2001/2 by saying 'but there were no policies then'. As stated, during the course of this review, the theme that in 2001-2 there were no policies and procedures has been expressed repeatedly both in some of the NST documentation and in some of the interviews. Furthermore, it has been stated by some members of the NST that the diocesan bishop acted 'appropriately for the time'. The Reviewer does not accept this view.

D.3.1.1. From the 1980s onwards, there had been increasing awareness of the issues of sexual abuse, including the issue of clergy sexual abuse. Although there were no adult safeguarding policies and procedures in place in the Church of England in 2001, it is the opinion of the Reviewer that a diocesan bishop should have been aware of the discussions that were taking place within the Church at that time.

i. *In January 1993 the sexual abuse and exploitation of women and children was an agenda item at the Joint Meeting of the Anglican Consultative Council and the Primates of the Anglican Communion. This was formalised in Resolution 37 passed at the Joint Meeting. This 'urges all Provinces to work to end sexual abuse and exploitation of women and children throughout the Anglican Church, and calls on congregations to provide pastoral care to victims of sexual abuse and exploitation; and further expresses its shame that there is evidence of cases of sexual abuse within the Anglican Church and calls on congregations to provide pastoral care to victims of sexual abuse and further condemns commercial practices of sexual exploitation, such as 'mail order brides' and child prostitution.*[1] *If bishops were not made aware of this as Bishop X has suggested, then this was a systemic failure within the Church of England.*

[1] https://www.anglicancommunion.org/structures/instruments-of-communion/acc/acc-9/resolutions.aspx#s37

ii. *In 2000 Kathryn Flynn's thesis examining trauma in the lives of woman who were sexually abused by clergy acknowledged that sexual abuse of women by clergy was a centuries old problem but one that had been hidden for generations.[2] Further work regarding clergy sexual misconduct was being done by Thomas Plante, Margaret Kennedy and Christian Survivors of Sexual Abuse and TT had signposted Bishop Y to this.*

iii. *Whilst the discourse in wider society might have bypassed sectors of the Church of England, senior clergy should have been aware of the ecumenical work of Churches Together in Britain and Ireland around the concerns about the treatment of abuse survivors in the church. Churches Together produced 'Time for Action', published in December 2002, which urged all churches to respond with compassion and more effectively to adults reporting abuse in the church context.[3] This was only five months after Bishop X's letter to TT advising her to go to the police. One would have hoped that the published concerns about the treatment of survivors would have prompted some reflection on the actions of himself and Bishop Y.*

D.3.1.2. Anyone who holds the office of priest should be expected to respond with compassion to someone in deep distress reporting that they have been abused and harmed and particular care should be taken if it is alleged to have been perpetrated by officers within the church. Letters and emails show that TT received anything, but a compassionate response and the actions taken by Bishop X and Bishop Y were far from appropriate.

i. *Communications seen by the Reviewer, particularly those from Bishop Y and the Archdeacon demonstrate the very opposite of care and compassion for TT. Instead, she was vilified and her character defamed. She was described as 'sexually experienced from an early age', a 'gold digger' and 'unstable'.*
ii. *Letters show that concern was expressed for the well-being of Rev A and his family, but no pastoral support was offered for TT, the victim.*
iii. *The Archdeacon's letter dated 28.03.02 advised Bishop X of the need to 'protect Rev A from hysterical and unreasonable accusations.*
iv. *There is no evidence that Bishop X ever challenged the attitudes and the language used by the other senior clergy.*
v. *Although TT had stated she did not want any direct contact with Rev A, Bishop Y had strongly encouraged TT to meet with him, the person she had reported to be her abuser.*
vi. *Bishop Y shared TT's information with her alleged abuser, something that could be detrimental in any subsequent police investigation into her allegations of rape. This was not only a seriously flawed approach but also showed no empathy or sensitivity to TT and led to further traumatisation through Rev A's communication with her and his solicitor's letter threatening legal action against her.*
vii. *Whilst Rev A's letter to the Bishop Y states that TT's allegations were 'exaggerated and bizarre' he nonetheless wrote 'I was stupid and wrong'. There is no record of what he meant by this or whether this was ever questioned or followed up by Bishop Y or Bishop X.*
viii. *Only the archdeacon appears to have acknowledged the possibility that the allegations might be true. His recommendation was that if that were the case, Rev A could be offered early retirement.*

[2] Flynn Katharine A. Clergy Sexual Abuse of Women: A Specialist Form of Trauma, Copyright 2000 by Bell & Howell Information an
[3] https://www.abebooks.co.uk/9780851692814/Time-Action-Sexual-abuse-Churches-0851692818/plp

This, when combined with other evidence, suggests that protection of a clergy colleague and the institution of the church was the paramount consideration, not the protection of the alleged victim.

ix. *Correspondence from July 2002 shows that both Bishop X and Bishop Y absolved themselves of any responsibility on the grounds that 'Rape is a criminal offence. As such it should be properly investigated by the police…. It is very difficult for the church to investigate such an allegation when to do so might prejudice any police inquiry.' The Reviewer considers this completely disingenuous as they had both compromised any potential investigation by the actions that they had already taken.*

D.3.1.3. In summary, it is the opinion of the Reviewer that the senior clergy did not act appropriately (even for the time) as they potentially compromised any criminal investigation. In a letter to TT dated 19.10.01, Bishop X informed TT that he was passing her disclosure statement to the area bishop who was 'responsible for the day-to-day pastoral care of the area.' In the same letter he asked TT for permission to share her letter with Rev A:

> *'In the meanwhile, I would like to ask you whether I am free to send a copy of your letter and its accompanying statement to Rev A himself, so that I might seek his reaction?'*

This suggestion was entirely inappropriate. Although, in a letter dated 23.10.01, TT agreed to the sharing of her statement containing the allegations, she did not agree to her letter being passed on to Rev A. She received a letter dated 22.10.01 from Rev A's solicitor. This suggests that Bishop X passed on TT's letter without her consent which was a breach of confidentiality. The solicitor's letter threatened legal action against her, and this was a further source of heightened anxiety for TT. Senior clergy failed to support TT, the alleged victim pastorally, which should have been the role of a priest. Consequently, their failures caused significant re-traumatisation for the TT both at the time and in the following years. She reports that this had immense consequences for her physical and mental health and her emotional and spiritual well-being, consequences that also impacted her family.

There are some key themes in the 2001-2 response to TT's story by senior clergy. These include:

a. *Structural male dominance.*
b. *The misuse of position and power.*
c. *Lack of process or lack of adherence to process.*
d. *The vilification of and failure to believe victims.*
e. *A lack of victim focus or pastoral support. Not only was this not victim-focused it was a failure of those with priestly office to offer pastoral care for the vulnerable.*
f. *Protectionism of clergy colleagues and placing the reputation of the church above the needs of victims/survivors.*

The persistence of these themes across a number of different reviews has underscored the need for continued reflection and improvement in the Church of England's safeguarding response to victims of abuse.

D.3.2. Re-traumatisation

Prior to and during the time she reported her allegations of abuse to the Diocese of Southwark, TT had been supported pastorally by her line manager at X Theological College. He had encouraged her to report it in the first place, and he was angered by the response her report of abuse had received. He felt the treatment of her by Bishop Y had left her in a worse position than before she had reported.

It is clear from the chronology that he had written to Bishop Y in 2002 on TT's behalf but had received what he considered to be a deeply unsatisfactory response. He spoke to the Reviewer about the commitment shown by TT to her work, the integrity of her character and the credibility of her account. He said that the response of Southwark Diocese had left TT 'retraumatised'. In his opinion Bishop Y had misused his power in how he had dealt with TT's report of abuse:

> *I describe TT as being retraumatised because she was squashed by the response to her report of abuse. The suggestion by the bishop that a resolution might be found by her meeting face to face with Rev A was coercive because it was asking (TT as) the 'abused' to take responsibility for the 'abuse'. It was classic 'victim blaming'. There was a lack of humanity to the response; a lack of basic human competence and you don't need a Safeguarding Policy for that.*

The response TT received when she had tried to report, left her re-traumatised and deeply broken.

> *'At the time, I lost, I lost my faith in God. I lost my faith in the church. I felt I'd lost all my dignity. I felt completely abandoned by God, faith, church, priests.*
>
> *I still think the lowest time was after I'd spoken to (the diocesan bishop) and (the area bishop). Because I'd, because that took away the last bit of, you know, good thing in my life, apart from (my son). He was the only other good thing in my life at that point. And, so I, when I was preparing, I can't remember, how did that make me feel after? And the words I wrote were dirty, contaminated, powerless, silenced, begging.*
> *I felt destroyed, worthless. I also felt humiliation. I'd disclosed all this, all this really. I mean I just talked about (Rev A) and I hadn't said everything by any means, but I'd said enough to expose myself. So, I felt quite humiliated. And so, I also felt ashamed. And then, and dismissed, by particularly, by (the area bishop). But even (the diocesan bishop), by saying, well just go to the police. That felt dismissive.*
>
> *And I felt really unsafe, I felt really unsafe because the church should have been safe and it was the last bit that had been safe…… And, so, I think the bishops triggered me back into quite a lot of terror. And it was, that was why it was really hard to try and stay functional as a mother all while I was processing all the other stuff. And, I did, I did try and kill myself a couple of times. But I didn't do a very good job of it thankfully. And I think that's why I'm, in some ways, I'm saying that's worse, it's not worse obviously. You can't, well there's not a hierarchy is there, but it feels like at that point it had a bigger impact than actually what the original abuse was having. Because it took away that last bit of safety.'*

The Reviewer's opinion, having spent considerable time with TT and hearing her account of her experiences, is that she is an incredibly strong person to withstand everything that she experienced growing up and as a young adult. However, it was clear that by July 2002 TT had 'given up the fight'. This was not true to her character and reflected that she had indeed been metaphorically 'squashed' as described by her senior colleague. She left the church and her job and returned to secular work. TT described what she experienced as a 'breakdown'. Her doctor signed her off work for three months, having

diagnosed her with stress and depression. She was self-harming and experiencing suicidal ideation and spent the next seven years in counselling at her own expense.

Section E. National Safeguarding Team Investigation 2019-22

E.1. Introduction

For the purpose of this case review the Reviewer had access to a large cache of documents from the NST and these were read alongside and cross-referenced with documents from the dioceses of Southwark, Oxford and Leeds. See Appendix G .1. for details.

Interviews took place with:

i. Five members of NST staff who had had different areas and levels of involvement during the NST investigation.
ii. The DSA at the diocese of Southwark and the Head of Safeguarding at Oxford. Both took up their posts toward the end of the NST investigation.
iii. Senior Clergy at the dioceses of Southwark and Oxford.
iv. A former DSA at the Diocese of Leeds at the time of the NST investigation.
v. TT's former line manager who is referred to in Section D.

As stated, due to the privacy agreement in place and out of respect for the wishes of some NST personnel it was agreed that individuals would not be named in this report.

E.1.1. Challenges of this review

E.1.1.1. As outlined in Appendix G.6 Methodology, neither the ICIR nor the Reviewer anticipated the level of challenge they would face in accessing the information needed to complete this review. Fall-out from the Makin Review, data storage and data migration exercises, overall concerns about GDPR, data-control and privacy agreements, plus staff sickness and staff turnover within diocesan safeguarding teams, have all impeded progress and delayed the completion of the report and caused prolonged stress for the survivor TT. This is an issue that needs to be resolved in the interests of survivors for the future.

E.1.1.2. **Inconsistent labelling and filing of documents**

A further challenge has been navigating the sheer volume of documentation when it was released by the NST. This was exacerbated by the way documents have been labelled and filed and much time was lost sifting through these to locate information.

i. Although there were individual files for some individuals often documents relating to them were filed in another person's folder. This point was raised in the PCR2 report in 2021. *'It should be noted that not all material relating to individuals is held on their own case files, but the NST is in the process of transferring all relevant material onto the individual specific case files.'* It appears this task has never been completed and documents relating to Rev A are filed in Rev B's file and

vice versa. There were three different files relating to complaints made by TT but again documents have been misfiled in the incorrect folder.

ii. In addition, there appears to be no consistent labelling system. For example, Core Group Minutes are saved under a range of different titles with the consequence that they are not stacked together, and much time has been spent hunting for them. Some minutes have been incorrectly dated, and some documents are not dated at all. In some reports it is not clear who was the author. Agendas, minutes and associated documents for each meeting are not stored together, and much time was spent trying to match them up.

The Reviewer does not consider that attention to detail in keeping records and minutes and ensuring they were systematically stored was sufficiently thorough. This point was raised in the NST PCR2 report, but the experience of the Reviewer was that the filing system was still not sufficiently well or accurately organised at the time of this review.

E.1.2. October 2019: TT made the decision to report

In 2019 TT was following the IICSA Inquiry. What she heard led her to think the Church of England was learning from the lessons of the past and perhaps this was the time to report once more. She was also reflecting on whether Rev A and Rev B had abused or could still abuse others.

The 2017 Practice Guidance for Responding to, Assessing and Managing Safeguarding Concerns or Allegations against Church Officers states that '*if the respondent is a senior member of the clergy or an individual with a high national profile, the case will be managed by a National Safeguarding Team core group in conjunction with the diocese. If the case involves complex inter-diocesan issues the NST will act to coordinate local casework.'* Therefore, TT needed to report to the NST due to the PtO arrangements of Rev A and Rev B in different dioceses and the concerns regarding Bishop X who also had PtO in a different diocese. In total there were links to at least three dioceses. The Reviewer notes that whilst TT stated that she never wanted to vilify any individuals, she did want to pursue truth and justice and hoped that the NST investigation process would enable this.

E.1.3. May 2022: TT expressed regret about reporting.

TT felt that the investigation process by the NST had been personally costly and damaging. In her written submission for the Lessons Learnt Review in May 2022 she stated:

> *'My overall feedback is that, to my eternal regret, I wish I hadn't reported….it has been really damaging to me and my family. I am in a worse place now than when I started the whole process and it has robbed me of much joy, health and time…..there is no positive outcome from the formal process.*
>
> *Indisputably my experience demonstrates that there is something fundamentally wrong with the whole system, if a survivor can enter full of hope and optimism, in a place of relative healing and leave distressed, disillusioned, broken and with no justice, accountability or healing.'*

It is for this reason that TT has sought a review into how her case was managed. She has stated she wants this to feed into the wider learning discourse about how to develop an appropriate survivor-centred and trauma-informed approach to those who have been harmed by abuse within the church and notably the Church of England.

Although members of the NST have co-operated freely with this case review, the Reviewer has experienced considerable delays in getting responses to emails. This may be reflective of their heavy workload, but it does reinforce one of TT's concerns that such delays often increase distress for survivors.

The experience of TT along with that of other survivors highlights the importance of ensuring a more survivor-centred, trauma-informed process when working with those who have been abused so that none feel re-traumatised as a result of disclosing abuse and harm within the Church.

E.2. The investigation chronology and timeline

This is a complex case involving multiple individuals. In attempting to answer the key questions identified in the Terms of Reference the Reviewer has first tracked the chronology and significant milestones of the investigation process. Where appropriate further details relating to these milestones are documented later in the report.

The information in the table below was drawn from TT's own chronological records between 03.10.19 and 22.10.20. Her account is supported by documents supplied by the NST and the Diocese of Southwark and to a lesser extent the Diocese of Leeds. Where necessary, further clarification was sought during interviews.

The chronology demonstrates that the investigation began very positively for TT in October 2019 but over time she experienced increasing frustration and disappointment, which had a detrimental effect on her mental health and well-being. This led to TT making the three separate complaints and this had the effect of extending the process further into the summer of 2023. It is hoped this summary will provide a helpful overview of how the investigation progressed, the points at which TT's trust was lost despite the best efforts some individuals, and that it will provide a clear context for the following presentation and analysis of the findings.

Events between 3.10.19 and 22.10.20 are taken primarily from the chronological record supplied by TT herself and the information was supplemented by documents provided by the NST and the diocese of Southwark. These demonstrate how TT's perspective as the survivor changed as she became increasingly distressed by the process and disappointed by the outcomes.

After 22.10.20 TT stopped recording the chronology. Hereafter the chronology and timeline are informed by documents supplied by the NST and the dioceses of Southwark and Leeds plus correspondence between TT and others.

NST Safeguarding Investigation Chronology and Timeline.

The information contained in this chronology has been obtained from TT's own records, emails and statements together with those supplied by the NST and the Dioceses of Southwark, Oxford and Leeds.

Date	Event recorded by TT	Reviewer's comments
3.10.19	TT recorded that she had an exploratory meeting with an NST caseworker.	No notes or minutes of this meeting were found in NST files or case notes.
8.10.19	TT sent a formal disclosure regarding Rev A to the caseworker. An email from the case worker to TT stated: *'Your decision to disclose the identity of those involved and of what happened to you is courageous. This is clearly a serious matter and one which will need appropriate investigation, not least because Bishop X is still very active in ministry.'* This then gave TT confidence to disclose her allegations regarding Rev B.	Copy found in NST case notes.
15.10.19	TT recorded that she had initial contact with the advocate who would be supporting her during the investigation.	
16.10.19	The caseworker gave confirmation to TT that a Core Group would be convened.	
7.11.19	TT recorded she had a T/C from the caseworker advising that she would now be assigned to a different case worker.	
12.11.19	TT recorded she had a meeting the new caseworker.	
19.11.19.	**First Core Group Meeting**. TT sent a written statement which was read out by the new caseworker. The main action point was that a referral would be made to the police.	Minutes in NST files and copy of TT's statement.
Nov 19	**Shortly after the first Core Group, TT left the UK for a pre-planned trip abroad. The intention was that she would spend a brief time in UK in April 2020 and would finally return permanently in June 2020.** Arrangements were put in place to maintain contact with TT while she was away. However, due to the restrictions imposed because of Covid 19, TT was unable to return to the UK until June 2021. This had	

	a significant impact on communications between TT and members of the NST.	
23.11.19	Following the Core Group the caseworker sent TT details of the police contact person. TT received a letter from the current Bishop of Southwark with an apology for the response of bishops in 2001. He affirmed her by saying that he took her seriously and offered to meet when TT was scheduled to return in April 2020. He also offered financial support towards counselling.	
27.11.19	TT had a call with the police team. They needed to do an interview with TT when she was back in the UK.	
2.12.19	TT contacted the Police Sexual Offences Investigation Team (SOIT) and provided an initial statement.	
19.12.19	TT submitted a Subject Access Request (SAR) to her caseworker.	
20.12.19	On the advice of her caseworker TT sent the SAR to the diocesan secretary of the Diocese of Southwark.	
14.01.20	NST caseworker confirmed all necessary documents were now with the SOIT.	
21.01.20	TT received SAR information from Southwark but stated it was heavily redacted. TT learned from these that an unnamed person, now known to be an archdeacon in Southwark in 2001 (AD), had written to Bishop X. She also learned that Bishop Y had shared the content of her confidential letters with Rev A.	See previous chronology in D.2. 28.03.02.
22.01.20	TT recorded that NST caseworker informed her by email that an interview with Bishop X had been arranged together with the Leeds DSA.	
28.01.20	TT was informed by email from the SOIT that Rev A was not fit to be interviewed and no intelligence about other victims had been found.	
31.01.20	TT spoke with SOIT and then informed NST she did not wish to proceed with the police investigation. TT recorded that the SOIT felt the bishops were negligent in 2001 and would attend the subsequent Core Group to report that.	No records of this found in subsequent minutes or of their attendance

		at the Core Group.
10.02.20	NST caseworker informed TT by email that she and the Leeds DSA were to meet with Bishop X that week, but a decision had been taken not to interview Bishop Y.	NST files show the meeting with Bishop X was arranged for 14.02.20.
10.02.20	Further to the SAR, TT received additional information from Southwark, namely: • A letter from Archdeacon to Bishop X about TT and this called her a '*gold-digger'* who '*should put up or shut up'.* • A letter from Rev A to Bishop Y asking Bishop Y to help him draft his denial email.	Copies in NST Files.
21.02.20	**Second Core Group Meeting.** Caseworker called TT to give feedback. TT noted that: • Police did not attend the meeting. • There would be a process (not disclosed to TT) with Bishop X. • There would be a note on file of Bishop Y but no other action as he was elderly and living in overseas.	Minutes in NST files. There is a note in NST files, but this is undated and unsigned.
25.02.20	TT received an email from the SOIT explaining she had not been told of Core Group Meeting until the day before when she was already on leave. She said she would arrange to meet TT's caseworker. TT recorded that her advocate called her to tell her Rev A had died.	
03.03.20	NST caseworker emailed TT to say they would wait for the police response before interviewing Rev B. TT was informed that nothing further would happen with Rev A as he was now deceased. The Police had been unable to progress matters due to his failing health and now closed their investigation and handed matters back to the Church.	
16.03.20	**Caseworker advised TT that face-to-face meetings were cancelled due to Covid Restrictions.**	

27.04.20	TT requested a call with NST caseworker to give more details about Rev B. TT recorded being informed that a note will be put on Rev A's file about the investigation.	
27.04.20	TT recorded asking for help from NST to write to Bishop Y but was told this was a personal matter and her request was declined.	
July to August 2020	**TT was in an overseas location during that time with no communications facility.**	
01.08.20	TT arrived at a new destination, and the signal was restored. She anticipated an update regarding the investigation, but she records there were no communications waiting for her from the NST.	
04.08.20	TT emailed requesting an update and recorded being told nothing had happened, but a meeting was scheduled with Bishop X and arrangements were being made to interview Rev B.	
14.08.20	TT recorded that she was notified that an 'action' with Bishop X was postponed until shielding ended. TT was not told what the 'action' was. TT also recorded being notified that it was not the role of the NST case worker to investigate TT's concerns regarding systemic issues in the safeguarding culture of the diocese of Southwark.	
15.08.20	A meeting between Rev B, his wife, the NST caseworker and the Oxford DSA took place. The meeting notes recorded that: • Rev B recalled meeting TT when they were both on a working party relating to the future of youth work in the Church of England. • Rev B denied all the allegations of rape and non-consensual sexual contact. He recalled that on one occasion at a conference they had both been drinking and left together. • He alleged that, *'When they got to his room TT went in and took her clothes off and got into bed. The result was they kissed but did not have sex. He got in with her but felt it was wrong and made an excuse about not feeling well.'*	Record in NST files.
28.09.20	**Third Core Group Meeting**. A report was prepared outlining the purpose of the meeting i.e.	Report in NST files.

	i. Finalise investigations and agree outcomes with respect of clergy. ii. Identify and further tasks. iii. Support and consideration for TT. iv. Support and consideration for clergy and family. v. Identify the lessons learned and whether a separate LLR is needed. The report also included details of the meeting with Rev B in which he vehemently denied TT's allegations. Actions agreed included: i. Meeting with Chichester diocese re previous Archdeacon in Southwark. ii. Notification to the local Bishop overseas regarding Bishop Y. iii. Extension of counselling for TT. iv. Risk Assessment of Bishop X by diocese of Leeds. v. Bespoke SG training for Bishop X. vi. Support for Rev B, AD and TT's husband.	Minutes in NST files.
28.09.20	Following the meeting the NST caseworker attempted to provide feedback to TT but problems with the signal made this extremely difficult. TT reported being devastated to learn that Rev B had denied rape/intercourse and had suggested there was only one sexual interaction that was initiated by TT. TT lodged a formal complaint. This is addressed later in the report under Section E.7.	
30.09.20	TT 's advocate provided further information about outcomes from Core Group Meeting. She reported that the outcomes were: • Allegations regarding Rev A had been unsubstantiated and there would be No Further Action (NFA) by the police as he was now deceased. • Allegations regarding Bishop Y had been unsubstantiated. He had not been interviewed, and the Core Group had decided there would be No Further Action by the NST as they believed that as he was reported to have retired from active ministry he would not pose a risk. TT had asked for further clarity around these points. The Reviewer noted a lack of clarity in the Core Group Minutes around the NFA conclusions that were reported to TT regarding Rev A. The NST have subsequently stated *'This relates to the Police NFA decision which we do not have the detail for. This is the police's information'.*	

	There is further detail in the caseworker's report that is not recorded in the Minutes. This states that following his death *'the police confirmed that they would not be able to investigate and concluded their investigation NFA.'* The caseworker then writes *'I would recommend this is concluded as unsubstantiated.'* These may seem a minor point but for TT who was out of the country and very isolated, lack of clarity about who determined the finding of *'unsubstantiated'* was very important and the uncertainty was triggering high levels of anxiety. The minutes do not record an NFA outcome for Rev B. They state, *'the allegations in relation to sexual contact remain unsubstantiated, but there is no ongoing risk.'* The Minutes do not include the evidence for that conclusion.	
01.10.20	TT recorded receiving an email from her caseworker with a written account of the Core Group Meeting. She learned that: • Undisclosed action with Bishop X was deferred until shielding ends. • The AD would be interviewed by DSA's from dioceses of Southwark and Chichester. • TT confirmed she wished to pursue a formal complaint. She stated that she did not want to speak with her caseworker. TT emailed further questions to her case worker but asked for a response via her advocate. TT submitted her complaint.	
12.10.20	TT recorded that the DSA from Southwark was due to interview the archdeacon AD. This is also recorded in Core Group Minutes. The meeting took place with the DSA from the diocese of Chichester. Meeting notes from Southwark record that AD recognised he should not have said the things he did in the email, and it did not reflect good professional practice. He accepted there was no basis for the accusations he levelled at TT but also that he had recognised that Rev A might be guilty. He also said, '*He was operating in a context in which Bishop Y and Bishop X were aggressively committed to protecting clergy and would bat complaints away.'* The then DSA of Southwark did not consider there were risks that warranted the removal of PtO in either Southwark or Chichester.	Southwark files hold notes of that meeting, but these were not located in the NST files.

15.10.20	TT received feedback from the interview via her advocate. This confirmed that in 2001/2 the archdeacon had suggested to Bishop X that Rev A should be retired early. TT responded that this was a systemic issue within the culture at Southwark and asked how it would be investigated.	
19.10.20	TT was advised by NST that her formal complaint of 28.9.20 was not valid under the National Church Institute Complaints Policy. The NST follows the NCI policy and that this does not apply to or cover an instance where the survivor is not happy with the outcome of a Core Group. This highlights the unanswered question of where a survivor goes if this situation arises.	
20.10.20	The DSA from Southwark advised the Bishop of Southwark that the Archdeacon had apologised and that although he had PtO in Southwark he did not take services so removal of PtO would not be recommended. TT responded by email to the DSA and to NST that this was distressing for her and *'replicated exactly what IICSA was criticising the church for'*.	
21.10.20	The NST responded to TT's complaint with an apology for any distress caused but highlighting that *'the National Church Institute complaints policy only relates to complaints about an individual's actions, which does not apply in your complaint. There is no official complaints procedure in relation to the process and the decisions made by the core group, that is not to say that we don't take these matters seriously.'* This is explored more fully later in the report under Section E.7.	
22.10.20	TT had an online meeting with her advocate and the DSA from Southwark. They agreed to explore a restorative justice meeting between TT and AD. TT reported that the Southwark DSA did not know where a systemic issue could be raised but would consider this and come back to her.	

The chronological record supplied by TT ended here. The remaining timeline has been compiled by the independent Reviewer using information from the files supplied by the NST and by the diocese of Southwark and to a lesser extent by the diocese of Leeds together with correspondence and statements from TT.

19.11.20	TT met online with her advocate and the caseworker for further feedback following the meeting that had taken place with the NST caseworker, Oxford DSA and Rev B on 15.08.20. The NST caseworker had advised that Rev B stated he was not employed by the Church but by the local City Council. TT emphasised the age difference between them, his position of responsibility and her belief that he was not in secular employment but employed as a Church youth adviser at the time they met, and the alleged abuse commenced. TT had some different recollections about several aspects of his statement. TT felt that greater weight had been given to Rev B's account than to her own. The caseworker reiterated that the purpose of the Core Group was to determine risk, not make a finding of fact.	Meeting notes in NST files. Rev B's Extract from Crockfords in the NST files indicates that he had been involved in diocesan youth work between 1975 and 1979.
07.12.20	**Fourth Core Group Meeting.** This was an additional meeting to consider the issues TT had raised regarding the outcomes agreed at the previous meeting regarding Rev A, Rev B, Bishop X and Bishop Y. A paper had been prepared, and it appears this was circulated at the meeting, not prior to it. The outcomes remained unchanged. Minutes record that the Core Group knew this would be hard for TT to hear but felt they had followed due process.	Minutes in NST files.
26.01.21	TT wrote to the Core Group to affirm her thanks for the support of her advocate and to offer feedback regarding their conclusions about her case and expressing willingness to contribute to a Lessons Learned Review. She also acknowledged the efforts of her caseworker. However, she noted that she still did not know the names of all the Core Group members and had met only two, virtually. *'It feels like being a child shut outside in the garden while the adults talk about secret things indoors. I would appreciate at least knowing your names.'* The NST stated that it was not part of the investigation process for survivors to meet the Core Group Members. TT reiterated earlier requests for restorative justice approach with Bishop X and expressed her distress and frustration at the	Copy of letter in NST files.

	conclusions that the Core Group had reached regarding Rev A, Rev B, Bishop X and Bishop Y. The letter also complained (informally at this stage) about communications from the NST, citing that she did not receive the feedback from the previous Core Group on 7.12.20 until after Christmas, something she described as *'uncaring and neglectful'.*	
10.5.21	TT filed her first formal complaint regarding what she regarded as poor communication and delays. This related to the failure of a member of NST staff to respond sufficiently or in a timely manner to questions she had raised requesting information about her case. This is covered more fully under Section E.7. TT complained that she waited six weeks for a response and then received nothing in writing, only a verbal response that did not address the questions asked. TT perceived this as '*disrespectful and uncaring and dismissive of her as a survivor.'*	Copy of emails and letters in NST files.
08.07.21	TT received a letter stating that most of the elements of her complaint relating to the unnecessary delays in answering questions TT had raised in a letter to the Core Group dated 26.01.21 and also the lack of professionalism and empathy within letters were valid and upheld. An apology was issued for the failings identified and the stress caused.	Included in NST files.
15.07.21	A second letter dated 15.07.21 addressed the three remaining points which were not upheld. This is examined more fully under Section E.7.	
04.08.21	**Fifth Core Group Meeting**. **The focus of this meeting was the meeting that had been held with Rev B.** A report had been circulated prior to the meeting. Those present represented the NST and the diocese of Oxford. A paper had been circulated that highlighted Rev B's denials of TT's allegations. The Core Group had to consider the two conflicting accounts along with what actions should be taken and whether there should be any recommendation to the Bishop of Oxford regarding Rev B's PTO. The group were advised that the police had not interviewed TT in 2019 as she was overseas and so had not interviewed Rev B and had passed the case back to the church. On her return to the UK, TT had contacted the police regarding Rev B and they were reconsidering the investigation. They were due to interview TT on 19.8.21. Any recommendations regarding Rev B's PtO were deferred until after	Minutes in NST files. Report in NST files.

	that interview and pending a police decision about any further action. There was discussion as to whether the case should remain with NST or be managed within the diocese of Oxford. Opinion was divided and it was decided that TT's opinion should be sought. Ongoing support for TT and possible pastoral support for Rev B were also discussed.	
14.09.21	TT met with JC the independent Reviewer for the Southwark PCR2. This second Past Case review was taking place between 2019 and 2022. A key focus was listening to survivors who wanted to come forwards. Subsequently on 09.09.21 a senior member of NST met with TT, her husband and advocate to discuss the outcome of PCR2 and the recommendation. An email from TT said she found it positive and helpful.	
15.09.21	TT wrote to 2 members of the Core Group (representatives of NST and of the diocese of Oxford) advising that her relationship with one member of the NST had '*irretrievably broken down'*.	
21.09.21	**Sixth Core Group Meeting.** A report was prepared ahead of the meeting and highlighted that following the meeting with the case worker, Oxford DSA and Rev B, matters had been concluded as unsubstantiated as there was not considered to be an ongoing risk. However, following TT's ABE interview the police were now inviting Rev B for a voluntary interview. The report also highlighted that TT wished the case to continue to rest with the NST, as in her view none of the matters should have been concluded. Minutes of the meeting record that TT had communicated that her relationship with her case worker had broken down. Although TT wished the case to remain with NST, she requested feedback via the diocese of Oxford. Given the forthcoming police interview with Rev B, the group were asked to consider whether they should recommend to the Bishop of Oxford that his PtO be removed or he should be asked to step back. It was agreed that the police interview should take place first and	Report in NST files. Minutes in NST files.

	then legal advice should be taken about PtO if the police took the investigation further. There was discussion about how to be survivor focused and how to rebuild relationships.	
28.09.21	TT advised NST that she wished to submit her second formal complaint against a member of the NST casework team. This is addressed later in the report under Section E.7. The complaint involved the individual: • Being present at a meeting without TT being advised of their attendance. • Responding in a way that TT perceived to be defensive and, at times, *'aggressive, judgmental and patronising in tone.'* • 'Refusal to answer most questions or give proper explanations, beyond meaningless generalisations about the process.' This complaint was investigated by the Deputy Director of HR.	
15.10.21	**Seventh Core Group Meeting.** **The main purpose of this meeting was to consider TT's complaints about Bishop X and actions taken.** There was no written report from the caseworker which had been normal practice, but they did provide a verbal resume of the response of Bishop X in 2001 and of the meeting that took place between the caseworker, the Leeds DSA and Bishop X in March 2020. The Minutes state: *'Concerns were shared with the core group about Bishop X's understanding of current safeguarding policy and practice. He appeared to pride himself on not being pastoral in his approach.'* TT had been offered the opportunity to contribute to the meeting, and her statement was read out, describing the damaging impact of the church's response to her and on her faith, including her depression and suicidal ideation and the impact on her family. The minutes record that TT had requested a restorative meeting with Bishop X but noted that *'currently there are no procedures, guidance or policies relating to restorative meetings.'* The Minutes recorded that Bishop X underwent Safeguarding Training in September 2021, and it was recommended that he should resume	*Minutes not found in NST files* but supplied by diocese of Southwark.

	his safeguarding responsibilities and maintain an ongoing relationship with the DSA. This is explored more fully later in section E.6. The Minutes record the conclusion of the Core Group that '*At the time the bishop did not have the benefit of safeguarding procedures regarding vulnerable adults to guide his response nor a safeguarding advisor from whom he could seek advice and support.'* It was not clear from the Minutes whether this was the view of all the Core Group Members.	This detail was not found in the NST files but was later found in the Leeds files.
10.01.22	**Eighth Core Group Meeting.** An audio and written report from TT had been circulated prior to the meeting. Minutes record that following the police interview with Rev B there would be no further police action as there was insufficient evidence to bring charges. It was noted that in his 'No comment' interview with the police Rev B had denied any intimate contact with TT which was different from his interview with the caseworker and the Oxford DSA. When challenged about this, his response was 'no comment.' It was agreed that there should be a further meeting with Rev B to clarify this discrepancy. Opinion was divided regarding Rev B's PtO with NST members feeling the risk was low. However, Oxford diocesan representatives felt there should be a discussion with the Bishop of Oxford. TT's permission should be sought to share her audio statement with the bishop. The Core group heard that TT might now choose to submit a CDM. It was not felt that it was the role of the Core Group to do this on her behalf. It was agreed that it was time to think about a Lessons Learned Review.	Minutes in NST files.
18.01.22	A meeting took place with Rev B, Mrs B, Oxford DSA and NST caseworker. Regarding the police interview on 27.09.2021, he stated that his solicitor had advised him to deny everything and then reply 'No comment' to questions. He continued to deny TT's allegations.	Notes in NST files.
6.3.22.	Correspondence began between TT and Leeds DSA regarding the diocesan response to Bishop X. On advice from the NST, the DSA repeatedly confirmed the investigation was completed and referred TT back to the NST.	
8.03.22	**Ninth Core Group Meeting** Attended by representatives of Oxford Diocese, the meeting mainly considered the response to Rev B.	Minutes in NST files.

11.03.22	TT submitted a second complaint. This was related to the actions of one of the NST caseworkers.	
30.03.22	Diocese of Oxford had considered their moral response regarding Rev B. On 30.3.22 the Bishop's Chaplain and Rev B's area Bishop visited Rev B. Following their conversation Rev B relinquished his PtO. He maintained he intended to do this on health grounds.	Confirmation letters made available by Oxford diocese.
23.05.22	**First Lessons Learned Review Meeting.** The purpose of the Lessons Learned Review was to reflect on the church's handling of the case involving concerns raised against a number of clergy, and to consider the learning. TT provided a detailed document, and this began with her stating, *'My overall feedback is that, to my eternal regret, I wish I hadn't reported.'* She offered feedback in relation to thirteen areas - Disclosure, Accuracy, Understanding of Consent, Information sharing and timelines, Support for Survivors, Accountability, Restorative Justice, Apology, Complaints, Clergy who are 'frail' or deceased, Communication and Relationships, Trauma-informed approaches, and the operation of the Core Group. The Chair acknowledged TT's documents contained some valid points. As the document had only been received the day before, a further meeting was convened to allow all members to properly read and process its contents. At the same meeting the group were advised that *'there was no contact with Bishop Y who resides outside this country and holds no licence permission.'*	Minutes in NST files. These are all addressed in this report.
15.06.22	**Second (Re-convened) Lessons Learned Review Meeting** The purpose of this re-convened meeting was to consider the church's handling of the case once members had had time to read TT's submission. TT had requested the opportunity to meet with the group to contribute to the Learning Review. NST did not feel this was appropriate as the Guidance did not include meetings between Survivors and Core Groups. It was felt there was a need to bring the process to an end.	Minutes in NST files.

	The Core Group's response is addressed later in the report.	
22.06.22	**Third Lessons Learned Review Meeting** The purpose of this meeting was: 1.To discuss feedback from the respondents Rev B and Bishop X. These are both addressed later in the report. 2. To allow for final comments and reflections by the group.	Minutes in NST files.
16.09.22	TT emailed the NST, and the Southwark DSA having seen *'a lengthy and articulate obituary by Bishop Y'* in the Church Times. She argued that this fluent communication from him did not tally with the picture that had been presented of him as old and frail. In response, the NST caseworker wrote to the Bishop of Bishop Y's jurisdiction passing on TT's concerns. TT had herself written to Bishop Y previously but had received no response.	
06.07.23	TT submitted third complaint regarding the decision to end the support from her advocate. This was investigated by the Head of Safeguarding at NST but was not upheld. This is addressed later in the report under section E.7.	

E.3.Findings

It is both sad and shocking to hear and to read that a survivor who had already suffered the consequences of multiple layers of abuse should commit themselves to a process with new hope and optimism only to leave it with a renewed sense of despair, shame, frustration and a loss of self-worth. This story is not unique to TT alone and although it has never been the intention that this review should blame or vilify individuals, it is important for everyone involved in this work to understand and reflect on the factors that brought about this result.

E.3.1. The NST Process: Managing Risk

Members of the NST highlighted to the Reviewer that the purpose of an NST investigation was to focus on identifying and managing current and ongoing risk, not to make a finding of fact or to hold anyone to account. They stated this is in line with the Church of England Practice Guidance Responding to and Managing Safeguarding Concerns or Allegations 2017[4]. This focus appears repeatedly in the Core Group Minutes and TT has stated it was repeated to her when she raised questions about the process during the investigation. TT had entered into the investigation in the hope that she would receive apologies and that both those who had abused her and those who had not responded appropriately or compassionately

[4] Practice Guidance: Responding to, assessing and managing safeguarding concerns or allegations against church officers, 2017. Page 51

to her would be called to acknowledge their actions and treatment of her and offer a genuine apology. The tension between this and the NST agenda to identify and manage current or future risk came more sharply into focus during the course of the investigation and this raises a number of questions about how the differing needs and objectives of church abuse survivors can and should be addressed by the Church of England.

It is nevertheless important to record that all those interviewed from the NST expressed being moved by TT's story and deeply saddened both by her experiences and that she had found the investigation had no positive outcome for her. Some expressed regret that within the process they had to follow, they did not have the flexibility to attempt to meet at least some of her hopes and expectations.

E.3.2. TT's initial Optimism

TT had her first meeting with a caseworker from the NST on 3.10.19 to explore the possibility of opening an investigation. Following this positive initial meeting TT sent a formal disclosure regarding Rev A with copies of all supporting documents including her original statements and letters from 2001-2002. NST linked her with an advocate who would support her throughout the investigation. This was good practice, and TT greatly appreciated the support of her advocate. She therefore entered the investigation process with hopes of a very different experience from that of 2001-2.

E.3.3. The role of the Core Group

The NST state that throughout the investigation they followed the 2017 Practice Guidance on Responding to, Assessing and Managing Safeguarding Concerns or Allegations against Church Officers. One aspect of this is setting up a Core Group to oversee and manage the response to the safeguarding concern or allegation. This should ensure that both the victim/survivor and the respondent receive a fair and thorough investigation. The guidance outlines all the responsibilities of the Core Group. This includes clear guidance on who may be a member of the Core Group and who should not; the prompt circulation of Minutes; the safe storage of documents. The guidance states that diocesan groups should work under the guidance of the NST and that in the case of a church officer, consideration should always be given to suspension whilst the investigation is ongoing.

Due to the involvement of three different dioceses in addition to members of NST casework team and at times, members of HR and legal teams, the Core Group was particularly large. Due to the process not allowing for the survivor to meet the members of the Core Group, TT often felt that decisions were being made about her and the intimate details of her life by a roomful of strangers. This and the realisation that decisions were heavily process-driven, increased her sense of vulnerability, as a survivor of multiple layers of abuse.

E.3.4. Challenges with the NST Investigation

It is evident that there were some circumstantial challenges that negatively impacted the smooth progression of the investigation.

E.3.4.1. Staff Turnover

Individuals interviewed reported that there had been significant changes, including changes to people's roles and responsibilities within the NST prior to and during the investigation. Approximately a week after

TT's initial meeting on 3.10.2019 the case worker that she had made her initial report to took sickness leave and subsequently contacted TT on 7.11.19 informing her that she would be passing the case to a different member of the team. The relationship between TT and one of her caseworkers broke down. Another caseworker who had a significant role only joined the NST after TT's investigation began and did not become involved in TT's case until 2021. Other members of the team underwent role changes with the accompanying changes in responsibilities during the course of the investigation. In addition, the chair of the Core Group changed several times. Whilst this was nobody's fault, the impact of additional anxiety and stress for the survivor should not be underestimated.
During TT's investigation there were three different DSAs in the Diocese of Southwark, three in Oxford and two in Leeds. Within the dioceses the handover arrangements were at best varied and, in some instances, new or interim DSA's had to acquaint themselves with the case and some took a different approach from their predecessor.

The DSA at Southwark at the time of this Case Review replaced an interim DSA in September 2021. During her interview with the Reviewer, she stated that '*Southwark is a huge diocese, that PCR2 was underway, and there were a number of big cases which she needed to 'get to grips with*'. She recognised that the handover was not as good as it might have been, and she was not told that TT was awaiting contact from her. Had she known she would have made a priority of meeting TT and that would have avoided distress for TT when there was no immediate contact.

Whilst in some dioceses DSA's/DSO's have been in post for several years the Reviewer has observed that changes of personnel in the DSA/DSO role and issues of staff absence within diocesan safeguarding teams was and still is not uncommon across the 42 dioceses in England. This is a cause for concern for continuity and consistency in safeguarding work and particularly for the approach to supporting survivors.

E.3.4.2. TT's absence from the UK

During the early stages of the investigation TT had a pre-planned trip overseas. This, with the associated signal issues at times made communications with the NST very difficult and this was not helpful for TT. It was unfortunate that she had to hear some very difficult news during a time when she was extremely isolated, and this was very distressing for her. She has described suffering significant re-traumatisation as a result. These circumstances were beyond anyone's control. However, this is a serious reminder that the language and communication required for difficult conversations needs extreme care at all times. This is particularly true when working with survivors who have often experienced multiple layers of abuse and who are likely to be re-traumatised.

E.3.4.3. Impact of Covid 19

On 26.03.20 lockdown measures came into force in the UK. No one could have predicted the restrictions imposed as a result of Covid 19, nor their duration, and this had a significant impact on the investigation. Face to face meetings were suspended and the restrictions seriously delayed TT's return to the UK until June 2021. The significance of this is explored further during the report.

E.3.4.4. Rev A died without being interviewed by the police

Rev A died in 2020. Prior to this the police had been unable to interview him due to his failing health, and they now closed their investigation and handed matters back to the Church. This was very difficult news for TT to hear whilst she was away from the UK.

E.3.5. Reflections about the investigation process

There were a number of factors that compromised the smooth progression of the investigation that might have been avoided. These all had a negative impact on TT's well-being and contributed to her loss of confidence in the process. It is essential to learn lessons from these, if abuse survivors are to be better supported in the future.

E.3.5.1. Delays

i. Delay before the first Core Group Meeting

There was a delay of nearly seven weeks between TT's disclosure on 3.10.19 and the first Core Group Meeting. The 2017 Practice Guidance states that the first Core Group should be convened within 48 hours. This point was also picked up in the NST PCR2 Report in 2021.[5] The Reviewer has not received an explanation for this and can only conjecture it may have been the unfortunate combination of the initial caseworker taking sick leave and subsequently leaving the NST without taking the expected action of ensuring TT's case notes were available to be passed on to another worker. It is a concern that no notes or minutes of the first meeting on 3.10.2019 were found in NST files or in the thorough case notes compiled by the second case worker. This seems to be a significant failure in procedure that would need to be examined, and steps taken to ensure a better process in the future. By the time the first Core Group was convened in November 2019 TT was about to depart for a planned trip abroad.

At that first Core Group meeting on 19.11.19 a decision was made to refer TT's disclosure to the police. The case notes show the referral was made on the same day but by this time it was too late for an ABE (Achieving Best Evidence) interview to take place before TT's departure. Whilst it is not certain, it is possible that had there been a better handover between case workers (and if the Core Group meeting had taken place sooner), that the ABE interview might have been achieved before TT left the UK. As a result, it could not take place until TT returned to the UK, which she planned to do briefly in April 2020, and the Core Group had to pause any investigation on their part pending the police report and recommendations. This was correct practice in order to avoid prejudicing any criminal investigation, but not at all helpful for TT as the survivor. Due to the Covid restrictions in place TT's return to the UK was delayed until the summer of 2021 which was when the police ABE interview took place, and the police reopened the case of Rev B. Had the guidance on timing been followed, it is possible that the police interview might have taken place earlier and at least some of the distress experienced by TT might have been alleviated.

ii. Delays in forwarding feedback from key meetings.

In July and August 2020 TT was in an area with no facility for communications. When she arrived at her next destination at the beginning of August 2020, she anticipated that she would have received at least an email from the NST with any updates about the investigation. However, she recorded that she had

[5] PCR2 NST Review conducted by Independent Consultant, Bernie Kinsella, July 2021.

received nothing and had to email the NST to request an update. This increased her sense of disconnection from the investigation process.

On 26.1.21 TT wrote to the NST again and pointed out that she had not received any feedback from a Core Group Meeting held on 7.12.20 until after Christmas. TT described that waiting over Christmas was incredibly painful and that surely it was avoidable.

iii. TT's First Formal Complaint

On 10.5.21 TT made her first formal complaint. This was regarding the failure of an NST staff member to respond sufficiently or in a timely manner to questions TT had been asking about her case in a number of emails. The is covered more fully under Section E.7. According to the NST Case Investigation records, TT had first raised these in a letter to the Core Group on 26.01.2021 and subsequently with her caseworker. TT complained that having waited six weeks for a response to inquiries about the investigation process, she still received nothing in writing from the individual responsible for communicating answers to her queries, only a verbal response via her advocate that in TT's view did not address the questions she had asked. TT perceived this response as *'disrespectful and uncaring and dismissive of her as a survivor.'* The Reviewer agrees this was not acceptable practice. The NST's management of this complaint is dealt with fully under Section E.7. Complaints.

E.3.5.2. Core Group Minutes and Actions.

The Core Group had a complex task. The various allegations and complaints involved five different individuals, all of whom could be described as elderly, four of whom had PtO in different dioceses and one who was by then in an overseas jurisdiction. The Core Group included people with different roles from each diocese as well as the NST. Because different meetings focussed on different individuals, attendance at the meetings did not always include all members. In such circumstances it is even more important that meeting minutes are circulated promptly, and any amendments are formally agreed and minuted at the subsequent meeting. Progress against actions agreed should also be reviewed and minuted at the subsequent meeting.

The Reviewer has scrutinised agendas and minutes from eight Core Group meetings and has noted the following points:

i. During the investigation there were three different chairpersons for the meetings and there were good reasons for this. However, this did not help consistency. There were also different minute takers.
ii. Documentation indicates that draft minutes tended to be circulated to members for an accuracy check approximately two weeks after the meeting in question. This is quite a long delay for the circulation of draft minutes. Amendments to the minutes appear to have resulted from emails from individuals proposing corrections or clarifications following receipt of the draft. Although the Agendas include '*Confirm record of last meeting and any amendments'* this is not recorded in most of the minutes. It is therefore not clear whether all members of the Core Group had their attention drawn to the finalised minutes and agreed any amendments. This is not best practice.
iii. Minutes of the first Core Group end with a table of agreed actions, the person responsible and the timescale and this is good practice. However, this was not recorded so clearly in the minutes of all meetings. Some concluded with a list of actions, but it did not appear that all of these were

revisited systematically at the subsequent meeting. Some it appears were simply rolled forwards. Although there are full reports about some of the actions identified, others seem to have been lost, and it was not clear whether they had been carried out or no longer deemed necessary. Specific examples include seeking advice from the Charity Commission following the first meeting on 19.11.19 and the second on 21.2.20, and the completion of a Risk Assessment for Bishop X following the meeting on 21.2.10. During this case review, the Reviewer was assured by three members of the NST that the risk assessment was completed although no copy was found in the NST's files. On further investigation the Reviewer learned from the previous DSA in diocese of Leeds that the risk assessment was not completed. However, there was no formal record of why this was not followed up by the NST or deemed no longer necessary.

E.3.5.3. Record Keeping

There are some concerns around record keeping and the inconsistent labelling and filing of documents by the NST was addressed under E.1.1.2.

It is clear that TT's second NST case worker kept a detailed case file from 12.11.19 when they took over the case. The lack of handover records from the first case worker has been highlighted under E.3.1.1. Staff Turnover. This had the regrettable consequence that TT then had to re-tell her story and this is an issue to consider when thinking about good trauma-informed practice going forwards.

There is a wider issue of record storage and the handover of records when there is a change to key personnel such as DSOs and this is addressed later in the report.

E.3.6. Findings regarding TT's specific allegations

As TT's allegations involved five clergy in total, the next sections of the report examine how each case was managed both by the NST and as applicable by the relevant diocese.

i. NST and Diocese of Southwark – Rev A, Bishop Y, AD.
ii. NST and Diocese of Oxford – Rev B.
iii. NST and Diocese of Leeds – Bishop X.

E.4. NST and the Diocese of Southwark – Rev A, Bishop Y, the AD

The DSA for Southwark during this case review had joined the diocesan safeguarding team in September 2021, by which time PCR2 was underway, and this was preoccupying the safeguarding team. There had been a succession of DSAs and interim DSAs prior to this DSA's appointment, and although she knew of TT's case, she reported that the handover was not good, so it was several months before she formed a relationship with TT.

Whilst it was the role of the NST to manage the investigation when TT reported in 2019, it was a very significant case for the Diocese of Southwark, which required the Diocese's significant involvement and co-operation, as it involved allegations against Rev A (who had been working in the Diocese at the time of the events in question) and also allegations about the handling of the case by two previous bishops and an archdeacon. The Core Group meetings were attended by the then DSA, the Bishop's Chaplain and

the Diocesan Director of Communications, who were all party to TT's statement which was read at the first Core Group Meeting.

E.4.1. First Core Group on 19.11.19.

i. **The DSA gave a briefing.** She reviewed the chronology of events in 2001 and the correspondence. The Core Group noted the repeated pressure by Bishop Y upon TT to meet with her alleged perpetrator and also the recommendation of the Archdeacon (AD) that early retirement might be an option for Rev A. Other members of the group who knew Bishop X, Bishop Y and AD described them all as *'powerful personalities that could be challenging at times to work with.'* It was also noted that no mention of the allegations was made in Rev A's annual reviews in 2001 or 2002.

ii. **The current status of the clergy was reported as follows:**

- Rev A was in poor health, and it was not clear if his PtO had been renewed that year. TT had asked for some form of apology from Rev A, but the group recognised that might be difficult to achieve under the circumstances. It was noted that his file would be reviewed as part of the forthcoming PCR2 process.
- Rev B still had PtO in the Diocese of Oxford.
- Bishop X still had PtO in the Diocese of Leeds.
- Bishop Y was retired, in poor health and living in in an overseas jurisdiction.
- AD the former Archdeacon still had PtO in the Diocese of Chichester.

iii. Actions were agreed:

Rev A: The Core Group unanimously agreed that:

- The alleged rape by Rev A should be reported to the police by NST.
- Southwark Bishop's Chaplain would check his PtO status.
- Southwark DSA to update Rev A's blue file. This would state the allegations, the outcome in 2002 and the outcome of the NST Investigation.
- NST to clarify whether Charity Commission needed to be informed.

Rev B: A meeting would be arranged which would also involve the Diocese of Oxford. This aspect of the investigation is further reported under Section E.5.

Bishop X: A meeting would be arranged which would also involve the Diocese of Leeds. This aspect of the investigation is further reported under Section E.6.

TT: The group agreed that:

- If TT agreed, the Southwark DSA would share the contents of her statement with the current Bishop of Southwark.
- Contact would be maintained with TT by the NST caseworker and her advocate.
- It would clarify funding source for TT's counselling support.

iv. It appears no action was agreed regarding Bishop Y or AD.

E.4.2. Bishop of Southwark's letter.

Following the Core Group, with TT's permission, the content of TT's statement was shared with the Bishop of Southwark who immediately wrote to her with a specific apology for what had happened to her in 2001-2 and offered financial support for ongoing counselling. This apology has meant a great deal to TT and the influence of his background support both then and later during the investigation should not be underestimated.

He also asked to hear her statement which the NST caseworker went to read to him. His quick apology and his concern for her meant a lot to TT. TT explained that later, when he apologised for the actual abuse, that meant a great deal more. The Reviewer noted that this was an action taken by the bishop and was not a recommendation from the NST core group.

E.4.3. TT's letter to the Core Group dated February 2020.

TT was now out of the country and was beginning to struggle with the process. She had written a letter for the Core Group in which she thanked them and her caseworker and her advocate for their support so far. However, she also expressed the misgivings she had about the investigation and the impact this was beginning to have on her well-being:

> *'Like many survivors reporting, it has triggered PTSD responses and at times I have been overwhelmed with waves of pain and shame that can feel unbearable….. since October 8th I have been wondering what is happening, and what your response will be, whether you believe me, if there will be accountability and justice.'*

She went on to address the fact that Synod had just renewed its commitment to a survivor-centred process but felt that currently it was perpetrator-centred. She asked that when she returned to the UK she might be able to meet the core group and be part of the process. TT also raised the matter of the impact of GDPR on case reviews saying, *'I am very concerned about this, as to survivors it feels like the perpetrators are being protected over the need for transparency and openness for victims.'*

E.4.4. Second Core Group Meeting on 21.2.20

i. Update

Rev A: It was reported that his health was very poor, to the extent that the police did not consider him fit for interview. Although the allegations had been reported to the police, there was no police representation at the Group. TT was subsequently informed that the police Sexual Offences Investigation Officer was only invited on the previous day and by then had been on leave. This was not good practice on the part of the NST. It was clear from the Minutes that members of the Core Group were not clear whether the police investigation was ongoing now that Rev A was not considered fit for interview.

Bishop Y: It was reported that Bishop Y was living overseas and did not have PtO and therefore the likelihood of him receiving a disclosure was low. It was decided no further action would be taken but a note would be put on his file.

AD: The Southwark DSA would meet with him either with the NST caseworker or the Chichester DSA.

ii. It was noted that clarification was still needed from the Charity Commission about Serious Incident Reporting. The Reviewer was unable to determine from later minutes or an inquiry to the NST whether this was actioned, whether this question was answered and whether a report was made to the Charity Commission.

iii. TT had made a Subject Access Request to the Diocese of Southwark on 19.12.19. They responded on 21.1.20 providing disclosure of information, and following legal advice a further disclosure was made on 10.2.20. The information contained, particularly the very unpleasant correspondence from the archdeacon dated 28.03.02 which described her as *'unreliable and unstable, a gold digger making hysterical and unreasonable allegations',* was extremely difficult for TT to receive especially given her isolated circumstances away from the UK.

E.4.5. Third Core Group Meeting on 28.9.20

It should be noted that there was a new interim DSA at the Diocese of Southwark who was in attendance.

i. The NST caseworker had prepared a report for the Core Group which included the following:

Rev A: Following the police decision not to interview Rev A as he was in ill health, the Minutes recorded that he had died shortly after the previous Core Group meeting. The police subsequently confirmed that, as they would not be able to continue to investigate, they would not be taking any further action. This was extremely difficult news for TT to receive, particularly as legal advice had previously recommended that Rev A's health information could not be shared with her and so she was unaware that he was seriously ill. The NST Core Group Minutes stated that: *'the allegations were considered unsubstantiated. There is no ongoing risk as Rev A is deceased.*' TT had asked if this were the case that she could place a victim impact statement alongside in his file. The Diocese of Southwark has confirmed to the Reviewer that TT's impact statement has been retained, and a note has been placed in Rev A's file to this effect.

Bishop Y: The report reiterated that Bishop Y had neither licence nor PtO and was not in good health. Whilst it was stated *'the language used in some of the correspondence towards TT is difficult to read'* the group were also reminded that safeguarding policies, guidance and support were very different from today. NST recommended that it was not proportionate to interview Bishop Y, but the concerns raised would be placed on his file and should be addressed prior to any PtO being granted in the future. Subsequently the group heard that TT had written to Bishop Y in June 2020 and this was read out at the meeting. She had not received any response.

AD: TT had raised the issue of the emails written by AD in 2001-2 which she had received as part of her SAR. This was to be addressed by Southwark and the new interim DSA. At the meeting the group heard that a meeting had been arranged for 12.10.20.

ii. TT had requested an apology from the clergy concerned and that a restorative approach be adopted, on her return to the UK. By this she meant the opportunity to meet within a safe environment and explain the impact their actions had had upon her and offer the opportunity for acknowledgement of this and to

give an apology. The Minutes recorded that this would need to be discussed with the Deputy Director of Casework as this was not part of the investigation procedures. There would need to be consideration of the welfare of all parties before embarking on this.

iii. The Core Group were advised that TT was finding the whole process very stressful and had taken a break from direct contact with the NST caseworker. All communications were taking place via her advocate.

E.4.6. Meeting between Southwark DSA, Chichester DSA and AD 12.10.20

i. The Southwark DSA explained the reasons for the meeting and the inquiry into the email sent by AD to Bishop X in 2002 and the derogatory comments about TT. AD said that he was not aware who TT was. Having seen a copy of the email prior to the meeting AD recognised he should not have said some of those things, and that *'he was naïve for thinking it would only ever be seen by Bishop X'.* He said, *'The comments were better suited to a "blokey" conversation, not an email'.* AD pointed out that the email did contain a recognition that Rev A might have been guilty. He said he had been archdeacon in the area long enough to not be naïve about safeguarding and described a number of cases of which he had been aware. He said, *'he was operating in a context in which Bishop Y, and Bishop X, were aggressively committed to protecting clergy, and would 'bat complaints away'.*

It is a concern that this comment was not picked up or followed up (particularly in relation to Bishop X) as it highlighted a view that the prevailing culture that Bishop X had presided over in Southwark, sought to protect clergy at the expense of those reporting concerns and allegations. This point was picked up in the Southwark PCR2 Report which recommended that the Archdeacon (AD) should be asked more about this statement and that this information was marked as relevant for Bishop X's file. However, it appears this was not followed up by Southwark, nor shared with the Diocese of Leeds. The NST investigation relating to Bishop X was being completed by the NST with the Diocese of Leeds, but it appears from documentation reviewed that this line of inquiry was not pursued there either.

Returning to the email, AD said that he accepted it did not reflect good professional practice, in that it was based on emotions, not facts. He accepted he had no basis for the accusations made against the person involved.

ii. The Southwark DSA recorded:

> *'AD accepted the email was poor, and that he would not do the same again. Our impression was that this was in part because he recognised that rules and expectations around safeguarding had changed, rather than having completely changed his own views. That said, however, AD did over the course of the conversation, display examples of safeguarding awareness. He said he would now refer any safeguarding concern to the parish safeguarding officer.'*

iii. The DSA of Southwark did not consider there were risks that warranted the removal of PtO in either Southwark or Chichester. He reported that AD was up to date with his safeguarding training and only held PtO in Southwark at the request of the current bishop, he took no services and intended to relinquish PtO once the bishop retired. AD was taking some services in the diocese of Chichester and there was a level of confidence that should he receive a disclosure he would know how to refer it to the appropriate person.

iv. AD expressed a willingness to apologise to TT.

v. The Southwark Files contain an undated briefing written by the DSA to the Bishop of Southwark following the meeting with AD, on 12.10.20. This recommended that AD's PtO should not be revoked, saying:

> *I do not think there is a credible risk that his response would be unacceptable now; there are no allegations of abuse; and AD is up to date with his training, and aware of his responsibilities under current guidance. I also note, in considering risks, that AD, makes no use of his PtO in Southwark.*
>
> *Not revoking the PtO may be painful to TT, and she has expressed an intention to make a complaint if that is the case. In more recent conversations, she has expressed an interest in a restorative justice-style conversation with AD, however, saying if that were possible, and went well, she would have no interest in him losing PtO.*

vi. During her PCR2 interview on 14.9.2021, TT reported that when the Southwark DSA met with AD in October 2020, she (TT) had suggested that a virtual restorative meeting between herself and AD might be a way forwards. The Southwark case file contains an undated draft apology letter in the name of AD, but this was not sent to TT. The Reviewer later learned that early in 2021 there was a change of DSA at Southwark, and it is possible the sending of the apology letter was lost in the handover. TT reported to the PCR2 Reviewer that in April 2021 the acting DSA had promised to follow it up, but the letter was not sent to TT until June 2021, eight months later. TT described how the waiting created additional anxiety and sleeplessness. The PCR2 report explores this and indicates that AD did not write the letter himself stating that '*seemingly due to the overbearing influence of the fear of litigation he did not even write his letter of apology himself.'* The acting DSA confirmed that she had drafted it for him. In that letter AD had expressed a willingness to meet with TT after lockdown ended. However, after lockdown ended and TT was back in the UK, TT was informed that AD was no longer willing to meet with her *'because as far as he was concerned the matter was closed.'*

TT's Safe Spaces advocate followed this up with the Chichester DSO on behalf of TT. The DSO responded that there was no realistic prospect of AD agreeing to a meeting. The reason given was that AD had come to this conclusion to '*take account of both parties' welfare'.* This was extremely upsetting for TT. She was still hoping for a meeting with AD, and his refusal left her feeling his apology was empty and meaningless.

E.4.7. Fourth Core Group on 7.12.20

i. The NST caseworker reported that TT was unhappy with the outcomes agreed at the previous Core Group meeting.

TT felt that more weight had been given to the respondents than to her. Each case was reconsidered and the following points noted:

Rev A: Although the group recognised the seriousness of the rape allegations, they felt these were impossible to verify now that Rev A had died and the police investigation had ceased. Therefore, they concluded that the allegations remained unsubstantiated.

Bishop Y: Although the group recognised his response fell far below that expected today, without a license or PtO, he did not pose a current risk. The Core Group recognised this would be hard for TT to hear but felt that due process had been followed.

ii. Communication following the meeting.

As it was the NST who were overseeing the investigation, the outcomes and decisions were communicated in writing to TT by the NST caseworker. However, communication regarding this meeting did not reach TT until nearly a month after the meeting. Following receipt of this information, TT wrote to the NST. In this letter she highlighted that she did not receive feedback from the 7.12.20 Core Group until after Christmas, something she described as *'uncaring and neglectful'.* She noted that she still did not know the names of all the Core Group members and had met only two, online, saying:

> *'It feels like being a child shut outside in the garden while the adults talk about secret things indoors. I would appreciate at least knowing your names'*

In the same letter TT reiterated earlier requests for a restorative justice approach with Bishop X.

E.4.8. TT's First Formal Complaint.

TT made three complaints in total. She reported that she was told she could not make a complaint about the process, only about a person. She therefore made complaints about individuals within the NST. These complaints are addressed later in the report.

E.4.9. Southwark Diocese was not in attendance at the Core Groups on 4.8.21, 21.9.21 or 8.3.22 as these related solely to Oxford diocese and Rev B.

E.4.10. Seventh Core Group on 15.10.21.

A new DSA had been appointed at Southwark in September 2021, and she was in attendance along with the Leeds DSA. The purpose of the meeting was to consider Bishop X. Additional detail of this meeting is examined under E.6.5.

i. The group heard that communication between TT and her NST caseworker had broken down. She had requested a new caseworker, but NST advised this would not be helpful and *'the same issue would recur if someone else took the role'.*

ii. The NST caseworker gave a verbal summary of Bishop X's responses when TT reported in 2001, and of the meetings held with him as part of the NST investigation. The group heard that his bespoke training had been delayed. This was partly due to Bishop X shielding but also partly due to staff shortages within the training team. The minutes referred to an attached report from the safeguarding training team about the Bishop's response to the training but that was not found in the NST files and the NST were not able to provide it. However, it was subsequently found in the files held by the Diocese of Leeds. See under Leeds.

iii. TT had been offered the opportunity to contribute and had sent a written statement. The key points were highlighted and to avoid repetition these are examined under E.6.5. together with other points from the meeting.

However, it should be noted here that the Core Group concluded that there was no evidence that Bishop X attempted to cover up abuse or protect clergy. The Reviewer examines this conclusion later in the report under E.6. Diocese of Leeds.

E.4.11. Support for TT following the NST Investigation

The DSA from Southwark was at the Lessons Learned Review meetings where she had raised some matters in respect of good trauma-informed practice.

i. The need for consistent support for TT and for any survivor during an investigation. TT's experience had been that the funding had to be reviewed at different stages of the investigation. This continued uncertainty had been a source of much anxiety for TT. The DSA pointed out that any cessation in counselling support could have serious consequences and the importance of clarifying at the start of the process what support would be available was paramount.
ii. The impact of staff changes and delays and the impact for TT.
iii. The tension between achieving accuracy such as using a notetaker during disclosures and ensuring a confidential safe space for the survivor.
iv. The importance of supervision for those working with survivors.

As the investigation process came to an end, the DSA was conscious of how much the experience had traumatised TT. She recognised that TT needed someone to quietly listen as TT felt that no one in the NST or in the Diocese of Southwark had ever heard her full story. After the LLR, the DSA arranged for TT to tell and record her entire story, in her way and in her own time, within a safe environment. She felt that if the NST had listened to TT's whole story and appreciated its power dynamics, some things might have been approached differently. The recording was then transcribed. Subsequently that recording and the transcriptions were shared with this Reviewer. This meant that the Reviewer understood the story, the journey and the pain without subjecting TT to the trauma of re-telling it or being subjected to a battery of questions.

The DSA had also recognised that as a survivor, it was very important for TT to know that she was believed. When the DSA came to the diocese, she reported that there was a message to be careful about saying you believed a survivor as that could result in litigation. However, as a human being she realised that being believed was so important for TT. She pointed out that in the telling her story TT sometimes reorganised things, something that she and those who work with survivors recognise as '*perfectly normal'.* She and the Bishop agreed together that there was no reason to disbelieve TT's story. They also understood that TT had been a traumatised young person who was seeking spiritual support and there had been a power dynamic in the situations with Rev A and Rev B. They decided their response should not be process-driven but must become, in the DSA's words '*a bit more humane'.*

E.4.12. Bishop Y

The Core Group had agreed there should be no further action regarding Bishop Y as he was elderly and frail, living overseas and not in active ministry. TT had written to him herself but had not had any response. She had also attempted to take out a CDM, but this had been dismissed by the President of Tribunal's office. One reason was that it was out of time.

On 16.9.22 TT wrote to the NST and to the Bishop of Southwark having read a lengthy obituary written by Bishop Y in the Church Times. She asked what they would do in the light of this to *'hold him accountable and facilitate restorative justice'.* The NST caseworker subsequently communicated with the Bishop of his jurisdiction by email and forwarded a copy of TT's letter. In their accompanying letter they asked, *'I would be grateful if you could acknowledge receipt of this email and letter.'* The NST files contained no record of any response from the Bishop of his jurisdiction or any further follow up.

However, the Bishop of Southwark felt it was important to follow this up himself and reached out to the Bishop of Bishop Y's jurisdiction via a letter which he delivered by hand whilst meeting with him. In this letter he explained the background and his wish to resolve the *'deep distress and hurt*' that TT continued to feel. He suggested the use of restorative justice to bring Bishop Y and TT together. The Bishop of Southwark reported that subsequently the Bishop of his jurisdiction had a conversation with Bishop Y to this effect and as a result Bishop Y wrote back to him.

Bishop Y's response in a letter to the Bishop of Southwark was disappointing and reflected that he still carried some of the entrenched attitudes that had been evident in 2001. Nevertheless, the attempts by the Bishop of Southwark were much appreciated by TT and demonstrated how, where appropriate, networks can be used. This demonstrated the persistence shown by the Bishop and perhaps the lack persistence by the NST.

E.5. NST and the Diocese of Oxford – Rev B

The diocese of Oxford was represented on the Core Group because of the connection with Rev B.

Rev B

During the period in which TT's alleged abuse by Rev B began he was involved in the Church of England work regarding the future of Youth Work in the Church of England. This group involved diocesan youth officers, statutory and voluntary agencies and young adults nominated by the Young People's Assembly. Crockfords states that Rev B had been ordained as a priest in the Church of England several years earlier. The NST had advised the DSA at Leeds that although he was ordained, he was not employed by the Church at that time and instead he worked for one of the local City Councils in the Leeds area. However, it needs to be noted that the extract from Crockfords that was included in the NST files states that Rev B was also a diocesan youth adviser at the time when TT first met him. There is no record of Rev B in the Leeds files, and this is to be expected as TT did not make any report about him or the events in question whilst he was living and working there.

Rev B had moved to Oxfordshire following his retirement from full-time ministry and was granted PtO in the diocese. During the investigation there were two different DSAs in post. Continuity on the part of

the Diocese of Oxford was helped by the continued presence of the Bishop's Chaplain as a member of the Core Group.

E.5.1. First Core Group on 19.11.19

The Oxford Caseworker reported that Rev B still had PtO and there were no further known safeguarding concerns. Nothing had been flagged and there were no records of disclosures in his Blue File or elsewhere during his ministry. It was agreed that the NST caseworker would need a conversation with him.

E.5.2. Second Core Group on 21.2.20

The Oxford Caseworker clarified that Rev B takes occasional services, but his current level of activity and state of health was unknown. It was agreed that once the police investigation was concluded a meeting would be arranged with him.

E.5.3. Third Core Group on 28.09.20

This was attended by the Oxford DSA and Bishop's Chaplain, and they continued to attend subsequent meetings. The Group were informed that on the basis of the information reported to them, police found this did not meet the criminal threshold. (This was in the absence of an ABE interview due to TT still being out of the country.) The Group were told that *'Rev B may not have necessarily understood that TT was not consenting. As she was attending college, involved in Youth Work placement, she may not have presented as being vulnerable.'* TT has confirmed that this is not correct. She was a school leaver and not attending college at that time.

The NST caseworker and the Oxford DSA had visited Rev B. They reported that he was '*frail and suffering from anxiety related stress'*. His wife was there to support him. He was embarrassed about his contact with TT and although he admitted being '*briefly intimate together'* he denied it led to sexual intercourse. He also reported rumours relating to *'TT's relationship with Rev A'* though said he had never observed anything inappropriate himself.

The Group were informed by the NST caseworker that the outcome was therefore that the allegations remained *'unsubstantiated'* and there was no ongoing risk.

E.5.4. Fourth Core Group on 7.12.2020

The Group heard that TT felt her account had not been taken sufficiently seriously and she now used the word 'rape' in reference to the sexual activity with Rev B. She affirmed that the sexual activity took place in various locations, including service station car parks, increasing over time and that she did not want this and had remained unresponsive and passive throughout. The Group also heard that Rev B consistently denied the allegations. TT had requested a meeting with Rev B to pursue a restorative justice approach, but the NST caseworker had some concerns that this would not be helpful. It is not clear whether the Core Group heard what these concerns were. The Bishop of Oxford had offered to meet with TT when she was next in the UK.

The Group recognised the challenge of the case. The NCI's (National Church Institutions) senior advisory lawyer was present and highlighted that '*safeguarding guidance and training to which clergy were working at the time of the allegations was significantly different to what is in place currently, so it is*

difficult to hold people to account for knowledge which was simply not there'. There is no record of any conversation about clergy conduct and the questions raised by Rev B's acknowledgement of being '*briefly intimate together'* with TT.

However, the NST caseworker did note that if Rev B disclosed conduct unbecoming, then there could be a further conversation with him '*to tease out any safeguarding concerns*.' If none were found it would be for the Bishop of Oxford to determine and follow any disciplinary procedures he felt necessary.

E.5.5. Fifth Core Group on 4.8.21

This was held following TT's return to the UK.

The Bishop's Chaplain advised that TT had requested a meeting with the Bishop of Oxford which he would be involved with as well as being in attendance at two meeting with TT's advocate and asked whether members of the group saw this as a conflict of interest. The Core Group's response was that they did not see this as a conflict of interest.

TT had now contacted the police regarding Rev B, and it was noted that the police were reconsidering their investigation. They were due to complete an ABE interview with TT on 19.8.21 and would provide a further update once that had taken place. Any recommendations regarding Rev B's PtO were deferred until after that interview and pending a police decision about any further action.

The Group discussed whether they should make any recommendations to the Bishop of Oxford at this stage. If there were a formal police investigation the position on Rev B's PtO would need reconsideration. It was not clear to the Core Group how Rev B had been exercising his PtO since lockdown. Any decision was deferred pending the police interview.

The Group discussed whether the case of Rev B should now be managed within the Diocese of Oxford as Rev B was not senior clergy and there were no cross-diocesan issues, with NST continuing as a member of an Oxford-led Core Group. Opinion was divided and it was recommended that TT's view should be sought before the next Core Group meeting.

Pastoral support for Rev B was also considered pending the police investigation with the Bishop of Oxford's Chaplain tasked to ensure appropriate support was put in place.

E.5.6. Sixth Core Group on 21.9.21

The Group were advised by the caseworker that TT's ABE interview had taken place, and police had advised of their intention to arrange a voluntary interview with Rev B. The support was in place for Rev B when the police contacted him, through the area bishop. After discussion it was agreed that if the police took their investigations further the issue of Rev B's PtO would need to be revisited, and legal advice would be sought.

It was noted that TT was not communicating directly with the case worker but via her advocate. There was a need to seek to rebuild the relationship between TT and members of the NST.

Since the last meeting TT had met with the NST PCR2 Reviewer.

The seventh Core Group meeting did not involve the Diocese of Oxford.

E.5.7. Eighth Core Group on 10.1.22

i. At this meeting the minutes referred to the Oxford Bishop's Chaplain making some suggested amendments that were added as an addendum. These were not recorded in the minutes as they had been received after the minutes had been finalised. These were to be added as an addendum to the minutes of 4.8.21. The Reviewer was unable to access these due to either password protection or their format. This problem with accessing some files was raised with the NST more than once but the issue remained unresolved.

ii. TT had provided an impact statement that members had heard or read. A further email from TT had highlighted that the Core Group had never heard her whole story.

iii. The Group were reminded that following TT's interview in August 2021 the police had reconsidered the case. They had now concluded their investigation and would not be taking any further action.

iv. The police victim liaison officer reported that Rev B had suggested the allegations were financially motivated. He had given a broadly '*no comment*' interview but there was a discrepancy between a prepared statement and what had been said at the meeting with him that was part of the NST investigation which the liaison officer thought was '*odd*'. Due to this discrepancy, it was agreed that the NST caseworker and Oxford DSA would meet again with Rev B.

E.5.8. NST PCR2 Report

The Reviewer notes that NST PCR2 Report (July 2021) stated that Rev B's PtO status should be formally considered:

> *Notwithstanding the assessment regarding whether he posed a safeguarding risk, in order to display transparency with the House of Bishops' policy, it is recommended that Rev B's PtO status is formally considered and recorded.*
>
> ***Recommendation 2***
>
> *The PtO status of Rev B should be formally reviewed and recorded given the serious criminal allegations that were made against him and the subsequent police investigation.*

However, the NST view regarding Rev B's PtO was that the risk was low and so PtO did not need to be removed. It is the opinion of the Reviewer that the NST made a significant omission here and should have followed the best practice guidance of the PCR2 Reviewer. Oxford's Head of HR and Safeguarding felt this should at least be discussed with their Bishop for further consideration. TT's consent would be sought to share her audio statement with the bishop. If TT granted consent for this, then the Head of HR and the Bishop's Chaplain would have a conversation with the Bishop of Oxford.

E.5.9. Final Meeting with Rev B

The notes of this meeting state:

On 18.1.22 the NST caseworker and a new DSA in the Diocese of Oxford visited Rev B again. Regarding the police interview he stated that his solicitor had advised him to deny everything and then reply *'No comment*' to questions. He continued to deny TT's allegations.

He stated he had been conflicted about his PtO but had meanwhile continued to exercise limited ministry that required PtO.

He reported that outside of the NST investigation process he had been visited by the Bishop's Chaplain and his Area Bishop. He described them as polite and respectful but was left with the impression they believed TT rather than him. They informed him TT's claims were not about money but about wanting to be listened to. Rev B wanted TT to be told he was relinquishing PtO on health grounds.

E.5.10. Meetings between the Independent Reviewer, Diocesan Bishop, Bishop's Chaplain, Area Bishop and DSA at the Church House, Diocese of Oxford.

As part of this case review, the independent Reviewer visited the Oxford Diocesan Office on 8.1.25 to meet with the current DSA and with the Bishop's Chaplain. The Chaplain had been a member of the Core Group. The DSA only took up her post at the end of January 2022. They supplied a list of all the documents they held (copies of which were also in the NST files) and copies of relevant correspondence. In addition to meeting with the DSA and the Bishop's Chaplain, conversations also took place with the Bishop of Oxford and with Rev B's area Bishop.

The NST Core Group meetings had been well attended by personnel from the diocese. The Bishop's Chaplain had consistently attended most of the Core Group Meetings himself along with other officers, including at different times, a safeguarding case worker, the different DSA's and ADSA's.

Up until his invitation to the Core Group Meetings, the Bishop's Chaplain did not know Rev B and reported there had been no other concerns raised about him. As a member of the Core Group, he had kept abreast of TT's case and the investigation process. As TT's relationships with the NST and the Core Group had become more difficult she had asked if he would be her point of contact with the Core Group, but he had felt that it was important to keep clear boundaries going forwards. Whilst this may have been disappointing for TT, it was a wise judgment, especially in light of his later role in addressing the issue of Rev B's PtO.

He and the DSA were at the Lessons Learned Review Meeting 22.06.22. where members heard TT's impact statement which they described as very powerful. Subsequently TT sent him an email and the recording which she asked him to share with the two bishops. The Bishop of Oxford also described the impact upon him of hearing her story, of meeting her via Zoom and assuring her that he believed her.

The Bishop of Oxford and his Chaplain met together following the conclusion of TT's case investigation by the NST and in the Bishop's words they '*considered their moral obligations to TT'*. They acknowledged that this was prompted by TT's persistent requests to consider Rev B's PtO and stated that her persistence should not have been necessary. They had decided this was a practice they should now embed after any similar investigation. A concern was noted by the Bishop of Oxford and his Chaplain about Rev B's '*no comment'* interview and the discrepancy between this and his previous interviews and discussions with the caseworker as part of the NST investigation. The Bishop's Chaplain noted that his view about whether any action should be taken in relation to Rev B had always been different from that of the NST. As a result, the area bishop contacted Rev B about the need to consider his ministry and requested a meeting with

himself and the Bishop's Chaplain. Rev B had agreed to the meeting stating that the case had had '*a heavy toll.*' The meeting took place on 30.3.22. At that meeting Rev B admitted to '*some brief moments of inappropriate intimate behaviour'* at a conference centre. He still denied that there were any meetings at service stations and stated the '*no comment*' interview was on the advice of his solicitor. He agreed to relinquish his PtO which was the intended outcome for the meeting. Rev B has maintained that it was already his intention to relinquish his PtO for health reasons.

Later, in September 2022 the Chaplain and the area Bishop had met with TT and her advocate in person. TT had reported this meeting was most helpful for her, as was the Bishop's immediate response that he believed her account.

The Bishop of Oxford, together with his Chaplain and the DSA, expressed their commitment to building a strong safeguarding culture in the diocese and the importance of learning from past mistakes. The Bishop is careful to share any safeguarding questions or concerns with the DSA and together with the Chaplain they have formed a strong and proactive team. They expressed regret that TT had needed to pursue them for the right response and agreed that after an NST investigation more should be articulated about what the next step was and what more could or should be done within the diocese. This view about the importance of being more proactive in considering the right moral response after such an investigation was also articulated by the area Bishop. The diocese has advised that it is pro-actively working to support survivors through the Oxford Chaplaincy for Survivors and the Oxford Survivor Group.

E.6. NST and the Diocese of Leeds – Rev B and Bishop X

The Diocese of Leeds was represented on the Core Group because of the connection with Bishop X. The Diocesan Secretary has emphasised that this investigation was led by the NST and that as a diocese they followed the direction of the NST Core Group.

Bishop X

After his retirement as Bishop of Southwark, Bishop X moved to the Diocese of Wakefield and was licensed as an honorary assistant bishop there. The Bishop of Bradford, who had previously served as an area bishop in Southwark, was appointed Bishop of Leeds in 2014. This followed a reorganisation in which the dioceses of Wakefield, Ripon and Leeds, and Bradford were dissolved and the new Diocese of Leeds was formed. Bishop X was appointed as honorary assistant bishop of Leeds. At the time of the NST investigation Bishop X still had PtO in the Diocese of Leeds. He was a public figure who was well-known locally.

During the NST investigation there were two different DSA's in post in the Diocese of Leeds. Neither are now in post. As stated, the current Director of Safeguarding had been in post only six months when this case review began. She was not aware that Bishop X had PtO in the diocese, nor that he had been part of an NST investigation. The Diocesan Secretary has advised that records from the investigation pre-dated the implementation of an electronic data system. A substantial folder of documents from the investigation was located, and the independent Reviewer scrutinised these at the diocesan office at Church House, Leeds on 12.2.25.

The following findings are drawn from the NST files, the Leeds folder of documents and one interview with the DSA in post at the start of the NST investigation.

The respective DSA's from Leeds were invited to and attended the Core Group Meetings that were relevant to the consideration of Bishop X and to the Lessons Learned Review Meetings. The minutes indicate that there were no other personnel from the diocese in attendance at any of the meetings unlike Oxford and Southwark where there was a broader representation from the two dioceses. The Diocesan Secretary has clarified their reason for this: *'It was not our core group and only the DSA was invited. It would not have been appropriate to send any further representatives when we were not responsible for any other respondent or providing support to any victims'.*

Documents reviewed at the Diocese of Leeds show the NST caseworker contacted the DSA by email on 8.11.19 and they convened a telephone call to discuss the case. The Leeds file contains handwritten notes of that conversation and subsequent correspondence. These show that following the conversation, both the NST Caseworker and the DSA informed the Bishop of Leeds of their telephone conversation and that they were investigating a case relating to the actions of Bishop X and how he had dealt with disclosures in Southwark in 2001. The DSA noted that the Bishop of Leeds commented that '*Bishop X was a stickler for safeguarding*.' However, an interview that is referred to later in this report under E.6.7. indicates that when this DSA had worked with Bishop X in Leeds, she had concerns about some of his safeguarding responses.

E.6.1. First Core Group on 19.11.19.

The DSA at the time confirmed Bishop X still has PtO in Leeds, having retired there from Southwark in 2010. The extent of his current ministry was not clear and would be investigated. His blue file had been reviewed under PCR1, which indicated that no safeguarding concerns had been raised in Leeds. It was noted that the renewal of his safeguarding training was overdue.

When the Reviewer examined the Leeds files, the safeguarding training record for Bishop X showed he had last attended training in January 2014, which had expired in January 2017. The Reviewer noted that there was no record of the PCR2 review that had noted the Archdeacon's comments that at Southwark, '*he was operating in a context in which Bishop Y, and Bishop X, were aggressively committed to protecting clergy, and would 'bat complaints away'.* The Reviewer regarded this as a concern.

The Southwark PCR2 Report had recommended that the Archdeacon (AD) should be asked more about this statement and that this information was marked as relevant for Bishop X's file. It appears that the Southwark DSA at the time had not followed through on this and may not have communicated this information to the Diocese of Leeds.

The Core Group expressed their concern about Bishop X's handling of TT's case in 2001. The Minutes record that although his final letter advised TT to go to the police as a church investigation would jeopardise their investigation, it was already compromised by the extensive contact with Rev A. The DSA had noted that Bishop X could be '*quite forthright in his views.*'

It was agreed the NST caseworker, and the DSA should explore issues further, along with Bishop X's current understanding of safeguarding.

E.6.2. Second Core Group on 21.2.20

The NST caseworker reported that she and the Leeds DSA had met with Bishop X to discuss his handling of TT's case in 2001 and they fed back to the Core Group from that meeting. They reported their concerns that he still had difficulty understanding why his response in 2001 had been inappropriate and believed the letters he wrote were good. He seemed unable to understand that it was unreasonable to expect the complainant to meet the alleged perpetrator or that the 8–9-month involvement by the church including discussions with Rev A, would have compromised a police investigation had TT followed his advice to report matters to the police. Bishop X referenced cases of false allegations as if to validate his actions and appeared to have no empathy for TT. The only difference was that he said today he would '*do as he was told'* by the DSA. He did acknowledge that TT should have received pastoral support.

It was confirmed that Bishop X still held PtO and conducts a small number of services but is a public figure who is well-known locally. There is therefore the potential that he could receive a disclosure. He had had no safeguarding training for six years. He seemed happy with his reputation and that his approach was often seen as *'unpastoral'.*

The Reviewer is concerned that in 2020 such a senior leader within the Church of England who is still in a position of trust both locally and nationally still demonstrated such a lack of empathy towards someone who had reported a serious sexual offence and crime and showed little understanding of why his actions were neither appropriate nor compassionate.

Two actions were agreed by the Core Group:

1. Bespoke safeguarding training would be offered to Bishop X by the NST training team, with an assessment at the end to determine the impact and whether Bishop X demonstrated a change in attitude.
2. The Leeds DSA would complete a risk assessment to determine whether Bishop X should have his PtO suspended pending the training and the reassessment.

Pastoral support had been offered to Bishop X, but he had declined.

E.6.3. Third Core Group on 28.9.20

Since the previous Core Group there had been a change of DSA in the diocese. The new DSA was in attendance.

Minutes repeated the account at the previous meeting of the NST caseworker, the former DSA and Bishop X. Due to Covid 19 restrictions the bespoke training had not been put in place. As Bishop X was not currently exercising public ministry, it was therefore assumed there was no current risk. The Minutes indicate the NST training would take place once restrictions were lifted. The risk assessment was still included as an action point.

E.6.4. Fourth Core Group on 7.12.2020

No decisions were taken regarding Bishop X as the NST's bespoke training had not yet taken place. Whilst it is acknowledged that the restrictions on face-to-face meetings had delayed the training, it is a further cause for concern that there was no provisional timescale in place for the completion of the training nor for the completion of the risk assessment once Covid restrictions eased.

At the same meeting the NCI's senior advisory lawyer noted that *'safeguarding guidance and training to which clergy were working at the time of the allegations was significantly different to what is in place currently, so it is difficult to hold people to account for knowledge which was simply not there.'*

There appears to have been no discussion around clergy conduct or the failures in pastoral care and support that were evidently lacking.

Core Groups on 4.8.21, 21.9.21, 10.1.22, 8.3.22 focused on Rev B and were not relevant to the diocese of Leeds so it was not necessary for the Leeds DSA to attend.

E.6.5. Seventh Core Group Meeting on 15.10.21

The purpose of the meeting was to consider issues in relation to Bishop X. The NST, Diocese of Southwark and Diocese of Leeds were represented. The Reviewer was unable to locate the Minutes in the NST files, but they were supplied by Southwark.

Following the breakdown in communications with her caseworker TT had requested that the caseworker would no longer be the person sending her information. The Chair asked the Core Group if another person should take on communication from the Group to TT. It was agreed that the same caseworker should continue as the Chair stated that *'the same issue would recur if someone else took that role.'* It is the opinion of the Reviewer that whilst the breakdown in communications was due in part to TT's frustration with the process, it was also a trauma response. The possibility of offering TT a different person should have at least been explored more fully in order to diffuse the situation and retain the confidence of TT.

In addition to information shared previously, the Group were informed that after TT expressed her dissatisfaction to Bishop X about Bishop Y in 2002, he had not followed that up with Bishop Y as he was due to retire and had experienced some ill-health, the details of which were not disclosed to TT. Therefore, Bishop X had not addressed TT's complaint as a complaint and reported that he had considered the issues. He wrote to TT advising her this was a serious allegation, and she should go to the police. This was inappropriate in that senior clergy had been engaging with the respondent for eight months and Bishop Y had made strenuous attempts to get TT to meet with her alleged perpetrator. As a result of Bishop X sharing information with Rev A, TT experienced the further distress of letters from Rev A's solicitors threatening legal action.

The Minutes record that the content of the meetings between the NST caseworker, the former Leeds DSA and Bishop X were shared again.

TT had been given the opportunity to contribute to the meeting but, not being allowed to attend in person, she had provided a written statement. The key points are highlighted here:

- The dismissals by Bishop X in 2001-2 had broken her confidence in the church and left her feeling '*worthless, discarded, irrelevant and alone*.'
- This was why she had not reported Rev B at that time. It '*shattered her trust in the church and ruptured her relationship with God'. The church wasn't going to act and the whole process had been so painful I did not have the strength or the will to continue….. Now I felt abandoned and betrayed by both God and the church when I needed their support so much. This was like being abused all over again.'*
- The church was no longer a safe place. There followed a period over many years of stress, depression, anorexia and self-harming and suicidal ideation. This had an immensely detrimental impact on her son.
- Eventually through the support of friends and a therapist, TT found a place of some restoration but found her faith place outside the Church of England.
- She believed that in 2001-2 her abuse was covered up in the interests of protecting other clergy.
- She asked the Core Group to consider the appropriateness of Bishop X holding PtO and whether a CDM process could be instigated.
- She added that she felt the church was no longer a safe place when victims were treated in this way and she left her job with the diocese, with X Theological College and her parish church.
- TT also indicated that she would be willing to engage in a restorative process with Bishop X.

The meeting heard that NST had no procedures, guidance or policies relating to restorative meetings. The Group noted that there would need to be some agreement by both parties, on which to build. Furthermore, by the time the meeting took place TT had submitted an application for an out of time CDM and legal advice was that any restorative process should wait until after its completion.

The bespoke Safeguarding Training for Bishop X had now taken place. The minutes record the three questions that the trainers should be asking:

- Does the person understand what has happened, their role in it, their responsibility and the impact on victims/survivors?
- Does the person see themselves on a safeguarding journey, with continued growth and development needed and welcomed?
- What are the contextual/systemic factors impacting on that person's journey and are these being addressed?

The Reviewer was unable to locate any written report or feedback in the NST files, but this was found in the Diocese of Leeds file. This highlighted that safeguarding competence is a journey, not an event and it *'must develop over time, with a focus on self-reflexivity and dialogue, and engagement with people's core values and beliefs'*. Whilst this is true the tiered system of NST training is based on the premise that different levels of safeguarding competencies are required for different roles. The feedback from the trainers regarding Bishop X comprised three bullet points of recommendations in the minutes.

- *Bishop X should resume his safeguarding responsibilities*. (However, it was not clear in the minutes what these might be in his role.)
- *Bishop X was to establish an ongoing relationship with the DSA. Safeguarding is everyone's responsibility within the diocese; it is imperative that policies and procedures are understood*

to ensure Bishop X is responding well. The development of this ongoing relationship will ensure that Bishop X always works alongside and seeks professional guidance moving forward.

- *Bishop X continues to access safeguarding training. Safeguarding competence and learning are journeys and not events, therefore it is imperative that Bishop X continues to meet his professional requirements regarding training and development, in terms of mandatory and bespoke safeguarding training arranged by the diocese.*

The Core Group concluded that Bishop X had complied, he was up to date with general safeguarding training and there was no need to recommend removal of PtO. Bishop X had declined offers of support but would be offered support again if and when the CDM process went ahead.

The Reviewer was told that after the training Bishop X was '*in a different place'* but the minutes of the meeting do not record any discussion or clarification of what this brief feedback actually meant in terms of Bishop X's understanding of his response in 2001, why this was inappropriate, or his commitment to the safeguarding standards of today. This is a concern particularly in the light of AD's report that in Southwark Bishop X was 'a*ggressively committed to protecting clergy and would bat complaints away*.'

When the Reviewer examined the files in Leeds, the safeguarding training records for Bishop X showed that although he still has PtO, his safeguarding training was nearly a year out of date. Since that time the diocese of Leeds has informed the Reviewer that Bishop X has completed the training.

E.6.6. Correspondence between TT, Leeds DSA and NST

As the NST investigation drew to a close, TT approached the Diocese of Leeds expressing her continued concerns about Bishop X and asking the DSA and senior clergy what their response would be.

i. Between 8.3.22 and 7.7.22 correspondence took place between TT, the Diocese of Leeds and the NST**.** By this time, the NST had concluded their investigation, and Oxford diocese were taking their own steps to address the issue of Rev B's PtO. On 08.03.22 TT sent an email to the DSA in Leeds, the diocesan bishop, and the area bishop who was also the bishop for safeguarding nationally at that time. She asked them to take a similar approach as a diocese and hold Bishop X accountable, saying, *'The NST Core Group state that their only role is to manage risk. I'm therefore approaching you to ensure that Bishop X is held to account for his failings and expected to try to repair the damage he has caused.*'

ii. No record was found of any conversation between the DSA and the bishops, but an email dated 09.03.22 from the NST caseworker to the Leeds DSA was found in the Leeds files. This strongly guided the Leeds DSA in terms of the approach to take, stating:

> *'The Leeds DSA was part of the core group process which concluded with no ongoing concerns about Bishop X. It would not be appropriate to start again. TT has taken out a CDM and was not granted permission for an out of time application.'*

There are currently no policies about restorative justice, and we do not have people trained in that approach. My view is that even if we had restorative processes they could not start unless we had some agreement on which to build. It is important that no one is harmed in the process. As you are aware, we are meeting with Bishop X on Friday, and we will be guided by his responses. It is your decision, but I think it would be helpful to acknowledge that you/Leeds were part of the core group processes and that the actions have been completed and the matter closed from your point of view too, and that there is not currently a restorative process.'

Emails found in the Leeds files also dated 09.03.22 show that the diocesan bishop and the area bishop agreed this should be referred back to the NST by the DSA. The area bishop wrote an email to the diocesan bishop saying, 'My advice is to leave this to the NST. The problem is that this person has never been satisfied with whatever has been done'. It is the view of the reviewer, that this comment portrayed the same attitude of victim blaming that the survivor experienced in Southwark in 2001.

Through a succession of emails to TT the DSA held to the NST advice, confirming the case was closed. She wrote to TT saying: *'As Bishop X is a bishop the NST took the lead with your case, but I think it would be helpful to acknowledge that the Diocese of Leeds were part of the core group process and that we acknowledge that the actions have been completed and the matter is now closed. The Church of England does not currently have a restorative justice process'.* The Reviewer found no record of any correspondence from either of the bishops to TT and she states she received none. The diocesan bishop later confirmed that he believed it would not be appropriate to become involved in the process as it had been managed by the NST.

On 17.3.22 TT wrote again to the DSA having learned that despite telling her the Church had no restorative process, members of the NST had discussed her original request for a restorative justice process with Bishop X, but that he had declined to engage. The reason given by NST for not discussing this with TT was that at that time the communication between TT and her caseworker had broken down. A further complication was they by this time TT had submitted a CDM request regarding Bishop X. However, communications were taking place via TT's advocate, and the advocate could have been involved with TT in a conversation about her current wishes. TT felt it had been wrong for the NST to make that approach to Bishop X without any prior discussion with her about what she was hoping for and what would make the process safe for her. The Reviewer's opinion is that this was not good practice and not survivor led.

This appears to have been the point where the engagement of the Diocese of Leeds ended other than for the DSA to attend the Lessons Learned Review Meetings.

E.6.7. Telephone conversation with former DSA at the Diocese of Leeds

As there was no one available within the diocesan safeguarding team who had been involved with the NST investigation, the Reviewer contacted the Diocesan Secretary. With his agreement, the Reviewer contacted and interviewed a former DSA who had been in post and part of the NST Core Group. This took place by telephone on 16.4.25.

The former DSA confirmed that the Core Group had agreed that she and the NST Caseworker should meet with Bishop X. The DSA had attended that meeting with the NST caseworker and Bishop X and reported

that the Bishop of Leeds had asked her to ensure that Bishop X was pastorally supported at that meeting. She reported she thought she was being asked to provide pastoral support for Bishop X. Given her role in the investigation, this would have been a conflict of interest. A letter from the NST caseworker to Bishop X shows she had offered support to him, but he had declined.

The DSA recalled that Bishop X was '*defensive*' at the meeting, and she was not sure how much he remembered about TT's allegations in 2001. She also reflected that Bishop X was of the generation of Bishops that were accustomed to a culture of deference. She had worked with him in Leeds and reported that she had had to 'pick up the pieces' in safeguarding matters when Bishop X had not determined the right course of action and cited an example. This seemed to be at variance with the assertion by the Bishop of Leeds that Bishop X *'was a stickler for safeguarding'*. She had considered the NST bespoke training was absolutely necessary for Bishop X, alongside the normal diocesan training.

The former DSA also confirmed that she left the diocese part-way through the NST investigation and that involvement in the case passed to another DSA. She recalled this was shortly after the meeting with Bishop X and said the NST caseworker had not communicated with her again after she left.

Asked about the Risk Assessment for Bishop X, she confirmed that it had not been completed before she left. According to Core Group Minutes, the matter was not followed through, though there is a note that as he was not taking services during Covid, he was not a risk. It appears from subsequent minutes that the matter was never reconsidered.

The former DSA commented that there had been a number of DSA's at Leeds in the few years before she left. Her personal reflection was that when she left it was not an easy handover. She reflected that the NST and often the dioceses are very process driven. She also felt there needed to be greater attention to explain the whole investigation process to survivors, that the words used are very important and that those involved need to be able to put themselves in the survivor's shoes. She also thought that as a principle the NST should oversee the investigation process to its completion.

It is the opinion of the Reviewer that the definition of risk was not sufficiently broad, and the Core Group did not consider the potential for those in a position of authority and influence to influence both practice and culture for good or ill. As a demonstration of good practice, an independent risk assessment should have been completed in addition to the NST bespoke safeguarding training. The Reviewer believes an independent risk assessment would not have been out of keeping with Point 2 on page 51 of the 2017 Responding to, Assessing and Managing Safeguarding Concerns or Allegations Against Church Officers which states that if:

> *The initial investigation finds the concern or allegation was unsubstantiated but there are ongoing safeguarding concerns – in this scenario a risk assessment is required, for church officers who are ordained, licensed, authorised, commissioned or holding permission to officiate the DSA should recommend to the bishop that an independent risk assessment is undertaken. For other church officers, the core group should inform the DSA who will either carry out a standard assessment or make arrangements for it to be carried out.*

E.7. Complaints

During the course of the NST Investigation TT lodged three separate formal complaints.

E.7.1. First Complaint

10.05.21. TT lodged her first formal complaint, highlighting what she regarded as poor communication and unnecessary delays. This was regarding the failure of an NST staff member to respond sufficiently or in a timely manner to questions TT had been asking about her case in a number of emails. According to the NST Case Investigation records, TT had first raised these in a letter to the Core Group on 26.01.2021 and subsequently with her caseworker. TT complained that having waited six weeks for a response to inquiries about the investigation process, she still received nothing in writing from the individual responsible for communicating answers to her queries, only a verbal response via her advocate that in TT's view did not address the questions she had asked. TT perceived this response *as 'disrespectful and uncaring and dismissive of her as a survivor.'* The Reviewer agrees this was not acceptable practice.

The recipient of the complaint was on leave at the time and first read it on 18.5.21. An investigation was duly carried out by the person's line manager under Stage 1 of the Church of England National Church Institutions Complaints Policy and Procedure for the NCIs[6]. They met with TT and her advocate online on 24.5.21. The process was fully documented, and advice taken from the Legal Team and the Information Governance Officer. Documents were reviewed and the member of staff in question was interviewed. NST have made it clear that some of the questions TT raised could not be answered fully due to GDPR and the need to protect other individuals' personal information.

The report of the investigation was completed on 06.07.21. TT received a letter 08.07.21 stating that most of the elements of her complaint relating to the unnecessary delays in answering questions TT had raised in a letter to the Core Group dated 26.01.21 and also the lack of professionalism and empathy within letters were valid and upheld. An apology was issued for the failings identified and the stress caused.

There were still some outstanding questions and answers were promised to TT by 16.07.21. This deadline was met. A second letter dated 15.07.21 addressed the three remaining points which were not upheld. They were not considered valid as they fell outside the 2017 Responding to, Assessing and Managing Safeguarding Concerns or Allegations Policy and Procedures. The letter reinforced that TT's concerns and vulnerability were considered by the Core Group but *'In clarification, it is not the role of the Core Group to come to a definitive conclusion of events but rather to address current risk'.*

The Reviewer has seen the correspondence and documents relating to TT's complaint and is satisfied that the complaint was dealt with appropriately, but it is important to recognise that this should not have been necessary in the first place. It is a very regrettable concern that a member of staff at the NST should delay communicating with an abuse survivor and do so in such a casual way that demonstrated no understanding of a trauma-informed response. This highlights the need for all staff to be properly trained on acceptable practice and communication, and when interfacing with survivors they should undergo trauma-informed practice training. (The NST has subsequently reported that training has been implemented.)

E.7.2. Second Complaint

[6] National Church Institutions: Service Complaints Policy and Procedures November 2023

28.9.21. TT advised NST that she wished to submit her second formal complaint against a member of the NST casework team and this was formally lodged on 9.3.2022. The complaint was in relation to communication issues and failure to seek the views of her as the survivor and was directed to a second member of the NST. TT complained that:

i. This person attended a virtual meeting to give TT feedback from a Core Group Discussion related to her case on 09.03.2022. TT was only expecting her case worker and her advocate to be attending and was not advised of the change, which she found very unsettling.
ii. She felt this person's tone towards her was at times *'patronising and judgmental'* in tone and sometimes '*defensive and aggressive*.' She felt this also came through in a letter they had written to her on 28.03.2022.
iii. She felt she did not receive direct answers to her questions but only general information relating to the investigation process.

The complaint was investigated by a Deputy Director in the Human Resources Department of the NCIs to ensure independence from the NST. They agreed with TT's views that these issues were not disciplinary matters. Having reviewed all the evidence they concluded that the complaint should be partially upheld. They agreed that, in line with the principle of asking a survivor what they want, TT should have been advised about the proposed change to who would be present at the meeting on 09.03.2002 and for that TT received an apology. The subject of these complaints recognised that their professional training had emphasised the importance of asking survivors what their wishes are and was willing to apologise to TT for their mistaken assumptions that she would accept his unannounced appearance at the meeting.

TT's complaints regarding the tone used in the meeting and the letter were not upheld. The investigator noted that TT was deeply distressed by the decisions she heard in the meeting and that the subject of the complaint *'did interject assertively from time to time but not in a way that seems to have been either aggressive, defensive or inappropriate'.*

It is evident from the records held by the NST that the Complaints Process was followed. What is not in evidence is any reflection by the casework team regarding whether TT's complaint could have been avoided through a more trauma-aware process or managed differently in order to achieve a resolution of the dispute.

E.7.3. Third Complaint

As the NST investigation came towards an end, NST informed TT that it was time to transfer her to Safe Spaces to provide advocacy support going forward as the ISB process started. They believed that this was in the best long-term interests of both TT and her current advocate. This became a source of great anxiety and distress for TT due to her confidence in and reliance upon the advocate who had been supporting her throughout the investigation. Having listened to both TT and her advocate and considering the correspondence from the NST, the Reviewer is of the opinion that this decision had not been taken lightly and that the NST believed this was the best way forwards for both the needs of TT and the needs of her advocate. TT's advocate confirmed that she was in agreement with the decision, that she had supported TT for longer than was usual in an advocacy role, and it had been intended that she would only support TT as the ISB process started, until alternative support was in place via Safe Spaces.

TT felt that this was not a trauma-informed decision and it did not take sufficient account of her vulnerability at that time. She did not feel the support from Safe Spaces at such a time of transition and going forwards to the ISB Review was adequate because it was not in-person and would necessitate beginning a new relationship and building trust all over again. She therefore instigated a complaint about this. The complaint was heard by the Deputy Lead of the Safeguarding Team. The complaint was not upheld, and TT was informed of the decision and the NST's reasons for this in a letter dated 17.08.23.
Initially arrangements were made for TT to meet online with the new advocate from Safe Spaces, with her existing advocate present in the first instance. Subsequently TT was provided with advocacy from FearFree when they took on advocacy for those whose cases at the time were under the remit of the ISB.

E.8. Lessons Learned Review

The Lessons Learned Review (LLR) which was commenced in May 2022 was conducted to reflect on how the church had responded to TT's case and this was good practice. The review was led by the NST but the DSA's from Southwark and Leeds and the Bishop's Chaplain from Oxford were also involved and attended the meetings. This section highlights the key points that were discussed as part of the LLR and recorded in the Minutes of meetings and the LLR Action Plan.

E.8.1. TT's comments. TT had asked to meet with the group in person to share her reflections, but NST members felt this was not appropriate as there was no provision for this in the guidelines. TT therefore sent a comprehensive document. To allow for the group to peruse this thoroughly, the first meeting on 25.5.22 was reconvened on 15.6.22 with a further meeting taking place on 22.6.22.

E.8.2. The minutes of the 15.6.22 meeting show that the DSA from Southwark and the Bishop's Chaplain from Oxford offered some pertinent reflections that then prompted the discussions about meeting the support needs of survivors.

The key points that were discussed as part of the LLR are included below:

i. **Survivor Support.** This included a lack of consistency in the counselling provision. The initial funding stream had been discontinued after a year. The NST clarified that funding did not provide in-depth therapeutic counselling but was there to support TT through the investigation process. It was noted that there was no formal process for assessing need at the outset. It was suggested that if a survivor were referred to an outside body to meet with the survivor, assess their need and offer what was available, the NST could concentrate on their remit of assessing risk.

This discussion reinforced the need for a more robust conversation at the start of an investigation about what the Core Group and the NST can and cannot do. The NST reported that they were working on a pamphlet for survivors and that the casework team would develop an email to set boundaries and get agreements in place.

ii. Disclosure. The Chaplain noted TT's point that disclosure is a journey and not an event. The need for the caseworker to hear TT's disclosure over Zoom had not been helpful and sometimes these sessions

had had to be ended due to TT's level of distress. This may have been a contributory factor in TT feeling that she had not been fully heard. It was acknowledged that there was a tension between a survivor needing to disclose over a period of time and the Core Group's need to progress the process of managing risk. This demonstrated the inflexibility of the investigation process.

iii. Staff Turnover. It was acknowledged that staff turnover had been a significant issue in this investigation.

iv. Access to the Core Group. The Oxford Chaplain felt that TT should have been able to meet the Core Group. He commented that from his experience of other core groups, a lack of access to the group left survivors feeling *'there was something going on in the core group and that they are not accountable.'* He added that in other places survivors could come and meet the core group, though he recognised this would also have to be offered to respondents. The NST caseworker reinforced that their remit was risk, and this was not part of the process but agreed both the survivor and respondent(s) should be able to make a submission in writing.

v. Accuracy. It was agreed that there should be a note taker present in face-to-face meetings, and this should be agreed from the outset.

vi. Consent and Vulnerability. Whilst it was acknowledged that the legislation in place was different at the time of the allegations the Oxford Chaplain raised the need to be clear about power imbalance. It was agreed that further clarity was needed about what constitutes vulnerability.

A further meeting was convened to complete the Lessons Learned Review.

E.8.3. The minutes of the 22.6.22 meeting show that the main purpose was to discuss feedback from the respondents, Rev B and Bishop X and to allow for final comments and reflections from the group.

i. Feedback from Rev B

Rev B had expressed gratitude for the support from his area Bishop. He had found the police investigation very stressful, and it had taken the police '*a long time*' to confirm in writing that they would not be taking any further action.

The Oxford Chaplain noted that the Core Group had lacked certainty about the House of Bishops' Policy regarding PtO[7] for those under a police investigation. He suggested that removing or suspending PtO might have been helpful and might have prevented TT from feeling the need to take out a CDM. The Core Group had been informed by the NST that the policy was currently being rewritten, and the new policy would give clearer guidance.

The Reviewer is not aware that the 2018 policy has been superseded and notes that the 2018 Policy that was in place at the time of the NST investigation stated:

[7] https://www. churchofengland. org/sites/default/files/2018-07/house-of-bishops-policy-on-pto-july-2018. pdf

PtO should not be suspended, but must be withdrawn, whilst investigations are carried out into any allegations made against a cleric in line with the House of Bishops Responding to, Assessing and Managing Safeguarding Concerns or allegations against church officers.

This supports the view of the Chaplain and indicates that it would have been prudent for the NST to at least discuss the matter with Rev B's bishop. At the very least a risk assessment could have been completed to demonstrate that this was being taken seriously.

ii. Feedback from Bishop X

The NST caseworker reported that Bishop X had been quite defensive and thought the letter he had written to TT in 2001 had been good. His training had been greatly delayed but, in the meantime, he had completed the overdue diocesan training. The caseworker thought that following the training he was in a different place in terms of his understanding.

The Oxford Chaplain thought there were generational issues where senior clergy were used to being 'the boss' and wished they would listen more and be less defensive. (This had been echoed by the former DSA from Leeds in her telephone interview.)

iii. Challenges with the investigation

These were discussed by the group and included:

- The need to make clear to survivors the focus and rationale for the Core Group.
- Communications while TT was out of the UK. This highlighted the need to be circumspect about using Zoom when communicating with survivors.
- The use of language and the difficulties of using non-verbal communication.
- The conflict around confidentiality and perceived secrecy.
- Issues of staff changes and the changing approaches of different managers. This had exacerbated the difficulties both for TT and for the case workers.

iv. Viewpoint of the DSA from Leeds

The DSA from Leeds expressed the opinion that Bishop X had done *'what he needed to do and that risk has been assessed and managed.....Bishop X had nothing to answer for. He had advised TT to go to the police. He passed the concern to the right person vulnerable adults' policies did not exist at that time. His letter could have been more caring, but this has been addressed.'*

The Reviewer believes this viewpoint is problematic for reasons outlined earlier in the report. In summary:

- Bishop X only told TT to go to the police after the prompt from the Archdeacon. However, the investigation by Bishop Y and the correspondence with Rev A had potentially already compromised any police investigation.
- No support was offered if she did decide to report to the police.
- Although there were no Vulnerable Adults policies in 2001 there was an ongoing discourse within the church of England at the time regarding the need to provide pastoral support for women as well as children who were victims of abuse. As a senior bishop, Bishop X should have been aware of this.

- Bishop X exercised no duty of pastoral care to TT.

It was reported that when interviewed by the caseworker and the Leeds DSA, Bishop X did not understand the issue with his response in 2001.
Furthermore, during this case review it has come to light that although Bishop X eventually completed his bespoke safeguarding training there was no clear evidence provided that his understanding had changed through a process of critical reflection and the formal risk assessment was never completed. As of February 2025, his safeguarding training had lapsed once again. (The diocese of Leeds has advised that this has subsequently been completed.)

E.8.4. Lessons Learned Review Action Plan

Holding the Lessons Learned Review was good practice and TT was invited to have an input though not allowed to attend in person. It is clear from the minutes that the representation from Southwark and particularly Oxford raised important issues and brought rigour to these discussions.

A plan of actions going forwards was produced and shared with TT who responded with her own comments. However, the plan seen by the Reviewer had only two columns, the first stating the issue identified, and the second stating how it would be progressed. There were no details of who would be responsible nor the timescales for review or completion and no record of expected outcomes.

At the request of the Reviewer, the NST provided a new undated document which included an additional column for 'Action Outcomes'. This entire column was blocked out in green indicating that all the issues identified had been achieved, yet no dates had been recorded and some entries indicated, for example, that the issue had been shared with the policy development team for Responding Well to Victims and survivors, or that the issue had been discussed as part of team professional development. Where actions had been taken, for example, a four-day course on trauma-informed practice, this did not indicate how many staff or which roles were included, and there was no record of how this was impacting on everyday practice.

An effective action plan should document each objective and the actions to be taken, together with the person responsible and the date for completion, along with the criteria to measure the impact of actions. There should be an agreed timetable for reviewing progress. Where actions have not been completed or only partially completed, the reasons should be documented. Without this rigour there is no effective tracking of actions through to implementation or evidence of any impact on practice.

There is therefore no record of how learning from the Lessons Learned Review has influenced practice and it is not possible in this case review to comment on whether there has been any significant learning from the investigation into TT's case. The church's response to investigations and reviews is a wider issue across the Church of England.

E.9. Findings and Analysis

E.9.1. The survivor's view. Shortcomings in the investigation process.

TT has expressed the view that during the NST investigation there were a number of short comings. These are detailed in the terms of reference, and the Reviewer makes reference to them whilst attempting to address the Key Lines of inquiry. In summary they were:

i. **The survivor's voice.** TT felt she was not sufficiently listened to during the investigation.
ii. **Accountability.** TT felt that the Church of England processes were not consistent with what is now considered best practice and that consequently no one was held to account failures.
iii. **Communication.** TT felt that she was not provided with sufficient information about the rationale for decisions and actions and that at times the manner in which people communicated with her was '*adversarial'* and lacked the sensitivity of trauma-informed practice.
iv. **Raising Concerns.** TT states there was no provision to raise concerns about the process, only about individuals.

E.9.1.1. The survivor's voice. TT felt she was not sufficiently listened to throughout the investigation.
There is evidence from TT herself that at the start of the NST investigation in 2019 she did feel that she was listened to, and this gave her confidence that this would be a very different experience from the one in 2001. She commented that it was because the NST caseworker who was her first point of contact, listened so well that she decided to proceed with the investigation. After her meeting with the second caseworker in November 2019, TT wrote saying:

> *I wanted to thank you for your honesty, and understanding, and good listening. I felt heard and validated, which is a huge relief after last time.*

She reiterated this on the day of the first Core Group, writing:

> *Whatever the outcome today, I just wanted to say thank you to you for the way you have supported me to get to this point. Your understanding, kindness, consideration and compassion have made this part of the journey bearable, and I have felt heard and validated, which is so powerful. I am still terrified, but I feel you are standing with me, which brings such strength.*

However, as time went on TT grew less and less confident that her voice was being heard and that at no time had anyone attempted to listen to her full account. It does appear that this is the case. She had told her story in instalments and consequently would re-order things as she told the next part. This is perfectly normal for survivors for whom disclosure is often a journey and not an event.

As stated earlier in the report, after the LLR in 2022 the DSA of Southwark provided the facility for TT to record her whole story in her own time and in a safe space and this provided a powerful piece of evidence for this case review. This was good trauma-informed practice that could have been considered and employed by the NST particularly when TT was showing distress because she felt no one had fully heard this.

E.9.1.2. Accountability. TT felt that the Church of England processes were not consistent with what is now considered best practice and that consequently no one is held to account failures.
When TT engaged with the NST investigation she hoped that both those who had had abused her as a young adult and those who had caused further harm when she tried to report, would acknowledge this, be held to account and she would receive a full and unreserved apology. It was a source of hurt and grave

disappointment that Rev A was considered by the police to be too frail to interview and died soon after the investigation commenced.
The Reviewer notes that decisions made by the police are outside the control of the church. However, there were delays that led to missed opportunities which might have enabled the police investigations to take place sooner and reduce the protracted timespan of the investigation.

Whilst she is grateful to those in the Diocese of Southwark and of Oxford who have validated her experience and apologised for the failures of the past, she believes the NST should themselves been more proactive in relation to Rev B, Bishop X and Bishop Y.

E.9.1.3. Communication. TT felt that she was not provided with sufficient information about the rationale for decisions and actions and that at times the way people communicated with her was '*adversarial*' and lacked the sensitivity of trauma-informed practice.

i. TT felt strongly that she had not been listened to sufficiently and that there had been a lack of transparency throughout the NST investigation. She appreciates the tension that exists between confidentiality, privacy, GDPR on one hand, and safeguarding, transparency and the empowerment of the survivor on the other. Her perception was that GDPR had been used as an excuse to withhold information from her. She had to use SARs to obtain information, and she felt this should not have been necessary and made the process yet more stressful for her as an abuse survivor.

ii. Communications about and the limitations of the investigation were not set out sufficiently clearly for TT at the outset.
It is the opinion of the Reviewer that one of the root causes of TT's disappointment, dissatisfaction and distress about the NST investigation process was that she was not given sufficiently clear information at the very outset regarding what the investigation could and could not deliver.

NST have told the Reviewer that at the initial meeting it would have been explained to TT that the NST investigation would focus predominantly on identifying and managing current and future risk. However, no one from NST has been able to supply any record or written notes from that initial meeting and TT states she did not receive a summary. This was not good practice, and this is a concern that has been highlighted already in this report.

TT acknowledged that she knew at the time that the NST investigation did not necessarily guarantee a good outcome in terms of a prosecution, nor would she avoid pain and frustration. She did expect more focus to be on the survivor and what they need, and for there to be accountability and an attempt at restorative justice. She wrote to the caseworker saying, *'I was reassured that if I report again, it will be taken seriously and investigated properly.'* She felt that the full implications of the narrow focus of the investigation were not made clear enough or fully impressed upon her at the beginning. The message she recalls most vividly at the initial meeting was the one that was reiterated in an email from the caseworker and which raised her expectations:

> *'Your decision to disclose the identity of those involved and of what happened to you is courageous. This is clearly a serious matter and one which will need appropriate investigation, not least because Bishop X is still very active in ministry.'*

She therefore entered the process with a false hope that she would at least receive an apology from the Church and some form of restorative justice. As the investigation progressed TT was reminded repeatedly that the purpose of an NST investigation was '*not to make a finding of fact nor to hold people accountable'* but to *'assess and manage current and ongoing risk*'.

NST have acknowledged that there were no leaflets or written guidance to highlight this and explain what the investigation could and could not deliver, and this was a significant weakness at the start of the process. Clear written guidance should be available to survivors before they make the weighty decision to proceed with a process that is likely to cause re-traumatisation, even if the outcome is good. The 2021 NST PCR2 report noted this and recommended that such material should be made available to survivors. However, to date NST acknowledge this material has not been developed although this was included in the LLR Action Plan. The reason given is that they have been waiting first to complete revisions to the managing allegations policy - over the last 5 years, and as a result that key issue has still not been acted upon. Further attention is needed regarding managing expectations for anyone considering entering an NST investigation.

iii. Insufficient explanations of the process that would be followed, for example who would form the Core Group. TT wrote to the NST on 26.1.21 and pointed out that she still did not know the names or roles of members of the Core Group and had only met the two she did know virtually.

> *'I wonder if you can understand how it feels to have something of such fundamental importance to your life, something that makes you so vulnerable, and all your incredibly intimate and personal details discussed by a group of strangers, in a process that, from your point of view, appears shrouded in secrecy? I am disappointed that you never took up my requests to meet me. It feels like being a child shut outside in the garden while the adults talk about secret things indoors. I would appreciate at least knowing your names.'*

Whilst the Reviewer understands the need for Core Group to operate within prescribed boundaries, TT's concerns are completely understandable. A survivor-focused approach should ensure that any practice that increases the survivor's sense of isolation and alienation is considered and modified appropriately and this would start with listening to the voice of survivor, understanding the things that trigger their stress and hyperarousal and together finding measures that can reduce this. This was raised during the Lessons Learned Review.

iv. Two – way communications with TT were seriously compromised whilst she was away from the UK. Almost immediately after the first Core Group Meeting, TT left for the planned trip abroad, intending a brief visit to the UK in April 2020 and a final return in June 2020. No one could have foreseen the impact of the restrictions imposed due to Covid 19 and that her return would be delayed until the following year.

Nevertheless, the trip was known about at the time of TT's disclosure in October 2019 and the first Core Group in November 2019. Arrangements were put in place for the NST caseworker and her advocate each to contact her once a month whilst she was away, which would be expected practice. The Reviewer has

not seen any mention in meeting notes, minutes or emails of the recognition of the challenges of communicating with TT during her physical absence and imparting information that could be re-traumatising, nor was there any formal risk assessment that would consider how to mitigate any risks to TT's mental health and well-being.

v. At times communication lacked the sensitivity of Trauma-Informed Practice

Between November 2019 and June 2021 all communication between the NST and TT was either by telephone, online or through emails and letters. One of the lessons in a world where much face-to-face contact and communication has been replaced by virtual meetings is that in consequence much of the nuance and empathy that is communicated though tonal changes, body language, and facial expression can easily be lost. In addition, as a survivor of multiple layers of abuse, TT suffers, severely at times, from the traumatic effects of that abuse. Careful attention to choice and use of language should be of the utmost importance when communicating online or in writing at any time, and especially when those messages will be difficult for the survivor to hear and process. Whilst terms such as 'unsubstantiated' and 'no further action' are the common terminology, hearing or reading these terms when physically isolated can be deeply upsetting for a survivor. There is a need for caseworkers to plan ahead for careful and sensitive explanations of how and why these decisions have been reached, how and when this is communicated to survivors, and ensuring that additional support is available if needed.

vi. Insufficient attention to seeking the views of the survivor.

As time went on the Core Group minutes noted that TT was finding the investigation increasingly difficult and there were discussions and actions about her support. However, TT reported that she was not consulted about what would be most helpful for her, and the Reviewer agrees this would have been the best trauma-informed approach.

On 9.3.2022 TT made a complaint in relation to communication issues and failure to seek the views of her as the survivor. This was directed to a specific member of the NST and is reported fully in Section E.7.2. The NCIs Complaints process was followed. the complaint was partially upheld, and for that TT received an apology. What is not in evidence is any reflection by the casework team regarding whether TT's complaint could have been avoided through a more trauma-aware process or managed differently in order to achieve a resolution of the dispute.

E.9.1.4. Raising Concerns. TT states there was no provision to raise concerns about the process, only about individuals.

TT states that it has never been her intention to vilify or undermine any individuals. She views this case review as an opportunity to offer a contribution to the discourse around how survivors of church abuse can have their voices heard, receive genuine apologies from the institutional church for the harm and the consequences of the harm survivors have suffered, and for support along a pathway of restorative justice.

During the NST investigation TT states that she observed practices she thought could be improved but felt that when she tried to raise these observations there was only one message coming back – that due process was being followed. Therefore, she eventually filed the three different complaints in relation to individuals, namely:

i.10.5.21 Regarding failure to respond to questions from her in a timely manner and when the response came it was unprofessional.
ii.11.3.22 Regarding a senior caseworker for being present at meeting without her being informed and for responding in a way that TT felt was at times, aggressive in nature, and judgmental and patronising in tone.
iii. 6.7.23 Regarding the decision to end the support from TT's advocate in July 2023.
These are all explored more fully in Section E.7. of the report:
Making these complaints was emotionally costly for TT and resource-costly for the NST. It was never TT's intention that the complaints should be personal, and it is the opinion of the review that a mechanism is needed for concerns to be raised about the process itself.

E.9.2. The key lines of inquiry for this case review were stated under A.2.4. and are repeated here for convenience:

i. Whether the processes used by the National Safeguarding Team were just to all involved, timely, and done in line with best practice in the wider safeguarding environment.
ii. Whether the investigation in this case was thorough and properly conducted, including whether the National Safeguarding Team responded appropriately in the case of a deceased alleged perpetrator.
iii. Whether sufficient accountability been demonstrated and consistent survivor support maintained.
iv. In addition, the Reviewer was asked to highlight examples of good safeguarding practice and the factors that contributed to this.
The Reviewer was also asked to:
v. Recommend improvements in policy, procedures, and practice where the Reviewer considers the evidence in this case shows that these are necessary.
vi. Make any recommendations that arise from this case to enable the Church of England to embed a proactive, preventative, safe culture.

E.9.2.1. Whether the investigation in this case was a) thorough and properly conducted and b) whether the National Safeguarding Team responded appropriately in the case of a deceased alleged perpetrator.

The National Safeguarding Team had a process which they followed. The bigger question of appropriateness of the process is examined in Section F of this report.

a) Whether the investigation in this case was thorough and properly conducted
There were aspects of the case that were very thorough and where NST workers paid careful attention to detail.

- At Group Meetings members were also reminded of the background to the case and this was important as additional people such as legal advisors and communications officers attended some of the meeting.
- Core Group members were always reminded of the importance of confidentiality.
- The main caseworker's records were meticulous and thorough.

This was all good practice.

However, there were areas where there was a lack of thoroughness. These have been addressed in greater detail earlier in the report but are summarised here:

i. Delays

The delay of nearly seven weeks before the first Core Group meeting took place fell well outside the time limit in the Managing Allegations Guidance which was in force at the time of the NST investigation. Without an effective process for handover, valuable time was lost in calling the Core Group together and making a referral to the police. Consequently, there was no possibility of the police interviewing TT before she left the UK and this impacted on the progress of the investigation and the mental health of the survivor.

Delays in communicating the outcomes of meetings with TT or responding to questions had a very negative impact on TT. At times this resulted in responses that reflected the dysregulation of her emotions. This was difficult for NST workers to manage and in the opinion of the Reviewer created a vicious cycle. A more sensitive trauma-informed response when this happened might have alleviated some of TT's distress.

ii. Minutes and actions from Core Group meetings.

The recording of follow up on action points was inconsistent and this was an opportunity for confusion. One of the most significant examples of this was the recommendation that a risk assessment should be completed for Bishop X at the meeting on 21.2.20. During this case review the Reviewer was told repeatedly that this was completed but has subsequently learned from the DSA in post at the time that it was not completed. Consequently, Bishop X's entitlement to holding PtO remained unquestioned and he was able to engage with people and represent the church whilst concerns remained about his previous actions, and his training was allowed to lapse again. The Reviewer would suggest that if he was really in a different place as the NST suggested he would want to own his past actions and issue an apology to TT.

iii. Bishop Y

TT has asserted that the Core Group were not sufficiently thorough in the case of Bishop Y. Meeting minutes confirm that from the early stages of the investigation the core group decided that no action would be taken regarding Bishop Y, even though it was agreed that his actions and attitudes were '*far below the standards that would be expected today'.* It appears the Core Group accepted that being elderly, living overseas, and apparently not having PtO, meant that there was no purpose in following up this strand of the investigation nor seeking any form of accountability or apology for TT.

When TT discovered some evidence that Bishop Y was in some outward-facing roles in 2022, the caseworker did write to the bishop of his jurisdiction about the investigation stating the case was now closed and asking for an acknowledgement of the letter. What the caseworker was hoping to achieve is not clear.

In contrast the Bishop of Southwark said that he felt he should take some responsibility for TT's wellbeing and put TT's proposals (for a restorative justice meeting) to Bishop Y as reported under E.4.12. He utilised his network and during a timely meeting with the Bishop of Bishop Y's jurisdiction he delivered a message

for Bishop Y via that Bishop, informing him of the case review and seeking his response. Following a conversation between the bishop of his jurisdiction and Bishop Y, he received a response from Bishop Y. This was a firm rebuttal of TT's allegations, and the tone indicated that his mindset had not changed significantly. The Bishop of Southwark reflected that risk is wider than whether a person has a ministerial role and agreed that while such attitudes are allowed to remain the culture will not change. This is an example of a more thorough and persistent approach to risk than that of the NST and it was helpful for TT to know that the Bishop had done his best for her.

iv. Bishop X

TT also asserted that the Core Group were not sufficiently thorough in the case of Bishop X. There are certainly a number of factors that in the Reviewer's opinion suggest that the approach by both the NST and the Diocese of Leeds towards Bishop X was not sufficiently thorough.

(i) The Core Group Minutes indicate that the NST caseworker and the Leeds DSA would meet Bishop X together to investigate the concerns raised. The NST caseworker offered Bishop X support which he declined. However, that DSA has reported that the Bishop of Leeds asked her to ensure Bishop X was supported. She thought the bishop wanted her to fulfil this role, and this would have created a potential conflict of interest for the DSA between investigating TT's legitimate safeguarding concerns on the one hand and supporting Bishop X on the other. Greater clarity was needed to ensure roles were clear, that there was no conflict of interest and that any support person was completely independent.

(ii) The same DSA reported that in matters of safeguarding Bishop X may have been a stickler, but he did things his way and offered an example of when she had had to manage what she described as his '*missteps.*'

(iii) It is a concern that within the Core Group minutes there was no record of Southwark sharing the concerns that had been raised by AD about the culture over which Bishop X presided in Southwark, namely that '*he was operating in a context in which Bishop Y, and Bishop X, were aggressively committed to protecting clergy, and would 'bat complaints away'*. This was a serious failure of information sharing that perhaps can be traced back to a repeated turnover of DSAs in Southwark at that time. It may also highlight the limits of what the NST and dioceses believed they were able to do as part of the investigation. It is obviously concerning that questions about culture and protectionism were raised during this case review, given that Bishop X was still involved in the Church and Bishop Y was possibly involved in the wider Anglican church overseas.

(iv) Given the concerns expressed by the NST caseworker and the Leeds DSA after meeting with Bishop X, the Core Group agreed that he should undergo bespoke safeguarding training and that the Leeds DSA should complete a risk assessment. There was no timeframe for the training, and it did not take place until over a year later. The reason given was Covid, but it has also transpired that there was a lack of staff to deliver this. When the training was completed the Core Group were assured that Bishop X was '*now in a different place'.* However, the criteria were general, and the Reviewer has seen little evidence to support this assertion. A greater concern is that the risk assessment was never completed despite assertions that it *'would have been.'*

(v) When TT requested a meeting with Bishop X in the hope of some form of restorative justice, he declined, saying that in his view, it might not be good for her. The Reviewer notes that his refusal was never challenged by the NST.

(vi) As the investigation drew to a close, TT approached the Diocese of Leeds expressing her continued concerns about Bishop X and asking what their response would be. The Reviewer has seen emails between the NST, DSA and senior clergy that show they simply followed the NST guidance. One email expressed the opinion that, *'The problem is that this person has never been satisfied with whatever has been done'* and this portrayed the same attitude of victim blaming that the survivor experienced in Southwark in 2001.

(vii) In February 2025 Bishop X still had PtO and his safeguarding training was nearly a year out of date. The Diocese has subsequently informed the Reviewer that this has now been completed.

The Reviewer agrees with the views of TT that the investigation regarding Bishop X was not sufficiently thorough.

b) Whether the National Safeguarding Team responded appropriately in the case of a deceased alleged perpetrator.

This is a vexing issue for survivors whose perpetrators are now deceased or considered to be too ill or frail to be questioned. In the case of Rev A the police decided that he was indeed too ill to be questioned, and he died in February 2020. As a result, there was no further action by the police, and that aspect of the NST investigation reached its end. For TT as the survivor there would be no opportunity for an acknowledgement, no apology and no chance of any restorative justice.

TT has expressed that it was very wounding for her that no one at the NST felt able to step outside 'the process' and acknowledge the veracity of her statement about Rev A.

However, if there is one positive outcome for TT perhaps it is that the current Bishop of Southwark and the DSA have both expressed deep sorrow for what happened to TT in the diocese, salute her courage and welcome the opportunity to work with her now. This has been a source of help and validation for TT, but she still has not had an apology from any representative of the Church of England such as the lead Bishop for Safeguarding.

E.9.2.2. Whether a) sufficient accountability has been demonstrated and b) consistent survivor support maintained.

a) Accountability

i. The single focus of the investigation

One of TT's greatest frustrations stemmed from the single focus of the investigation being on managing risk. The role of the Core Group was not to make a finding of fact and as a result no one at the NST would actually say they believed her. Without either material evidence or an admission by the respondents, the

police were not able to pursue their investigations. Rev A was too ill to be interviewed and died and Rev B denied all the allegations and gave a 'no comment' interview.

With neither an admission of wrongdoing or a conviction of guilt, and no provision for finding the abuse proven on the balance of probabilities, TT came to realise she was never going to see anyone held to account for their actions and attitudes. Whilst the Diocese of Oxford took further steps outside the NST investigation process, the NST's position was that they had followed due process, and it was not appropriate for them to make recommendations to the diocese of Oxford.

ii. Neither did the NST consider it appropriate to take further steps to hold Bishop X or Bishop Y to account for their handling of TT's case.

It was a feature of this case that neither the NST nor the dioceses involved took steps to hold Bishop X or Bishop Y to account for their handling of her disclosure in 2001/2. It was due to her frustration with these decisions that TT made applications under the Clergy Discipline Measure both in respect of Bishop X and Bishop Y. Both of these were rejected not least due to the time limitation of 12 months having expired. Victims/survivors of past abuse often wait years before feeling able to make a disclosure. Under the new measure approved by Synod and now going through Parliament the 12-month limitation will not be applicable in cases classified as gross misconduct. However, at the time of writing this report the definition of what constitutes gross misconduct was not entirely clear and this is a concern. It is therefore not clear how or whether the limitation period would be disapplied for a case of this nature in the future.

It is the belief of the Reviewer, that the survivor should not have sole responsibility for bringing the complaint under the measure. Usual practice would be that on the receipt of a complaint from a survivor, this would be explored and considered by the Archdeacon and the Bishop and then the Archdeacon would normally bring the complaint forward. In TT's case the NST did not believe it was appropriate to do this. TT wanted to take out a CDM herself and asked for advice and support from NST and this was not given, on the grounds, stated in Core Group Minutes that she was *'intelligent enough to do it for herself'.*

In minutes of meetings and communications with TT it was repeatedly stated that Bishop X acted appropriately at the time. This was picked up in the Diocese of Southwark's PCR2 report pertaining to TT's case which notes:

> *'From her later Subject Access Request in 2020, TT has learned that the management of her case in 2002 by these bishops was judged, in the core groups on 2019-20 to be due to the fact that safeguarding processes were not the same back in 2002'.*

This same view was articulated in conversations with the Reviewer during this case review. Section D.3.1. of this report articulates why it is the view of the Reviewer that the responses of Bishop X were not appropriate for then or for any time. In short, he allowed any potential police investigation to potentially be compromised by the actions of Bishop Y but subsequently, after receiving correspondence from AD, he changed his approach and absolved himself of any responsibility and told TT to report to the police. He was party to correspondence between Bishop X, the AD and Rev A in which TT was vilified and failed to offer her any pastoral support. During the NST investigation the AD noted that in Southwark diocese

in 2001-2002 *'he was operating in a context in which Bishop Y, and Bishop X, were aggressively committed to protecting clergy, and would 'bat complaints away'.* It is therefore a real concern that members of the NST still consider Bishop X acted appropriately for the time despite the evidence set out in this report.

b) Survivor Support.

I. From the start of the NST investigation an advocate was provided for TT. This was good practice on the part of the NST, and TT has spoken very highly of the support she received from her advocate. However, it should be noted that the advocate was a part-time employee of the NST and although she had her own supervision from outside the NST, she was line-managed by a senior manager within the NST. Although the advocate sought to keep careful boundaries, she expressed that the advocacy role needs to be fulfilled by someone who is not an employee of the NST. It is the opinion of the Reviewer that at times having to make representation to her own line manager and her employer on behalf of TT created conflict of interest. A survivor's advocate should not be in that position and for this reason the advocate for a survivor should be independent of the NST. The NST have subsequently advised the Reviewer that they have been working to address this issue.

ii. From the start of the NST investigation the NST sought funding for further counselling for TT during the course of the investigation. This is recorded in the minutes of the first Core Group and funding was provided jointly by the NST and the Diocese of Southwark. TT was grateful for both these avenues of support.

iii. As the NST investigation came towards an end, NST informed TT that it was time to transfer her to Safe Spaces to provide advocacy support her going forwards as the ISB process started. TT felt that this was not a trauma-informed decision and it did not take sufficient account of her vulnerability at that time and this led to her third complaint. This has been explained fully under Section E.7. Complaints.

This was an extremely difficult time for TT and the prospect of change and uncertainty triggered high levels of anxiety and all the accompanying emotions. Had there been a more trusting relationship between TT and the NST this might have been an easier message for her to hear and pathway to navigate but in a situation where relations were already so fractured, this felt like a serious rupture to TT and a threat to her well-being.

iv. The area where TT had always felt less well supported as a survivor was in the ongoing communications she received from her caseworker about her case. In fairness to members of the NST the challenges of communicating with TT whilst she was out of the UK were immense. They were aware of TT's vulnerability, and some have expressed that they were concerned about TT's wellbeing during that time.

Nevertheless, there were some significant delays in communication and failures to involve her sufficiently in the Core Group. These increased TT's sense of isolation and the perception that a group of faceless people were making decisions about her in a process that felt disempowering. Her impression was that her support needs had been passed to her advocate and that those managing her case did not consult with her sufficiently about how and when she wished them to communicate with her, what she felt would and what would not be helpful.

E.9.2.3. The Reviewer was also asked to highlight examples of good safeguarding practice and the factors that contributed to this.

Throughout this case review TT has affirmed that any critical reflections that she has are about the process and group decisions, rather than anyone as an individual, and she has been ready to list areas where individuals have demonstrated good safeguarding practice.

i. Personal affirmation

When an abuse survivor takes the courageous decision to disclose, it cannot be emphasised enough how important it is that their story is fully heard, and the integrity of that story is believed. Despite the overwhelming sense that her voice was not being heard as the investigation progressed, TT can highlight examples of those who listened to her story in a way that was very different from 2001. At the beginning of the investigation, this included her two NST caseworkers as well as her advocate and one of the DSA's from the Diocese of Southwark. TT also speaks with gratitude for the current Diocesan Bishops of Southwark and Oxford and the area Bishop of Dorchester, who not only listened to her story but validated her and apologised for the experiences she has disclosed and confirmed that they believed her account.

ii. Offering an apology

After hearing an account of TT's testimony after the first Core Group meeting the current Bishop of Southwark wrote to her with an apology for what had happened to her in the diocese and offered further support on TT's return to the UK. Subsequently, the Bishop also apologised for the actual abuse which TT had described. He has continued to take an interest in TT and speaks highly of her courage.

iii. Provision of Support

Provision towards the costs of counselling for TT was offered by NST and the dioceses of Southwark and Oxford.

Following TT's PCR2 interview a senior member of the NST met with her together with her husband and her advocate to talk though this and the recommendations. This was good practice which TT appreciated.

iv. Provision of Advocacy

During this review TT has repeatedly confirmed how well she was supported during the NST investigation by her advocate whom she described as professional, skilful, supportive and compassionate.

v. Maintaining Confidentiality

The NST were scrupulously attentive to maintaining TT's confidentiality. Core Group minutes show that members were reminded of the importance of this at the start of every meeting. TT wrote:

> *'I appreciate my caseworker's diligence in protecting my confidentiality as much as is possible and always checking with me what I was willing to share and with whom.'*

vi. Ensuring there is a Lessons Learned Review or process of reflection at the end of each case. This is good professional practice. The inclusion of representatives from each of the different dioceses sought to ensure there was a robust reflection on the investigation process and how this could be improved in the future.

viii. Continuing Support after the NST Investigation

In Southwark diocese the current DSA, who heard TT's complaint that her *full* story had not been heard during the investigation, facilitated a recording of TT telling her story which was then translated into a transcript. That transcript was a very powerful resource at the start of this case review and ensured that TT did not need to experience the trauma of re-telling all that happened to her yet again. This is an excellent example of trauma-informed practice.

ix. Recognising a moral responsibility to survivors of church abuse

Within the diocese of Oxford, a small group who had been involved with the Core Group continued to work together with the Bishop of Oxford, to consider '*what their moral obligations should be'* to TT. They took the decision to address the issue of Rev B's PtO.

In a similar way, the Bishop of Southwark resolved to take responsibility for communicating with the Bishop of Bishop Y's jurisdiction and Bishop Y on TT's behalf as stated in E.4.12. In his message for Bishop Y, he encouraged him to engage in a process of restorative justice with TT. When he had no response, he persisted. and on 23.12.2023 he did receive a letter from Bishop Y. It would be an understatement to say that the tone was disappointing and showed no evidence of reflection about his responses in 2001. Instead, his attitude towards TT was as disturbing as it had been in 2001 and he told the Bishop of Southwark, *'I am surprised and disappointed by the stance you have taken.... you seem to have gone on to join TT in traducing my good name and reputation.'* This in itself was telling, but more importantly this demonstrated the Bishop of Southwark's best efforts to seek some kind of apology or restorative justice for TT.

x. Valuing the contribution of the survivor.

TT continues to work with the dioceses of Southwark and Oxford to develop better practice when working with abuse survivors.

E.9.2.4. Recommend improvements in policy, procedures, and practice where the Reviewer considers the evidence in this case shows that these are necessary.

i. The Responding to Assessing and Allegations Practice Guidance had been in place since 2017 and was under review at the time of writing this report. The new guidance was due for publication in September 2025, after this report for the ICIR was completed. The Reviewer noted that any new guidance should take full account of the overarching lessons learned and recommendations articulated as a result of IICSA, and the array of investigations and lessons learned reviews within the Church that have taken place since 2017 as cited earlier in this report. Most importantly, it is important that all recommendations are underpinned by the principles of a survivor-centred approach and trauma-informed practice as outlined in the Methodology section of this report.

ii. During the investigation, it was evident that the Core Group were not clear about managing allegations against clergy who were elderly or frail and did not receive a clear steer from the NST. The NST were therefore asked to formulate clearer guidance for the future. At the time of this review this was still lacking and this needs to be addressed urgently. Clear guidance is needed, and it is important that this should be applied consistently across all the National Church Institutions and its 42 dioceses.

iii. A clearer understanding is required regarding GDPR, confidentiality and privacy, and appropriate information sharing. It is essential that there is single data-sharing agreement across all NCI's and all dioceses and that everyone works to the same policy guidance and code of practice. Furthermore, there needs to be clarity from the NCI's regarding the legal status for data-sharing with the ICIR and the Independent Reviewer. Every diocese should have a specialist Data Protection Officer who would usually be employed the Diocesan Board of Finance. They should have access to appropriate training to equip them for situations like that of TT which is updated regularly, in order to help maintain their independence. It should also be considered whether it might be appropriate for further data protection and GDPR expertise to be included within the remit of the new Independent Scrutiny Body that has been recommended in Professor Jay's Report.

iv. Staff turnover, staff absence and role changes both in the NST and in the dioceses involved was detrimental to TT's investigation. These issues and the inconsistencies in practice were a cause for concern articulated in responses for Professor Alexis Jay's Report 'The Future of Church Safeguarding'. Consideration must be given to the recruitment and retention policies and the professional development of high-quality staff. Some steps have been taken by the NST to support diocesan safeguarding teams, particularly in the case of the long-term absence of a DSO, through the use of Regional Safeguarding Leads.

E.9.2.5. Make any recommendations that arise from this case to enable the Church of England to embed a proactive, preventative, safe culture.

The following comments reflect the findings of this case review and are made in the light of what the Reviewer considers will be helpful in the context of the wider church. Many of the findings of this case review resonate with those of Professor Alexis Jay's report on the Future of Church Safeguarding in the Church of England (2024).

Included among the thirteen recommendations of Professor Jay's report, is the establishment of two separate bodies independent of the Church:

1. Organisation A - Responsible for delivering all Church safeguarding activities.
2. Organisation B - Responsible for providing scrutiny and oversight of safeguarding.

The findings of this review indicate that there needs to be independent scrutiny and oversight of safeguarding in the Church of England. This should ensure there is accountability for past and current failings. As part of this there should be an independent 'Ombudsman-type' body to whom church abuse survivors can go if they are not happy with the response they have received from the Church including the NST.

The findings of this review are less convincing regarding the proposal to outsource the responsibility for operational safeguarding and fully support the view held by Thirtyone:eight in the following previously issued statement:

> *"We believe that removing operational safeguarding from the Church risks a belief that safeguarding is no longer their responsibility. This may lead to unintended consequences due to*

gaps in ownership, understanding, and practice. If responsibility for safeguarding is perceived to lie elsewhere, it could weaken efforts to foster safe, healthy church cultures."[8]

ii. The Role of Diocesan Safeguarding Officers.

This case review has shown inconsistency in the working relationships between DSA's/DSO's and senior bishops, and the levels of independent authority held by DSA's/DSO's.

The Jay Report on the Future of Church Safeguarding highlighted that:

> *There are no consistent line management arrangements for DSO/As across the 42 dioceses. Many are managed by diocesan secretaries, some are managed by human resources managers, and some directly by bishops. We heard of one case where a DSO/A was managed by a diocesan registrar. Few, if any, of these line managers had any professional background in safeguarding.*

It is important that there is a clear and consistent understanding across all the 42 dioceses in the church of England about the role and remit of the Diocesan Safeguarding Officer and the significance of the change in role title. There needs to be national arrangements for the professional development and line management of DSOs to help develop best practice and reduce the potential for conflicts of interest, this should be by safeguarding professionals and not diocesan staff.

iii. The Redress Scheme. This scheme is currently being developed and will consider the best ways to deliver financial compensation, therapeutic and pastoral support, and apologies for victims and survivors. However, TT has reported that survivors are concerned about the length of time this piece of work is taking. Whilst it is important that checks are carried out to ensure its eligibility criteria are robust enough in the light of the Makin report it is also important that there are not unnecessary delays, and the scheme is implemented in a timely manner.

iv. Spiritual Abuse

TT's allegations regarding Rev A included specific allegations of spiritual abuse.

Spiritual abuse has been a contested term, but the Reviewer offers the following definition from Oakley and Humphreys in Escaping the Maze of Spiritual Abuse.[9]

> *Spiritual abuse is a form of emotional and psychological abuse. It is characterised by a systematic pattern of coercive and controlling behaviour in a religious context. Spiritual abuse can have a deeply damaging impact on those who experience it. The abuse may include manipulation and exploitation, enforced accountability, censorship of decision making, requirement for secrecy and silence, coercion to conform, control through the use of sacred texts or teaching, requirement of obedience to the abuser, the suggestion that the abuser has a divine position, isolation as a means of punishment, and superiority and elitism.*

Having heard and read the details of TT's specific allegations and experiences, the Reviewer agrees that they do constitute shocking accounts of spiritual as well as sexual abuse. Whilst the term 'spiritual abuse'

[8] https://thirtyoneeight.org/news/thirtyoneeight-statement-on-the-future-of-church-safeguarding-report

[9] Lisa Oakley and Justin Humphreys, Escaping the Maze of Spiritual Abuse, June 2019, SPCK Publishing, https://spckpublishing.co.uk/escaping-the-maze-of-spiritual-abuse

has been contested within some areas of the church, the Reviewer recommends that this discourse should continue and form part of the safeguarding learning journey. The Reviewer recommends that the Church of England should continue to recognise spiritual abuse as a unique form of abuse that has a serious impact on the victim-survivor and often impacts on their ability to relate to God and their assurance that they are loved as his child.

This quotation used earlier in this report is added once more here as it perfectly encapsulates the experience of abuse that has deeply damaged not just the person but also the spiritual life of the person.

TT's experience shattered her trust in the church and ruptured her relationship with God. *'The church wasn't going to act and the whole process had been so painful I did not have the strength or the will to continue….. Now I felt abandoned and betrayed by both God and the church when I needed their support so much. This was like being abused all over again.'*

Section F: Conclusions and Recommendations

F.1.Conclusions

TT's case has been complex due to several factors, including the fact that four different bodies were involved, that five different individuals have been under consideration, plus the challenging circumstances in which the NST investigation took place during TT's absence from the UK which was extended due to restrictions of movement during the Covid 19 pandemic.

The story of an individual who was sexually abused from early childhood and re-abused by multiple individuals during their teenage years is in itself a personal tragedy that leaves its wounds and scars, traumas which are carried often into adult life. In the case of TT perhaps the even greater tragedy is that she sought safety in the Church of England, felt safe there for a while, but then had that sense of safety taken from her, which to date has not been restored within the Church of England. It is an indictment upon the church that an abuse survivor can disclose a deeply distressing account of abuse and long-term harm and walk away still carrying the sense of shame, sensing they have not been fully believed, and feeling devastated that those who have harmed them have not been held to account to acknowledge and apologise for the harm caused. That is what happened to TT in 2001-2. Despite early encouragement when she reported again in 2019, TT found the experience drained her physical, mental and spiritual health and felt that for her there was no positive outcome from the NST investigation.

It is important to reiterate here that in seeking this case review, it has never been TT's intention to vilify any individual person. Rather it is to highlight that the investigation process that is available for abuse survivors in the Church of England, and the process that she underwent, did not bring healing but caused further harm. TT's complaints have always been about the process and not about the individuals that were working within that process. Individuals at the NST were saddened both by TT's past experiences and by the fact that she found no benefit from the investigation. The Reviewer is satisfied that they sought

to do their best, but this was not always the same as doing the best thing for TT. They were themselves constrained by process and procedures.

In Section E, the Reviewer has responded to the questions in the Terms of Reference.
The following is a summary of the Reviewer's overall conclusions having examined TT's Case. In reaching these conclusions, the Reviewer has sought to look through the lens of TT as the survivor, that of those carrying out the NST investigation and diocesan safeguarding teams, and senior clergy that have contributed to this review.

F.1.1. The credibility of TT's original allegations of sexual and spiritual abuse
The Reviewer has heard and read graphic accounts of what TT alleged took place during her younger life and during the encounters with Rev A and Rev B, which are not detailed in this report. Whilst both these clergy denied the allegations, Rev A admitted he '*had been stupid*' and Rev B admitted sexual impropriety. The opinion of the Reviewer resonates with that of the Bishops, the DSA at Southwark, and the Head of Safeguarding at Oxford, namely that there is every reason to believe TT's account of what happened to her as a child, a teenager and as a young and vulnerable adult within the Church of England.

For TT, the fact that her NST caseworker would not say she believed her story, was highly problematic. TT was reminded on several occasions that the role of the NST Core Group was not to make a finding of fact. Furthermore, the Reviewer was informed during the case review, that within the church's culture there was an inculcated position that this should not be said as it might lead to litigation and financial costs to the church. This is completely at odds with survivor-focused, trauma-informed practice.

Section 7 of the 2021 House of Bishops guidance on issuing apologies[10] states under point 7.2. that where there has not been a conviction or where there has not been a finding that the alleged abuse is proven on the balance of probabilities, Church Bodies must consider whether to make an apology and, if so, when, irrespective of whether the Respondent is living or deceased.

The caveat under point 7.3.is that 'In all circumstances, Church Bodies must take their own legal advice before issuing an apology, particularly whether any apology should be made with or without an admission of liability.' Point 7.4. states that Senior leaders in the Church Body in which abuse occurred are responsible for organising and overseeing the issuing of an apology. In NST-led inquiries, this will be the Lead Bishop for Safeguarding. Point 7.5. underlines the importance of ascertaining how the survivor wishes to receive that apology. If the NST Core Group considered this, the Reviewer has not seen that discussion documented, and it was certainly not an action that was taken forwards.

The fact no member of the NST affirmed to TT that they believed her accounts of her alleged abuse by the two clergy, together with the realisation that she would never receive an apology was a key factor in TT losing faith in the process and this also had a significant impact on her physical and mental health. This is not a criticism of individual members of NST but a serious concern about the structures and limitations and the culture that they work within. One must question why there has been such a reluctance to provide

[10] https://www.churchofengland.org/safeguarding/safeguarding-e-manual/responding-well-victims-and-survivors-abuse/section-7-issuing-apologies-church-bodies

apologies and during this case review the opinion was expressed to the Reviewer that there is little doubt that part of this is to avoid liability.

F.1.2. TT's experience of reporting to the Diocese of Southwark in 2001

TT was encouraged and supported by those she trusted when she reported to Southwark Diocese in 2001. The Reviewer has written at length about the responses TT received from two bishops and an archdeacon. These included betraying TT's confidentiality to her alleged abuser, potentially compromising a police investigation, allowing her to be vilified in correspondence, and failing to offer any pastoral care or support. In his letter to Bishop X, the Archdeacon framed Rev A as the victim of TT whom he described as '*unreliable and unstable,*' a *'gold-digger*' who was making *'hysterical accusation*s' and who needed to '*put up or shut up.'* Bishop X never challenged these attitudes nor the actions of Bishop Y. Not one of the senior clergy offered TT any pastoral support. During this case review the Reviewer has read or heard opinions several times that Bishop X acted appropriately for the time as there were no adult safeguarding policies.

As highlighted in Section D.3.1. The Reviewer has considered the context to the time of TT's initial disclosure in 2001 and has ascertained that there were discussions at the time within the Church of England that recognised the importance of supporting women as well as children who were victims of abuse. It is the opinion of the Reviewer that none of the senior clergy acted appropriately or with any Christian or human compassion towards TT and thus failed her. This had serious consequences for her physical and mental health and her spiritual well-being over many years. The Reviewer does not therefore agree with the view of members of the NST that Bishop X and other senior clergy in Southwark acted appropriately for the time and considers that TT should have received a formal apology from the Church of England for the attitudes and behaviours of all the senior clergy involved in 2001-2002.

F.1.3. The response of the NST when TT reported in October 2019

The initial response from NST caseworkers left TT feeling positive and optimistic about the investigation. However, what nobody realised when TT made her first disclosure was that the timing of TT's case review would prove to be very unfortunate. No one could have foreseen that a global pandemic was on the horizon and restrictions due to Covid 19 would delay TT's return to the UK until the summer of 2021. There can be little doubt that this did exacerbate the stress of the process.

However, what might have been foreseen by the NST, was that TT's pre-arranged visit overseas for several months whilst the investigation was being progressed, could present some additional challenges that might impact on TT's mental health. It is the opinion of the Reviewer that more consideration could have been given to possible risk factors and how and whether these could be mitigated sufficiently, discussed with the survivor.

One such mitigating action might have been to ensure Core Group met if not within the 48-hour recommendation, then as soon as possible. Initial delays due, it seems, to staff changes and the lack of good handover processes, meant that the investigation was only just beginning nearly seven weeks after TT first reported, just as she was leaving the UK. Without time to interview TT the police investigation could not proceed. It is the opinion of the Reviewer that this delay could have been avoided.

F.1.4. Trauma-informed Practice

In Section E.8. of this report, the Reviewer has highlighted areas where they believe the investigation process could have been improved and could have been more trauma informed. Some of these were identified in the NST's own Lesson Learned Review.

The isolation that TT experienced whilst receiving disappointing news from the NST had a very negative impact on her mental health. She was understandably upset by the news she was receiving. It is the opinion of the Reviewer that this resulted in some dysregulation of her emotions. The NST casework team found this very hard to deal with. As a result, some of their responses were perceived as uncaring, defensive or aggressive by TT. This reinforced TT's sense that she was perceived as being to blame and she lost trust in the investigation process. Whilst this was not the intention of the NST it does highlight why maintaining positive relationships and trust with survivors is so essential for a safe process.

F.1.5. Survivor Support

TT affirms that she was very well supported by the advocate that was allocated to support her. However, the advocate was employed by the NST and was line managed by one of the caseworkers. Whilst the advocate kept strict boundaries this allows potential for a conflict of interest. Best practice would be for the survivor to be referred to an outside body who would meet with them as soon as the investigation began to, assess their need and offer what was available.

A concern for TT was that the funding for this support had to be reviewed throughout the investigation and the question of whether this would continue was a further source of anxiety for her.

F.1.6. Recruitment and Retention

Turnover of staff and changes of personnel in management roles impacted negatively on the NST investigation for TT. This was true both within the NST and the three dioceses involved. Inadequate or rushed handovers, inconsistent record-keeping, and changing approaches between different managers or DSA's have all added to the stress for TT herself but also some of the staff in key roles and led to issues with investigation. The Reviewer has learned and observed that the recruitment and retention of DSA's is still an issue in many dioceses.

F.1.7. Role of Diocesan Bishops in Safeguarding

Differences in approach by the three current Diocesan Bishops set the tone for diocesan participation in the NST investigation. One bishop believed he should follow the NST direction and not interfere with their process. Two bishops took further advice from their own safeguarding teams and made the decisions to act beyond the NST process.

When this case review began there was a new DSO in post in Leeds. As the case had been closed, they were not aware of the history of Bishop X, nor that he had PtO in the diocese. Without being able to interview any current staff who had been involved in the investigation, the Reviewer had to rely on the evidence from documentation and a former DSA.

The Reviewer learned that the former DSA who was meeting with Bishop X as part of the investigation was told by the Diocesan Bishop to ensure there was support for Bishop X. She understood this to mean she was being asked to support him herself. This created a potential conflict of interest for the DSA

particularly as she gave an example of having to *'undo'* a safeguarding decision of Bishop X whilst the diocesan bishop was on sabbatical. Meanwhile the NST had offered support to Bishop X which he declined. This lack of clarity highlighted the need for a greater shared understanding of roles and responsibilities to avoid any misunderstandings or any appearance of protectionism.
As the NST investigation came to an end, TT petitioned the Diocese to take action regarding her complaints about Bishop X. Correspondence seen, indicates that the Diocesan Bishop and the Area Bishop aligned the diocese with the advice of the NST and their procedures. The DSA in post at that time therefore followed the NST's advice and lead. (The area bishop has stated that he had understood that a restorative approach was being explored by the NST. However, this did not progress, and this is explained under Section E.6.6.v.) There was no evidence of anyone in the diocese considering any further moral obligation to the survivor.

In the other two of dioceses of Southwark and Oxford, there was clear evidence that the respective Diocesan Bishops carefully considered their moral obligations to the survivor and gave a clear apology for harm done. In this respect they both stepped outside the process. In both cases the Bishop works closely with DSA and in one case their Chaplain. In both cases the diocese is building good practice through working with survivor groups.

These points raise important questions for senior clergy about balancing the need for a compassionate response to survivors with the limitations of a framework, and when it is necessary to discuss the need to step outside that framework.

F.1.8. The role of Diocesan Safeguarding Officers. The varied responses seen during this review highlight the varied responses to safeguarding matters in different dioceses and the level of independent autonomy accorded to DSAs, now DSOs.

A key recommendation from the IICSA report reflected the need to change the role title from Safeguarding Advisor to Safeguarding Officer if those in these posts were to have independent responsibility for and oversight of key safeguarding tasks and decisions. This is reflected in the Diocesan Safeguarding Officers Regulations 2024. However, during this case review, the Reviewer noted that people were still using the term DSA. It is important that the significance of the change in title is understood and that DSO's have the necessary independence to adhere to best practice without being unduly influenced by others, particularly those in senior positions within the diocese.

The Reviewer considers there is a need for a national programme for the professional development and line management of DSOs by safeguarding professionals and not by senior clergy or other diocesan staff who may not have the experience or training to look through a safeguarding lens, free from other conflicted interests.

F.1.9. The appropriateness of the NST investigation process

F.1.9.1. During this review, a more fundamental question has arisen about the appropriateness of the NST investigation process for many abuse survivors. It is the conclusion of the Reviewer that there is an irreconcilable tension between this process that is solely focused on assessing and managing what is quite a narrow definition of risk, and the needs of a survivor who may be seeking validation, a recognition of

and apology for the harm they have experienced within the church, and some form of accountability. For TT the desired outcome was to be believed, to receive an apology and to be able to engage in some form of restorative justice. The process denied her all of these, but one of the most damaging issues was the inability of caseworkers to offer the validation of saying they believed her account of what had happened to her.

F.1.9.2. The unanswered question that remains regards where survivors can go within the Church of England. This is a concern that is being expressed not just by survivors themselves but by the wider public as they look in at the institution of the church. The Church has not yet fully implemented all the recommendations of IICSA. The Makin Review and the Tudor case have once again brought the failures of senior clergy to respond appropriately to concerns of abuse into the public spotlight. The Jay Report on The Future of Church Safeguarding in the Church of England rightly says:

> *'The Church needs to take action urgently to restore trust and confidence in its safeguarding by victims, survivors, those wrongly accused and the general public.'*

The Jay Report recommended the establishment of a separate body independent of the Church who would be responsible for providing scrutiny and oversight of safeguarding. However, as yet there is no such body within the National Church, and it is estimated that it will take at least two years for this body to be legally established.

F.1.9.3. One of TT's concerns about the NST Investigation was that the approach was not sufficiently trauma-informed and this has been addressed in Section E.

The National Association for People Abused in Childhood (NAPAC)[11] states that *'Rather than following a prescribed set of policies and procedures, a trauma-informed approach adheres to key principles'* and offers five key principles that should be adhered to.

i. Safety
ii. Trustworthiness
iii. Collaboration
iv. Empowerment
v. Choice

Despite the support of her advocate and the best efforts of some individuals within the NST and two of the dioceses, the process itself left TT feeling unsafe, unable to trust, disempowered and trapped. This report has highlighted instances when decisions were made for TT that she should have been consulted over. It is the view of the Reviewer that there were times when different actions and decisions could have been taken, and these have been highlighted in this report. However, it is also the view of the Reviewer that an investigation that was driven predominantly by policy and process, does not allow sufficient space for best trauma-informed practice and for this reason has been harmful instead of offering hope and healing.

F.1.10. General Data Protection Regulations, Confidentiality and Information Sharing.

[11] https://napac.org.uk/trauma-informed-practice-what-it-is-and-why-napac-supports-it/

The recommendations of the IICSA Report in October 2020 included the implementation of a formal information-sharing protocol. This resulted in the Information Sharing Framework published in January 2022. Nevertheless, neither the ICIR nor Thirtyone:eight anticipated the level of challenge they would face in the weeks that followed regarding access to information. Despite following a process that was fully compliant with GDPR it soon became evident that overall concerns about GDPR, data-control and privacy agreements was creating a hesitancy about making documents available. This resulted in significant delays that were difficult for the survivor. There is a need for a greater shared understanding of these issues in order to avoid such delays in the future. Whilst data protection concerns are often valid and important, protocols are needed to minimise delay and maximise cooperation to achieve the best outcomes for survivors.

F.1.11. In Summary, TT's experience of the NST Investigation was re-traumatising and, in her words, *'left her in a worse place than she was in before.'* Due to the time that had passed since the alleged abuse she has disclosed took place, TT was sufficiently realistic that there would never be any convictions, and she did not set out to vilify any individuals. She had hoped for an acknowledgement from all those who had caused her harm and an apology and in this there was always a risk that she would be disappointed.

This case review has focused on the concerns raised by TT about the investigation process itself. The report has set out to show where practice has been good but also to examine the concerns raised and highlight how the process itself can fail church abuse survivors, many of whom have already been deeply traumatised. It is TT's hope that the recommendations in this report will feed into the ongoing dialogue about the future of safeguarding in the Church of England and, particularly the church's response to abuse survivors.

F.2. Recommendations

In writing these recommendations it is important to note that they are informed by the review of an NST investigation that took place between 2019 and 2022. The Reviewer is aware that some things have not changed significantly since then. For example, there is still a lack of printed and electronic information for survivors considering an investigation. However, there may have been developments in practice that the Reviewer may not have been made aware of and if this is the case, some of the recommendations below may have already been addressed or partially addressed. The NST have advised that they have *'moved on significantly'* regarding a number of the issues that have been raised in this report. It is hoped that where improvements have been made that this will be articulated in any action plan or response they may wish to issue and that the impact for survivors will be evaluated and reviewed.

The Reviewer is also aware that much good work is going on in dioceses to improve safeguarding provision, guidance, and support for survivors. This is evidenced in particular by the positive responses and interactions received by TT from the diocese of Oxford and Southwark. Nevertheless, recent reports have highlighted that this is not consistent across all the 42 dioceses in England.

It is the hope of both TT and of the Reviewer that these findings and recommendations will inform the continuing discussions across the wider church about making the Church of England a safer place for everyone and a place where survivors of church abuse receive the best possible response if they choose to disclose.

F.2.1. Recommendations for the NST

No.	Recommendation	Outcome
1.	**Information for survivors** All survivors considering an NST Investigation should receive a full explanation of the purpose and focus of the investigation to inform their decision about proceeding with the investigation. This should include the process of the investigation, the anticipated timescales and the possible outcomes. This should be accompanied by written information leaflets that set this out clearly. These should also clarify the boundaries of GDPR. This information should be readily available on the NST website along with Frequently Asked Questions.	Comprehensive written information will be available in hard copy and in electronic format that details the NST investigation process. It will clarify what an investigation can and cannot offer.
2. i.	**Support for survivors** All survivors should be offered a range of support options at the point of disclosure. This should be considered and discussed with the survivor, so their preferences are understood and recorded.	Survivor feels well supported, cared for, and involved in the decision-making process.
ii.	Any advocate for the survivor should be from an outside body and independent of the NST. The NST have now confirmed that within the past six months they changed their advocacy arrangements and now use an independent consultant advocate. A good model would be to refer the survivor to an outside body who would meet with the survivor, assess their need and seek to advocate based on a range of options.	Advocacy and support for the survivor is independent of the NST.

3.	**Questions, concerns and complaints** Information should be available about how to raise questions or concerns about the progress or management of the investigation and how these will be responded to.	A readily accessible procedure for raising concerns and complaints will be available in hard copy and in electronic format. This will be separate from the generic NCI's complaints policy.
4.	**Records of the initial meeting with a survivor** There should be a written checklist for all case workers to use in the initial meeting with survivors to ensure consistency. This should include the keeping of a written record of the meeting, information given to the survivor and actions agreed.	Written checklists in place which will be used and completed by caseworkers, kept with records and passed on in the event of a handover.
5. i ii iii iv	**Record Keeping and Handover Arrangements** There should be mechanisms in place to ensure that in the event of any absence or role change, all relevant information is passed on immediately to avoid delays to the investigation process. This should include the rationale for decisions that have been made. During the investigation there should be a system in place for ensuring live case records are reviewed and actioned in the event of staff absence. All records should be kept updated and there should be a thorough handover process to a designated person when staff leave their post or change their role. There should be greater consistency in the labelling and filing of all documents.	Every step is taken to prevent staffing issues impacting negatively on an investigation. Records and meeting notes will be securely stored on a central server with appropriate levels of access rights. Senior managers will have access to these records in the event of staff sickness or staff turnover. There will be a clearly defined handover process in place when staff leave or take up a new role. There will be a more efficient system for locating files.
6. i	**Core Group Meetings** There should be a template that is used consistently for minutes of Core Group Minutes. These should include • Agreement that previous Minutes were a true record and	Template in place and used consistently. Consistent attention to items going forwards

	• All matters arising • All actions following the previous meeting. Any changes to these actions should be minuted. • Reasons for decisions that are made.	Clarity for all members of the Core Group.
ii	A folder should be created for each meeting that contains the agenda, minutes, and any reports of or supporting documents that were circulated before or during the meeting.	Clear, consistent and readily accessible filing system in place with consistent labelling.
7.	**Trauma-informed Practice**	Best practice is identified, shared, followed. and being developed. Key principles underpin all work with survivors, namely
i	Consideration should be given to underpinning the investigation process more strongly with survivor-centred trauma-informed practice.	i. Safety ii. Trustworthiness iii. Collaboration iv. Empowerment v. Choice
ii	At the start of an investigation there should be an assessment of the risks of survivors being re-traumatised and the measures that could be put in place to minimise the impact of this should be discussed with the survivor.	A risk assessment proforma will be in place and used by caseworkers in consultation with survivors at the start of an investigation.
iii	The survivor should be consulted as to how they wish to receive information about the progress of the investigation including the frequency and timings of updates. This should be kept under regular review with the survivor.	Records of survivors' preferences will be kept on file and reviewed regularly. S
iv	Whilst the survivor cannot attend Core Group Meetings there should be some provision for introduction to the members of Core Group that gives a face to names and an understanding of their respective roles.	Survivor feels informed and validated that they are a person and not just a case.
v	Core Groups should ensure that the outcomes of each meeting are shared with the survivor within a time frame agreed with the survivor. The survivor should also be consulted on how they would like this to be done and by whom.	Survivor is better informed about decisions being made about them and the reasons. This helps to alleviate the survivor's anxiety.

vi	Provision should be made for the survivor to tell their whole story within what the survivor feels is a safe space. Good practice was modelled by the Diocese of Southwark through the use of a recording and a transcript.	Survivor feels their story is heard and validated. With their consent that story can be shared without them having to repeat it.
vii	In both verbal and written communications consideration should be given not just to the message conveyed but how this will be received by the survivor. Both the use of language and the explanation of decisions are critically important. Whilst it is time consuming it is good practice to 'sense-check' intended communications with an appropriate colleague.	
viii	Caseworkers should be prepared that difficult news may trigger a dysregulated response in survivors and be ready with appropriate responses. This should be discussed with survivors at an appropriate time along with their support needs if this occurs.	Caseworkers are prepared for dysregulated responses and have considered strategies for supporting survivors if this occurs.
ix	Regular supervision meetings should be in place for all those working with abuse survivors. This should include critical reflection on practice and where this could be modified.	A timetable is in place for supervision meetings, and this is adhered.
x	All staff in all departments that may interface with abuse survivors should have Trauma-informed Practice Training, renewed every three years.	Training cycle will be in place for all workers. This should be discussed in supervision and at annual reviews to determine the impact on practice.
8.	**Definition of Risk** Consideration should be given to a wider definition of risk, regardless of age, or level of ministry.	Core group decisions are informed by a wider, and clear definition of risk.
9.	**Survivor Support Funding** At the outset of an NST investigation in response to a survivor's disclosures, there needs to be an agreed funding model for survivor support that extends for the duration of the investigation to ensure stability and consistency for the survivor.	Survivors are confident about the funding stream throughout the investigation process and are not subject to additional anxiety about their support.

F.2.2. Recommendations for the wider Church of England		
No.	**Recommendation**	**Outcome**
1.	**Alternative Pathways for Survivors**	
i	The NST Investigation process is focused almost entirely on assessing and managing current and future risk. There needs to be an alternative pathway for survivors seeking accountability, apology and redress for the harm caused and the long-term effects and consequences of that harm.	A more holistic, survivor-focused approach is in place that ensures risk is managed in tandem with seeking to be guided by the survivor's wishes for example this might be an apology, redress, or seeking a restorative justice approach.
ii	There should be an 'Ombudsman'-type service independent of all the National Church Institutions to whom survivors can go if they are unhappy with their treatment by the church and this remains unresolved following a complaint to the Church. The report by Professor Alexis Jay CBE on the Future of Church Safeguarding in the Church of England recommends the establishment of a separate body independent of the Church who would be responsible for providing scrutiny and oversight of safeguarding.	There is an independent body legally established, providing scrutiny and oversight who will hear feedback, concerns or complaints about the process.
iii	Full attention should be given in the establishment of this new body and to any interim arrangements to respond to the recommendations in this report in order to mitigate against a repeat in the failures identified in this case.	This should give survivors greater confidence about independence in the processes.
2.	**Consistency of safeguarding culture, policy and practice across the NCIs and 42 dioceses of the Church of England**	
i	The discrepancies in the safeguarding culture and practices in different dioceses needs to be addressed. That this is a widespread national issue is highlighted in Professor Jay's Report.	Consistency of culture and practice across the 42 dioceses. Role of DSO's and Bishops is clearly defined.

ii	DSOs should have the authority to make independent decisions on key matters of safeguarding. Safeguarding decisions should be led by DSOs, and senior church officers should be led by their professional expertise. Where DSO's and other professionals are thwarted in their pursuit of best practice whilst complying with national policy and guidance, they should be afforded the permission and authority to refer themselves and the matters they are dealing with to the Independent Scrutiny Body when this is established.	Safeguarding decisions are not influenced by potential conflicts of interest or by personal relationships. DSOs should have professional independence and ongoing professional development and support.
iii	There should be national standards for the line management of DSOs. Line management should be by safeguarding professionals and not by clergy or diocesan staff.	DSOs are well supported professionally, and their decisions are informed by best safeguarding practice.
3.	**Greater clarification is needed about GDPR, confidentiality and information sharing.**	This is well communicated and understood by Diocesan Secretary's, DSO's and Diocesan Date Protection Officers where these exist. There is a greater understanding of and confidence around the sharing of information for case reviews so that survivors do not face unnecessary delays. Reviewers and survivors experience fewer barriers and a quicker response to appropriate requests for information.
i	There is an agreement in place between dioceses and between dioceses and the NST. The same clarity is needed for information sharing with the Independent Reviewer and whichever part of the new Church of England safeguarding structures which takes on the legacy of the ICIR programme'.	
ii	A clear process needs to be established with agreed parameters for the sharing of safeguarding related information to ensure delays and further distress to the survivor are both minimised.	
iii	Whilst mechanisms have been developed to improve information sharing across dioceses, there need to be regular reviews to ensure this is being appropriately implemented.	Appropriate safeguarding information sharing takes place across dioceses where there could be elements of transferrable risk.
4.	**Greater Clarity is needed on managing allegations against deceased clergy and those who are elderly or frail**	A survivor-centred response ensures that allegations are heard, survivors are well supported and receive an appropriate apology from the church in accordance with

i ii	The revised Management of Allegations Policy seeks to address allegations against deceased church officers. It does not appear to address the issue of those who are elderly or frail and this needs to be addressed through guidance from the national church.	Section 7 of the Responding Well to Victims and Survivors of Abuse Guidance, Section 7. Families of deceased clergy are well supported. Greater clarity leading to appropriate support for both survivors and respondents.
5.	**Spiritual Abuse** This has been a contested term, and it was a recommendation in the Future of Church Safeguarding report that this was no longer used. However, it is a recommendation of this review that the Church of England should continue to recognise spiritual abuse as a unique form of abuse that has a serious impact on the victim-survivor and often impacts on the survivor's view of their position within the church and in some cases on their faith,	There is an ongoing dialogue around the terminology and understanding of the impact of abuse in faith-based settings. There is continued support and use of specialist training which is informed by research and the survivor voice. Awareness is raised and practice in this area is improved.
6.	**Safeguarding arrangements with other jurisdictions within the Anglican Communion** Steps should be taken to put in place reciprocal safeguarding arrangements throughout the wider Anglican Communion. This would include agreed protocols for informing dioceses overseas about concerns or allegations against ordained clergy in a position of trust who were residing there. This is also a recommendation of the Makin Review. Priority should be given to including this work within the programme for the Anglican Communion's Safe Church Commission.	There are clear measures in place to mitigate the risks of those who either pose a risk themselves or fail to uphold good safeguarding culture, training and practice if they move to other jurisdictions.
F.2.3. Recommendations for individual dioceses		
No	**Recommendation**	**Outcome**
1. i	**Role and Remit of DSO's**	

	In line with IICSA recommendations all Lead DSA's should now have Safeguarding Officer status (DSO) and the significance of this should be clearly understood by all. They should be independent of the bishop and other diocesan staff and have the authority to make independent decisions on key matters of safeguarding.	DSOs will have the ultimate authority in safeguarding decisions but will work within teams where there is a learning culture. Senior clergy will be part of these teams.
ii	There should be a national standard for the professional development and line management of DSOs. Line management should be by safeguarding professionals and not by clergy or diocesan staff. Consideration would need to be given as to how this can be achieved.	A consistent independent system for the support, supervision and development of DSO's is in place across all dioceses.
iii	When a new DSO is appointed, there should be a full handover process that includes raising awareness of all current concerns and how to access records of significant closed cases / investigations and how to access records and where these are stored securely.	Proforma in place as a checklist for handover procedures. Electronic data systems have a flag system to identify current and closed cases of concern in the event of fresh allegations being made. These files will have restricted access.
iv	They should have ready access to records of all those who have PtO in the diocese and their level of engagement in ministry.	
2.	**Clergy with PtO**	
i	There should be a process for regularly reviewing the type of ministry carried out by all clergy with PtO. Whilst many clergy may simply take services others, particularly during a vacancy, may be providing a higher level of support for the running of a church including providing significant levels of pastoral care. There should be a support and accountability framework for these clergy.	Support and accountability framework for clergy with PtO who undertake higher levels of responsibility, for example during a vacancy.
ii	Clear guidance is needed regarding clergy who have failed to challenge poor practice and failed to show remorse.	
iii		

	There should be systems for flagging when safeguarding training is due to be updated and for ensuring this is completed. This would prevent the situation that arose with Bishop X whose training had lapsed by 11 months in February 2025. The diocese has confirmed this has now been rectified. The Safeguarding Hubs that have now been incorporated into the Parish Dashboards provide this facility at parish level and a similar tool is needed for dioceses who oversee the DBS and training renewals of clergy and retired clergy with PTO.	Clergy wishing to retain their PtO will be required to update their training promptly. PtO will not be renewed if they fail to do so. Clergy with PtO will be expected to be champions for safeguarding and ensure they inform the DSO promptly of any safeguarding concerns.
3.	Where serious allegations have been made against a Church Officer, but it has not been possible to substantiate these, the diocese should consider commissioning an Independent Risk Assessment. The findings in this report raised significant questions regarding the conduct and attitudes of Bishop X. Consideration should be given to completing the risk assessment that was not carried out in 2021 to ascertain whether he fully appreciates the harm done by himself and other senior clergy to TT in 2001-2 and the degree to which he now supports and champions best safeguarding practice.	The diocese demonstrates that safeguarding has the utmost priority, and the highest standards are expected of all clergy.
4.	**Record keeping** Record keeping systems must be well maintained with a consistent system for labelling all records.	A clear process that promotes consistent labelling, recording and filing of all safeguarding related information is consistent across all dioceses.
5.	**Staff Training** All staff within safeguarding teams should undergo an appropriate level of Trauma-informed Practice Training in addition to safeguarding training.	Training cycle will be in place for all workers. This should be discussed at annual reviews to determine the impact on practice.

6.	**Working with survivors** All dioceses should be proactively seeking the views of abuse survivors and engaging with them to develop best practice.	The diocese is working with and learning from a group of people who have experienced abuse within a church context to develop best practice in survivor support, care and engagement.

Reviewer:
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BA, PGCE, MA (Woman and Child Abuse)

Section G: Appendices

Appendix G.1. Commissioning of the Case Review

Originally, TT's case review was being commissioned by the Independent Safeguarding Board (ISB) in 2023. However, in June 2023 the ISB was disbanded by the Archbishops' Council. The full history of the creation and subsequent disbanding of the ISB is detailed in the Wilkinson Review of the Independent Safeguarding Board along with the impact that this has had upon the survivors.1

The stated purpose of the ISB was to provide independent oversight to the Church of England's National Safeguarding Team, and to challenge internal cultures within the Church of England where these have prevented best practice from being embedded across all the institutions of the Church. Many of the victims-survivors of church abuse had described experiencing re-traumatisation because of the way the Church had handled their cases (after these were reported to the Church). Their hope was that the pain of their experiences would be recognised and that the Church would be held to account regarding safeguarding failures. In September 2023 Kevin Crompton (KC) was appointed as Interim Commissioner for Independent Reviews (ICIR). The ICIR is independent of the Church of England and employed through a third party. His stated remit was to progress the case reviews which had been promised to this group of survivors by the former ISB. The survivors were offered a choice of independent review bodies, and FearFree were engaged to offer advocacy and support. The terms of reference for this case review are informed by those initially agreed between the survivor and the ISB.

Thirtyone:eight were approached by the ICIR to undertake a case review in respect of an individual, TT. Karen Eakins (KE), Head of Safeguarding at Thirtyone:eight, and Helen Gilbert (HG), Safeguarding Consultancy Specialist with Thirtyone:eight, (prospective Independent Reviewer) met with KC, TT and TT's advocate from FearFree. Following that online meeting, TT confirmed her agreement to work with Thirtyone:eight and the proposed Independent Reviewer, Helen Gilbert, hereafter referred to as the Reviewer in this report.

The terms of reference were finalised in consultation with TT. The final Schedule of Service and Terms of Reference were completed on 8th October 2024 and are outlined below under A.3. Three dioceses in addition to the National Safeguarding Team (NST) were identified as the bodies to be involved in the review. This was because of the movement of clergy whose actions would need to be examined as part of the case review.

The initial submission date of the report for the ICIR and for TT herself, was set for 30th January 2025. However, it was recognised by all parties that this would depend partly upon how quickly the relevant documentary evidence could be made available and interviews could be held with key personnel. It was agreed that there should be monthly meetings between KC, KE, HG and TT to review progress. Neither the ICIR nor Thirtyone:eight had anticipated the time it would take for all the data-sharing and privacy agreements to be agreed, scrutinised by lawyers, finalised and circulated to each of the bodies involved in the review. The final privacy notices and Ad-hoc requests for information were sent to the three dioceses and to the NST on 13th December 2024.

As a result, the submission date was revised and set for the end of March 2025. However, there were yet further queries regarding data-sharing from some of the parties to be involved in the review and this led to further delays in the Reviewer acquiring the necessary documentation. There were some further delays in responses to invitations for interview dates from some personnel, some of which were unavoidable. Consequently, this date had to be revised again and was extended to the end of May 2025.

Although the survivor handled these repeated delays well, they were a source of further re-traumatisation in what was already a very challenging process, and this was a cause for concern both for this review and for other reviews in the future.

Appendix G.2. About Thirtyone:eight

Our vision is a world where every child and adult can feel, and be, safe. Creating safer places is how we achieve that, and we do this together in partnership with a wide range of organisations and individuals. People are at the heart of everything we do because we are driven to protect vulnerable people. Together. We will continue to:

- Equip society with the knowledge and skills to create safer environments for children and adults at risk.
- Empower society to respond appropriately to those who are vulnerable or have experienced abuse.
- Encourage society to stand against oppression and exploitation by informing legislation and striving to raise the standards in safeguarding practice.

Over the last 45 years that we have existed, we have seen some fundamental and positive changes in the safeguarding arena, particularly in the Christian community. From being a lone voice, we have seen many of the major church denominations now taking seriously their responsibility to safeguard those in their care. We have also seen some new and emerging issues arise, as organisations seek to tackle the challenges their communities face. Changes in legislation and governance have also meant the landscape of safeguarding has changed and greater political devolution has brought greater variances in guidance across the four nations of the UK. With an increase in awareness has come an increase in the need for our specialist advice and support.

Appendix G.3. About the Independent Reviewer

Helen Gilbert was formerly Head Teacher of a Church of England Primary School and then an Educational Consultant and Diocesan Inspector, working across two dioceses. Helen has over fourteen years' experience managing safeguarding in educational settings. She also sat on the Local Safeguarding Children Board as the Education lead. Subsequently, she has spent six years as Parish Safeguarding Officer in a large and busy urban church and for the last five years has been part of the Safeguarding Team as the PSO in a smaller rural parish. In these roles she has worked closely with the Diocesan Safeguarding Team to manage local casework and to develop training programmes in her previous diocese.

In 2013 she completed a MA in Woman and Child Abuse with distinction. Modules taken included Violence Against Women, Sexual Violence and Sexual Exploitation. Helen has worked as a Safeguarding Associate and then Consultancy Specialist for Thirtyone:eight since 2014 and has a wide-ranging portfolio of work including development and delivery of training programmes for various denominations and secular organisations, Safeguarding Audits, Risk Assessments, Past Case Reviews, Stage 3 Complaints Reviews, Lessons Learned Reviews and supporting and advising faith-based and non-faith organisations working in the charity sector including those working in overseas contexts and conflict zones. She has been accredited to complete Risk Assessments for the Church of England and has undertaken these across a range of different dioceses. She has significant experience of working with and supporting those who have been victims of abuse in religious settings.

Appendix G.4. Context of the review

G.4.1. TT's case review took place against a background of turbulence in the Church of England. One month after the Terms of Reference were finalised, the Makin Independent Learning Lessons Review1 regarding the case of John Smyth was published on 7th November 2024.
As a result of Makin's findings relating to failures by senior church leaders, the Archbishop of Canterbury, Justin Welby, resigned a week later, on 14th November 2024. A negative consequence of this was that the three dioceses and the National Safeguarding Team had a new priority, to respond to the findings of the Makin report and to answer the hundreds of calls and inquiries they were receiving. This proved to be another factor that delayed progress with TT's review. In the weeks that followed, survivors like TT felt that their voices had been lost in the coverage in both mainstream media and social media and the noise and clamour that went with that. However, there was little if any acknowledgement from the national Church regarding the needs of the wider community of Church abuse survivors.
G.4.2. The Makin Review was only one of several reports and disclosures that emerged around this time that were to expose the cover up of instances of abuse and the protection of those who had abused children and women within the Church of England.
G.4.3. There is much in all these reports that resonates with the experiences of TT both in 2001 and more recently. They all brought into sharp focus the way in which abuse survivors felt they had been re-traumatised by failures within the Church of England to respond appropriately to safeguarding concerns and allegations over a period of decades. This created the context for General Synod February 2025 to consider its safeguarding measures and also the backdrop against which TT's review took place.

Appendix G.5. Review of relevant Literature

During the course of this review, the Reviewer read in meeting minutes and was told on more than one occasion by members of the NST that the Diocesan Bishop in Southwark at the time of the disclosures in 2001 'acted appropriately for the time.'
It was therefore helpful to review some of the literature of that period. This demonstrates that back in the 1980s there was a body of work around the issue of clergy abuse and also that abuse of adult women by clergy was a recognised phenomenon but one that had been kept hidden. Also documented was the fact that prior to 2001 there were conversations within the House of Bishops and a recognition of the need to end the sexual abuse and exploitation of women and children throughout the Anglican Church and to provide pastoral care to victims of sexual abuse.
Appendix G.9. contains details of articles and reports referenced in this report.

Appendix G.6. Methodology

1.The Terms of Reference and Schedule of Service
Once these were finalised between the ICIR, Thirtyone:eight and TT on 8th October 2024, it was agreed the ICIR would make the initial contact with the diocesan secretaries in each of the three dioceses involved and with the NST, advising them the review was commencing, asking who the Single Point of Contact (SPOC) would be and putting in place all the necessary data-sharing agreements and privacy notices. This was done on 31st October 2024.
2. The Review Process

1. Meeting(s) with TT and examination of any documentation she wished to provide.
2. Letters of introduction to each of the three dioceses to arrange for examination of case files.

3. Preparation of Ad Hoc Data Requests sent to each diocese and the NST. These specified the documentation required for scrutiny.
4. Arrangement of dates for interviews with the key personnel within each of the dioceses.
5. Liaison with NST for examination of case files.
6. Arrangement of dates for interviews with the key personnel involved with the NST investigation.
7. Maintaining contact with TT throughout the review process.
8. Collation, examination and cross-referencing of all documentary evidence.
9. Analysis of findings and drawing conclusions.
10. Making Recommendations.
11. Working with the ICIR to complete a full Maxwellisation process and to consider any responses.
12. Preparation of final report for the Learning Outcomes Working Group, a subgroup of the NSSG.
13. Preparation of a final report for publication.

It was originally anticipated that stages 1–12 of this work would be largely completed by the end of December 2024 and the report written with a final draft submitted to the ICIR by the end of January 2025. This timeline was delayed until the beginning of June 2025 due to a number of issues and challenges. These are detailed below in Appendix G.6.3. Challenges

G.6.1. Gathering and reviewing documentation

G.6.1. Documentation provided by TT

Case Chronology and TT's Comments
Confidential Chronology
ISB Review Outline Nov 2022, updated October 2024
Recording and Transcript of TT's personal story
Statement for Core Group 19.11.19.
CDM Application and Associated Correspondence
Correspondence
Correspondence with Diocese of Southwark in 2001-2002
Correspondence with Diocese of Leeds in 2002
Correspondence with NST 2019 – 2023
Lessons Learned Review Responses
Letter for NST Core Group 21.2.20
SAR Requests

G.6.2. Documentation provided by NST

Core Group Meetings Agendas and Minutes

19.11.19
21.2.20
28.9.20
7.12.20
4.8.21
21.9.21
10.1.22
8.3.22

Reports for Core Group Meetings
Correspondence with TT
Lessons Learned Review Meetings
23.5.22
15.6.22
26.6.22
Notes of Meetings
20.8.20 Rev B, Mrs B, NST, DSA Oxford

G.5.41.3. Documentation provided by Diocese of Southwark
1. Case Summary Sheet
2. Core Group Meetings Agendas and Minutes and Reports
3. Confidential Subject Access Requests and Responses
4. Correspondence
i. Bishop and TT
ii. Bishop and DSA regarding the AD
iii. Regarding Bishop Y
5. Documents from Blue Files
6. Notes of Meetings

G.5.4.1.4. Documents provided by Diocese of Oxford Spreadsheet listing all documents held
Correspondence with Rev B
Record of meeting with Rev B

G.5.4.51.5. Documentation provided by Diocese of Leeds
Core Group Meetings Agendas and Minutes
19.11.19.
21.2.20
28.9.20
7.12.20
15.10.21
DSA's Notes
Meeting with Bishop X
Handwritten Notes at Core Group 29.9.20
Handwritten Notes at Core Group 15.10.21
Correspondence
January 2020 Letter from NST inviting Bishop X to meet dated January 2020.
19.2.20 Letter from NST to Bishop of Leeds
16.3.20 Letter from NST to Bishop X following the meeting
9.3.22 – 7.7.22 Correspondence between NST, TT and DSA at Leeds
Reports and Statements for Core Group Meetings
28.9.20 Report
28.9.20 Statement for Core Group's consideration from TT's advocate
15.10.21 Statement from TT

Safeguarding Training Records for Bishop X
23.5.22 Lessons Learned Review Meetings

G.5.4.1.6. Past Case Review CR2 Reports
PCR2 NST Report, Rev A, Rev B, Bishop X, Bishop Y; Bernie Kinsella July 2021
PCR2 Case of TT, Diocese of Southwark; Josie Collier November 2021
PCR2 Executive Summary, Diocese of Southwark.

G.6.2. Interviews

G.6.2.1. Interviews were arranged with the following people on the basis that they had all had a role during the NST Investigation.
TT
Two advocates for TT
Members of the National Safeguarding Casework Team
DSA and senior clergy from the Diocese of Southwark
DSO and senior clergy from the Diocese of Oxford
Former DSA from the Diocese of Leeds
Former colleague and employer of TT

All individuals who agreed to meet with the Reviewer were sent the Privacy Notice and the Thirtyone:eight Information Sheet and Consent Form. Although they had already been sent the Terms of Reference for the review, these were included again in the Information Sheet. Where meetings took place online, they were recorded and a transcript sent to the person interviewed for fact checking.

G.6.2.2. Interviews and meetings with TT.
At the beginning of the case review in October 2024, TT supplied audio recordings and a transcript of her story. This began in early childhood and continued up until the end of the NST investigation and the referral of her case to the ISB. The Reviewer then spent a day with TT to hear her further reflections and to answer any questions about the process. Towards the end of the information gathering phase the Reviewer and TT spent a further day together. In between these face-to-face meetings they met online as often as TT felt was helpful. This was to ensure TT was kept informed about progress with the review and, where there were delays, the reasons for this. In addition, TT was invited to monthly review meetings with the ICIR. Where appropriate the Reviewer sent notes from meetings to TT. TT's advocate was invited to all of the meetings.
At the report writing stage the Reviewer sent TT drafts of those sections of the report that contained her own contributions so that she could fact check these and offer any further comments or amendments. The Reviewer recognised that whilst this was important it could be difficult and trigger past trauma. It was important to ensure that TT's advocate was available to give support during this process.

G.6.2.3. Interviews and meetings NST

Securing meetings with NST personnel was a challenge for the Reviewer. Emails were not always answered promptly, and some individuals had to be contacted two or three times before a response was received. Although some of those interviewed forwarded follow up information as they had promised, the Reviewer at times did not receive a response to subsequent requests for further information or clarification. This was the case throughout the course of the review and may reflect the challenges of workload and staff changes.

G.6.3. Challenges

Neither the ICIR nor Thirtyone:eight anticipated the level of challenge they would face in the weeks that followed regarding access to information. Despite following a process that the ICIR believed was fully compliant with General Data Protection Legislation and awareness that agreements were in place between dioceses and the NST, it soon became evident that overall concerns about privacy agreements and sharing information with the ICIR and the Reviewer was creating a hesitancy about making documents available for the review. Issues around data storage and data migrations also slowed access to some of the necessary documentation. This was also compounded by the age of some documents / records which made locating them a challenge.

In addition, staff absences and staff turnover within diocesan safeguarding teams and to a lesser extent within the NST, all impeded progress with the review. Finally in the weeks following the publication of the Makin review some of the agencies involved in this review had to concentrate on the response to that review. Whilst recognising some of these things were unavoidable, it is important to note how these factors delayed the undertaking of this review and the impact that this had on the survivor. It triggered similar feelings and experiences of the trauma from the handling of her case in the past.

G.6.3.1. National Safeguarding Team On 15.11.24 NST requested a 'period of grace' in the light of the additional work generated post-Makin. NST subsequently raised a number of queries regarding data control, privacy statements and the protection of personal identities all of which had to be referred back to the ICIR and his legal team. These were finally resolved in January 2025, but it took some considerable time for the Reviewer to secure meetings with individuals.

G.6.3.2. Diocese of Southwark

The Diocese informed the ICIR that they needed to consider the data sharing basis initially proposed by the ICIR. They therefore declined to provide information to the Reviewer until they were satisfied of the legal basis for such sharing, which took time and involved legal advice to the Diocese, the ICIR and the Reviewer. In November 2024 the Diocesan Secretary had also advised the ICIR that they were unable to provide any documentation due to a data migration exercise which was being carried out by a third-party provider at the request of the National Safeguarding Team (NST). Initially they advised that the data migration would not be completed before the end of 2024 as this was the timetable initially provided by the NST. However, this was then extended to the end of January 2025 due to an issue with the NST's third-party provider.

In mid-January 2025 the Diocesan Secretary sought clarification from the ICIR around the legal basis for sharing data. Whilst the ICIR's legal team responded in late January, it was necessary for the Diocesan Secretary to consult the Diocesan registrar on that response. Further correspondence took place until a

final agreement between the Diocese the ICIR and the Reviewer was reached in early March 2025. Following further intervention by the Diocesan Secretary at the request of the ICIR, documents were finally released to the IR in early April 2025.

It should be noted that in October 2024 the former DSA had responded promptly to the Reviewer and both they and the Assistant DSA who was nominated as the SPOC had sought to assist the progress of the review. However, due to the protracted discussions and the need for further legal advice around data sharing and the delays to the data migration process, the Reviewer found it difficult to agree meeting dates with individuals and this was compounded by some sickness leave amongst Diocesan staff. The interview with the DSA that was key to the review did not take place until 12th May 2025, long after the original completion date for the report.

The ICIR acknowledged that the delays to the data-migration process were a further complication for Southwark and that in the first instance the Diocese needed to consider the data-sharing basis initially proposed by the ICIR. The impact of these delays on the survivor was a source of deep regret.

The time taken for Southwark to agree the legal basis for sharing information with the ICIR's office was over four months. The Reviewer observed this was disproportionate to the response of the other dioceses involved who did not raise the same legal issues and made their documents available in January 2025. The delay and uncertainty as to when Southwark would be ready to engage with the review caused additional stress to the survivor and the impact this had upon the survivor's health and mental well-being must not be understated. It reinforced for TT the sense that yet again she was insignificant and that the trauma she experienced did not matter.

It is vital that such issues are not replicated for other survivors. Clarity was and is needed regarding the legal status for data-sharing between the NCIs, the dioceses, the ICIR and Independent Reviewers. This should ensure that before the commencement of future reviews, the ICIR can be confident that data sharing arrangements will not be an issue and will not affect the timeline for the review agreed with the survivor.

G.6.3.3. Diocese of Oxford

Email correspondence with the SPOC, the Diocesan Safeguarding Officer at the Diocese of Oxford demonstrates that she responded promptly to the introduction letter and pending receipt of the privacy notices, made provisional arrangements for the Reviewer to visit the diocese, see documentation and meet with the DSO and the Bishop's chaplain. Although the DSO only took up the post towards the end of the NST investigation she was very familiar with the case. During the site visit she also arranged for the Reviewer to meet with the Diocesan Bishop and the appropriate area Bishop.

G.6.3.4. Diocese of Leeds

Following email correspondence, a Teams call was arranged with the Director of Safeguarding at the Diocese of Leeds (also referred to as the Diocesan Safeguarding Officer or DSO) as she had been identified as the SPOC. She had only taken up the role within the previous six months and explained that consequently was not aware of the case, which had been closed by Leeds at the end of the NST investigation. During the NST investigation a previous DSA had been a member of the NST Core Group. The NST had reported that the first of these DSA's had carried out a risk assessment and participated in an interview with Bishop X as part of the NST investigation. When she left the diocese, she was replaced by another DSA who then joined the Core Group but who was no longer in post at the time of this case review. As this was a closed case the new Director of Safeguarding was not aware of Bishop X having

PtO in the diocese or the significance of this for the review. The Diocese of Leeds did not have a digital case management system until it adopted the national case management system (MyConcern). All records relating to the role of the diocese in the NST investigation have been retained in a paper file. Once the file had been located the Reviewer made arrangements with the Director of Safeguarding to travel to Leeds to review the contents on 12.2.25 as mutually agreed.

On arrival at Church House a private office was provided, the file was comprehensive although documents had not been filed systematically. Staff were available to photocopy any documents requested. However, it contained no evidence of the risk assessment. The Reviewer was able to speak briefly with the Director during the day but felt that following the file review, given that the Director had not been in post during the investigation, there was no need to arrange a further meeting. There was one current issue arising from the file and the Reviewer communicated with the Director by email following the visit. Leeds have subsequently confirmed that this has been actioned.

Subsequently, the Reviewer communicated with the Diocesan Secretary by email asking if he had any objection to her contacting one of the previous DSA's about the NST investigation as it appeared there was no one currently in post to fill in some gaps in the information. He responded that he had no objection at all and did not suggest anyone else currently in post who might be able to assist. The Reviewer, therefore, contacted and interviewed a previous DSA who had been in post during the NST investigation. The Reviewer is not raising any of the above points as a criticism of any specific individual. Rather these concerns demonstrated the challenges of gaining access to information, either in the form of documents or the people who hold the information through their experience, when a review of this kind is undertaken.

Appendix G7 Terminology

Ad-hoc Information Sharing
Sharing information not covered by Sharing Agreements on a one-off basis, or disclosure without the Data Subject's knowledge.

Anglican Communion
A group of Churches world-wide with historic and present links with the Archbishop of Canterbury. All Anglican diocesan bishops are members of the Lambeth Conference.

Archbishops' Council
The Archbishops' Council was established under the National Institutions Measure 1998. Its purpose to provide leadership and executive responsibility for the National Church as well as being a forum for strategic planning.

Bishop

Chief minister (of diocese) with spiritual oversight of clergy and lay people. Bishops are the first and most senior of the three Holy Orders of the ordained ministry in the Church of England. A diocesan bishop often has the help of other bishops – see Area Bishop, Assistant Bishop, Suffragan Bishop.

Church of England
The Church of England is part of the world-wide Anglican Communion. The National Church is not a single body or entity. It comprises many different office holders and legal entities which are separately governed. These include seven National Church Institutions (NCI's) and forty-two dioceses.

Church Officer
Anyone appointed to a post or role, whether they are ordained or lay, paid or unpaid.

Clergy
The general name for all ordained ministers in the Church of England (Crockfords).

Clergy Discipline Measure (CDM)
The Clergy Discipline Measure (2003) is a process for handling serious misconduct on the part of clergy. Lodging a CDM allegation of misconduct is the start of a legal process in which an investigation will take place into the alleged misconduct. Following General Synod 2025, this is to be replaced by the Clergy Conduct Measure. The principal feature of the new Measure is that complaints will be categorised as either a grievance, misconduct, or serious misconduct.

DSA/DSO
Up to and including the time of the NST investigation the lead officer for Safeguarding in every diocese was referred to as the Diocesan Safeguarding Adviser (DSA). This was the term used in much of the documentation related to the NST Investigation including Core Group Minutes.
Following one of the recommendations of IICSA Report published in 2020, the General Synod in July 2023 voted to amend Church Law to rename the Diocesan Safeguarding Advisers as Diocesan Safeguarding Officers.

Independent Safeguarding Board (ISB)
The Independent Safeguarding Board was set up to provide vital scrutiny of the Church of England's safeguarding processes. It was disbanded by the Archbishops' Council who claimed, "working relationships between two members of the Independent Safeguarding Board (ISB) and the Council have broken down." Two members of the ISB had alleged that the Council had frustrated the Board's work of providing independent scrutiny of Church of England Safeguarding practices. See A1.

Information Sharing Agreement (ISA)
An Information Sharing Agreement/ISA is a document that sets out in detail any information sharing arrangements between parties who have signed up to the Framework.

National Safeguarding Team (NST)
The NST was set up in 2015. The function of the National Safeguarding Team is to manage complex safeguarding cases (involving a number of dioceses) and those relating to senior clergy including bishops

and deans. The NST is also responsible for leading on House of Bishops policy and practice guidance and developing safeguarding training.

Spiritual Abuse
Spiritual abuse is a form of emotional and psychological abuse. It is characterised by a systematic pattern of coercive and controlling behaviour in a religious context. Spiritual abuse can have a deeply damaging impact on those who experience it.

Victim/Survivor
In the Church of England these terms used for people who have experienced sexual abuse or sexual violence. Many victims choose the term survivor as this indicates their agency and a refusal to be defined by what was done to them. They should be asked for their preference.

Appendix G.8. Safeguarding Milestones and Development in the Church of England

Safeguarding Milestones 1949 – the present

1949	Universal Declaration of Human Rights https://www.un.org/en/about-us/universal-declaration-of-human-rights
1950	European Convention on Human Rights https://www.echr.coe.int/documents/d/echr/convention_ENG
1984	Convention against Torture and other Inhuman, Cruel or Degrading Treatment https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading
1993	Resolution passed by the Anglican Consultative Council and the Primates of the Anglican Communion passed a resolution urging all Provinces to work to end the sexual abuse and exploitation of women and children throughout the Anglican Church. They called on congregations to provide pastoral care to victims of sexual abuse.
1998	The Human Rights Act https://www.legislation.gov.uk/ukpga/1998/42/contents
2000	The Care Standards Act https://www.legislation.gov.uk/ukpga/2000/14/contents No Secrets
2002	Time for Action https://ctbi.org.uk/books/time-for-action/

The General Synod took note of "*The Guidelines for The Professional Conduct of the Clergy*" produced by the Convocations (the upper and lower houses of clergy) (para 2.13 every ordained person should have training in child protection; para 3.14 a child or vulnerable adult who discloses abuse to be taken seriously and referred to appropriate agencies; para 7.3 confession and disclosure of abuse) https://www.legislation.gov.uk/ukcm/2003/3/section/8#:~:text=8MisconductE&text=(d)conduct%20unbecoming%20or%20inappropriate,by%20way%20of%20such%20proceedings.

2007 Past Case Review1

2014 The Care Act
https://www.legislation.gov.uk/ukpga/2014/23/contents

2018 Past Case Review 2
https://www.churchofengland.org/safeguarding/safeguarding-news-releases/national-report-church-englands-second-past-cases-review

2019 Social Care Institute for Excellence (SCIE) Report of the independent diocesan safeguarding audits and additional work on improving responses to survivors of abuse.
https://www.churchofengland.org/sites/default/files/2019-04/scie-final-overview-report-of-the-independent-diocesan-safeguarding-audits-and-additional-work-on-improving-responses-to-survivors-of-abuse.pdf

Independent Investigation into Child Sexual Abuse
https://www.iicsa.org.uk/reports-recommendations/publications/investigation/anglican-church/executive-summary.html

Development of Safeguarding Policy and Practice within the Church of England

As in wider society, the shaping of a safeguarding agenda in the Church of England began first with the issues of Child Protection. In 2001 when TT first reported the abuse that had taken place during the period between 1979 and 1990, there were no policies and procedures in place in the Church of England for addressing the abuse of adults and there was no recognition of the conditions that can render adults vulnerable to abuse and harm.

Nevertheless by 2001 there were both international conventions and UK acts of parliament in place. Bishops and other senior clergy should have been informed regarding the conversations that were taking place within the House of Bishops and what was an appropriate response by senior clergy to allegations of the sexual abuse of adults.

In his paper Safeguarding in Church and State over the last 50 years or 'From Ball and Banks to Beech via Bell'[12] His Honour Peter Collier QC records that in January 1993 a joint meeting of the Anglican

[12] From Ball and Banks to Beech and Bell, His Honoured Peter Collier QC, January 2020 https://ecclawsoc.org.uk content/uploads/2020/01/Collier-From-Ball-and-Banks-decade-by-decade-1.pdf

Consultative Council and the Primates of the Anglican Communion had passed a resolution which urged all Provinces to work to end the sexual abuse and exploitation of women and children throughout the Anglican Church. This also expressed shame at the evidence of sexual abuse within the Anglican Church and there were also calls on congregations to provide pastoral care to victims of sexual abuse.

Promoting a Safe Church[13], the first safeguarding policy to address the safeguarding needs of adults, was not published until 2006. However, during the years preceding the publication of this policy document, both society as a whole and the churches were becoming increasingly aware of the extent of abuse and harm suffered by adults. In 2000 Parliament published the Care Standards Act[14] and the Department of Health produced No Secrets[15], the guidance around protecting vulnerable adults from abuse that remained in place until the 2014 Care Act. Both the Care Standards Act and No Secrets centred around protective frameworks that very much linked vulnerability to those in receipt of Local Authority care and provision. Nevertheless, they served to raise awareness of across all sectors of the vulnerability of adults to abuse and the importance of statutory agencies and those in the voluntary sector working together.

In 2002, the time at which TT was fighting for a response to her allegations of sexual abuse, Churches Together in England and Ireland published, Time for Action[16]. The description of the book highlighted its importance for all churches in responding to sexual abuse within the church.

> *Sadly, a large number of survivors of sexual abuse have been left nursing their deep pain and anger. Churches Together in Britain and Ireland have responded by setting up a group to explore these issues and to make recommendations. In "Time to Act", the Churches are called upon to recognize the ways in which their institutional life has silenced the abused and protected the abusers. The book makes suggestions for the pastoral care of those who have been sexually abused, the training and screening of clergy and the rehabilitation of paedophiles in ways that continue to protect children and vulnerable adults. It also presents the record of the meetings of the group and the background to their recommendations to the Churches. If the Churches recognize that it is the time to act on the recommendations of the Group on Sexual Abuse, then a new day will dawn for many people who have experienced great sadness and yet have somehow held on to hope.*

The book highlighted the needs of children who had been sexually abused, adults who had been sexually abused as children, and adults who had been sexually abused as adults.

We were particularly concerned with the points where sexual abuse intersects with the church in the following ways:

i. Where the abused person is a member of the church
ii. Where the person who has abused is a member of the church
iii. Where the person who has abused holds a position of leadership or prominence in the church

[13] https://exeter.anglican.org/wp-content/uploads/2014/11/promotingasafechurch.pdf
[14] https://www.legislation.gov.uk/ukpga/2000/14/contents
[15]https://assets.publishing.service.gov.uk/media/5a7af2a640f0b66a2fc03f4d/No_secrets__guidance_on_developing_and_implen
ng_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf
[16] Time for Action, Authors: Revd David Gamble, Revd Kathy Galloway,2002,ISBN: 9780851692814

iv. *Where the Scriptures and doctrine have been used to explain, justify, excuse of in any way legitimize sexual abuse*
v. *Where sexual abuse has taken place within church establishments, organisations, institutions, property, or in any context under the auspices of the church.*

Past Case Reviews

In 2007 the Church of England Commissioned a Past Cases Review (PCR1) to examine the handling of child safeguarding cases by the Church. This involved a scrutiny of the files of clergy and other church officers to identify any person who might present an ongoing risk to children and young that had not been act upon appropriately. However, abuse survivors were not invited to contribute to this review.

In 2018 a second review was commissioned (PCR2). This followed concerns being raised regarding the judgments and responses from PCR1. The stated purpose of PCR2 was to ensure that there were no outstanding and unmanaged risks from clergy or church officers and this time this extended to vulnerable adults in addition to children and young people.[17] This time abuse survivors were invited to come forwards via their Diocesan Safeguarding Team. In addition, a dedicated helpline was set up that was operated independently of the Church of England, by the NSPCC. During the NST review of this case a PCR2 review was carried out and completed in July 2021, and this will be referred to later in this report.

Independent Inquiry into Child Sexual Abuse (IICSA)[18]

Whilst the focus of IICSA was child sexual abuse, the findings highlighted under B.6. of the IICSA report speak into the culture within the national Church of England that is relevant to this case review and for this reason are highlighted here.

The report states:

It was suggested, during the third public hearing, that many individuals struggled to reconcile pastoral care for fellow clergy, with whom they may have professional and personal ties, with their duty to uphold effective safeguarding (IICSA: B6.1.2.). The report also highlighted the entrenched characteristics that had been identified in the Chichester/Peter Ball Investigation Report[19]. These included:

i. ***Clericalism****: A culture of clericalism existed in which the moral authority of clergy was widely perceived as beyond reproach*
ii. ***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.*
iii. ***Naiveté:*** *Reports of abuse were on occasions dismissed without investigation.*
iv. ***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*

[17] https://www.churchofengland.org/safeguarding/safeguarding-news-releases/national-report-church-englands-second-past-cases-review

[18] Independent Inquiry into Child Sexual abuse Inquiry report finds Anglican Church failed to protect children from sexual abuse, https://www.iicsa.org.uk/news/inquiry-report-finds-anglican-church-failed-protect-children-sexual-abuse

22 https://www.iicsa.org.uk/reports-recommendations/publications/investigation/anglican-chichester-peter-ball.html

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.

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