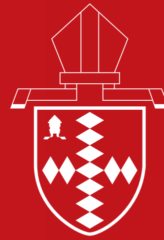

The Diocese of
Southwark

Diocese of Southwark PCR2 Executive Summary

October 2022

Commissioning arrangements for the PCR2 - Independent Reviewers

The Diocese appointed Martyn Burrell, a qualified Social Worker with over 28 years of experience in child protection, as Lead Reviewer. Martyn also came with expertise in Church of England safeguarding policies and procedures, having worked as an adviser to the Archbishop of York and also as a project manager with the National Safeguarding Team (2018 to 2020). He and three other reviewers were all independent of Southwark Diocese and had NST approval.

Executive Summary

Southwark is a large Diocese, covering London south of the Thames, and East Surrey. There are 359 churches in 292 parishes and a total population of about 2.75 million. Forty-six thousand people are on the electoral rolls of the parishes. In addition to the Diocesan Bishop, there are three Area Bishops covering three Episcopal Areas, and two Archdeacons per Episcopal Area.

This report presents the findings of a team of four Independent Reviewers, including a Lead Reviewer, who were commissioned to undertake the Past Case Review 2 (PCR2) by the Diocese of Southwark. All the Reviewers were independent of the Diocese and their appointment was approved by the National Safeguarding Team (NST).

The objectives of the PCR2, as stated in the PCR2 Practice Guidance, (2019) were adhered to throughout the process, which involved a review of 2536 files and records. Of these, less than 1% were considered as Annex D, warranting further investigation by the Diocesan Safeguarding Team (DST).

Arrangements for the PCR2

The Reviewers would like to thank the Bishop of Southwark and the Bishop's Lead for Safeguarding for the support and resources made available to the Review Team, and all Diocesan staff and clergy for their time and commitment to the PCR2.

The Review Team commenced work in September 2020 and the PCR2 was completed in March 2022. The Diocese ensured that facilities were made available to enable work on the Review to continue during periods of disruption due to the Covid Pandemic.

The Diocese appointed a Project Manager to oversee the PCR2, who created and maintained a series of data bases to assist the review process. These consisted of a Review Log, a Known Case List (KCL) based on information from the Past Case Review in 2009, the parish returns and knowledge from the Diocesan Safeguarding Team (DST), and an Issues Log where the Reviewers could log any non-urgent queries. The use of the Issues Log was an effective tool for communication between the Reviewers and the DST, resulting in an overall lower number of Annex D concerns. A PCR2 Project Reference Group was established in December 2019. A small Quality Assurance Subgroup was established with two members from this group, including a member of clergy and the Survivors Representative. Their input was instrumental in considering the findings and recommendations of any cases identified by the Annex D documents.

The Review Team conducted a comprehensive review of all Clergy Blue Files, including clergy at the Cathedral; Readers and Southwark Pastoral Auxiliary Officers, Permission to Officiate (PTO) files, and current and historic safeguarding casework records.

Key Findings from the Review of Information

Diocesan Safeguarding Team Records

Queries, which arose from DST records, were resolved following discussion with the DSA, and those that could not be, were then considered as potential cases of concern. An overview of the causes for concern (Annex D) shows that of the 19 cases raised, 16 remain open. Of the other three, the recommended actions were concluded by the time the reviewing phase was completed.

The Reviewers saw an additional 289 safeguarding files identified from the DST spreadsheet. These were for Church Officers who did not have an HR type record held by the Diocese. There were 89 queries raised by Reviewers around practice and case management within these cases. Safer recruitment regularly featured in these queries.

The Reviewers found the quality of the safeguarding case recording to be variable, but the recording on case files since 2014 was far more comprehensive. The response of the Diocese to concerns raised in relation to both children and adults showed that practice had improved considerably over time, and especially since the Past Cases Review in 2009. The Reviewers noted evidence that the more recent casework considered the specific needs of children and adults.

Active Clergy

767 active clergy, including those with PTO and chaplains, were subject to review. All the Clergy Blue Files and PTO files are in paper form and maintained in accordance with the House of Bishops Guidance, 2018. The Review Team raised 80 queries (10.4% of these files) with the Diocese regarding the information seen in these Clergy Blue Files and associated safeguarding files. Of these, 11 members of the clergy had moved to other dioceses or to non-parochial roles. The reviewers saw 411 retired Clergy Blue Files. The Reviewers raised 31 queries (7.5% of these files) regarding retired Clergy Blue Files and any associated safeguarding files.

The queries were generally about the content of the files and to ensure information sharing. The Reviewers noted a lack of consistency in the content of the Clergy Blue Files. While they all had the standard sections, the content was variable. However, there is a robust process now in place in the Diocese, to ensure that safeguarding records are not removed. The content of the more recent Clergy Blue Files was generally of a more robust standard.

The Reviewers had less confidence in the robustness of the Clergy Current Status Letter (CCSL), received when a member of clergy joined the Diocese. This resulted in their raising a national recommendation (see Recommendation 11).

Southwark Pastoral Auxiliary Officers (SPA) and Readers

Of the 431 active and retired SPAs there were 5 queries (0.01% of all SPA files). Of 453 active and retired Readers there were 23 queries (5% of all reader files). The SPA files and the Reader files are held electronically in the Department of Discipleship and Ministry. The most frequent queries raised by Reviewers were around safer recruitment and safeguarding training.

Safeguarding Agreements

The Reviewers found an inconsistent and confused approach to Safeguarding / Worship Agreements. The threshold for agreements was variable and terms used to describe an agreement inconsistent and interchangeable. It was reassuring to discover that the newly appointed DSA had recognised the issues and is improving working practice in this area.

Engagement with Partner Agencies

The Reviewers saw examples of positive engagement with partner agencies on practice matters. Appropriate referrals were made when required. Sufficient and relevant information was provided within the referrals to allow the partner agency to form a meaningful response.

Safer Recruitment

The Reviewers were assured that a comprehensive system for undertaking appropriate preemployment and DBS checks was in place.

Survivor Engagement

When considering survivor engagement, the Reviewers recognised some cases where there was strong and meaningful work undertaken by the DST with survivors. This was particularly evident, although by no means exclusive, to the period between 2014 to 2020. The survivors who shared their views have been valuable in enabling the Reviewers to make recommendations to the Diocese going forward in plans for survivor engagement. The Reviewers would like to thank the survivors for their time and for the views shared.

The Views of Children who were Victims and Survivors of Abuse

From the more recent safeguarding files seen, the Reviewers had confidence that the views of children were being listened to and appropriate protective action taken. Referrals were made to statutory services within a reasonable timeframe and the Diocese participated in multi-agency plans. The needs of children were considered separately to those of adults and appropriately prioritised.

Response to Domestic Abuse

The Reviewers were able to see how the Diocesan responses to domestic abuse had improved significantly over the past 30 years.

Key Themes Emerging from the PCR2

It is apparent there are four key themes emerging from the Review, which are as follows:

- **Clergy Blue Files:** there is a need for consistency in the content of Clergy Blue Files. Any removal of information from a Clergy Blue File needs to be recorded. The accuracy of the content of the CCSL and the assurance that a member of clergy is ‘safe to receive’ are safeguarding issues which the PCR2 has highlighted and require bringing to the attention of the NST (see Recommendation 11).
- **DST Recording:** the need for more focused case recording was an issue arising from the PCR2. It is anticipated that the introduction of a National Case Management System will improve practice in this area. A significant number of casefiles were awaiting closure, which is a concern that has been prioritised by the appointment of the Safeguarding Information Manager in February 2022. The importance of ensuring that recording on casefiles is maintained and updated is recognised as an issue arising from the PCR2 and will be addressed.
- **Safeguarding Agreements:** there was an inconsistent and confused approach to safeguarding agreements. The issue of safeguarding agreements has been recognised as a concern by the Diocese and plans have been put in place to undertake a full audit of the existing agreements to review their status and any outstanding actions required.

- **Survivor Engagement:** the issue survivor engagement by the Diocese has been exemplified by the findings of the PCR2.The DSA has recognised the need for better engagement with those who have been subject to abuse by clergy and is committed to further improve the work of the DST and the wider Diocesan Team. The importance of a Survivors Advocate to enhance the experience of survivor engagement is recognised by the Diocese. The DSA is committed to ensure that the experiences shared by survivors with the Reviewers would be considered within the Action Plan arising from the PCR2.

Best Practice

An example of best practice was when the Reviewers were reassured to find every case, which had been reviewed and a concern identified, had already been recognised by the DST. The Reviewers also noted best practice in core groups and in the initial responses to referrals made.

Conclusions and Recommendations

It can be concluded, as was the finding from the Review of Past Cases in 2009, that no major issues concerning the safeguarding of children and adults in the Diocese of Southwark arose from this Past Review of Cases. Although 21 recommendations have been made arising from the PCR2, it is recognised that action has already been taken by the Diocese of Southwark to implement a number of the recommendations made.

Recommendations

All recommendations apply to both child and adult safeguarding responses provided by the Diocese of Southwark.

Next stages of the Past Cases Review

1. The Diocese should create an action log to ensure all the individual case work issues raised by the Reviewers through the concerns documents and the Issues Log are considered and recorded when completed.
2. The Diocese should ensure that all the records generated by the PCR2 Review Team are ordered and secured so that future reference can easily be made to the work of the PCR2.
3. Any wider practice issues arising from the PCR2 should be logged and considered by the Diocese and, where applicable, included in plans for improvement.
4. The DSAP should consider if assurance is required for areas considered outside of the scope of the PCR2. This could include areas such as a file review for volunteers and staff at the Cathedral and a review of the HR files for key Diocesan staff working with children and / or vulnerable adults.

The Engagement with Survivors by the Diocese

5. The Diocese should actively consider the comments made by the survivors who engaged with the PCR2 and ensure these are reflected in any action plans.
6. The Diocese should consider how they might engage with a wider group of survivors in any future reviews or service developments.

7. The Diocese should consider the benefits of employing an independent advocate to enhance their work with survivors both on individual casework and a wider strategic level.

Practice Issues

8. The Diocese, preferably alongside partner agencies, should review their use of safeguarding agreements to ensure consistency of application, that they are reviewed regularly, and their overall effectiveness in managing risk. (Local and national recommendation).
9. That an audit is undertaken to ensure that all current safeguarding agreements are still relevant and known to both the DST and to the key church officers at a local level.
10. The Diocese should ensure that they are using a wide panel of risk assessors to ensure skills are matched to the requirements of individual risk assessments and that there are no potential, perceived or otherwise, conflicts of interest. (Local and national recommendation).
11. The use and application of the CCSL as a tool for safeguarding and compliance should be re-considered. (National recommendation).

Recording and File Management

12. A review should be undertaken of all current open safeguarding files to ensure that there is no current drift and that the reason for the case being open remains.
13. The DSA should consider how to ensure that all open cases are subject to regular and meaningful review.
14. To aid understanding of safeguarding files it is recommended that key documents should be highlighted and short case summaries used.
15. It is recommended that when cases are closed a closure summary is completed.
16. Given the difficulty in accessing password protected electronic documents it is recommended that no current paper safeguarding records are destroyed until the Diocese is assured all the key electronic records are accessible.
17. An audit should be undertaken to understand which miscellaneous files are held at Bishop's House.
18. Where separate recording systems are used for distinct purposes, for example safer recruitment and the assessment of an adverse DBS, there must be clear links between the different records.
19. If the DST continues to use a Safeguarding Database then a process should be considered to ensure that at the closure of a case the referral information is accurate and any details previously unknown are updated.

The Diocesan Safeguarding Team

Whilst not directly within the scope of the PCR2 the reviewers made the following observations:

20. A review should be undertaken of the nature of the casework being undertaken by the DST to ensure the specialist skills of the team are being used where most needed.
21. Consideration should be given to the resourcing and management of the DST to address the recommendations arising from PCR2.