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Final overview report of the independent diocesan safeguarding audits and additional work on improving responses to survivors of abuse



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This report benefits from the generous contributions provided by abuse survivors and others with first-hand experience of receiving, or expecting to receive a safeguarding response from dioceses of the Church of England, in England. Taking part is likely to have to have had an emotional cost and this must not be taken lightly. The majority of people asked not to be named as contributing. Confidentiality for some is critical.

If you participated in the SCIE survey, please accept our heart-felt thanks. You will find the write-up in Part Two of this report. We hope we have done justice to the experience and views that you generously shared. We hope you will recognise your contributions in the themes presented.

If you did not feel able to take part, or only belatedly found out about the survey, we also hope the themes presented will resonate.

If you have any questions or feedback, please do not hesitate to get in touch. Email learningtogether@scie.org.uk in the first instance and let us know if you would prefer an email response or to arrange a time to speak.

The National Safeguarding Team will be deciding on action in response to the findings of this report. SCIE will provide a link on our website, to available detail on the Church safeguarding website.

1 OVERVIEW AND SUMMARY

1.1 A REPORT OF TWO PARTS

This is the final report of the programme of independent work focused on diocesan safeguarding arrangements and practice. It is made up of two parts. They are brought together in this final report as means of integrating learning from engaging directly with people with first-hand experiences of Church responses to issues related to safeguarding, with learning from the diocesan safeguarding audits.

1.2 PART ONE. OVERVIEW OF FINDINGS OF INDIVIDUAL DIOCESAN AUDITS

Part One of the report provides an overview of learning from the independent diocesan safeguarding audits. In it we present an overview of learning from all 42 diocesan audits and draw out underlying, systemic issues that represent barriers and vulnerabilities to creation of a safer Church for all. The audits have taken place in a changing context and the Church has done much to address early systemic issues raised by SCIE. Therefore, in Part One we also summarise and appraise activity completed, underway and planned, to address issues raised, and make clear areas still outstanding.

The overview of findings for each area listed below, includes:

- Examples of good practice
- Changes implemented in response to considerations in previous scie audit overview reports
- Overall conclusions
- Considerations for further action by the national church.

P 10 A Summary Of Findings

1.2.1 Areas covered by the findings

P 14 Structure of safeguarding leadership, management and organisation – including diocesan safeguarding service, diocesan safeguarding advisory panel

P 36 Policy and practice guidance – including complaints, whistleblowing, and framework of national and local guidance

P 44 Quality of service provision – including recording systems and IT solutions, casework, risk assessment & safeguarding agreements

P 51 Information sharing – including within and between dioceses, with statutory agencies and agreed protocols.

P 54 Support services for children and vulnerable adults – including authorised listeners

P 57 Training – diocesan and nationally

P 60 Safe recruitment of clergy, lay officers and volunteers – including blue files, volunteer appointments, chaplains, DBS checks

P 64 Quality assurance process – including role of DSAP, learning lessons reviews, safeguarding in parishes

1.3 PART TWO. IMPROVING CHURCH RESPONSES TO VICTIMS AND SURVIVORS OF ABUSE: LEARNING FROM AN INDEPENDENT, CONFIDENTIAL SURVEY

Part Two of the report introduces the additional work conducted by a survey to ascertain the views of people who have first-hand experience of Church responses, including survivors of clergy and Church-related abuse.

P 69 Introduction

The survey focused on how the Church should be engaging with people who come forward, whether to:

- To disclose abuse,
- To shared concerns about poor practice,
- To share concerns about past failures in Church responses to knowledge of abuse or safeguarding concerns in Church contexts
- Or because people need to keep safe for other reasons such as life circumstances, ill health or disability of any kind.

58 people took part. The vast majority reporting to be victims of clergy and church related abuse (47). When asked directly how satisfied they were with the timeliness and quality of Church responses, participants who replied, were overwhelmingly unsatisfied.

P 77 Who took part

1.3.1 What Church responses to abuse survivors and other coming forward to the Church with safeguarding concerns should look like.

First we present themes drawn from the survey. These themes illuminate features of what good practice looks like, from the perspective of people on the receiving end of Church safeguarding responses. They are differentiated across different stages of engagement with people who come forward.

All stages include:

- What's important
- What to avoid
- Particular situations/circumstances to be recognised

P 81 STAGE ONE - Making it easy to tell someone

P 88 STAGE TWO - When initially told

P 97 STAGE THREE - Throughout the processes that follow

P 108 STAGE FOUR - Grievances and complaints

P 111 STAGE FIVE – After processes have ended

These sections provide a wealth of detail, and from a wider group of people than previously brought together by the Church. What stands out is how reasonable the aspects of good practice appear. The findings are also stark in their consistency and compatibility.

1.3.2 Additional systemic issues in Part Two

The concluding section of Part Two, draws out additional systemic issues to those

we were able to identify from the diocesan audits and have captured in Part One of this report. On the basis of what we now know from the diocesan audit programme, about diocesan safeguarding requirements, arrangements and practice, are there any systemic issues that will make it hard for the Church to achieve the features of good practice that abuse survivors and others have identified through the survey? Our answers to that question form the concluding section of Part Two.

Engaging directly with abuse survivors and others who have turned to the Church about safeguarding issues, expecting effective responses to concerns as well as help and support, has raised additional issues that on their own the audits did not reveal. Conversely, we feel better able to understand these issues, with the understanding that we have garnered from the audits themselves.

P 116 Systemic issues for the Church to consider:

P 119 Telling difficult stories about abuses and abuse

P 121 Recognising the contributions of survivors in public narratives about the safeguarding journey of the Church

P 121 Positive senior role models of holding your hands up to having got it wrong

P 124 Long term support

P 125 Person-centred responses

P 126 Keeping the person who came forward at the heart

P 128 Allegations management processes

P 130 Support vs. advocacy

P 132 Routinely seeking & using survivor feedback, including complaints, to drive learning and improvement

1.4 WHY THERE WAS NO DIRECT ENGAGEMENT WITH ABUSE SURVIVORS AND OTHERS WITH FIRST-HAND EXPERIENCE OF DIOCESAN RESPONSES IN THE AUDITS

There are various principles that inform SCIE's work to support partners in improving safeguarding practice:

- Co-production – striving for the ideal of working in an equal partnership with people with lived experience relevant to the service being considered
- Collaboration – working together with commissioners, leaders and practitioners on a journey of improvement and starting where people are at in the process
- Taking a systems approach – seeking to understand the social and organisational conditions that support or hinder good practice, and avoiding blaming or scapegoating individuals or groups for any poor practice identified
- Evidence-informed – drawing on a broad evidence base of reliable, available knowledge

So, in working with the Church of England, we joined the Church in a journey of improvement around safeguarding. In accepting the commission, we agreed to pilot

an approach to auditing diocesan safeguarding arrangements that did not originally include any direct work with abuse survivors.

Following the pilots, SCIE and the NST both agreed on the importance of including survivor views and experiences. Serious consideration was given to how best to do this. We strove to find the right balance between a) avoiding the efforts being only tokenistic and b) being proportionate enough to allow the whole programme of audits to be completed within a reasonable timeframe.

The latter was important because the diocesan audit programme had a two-fold purpose of:

- a) supporting learning within individual diocese
- b) producing a national overview and drawing out national systemic strengths and obstacles to timely and effective safeguarding by the Church.

For the overview to be most useful in driving and informing improvements, it needed to be completed in a reasonable timeframe. Yet it was a substantial undertaking, including 42 dioceses across England, Sodor and Isle of Man and the Diocese in Europe. Therefore, the fieldwork per site had been set at a maximum three days.

In considerations with NST, SCIE came to the view that attempting to engage with abuse survivors to understand their views and experiences, within the three-day structure of the diocesan audits, was simply not feasible in anything but a tokenistic way. Within the individual diocesan audits we looked for evidence of the quality of support provided to survivors only in the case files, and in conversations with clergy and those in safeguarding roles. We also looked at the strength of the systems that are in place to support survivors, such as Authorised Listeners, and the complaints process.

Further, we sought alternative means of ascertaining the views of people with first hand experiences of diocesan safeguarding responses. And we were pleased when the Church agreed to commission a supplementary project to engage directly with abuse survivors and others with first-hand experience of Church responses, and agreed that it focused on improving Church responses to survivors.

We conducted the work to engage with abuse survivors separately and toward the end of the diocesan audit programme, which meant it was not embedded in, and did not inform individual diocesan audit findings. It is in this report that we have strived to integrate the views of abuse survivors into the overall diocesan audit programme. As part of the final overview report of the diocesan audit programme, the survey findings inform the overall audit findings and national improvement work that these findings have already informed, and continue to inform.

1.5 ENABLING PARTNERSHIP BETWEEN SURVIVORS OF ABUSE AND THE CHURCH OF ENGLAND

In the completion stages of the work of this report, SCIE has been pleased to have been working closely with survivor support group Ministry and Clergy Sexual Abuse Survivors (MACSAS) in additional commissions from the National Safeguarding Team of the Church of England. These dovetail with the work presented here and are described briefly below.

1.5.1 Enabling abuse survivor engagement in General Synod, July 2018

With MACSAS, SCIE co-designed, managed and facilitated, the engagement of survivors and victims of abuse at the Church of England's General Synod in York in July 2018. This included a 'fringe' workshop aimed at enabling Synod members to hear directly from the survivors. It also enabled dialogue between survivors and Synod members. It also involved speaking directly to Synod as part of the debate on Safeguarding. Jo Kind of MACSAS was the first ever survivor to speak directly to Synod. One of the authors of this report, Sheila Fish shared early themes from the survivor survey.

These activities were linked to the scheduled discussion of safeguarding within General Synod, structured around the National Safeguarding Steering Group's safeguarding paper (reference GS2092). This provided an overview of the key themes emerging from the first set of hearings on the Anglican Church by the Independent Inquiry into Child Sexual Abuse (IICSA). It identified priorities for work related to these themes that the National Safeguarding Steering Group (NSSG) plans to progress on behalf of the House of Bishops and Archbishops' Council.

1.5.2 Supporting transitions toward partnership

The engagement of survivors at Synod and endorsement of the priorities for work was received very positively by the Church leadership and became referred to as a tipping point for the Church. In order to achieve meaningful participation of survivors in the priority areas of work agreed at General Synod, SCIE in partnership with MACSAS, has been working to progress additional areas of work to facilitate abuse survivors to help the Church improve safeguarding:

- The development of a survivor-led strategic framework for Church-wide engagement with survivors
- The establishment of a survivors reference group

The findings presented in Part Two of this report, draw on and exist in addition to proposals from the survivor reference group that have been presented to NSSG.

This is not an easy path. The people SCIE and MACSAS have worked with to-date have helped the SCIE team to understand some of the fundamental obstacles to partnership that exist. Core to these obstacles is the mismatch people experience between the Church that is offering an outstretched hand of partnership and the same Church whose very actions and processes continue to block personal resolution and often inflict further layers of abuse, betrayal and conflict. Evidence of working to achieve personal resolution for survivors of clergy and church related abuse and re-abuse, in an open, compassionate way, may, understandably, prove to be a prerequisite to wider, strategic partnership.

PART ONE

Final overview report of diocesan safeguarding audit arrangements in the Church of England

Acknowledgements

Many thanks to all those within each diocese, who contributed to the learning from the audits, by giving their time and sharing their perspectives on the progress of the safeguarding journey within their diocese. This includes all those who met with the auditors and/or prepared the documents for them to examine, including clergy, diocesan staff, the independent chairs of the Safeguarding Advisory Panels and the parish representatives who participated in focus groups.

1 INTRODUCTION TO AUDIT OVERVIEW REPORT

1.1 THE REPORT

This report provides an overview of the learning from the independent diocesan safeguarding audits, undertaken between July 2015 and February 2018. Each individual diocesan report examines the learning for the particular diocese. This report has a particular focus on bringing out the national systemic strengths and obstacles in the safeguarding journey of the Church of England. Where individual diocesan learning is of wider significance it is part of this overview. Important and critical learning which just applies to the individual diocese is not included here, such as that associated with the unique governance arrangements of the Dioceses in Europe and of Sodor and Man.

Since the start of the project there have been many improvements in safeguarding at a national and local level, including in response to the earlier overview report of the pilots and the interim report covering all audits completed up to July 2016. This report includes findings from the earlier overview reports, as it is the overall summary of the learning since July 2015. Many of the considerations for the National Safeguarding Team of the Church of England [NST] posed in the audits and previous overview reports have already been fully or partially addressed; for this reason, the report provides an update on the actions already taken.

1.2 CONTEXT

This report concerns the first programme of independent audits in the Church of England (C of E). It is part of the wider work led by NST to improve the safeguarding of children, young people and vulnerable adults in the Church and by the Church. The audits have been conducted by the Social Care Institute for Excellence (SCIE). They have covered all the dioceses in England plus the dioceses of Europe, Sodor and Man. In total 42 diocesan audits have been undertaken over the two-and-a-half-year period starting in July 2015. The findings are publicly accessible via published audit reports on the NST's website as well as individual diocesan websites.

Two previous interim overview reports provided a summary of the learning overall judged to have wider significance: one followed the initial four pilot audits, the second covered audits completed up to July 2016. This final overview report covers the findings from the entire audit project.

These independent audits do not provide a static national baseline of safeguarding standards across the Church due to the context of changing safeguarding standards and arrangements during this period. The key reasons for this are:

- The Independent Inquiry into Child Sexual Abuse in institutions (IICSA) has also taken place during the time period of the audits and included the C of E as a case study, raising the profile and sense of urgency to improving the safety of children and vulnerable adults involved with the Church of England.
- The changing role and expansion of the NST during this period, with increased resources to support diocesan practice, development of new and updated national policies, procedures and guidance and an action plan in response to the SCIE diocesan audits
- The close relationship between the progression of the audits across the country,

and changes instigated by the NST: some of these changes were the results of the NST's wider programme of work and others formed the responses to systemic issues identified audits themselves and brought together in the two previous overview reports.

- The dioceses themselves progressed their own safeguarding arrangements while the audit programme progressed, with many responding proactively to the findings of audits of other dioceses, prior to their own audit.

So, rather than representing a static baseline of safeguarding arrangements, the audit programme has taken place in a changing context and reflects therefore both local and national safeguarding journeys within the Church.

1.3 METHODOLOGY

1.3.1 The diocesan audits

SCIE was commissioned to undertake an audit of the safeguarding work of individual dioceses, with a focus on their compliance with House of Bishops' safeguarding policy and practice guidance. The quality of safeguarding in individual parishes and in the Cathedral is not part of this audit, except where issues are raised through a case.

The methodology included both an examination of case records and recruitment files along with the perspectives of key people in the diocese. The latter included individual meetings with key diocesan staff and clergy, a group meeting with parish representatives and written feedback provided by links in statutory agencies.

The perceptions of individuals, who have been the victims / survivors of abuse or been affected by the abuse of others, were not part of this audit. A parallel project commenced in 2017 to specifically consider how to improve Church of England responses to victims / survivors of abuse and directly inviting the involvement of all those who have been affected by such abuse – the report of this forms Part 2 of this combined report, with the executive summary linking the findings of the two projects.

The numbers of dioceses involved meant that the time available within each diocese was limited to three days, so as to be able to complete the audits within the timeframe. Whilst this does not provide a detailed comprehensive assessment of current safeguarding practice, it has provided a good understanding of the main strengths and weaknesses of safeguarding practice in each diocese.

The auditors who undertook the fieldwork and (after the four pilot audits) led on writing the reports are Hugh Constant, Susan Ellery, Lucy Erber, Sally Trench, Leethen Bartholomew and Meiling Kam. Edi Carmi, the lead auditor, provided quality assurance and finalised the reports.

1.3.2 The three overview reports

All three overview reports provided a summary of the findings from the individual diocesan reports. The focus of the overview reports is increasingly on national systemic strengths and obstacles in the safeguarding journey of the Church of England, which have emerged through an analysis of the individual diocesan audit reports, as explained in 1.1 above. Where learning only applies to an individual diocese it is not replicated in this overview.

The first overview report (pilot overview report) was from the learning emerging from the four dioceses who participated in the pilot audits. The second interim overview report, included the learning from the pilot audits and all other audits completed by July 2016. This final overview report is based on the learning from the audits of all dioceses, including those previously reported on in the two earlier overview reports.

The overview reports have all been written by Edi Carmi, the lead auditor, with feedback provided by the SCIE team, and in particular by Sheila Fish, the SCIE project lead. Heather Reid provided feedback from the NST.

1.4 SUMMARY OF FINDINGS

The audits show that since 2015 there has been a major improvement in the safeguarding resources, national policies and practice guidance and safeguarding training courses, with consequent positive changes observed in the practice within the dioceses. The outstanding concerns lie in underlying systemic arrangements and how safeguarding is managed within the C of E, which enable potential vulnerabilities to arise in the future.

1.4.1 Positive changes

The most significant factors behind the improvements in safeguarding have been made possible due to the growth in staffing resources since mid-2015 in both the national and diocesan safeguarding services, along with the wholesale revision of C of E safeguarding policy, practice guidance and training framework. These developments have enabled the changes described in chapters 2–7 of this report, which address the learning from the variety of exercises initiated by the NST, including this audit programme.

The increase in NST resources has facilitated the development of more communications and contacts with Diocesan Safeguarding Advisors [DSAs] and Diocesan Safeguarding Advisory Panel [DSAPs] through regional and national meetings as well as the increased availability of advice and support via the new provincial advisers. This helps minimise the isolation of DSAs as raised in the earlier audit overview reports (see 2.2 and 2.3).

The new practice guidance as a whole provides a more comprehensive and accessible format, with increased clarity, less duplication and more consistency than the procedures that have been replaced, albeit there remain further improvements to be considered as described within some sections in chapters 2–7, along with a more underlying issue in relation to practice guidance terminology and structure, as discussed below (1.4.3).

The new guidance does, to some extent strengthen and clarify the safeguarding role of the DSA (see 2.1.13) and the DSAP. It is now clear the DSA has the responsibility to decide whether to notify statutory agencies in the event of concerns and allegations, without having to obtain agreement from senior clergy in the diocese. An escalation process to the NST also strengthens the role of the DSA, albeit its existence is very difficult to locate in practice guidance (see 2.1.13). However, the underlying complexity and potential lack of clarity in relation to the different functions of safeguarding leadership (spiritual, strategic and operational) are essentially unchanged and unclear (see 1.3.2).

The new guidance and regulations clarify that DSAs should have safeguarding

professional background and experience and recommend that this should be a social work professional. Because this is a recommendation, dioceses remain able to disregard it if they so wish, thereby increasing the risk that vital expertise will be missing from the diocesan safeguarding service (see 2.2.12).

There have been major efforts by the NST to strengthen consistency of practice in relation to casework, in particular the introduction of core groups, the new guidance on allegations against Church officers, risk assessment training and the duty to have regard to House of Bishops' Safeguarding policy and guidance (see 4.2).

1.4.2 Work in progress

Some of the actions in response to previous reports and considerations are in progress:

- The recent changes to address weaknesses in the Permission to Officiate (PTO), clergy appointment and review processes as well as to the Blue File structure and content, need to be evaluated to assess their effectiveness and impact, because this is core to the safeguarding of children and vulnerable adults (see chapter 6)
- The guidance on complaints and whistleblowing with 'Safer Environment and Culture Practice Guidance' was due to be finalised, agreed and implemented in 2018 with further development of whistleblowing processes being part of the NST business plan for 2018 (see 3.2.4)
- A national case management system is being purchased and will be rolled out in 2019 along with an electronic safeguarding manual (see 4.1.2)
- The plans to address concerns about the CDM process: potential conflicts if the Bishop's role in both the safeguarding process and the CDM along with the underlying issue of the CDM being initiated by a complainant as opposed to it being a management responsibility (see 2.1.13)
- There are plans to strengthen information sharing requirements, especially in relation to internal arrangements within the C of E, within and between dioceses and cathedrals (see 4.3)
- Commissioning of SCIE to undertake a research project to improve C of E responses to victims /survivors and appointing a project manager to accelerate the pace of development for the Safe Spaces project to include an independent advocacy service for adult victims/survivors (see 4.4)
- Development of national expectations around diocesan quality assurance, albeit this remains in fairly early stages: the auditors commented that there was a focus on statistical information, but without the additional qualitative data to better understand any weaknesses in practice in parishes (see 7.1)

As is evident from the above, the last three years have seen major change in the development of a safer Church, where children and vulnerable adults are better safeguarded, albeit this is a work in progress, with some additional issues to be addressed in many of the above areas, as outlined in the following report.

1.4.3 Underlying vulnerabilities

The above changes are significant in improving the safety of children and vulnerable adults. This is a work in progress, with some additional issues not yet addressed at the time of finalising this part of the report [April 2018], as explained in this report. In particular what they do *not* address is the systemic underlying vulnerabilities arising from the way safeguarding in the C of E is organised structured and managed.

What remains intact is the lead role in safeguarding of clergy, and particularly Bishops, within individual dioceses. They are ultimately responsible for the appointments, management and decisions made by the diocesan safeguarding services. Whilst there had now been introduced an attempt of checks and balances, with a strong national team and an escalation process, the basic structure remains the same, and safeguarding remains locally managed and led by those without any requirement to have safeguarding knowledge and expertise.

Moreover, the lack of a 'command and control' management structure means that inevitably inconsistencies will develop in safeguarding arrangements between dioceses and between parishes. The current context with IICSA provides a driver for some uniformity in the response of the Church to its past failures, however, risks remain for the future due to the current structures and systems. Chapter 2.1 and 2.2 discusses these systemic weaknesses in more detail and the benefits of a national safeguarding service, able to provide local services, but retaining the appointment, management and supervision of the DSAs.

The agreement and ongoing implementation of a wholesale revision and restructuring of national practice guidance is an immense achievement by the C of E and the NST. However, it does appear that the framework of using 'practice guidance' to provide both procedural requirements and best practice advice leads to a level of confusion for the reader: which of the instructions *must* be followed and which are purely guidance allowing for local variations? In any field distinctions between procedures (instructions that **MUST** be followed) and guidance (advice on best practice) need to be clear for practitioners. Given the way safeguarding in the C of E is organised, structured and managed (see above), having a clear distinction is especially critical. The C of E terminology of 'practice guidance' to include policy, procedure and guidance, is itself inadvertently encouraging inconsistency as guidance suggests advice as opposed to procedures that must be followed.

1.5 **STRUCTURE AND CONTENT OF THE REPORT**

The report is structured as follows:

- Section 2 discusses the structure of safeguarding leadership, management and organisation in the diocese including the ways this is split between clergy and other senior diocese staff, how the Diocesan Safeguarding Service and Diocesan Safeguarding Advisory Panel fits into this.
- Section 3 considers the impact of national policies and procedural guidance on safeguarding
- Section 4 looks at the quality of service provision in relation to record keeping, casework, risk assessments, safeguarding agreements, information sharing and support services for children and vulnerable adults
- Sections 5–7 consider the role of training issues, safe recruitment and quality

assurance in improving safeguarding within dioceses

Sections 2, 3, 4, 5, 6 and 7 present an overview of the findings from the audits, discussion of what this indicates about national systemic strengths and weaknesses, along with the relevant national considerations that are indicated by the findings.

Each topic will present:

- Overall evaluation of the quality of safeguarding practice within each topic
- Changes implemented in response to considerations in previous SCIE audit overview reports
- Examples of good practice

The dioceses are all at a point of active consideration of how to improve safeguarding practice and each had its own individual strengths and areas for development. The report avoids identifying the practice of any particular diocese, as to do so for one practice issue alone could generate a biased view of the overall practice of that diocese.

1.5.1 Considerations

The considerations for the NST are provided at the end of each finding in section 2. These are not specific 'recommendations' to be implemented. Instead, in keeping with SCIE's collaborative 'Learning Together'¹ methodology, these are questions and points for the NST to consider and decide the best way to address the issue, and the priority to be attached to it. This approach enables that those best placed consider these issues do so, and helps generate ownership of and accountability for the decisions that result.

1.5.2 Conclusions

Section 3 provides an overview of what is working well and what further development is needed. The details behind these conclusions are in section 2.

1.5.3 Glossary

A glossary of abbreviations and terms used is provided at the end of the report.

¹ <https://www.scie.org.uk/children/learningtogether/>

2 STRUCTURE OF SAFEGUARDING LEADERSHIP, MANAGEMENT AND ORGANISATION

This chapter provides an overview of the findings of the individual audits into the structure of safeguarding leadership, management and organisation in the diocese, along with what this indicates about national strengths and weaknesses in practice and, where known, any underlying systemic obstacles in improving practice. For each section there is:

- An evaluation of the quality of safeguarding practice for the individual topic or theme
- Examples of good practice
- Changes implemented in response to considerations in previous SCIE audit overview reports and if applicable other learning projects / reviews
- Overall conclusions
- Considerations for further action by the national church and its National Safeguarding Team (NST)

2.1 LEADERSHIP & MANAGEMENT

Bishops have embraced their leadership role in safeguarding generally with some helpfully making positive public messages around its vital importance and integral place in Christian life. Most have taken a personal lead since their appointment in making efforts to change diocesan culture so that all recognise the integral role of safeguarding in all aspects of Church life.

Dioceses vary in the arrangements made for the organisation and management responsibility for safeguarding, but all have the following common arrangements and structures:

- The Bishop identified themselves as having lead responsibility for safeguarding.
- At least one Diocesan Safeguarding Adviser (DSA) is in post (see 3.2)
- All have an independently chaired Diocesan Safeguarding Advisory Panel (DSAP) monitoring the effectiveness of safeguarding arrangements for children and adults in the diocese (the name of this group varies between dioceses – see 3.3)
- All have a senior management group/Bishop's leadership team providing a strategic overview of safeguarding in the diocese, some operational management responsibility and with a level of oversight
- Archdeacons have responsibility for quality assuring of safeguarding practice within parishes.

There were variations within these broad commonalities in the structure and functions of safeguarding management.

2.1.1 Delegation of responsibility for safeguarding

Whilst all the Bishops accept that safeguarding is their responsibility, the arrangements for its delegation vary and include delegation to an Archdeacon, Associate Archdeacon, the Bishop's Chaplain, a Suffragan Bishop, the Diocesan

Secretary and in one instance each to a Head of Human Resources (HR) and to a Diocesan Safeguarding Adviser (DSA). In two dioceses, there was no delegation of any aspects of the leadership role.

What is less clear is the actual meaning of 'leadership' and 'responsibility for safeguarding'; in particular how this breaks down in terms of strategic, operational and theological/spiritual leadership. The latter is clearly the responsibility of the clergy, but responsibility for strategic and operational safeguarding leadership is less well defined and understood. One diocese however had clarity about how this was delegated, with the Bishop retaining 'spiritual' responsibility, whilst delegating to the Suffragan Bishop the operational and strategic responsibilities.

2.1.2 Theological / spiritual leadership

The remit for theological leadership in relation to safeguarding is clearly always with the clergy and especially with the Bishop. This is extremely valuable in helping congregations and clergy to understand why safeguarding is a priority and intrinsic to the beliefs of the C of E. Some Bishops have demonstrated this in various ways, such as intervening personally with any clergy whose training is not up to date and refusing to renew Permission to Officiate (PtO) without such training.

One Bishop spoke to the auditors of the need to articulate the safeguarding role of the Church beyond the confines of its borders, into the wider community and with statutory agencies, especially in the context of a decrease in statutory service provision.

This aspect of the leadership role is the foundation for the culture of the Church and is critical in terms of making it a safer place for children and vulnerable adults (see 2.1.7)

2.1.3 Operational leadership

The auditors reported positively on close links between the Bishop and DSA in most instances, with consensual agreement reached about decisions needing to be made, ready access to Bishops by DSAs with Bishops wanting to be briefed about safeguarding cases. In some dioceses this was facilitated by regular meetings between Bishops and DSAs whilst in others such discussions happened as and when needed.

The interim audit overview report (April 2017) made reference to evidence of disagreement in two dioceses, which highlighted the possibility that this could occur elsewhere. This potential lay in the lack of clarity around what can be delegated and who has the ultimate *operational* responsibility for case decisions including the initial responsibility for receiving and deciding next steps on referrals (in one diocese these went to the Bishop's chaplain), deciding if and when to make referrals to other agencies, initiating core groups and the responsibility for decisions (as opposed to recommendations) of core groups. This was not clear from existing policy and practice guidance, with contradictory and ambiguous procedures provided, as explained in the interim report.

The potential for disagreement indicated the need for more clarity around operational management and decision-making, and in particular ultimate responsibility for making safeguarding decisions around referrals to statutory agencies, including

consulting the local authority designated officer² (formerly known as the LADO). Should this decision be taken by those with professional background and experience in safeguarding or a member of the clergy, and if the latter, should this be the Bishop?

The last report highlighted the 'underlying systemic difficulties there can be in decision-making relating to allegations of church officers, and consequently the need for a national position on the appropriate safeguards that need to be in place to minimise any potential for conflicts of interest involved in any decision-making about referrals to statutory authorities'.

Since that report the NST have responded to the considerations posed in the report, as explained below (see 2.1.13).

In the subsequent audits there has been no evidence of any conflicts on such decision-making and many Bishops have been clear that operational responsibility for casework lies with the safeguarding team and their independence is critical.

2.1.4 Strategic management responsibility

The ways of managing the safeguarding service varied. All dioceses had some form of senior management team with regular meetings and which included in its remit safeguarding responsibilities. This group meets regularly and has different names in different places e.g. the Bishop's leadership / management team, diocesan safeguarding team. The DSA does not belong to this group, but in several dioceses does report to it regularly, and in some others attends if need be (e.g. in preparation for this audit). Some had two such fora, one a management / operational team and one a strategic leadership team. In one diocese the DSA was part of the management team.

The lack of professional safeguarding input into most of the senior management meetings creates risk because the grasp that others have of the safeguarding role cannot be guaranteed. Requiring the DSA to have, at the very least, a reporting function to such meetings would mitigate such risks.

2.1.5 Management of safeguarding service

Management of the DSA and the safeguarding service is rarely undertaken by those with expertise of safeguarding. It is often located within the operational management structure of the diocese, the responsibility usually of the Diocesan Secretary / Chief Executive (or her/his deputy) or the Head of Human Relations (HR). This has the advantage of a clear management structure. Such an arrangement is not universal, with other arrangements involving split management between a number of senior managers and in a sizeable minority of dioceses the management responsibility lies with the clergy, usually through the Bishop's nominated lead for safeguarding i.e. an Archdeacon or Suffragan Bishop, and in one diocese by the Bishop her/himself.

Management via clergy was perceived (within the dioceses who do this) as providing a strong link to senior clergy. However, this relationship could be provided via

² Working Together to Safeguard Children 2018 states that 'Local authorities should, in addition, have designated a particular officer, or team of officers (either as part of local multiagency arrangements or otherwise), to be involved in the management and oversight of allegations against people who work with children

alternative means, without the risk associated with the DSA being perceived, as the 'Bishop's Safeguarding Adviser' and insufficiently embedded in the organisational structure to provide an effective diocesan resource. In one diocese the Bishop's own perceived need for advice, as opposed to an adviser to the diocese, has led to the employment of both a DSA and a BSA (Bishop's Safeguarding Advisor).

The current arrangements lack consistency based on evidence of what provides a safe structure. More fundamentally, they are marked by a peculiarity common to many institutions whereby the safeguarding service is not managed by those with safeguarding expertise, knowledge or qualifications.

2.1.6 Parallel processes: Clergy Disciplinary Measures

The audit remit did not cover an examination of the operation of the CDM process itself. In relation to the data reviewed as part of the audits, the use of Clergy Disciplinary Measures (CDM)³ has not arisen as being problematic in safeguarding cases. However, information from one diocese highlighted how the CDM process can be very problematic if and when the individual making safeguarding allegations is the person expected to make the complaint to initiate the CDM. Such a scenario raises a fundamental question about the appropriateness of alleged victim making a complaint, as opposed to initiation by those in senior positions within the diocese. This links to the lack of organisational management of clergy in the way the Church is structured, based on the independence of each diocese and each member of the clergy within it.

Use of the CDM process for individuals involved in safeguarding cases also holds the potential for conflicts of interest; these were not subject of the audits and it is not known how often these arise and how resolved. The audits found one case in the first year of the audits where this was a live potential issue with the Bishop seeming to be involved in both processes. In contrast in more recent audits, two Bishops spoke about how they avoid this potential problem. In one audit a Bishop had delegated safeguarding to the Suffragan Bishop in order to separate responsibilities should any case involve a Clergy Disciplinary Measure (CDM). This is good practice. Another Bishop spoke of assiduously avoiding prior involvement in cases so as to be unbiased if CDM is used. The current CDM Code of Practice [2003] addresses this issue advising the Bishop avoid involvement in any safeguarding case where a CDM could also be initiated or by appointing another senior member of the clergy to hear the CDM. What is not known is whether this is consistently followed, as it relies on the individual Bishop to recognise the possibility of conflict.

2.1.7 Culture

The most critical aspect of safeguarding relates to the culture within a diocese and extent to which priority is placed on safeguarding individuals as opposed to protecting the reputation of the Church. Also integral is the ability of all members of the Church to 'think the unthinkable' about their friends and colleagues. This is particularly important where there are sub-groups bound together by particular common beliefs or types of worship. In such contexts there may be an increased risk

³ The Clergy Discipline Measure 2003 which came fully into force on 1 January 2006, provides a structure for dealing with formal complaints of misconduct against members of the clergy, other than in relation to matters involving doctrine, ritual or ceremonial.

to identify and protect colleagues.

There was a universal stated desire in dioceses to improve and develop safeguarding, and this was particularly evident in dioceses where there is experience amongst senior clergy of previous serious abuse cases. Such learning seems to contribute to some understanding of the need for openness and humility in approaching safeguarding issues, along with a cultural move away from responses which give too much attention to reputational issues and the welfare of (alleged) perpetrators, as opposed to the welfare of victims and survivors. However, there remains a tension between the difficulty some offenders have in changing their behaviour, with the imperative in the Church for forgiveness and renewal.

Increasingly, senior clergy speak of the need to embed a culture in the diocese whereby churches own and embrace safeguarding. Whilst this is a good first step, what dioceses appear to be less clear about is:

- what the components of a safe Church culture are
- how to support the parishes to develop this culture throughout the diocese.

Whilst training contributes to this change (see chapter 5), the next stage of development needs to consider how else to support such cultural change throughout the diocese.

A priority mentioned in some dioceses has been to develop a culture where challenge is considered to be positive and where information sharing thresholds are lowered. However, what is less clear is how to achieve such an open and challenging environment within a setting where power is perceived to derive from God, and where there is an unquestioned expectation of deference and respect according to such status.

One diocese has recognised the need to communicate about safeguarding and the significance of the messages sent and received for the kind of culture being cultivated around safeguarding. As part of this the need for skilled media and communications support has been recognised, when safeguarding concerns have been identified. Certainly, to be open about the known cases of abuse will contribute to recognition that those with perceived high status and/or 'God given' power can be questioned and can be capable of abusing others, along with anyone else in society.

Many dioceses identify that the focus historically has been on children's safeguarding and that there is a need, especially in the light of aging congregations, to develop increased awareness and response to the possibility of vulnerable adults being abused or neglected.

An important cultural aspect that has not been considered is the extent to which the wider culture is one which is sympathetic to victims and survivors of abuse and neglect and the extent to which support by clergy, staff, volunteers and congregation is perceived as positive or experienced as causing any further abuse. In one diocese there was mention of the Bishop meeting with and apologising to victims and survivors to reinforce such a culture. It is likely that the report on the parallel project involving the direct input of victims/survivors may provide further information on this (see Part 2 of this report).

2.1.8 Impact of size, complexity and wealth of diocese

A factor that can affect how well safeguarding arrangements work is the size and

complexity of the diocese, leading to potential challenges in the consistency of the safeguarding message and responses received to it in larger and/or rural dioceses. This can risk the development of attitudes and/or practice that are highly localised and outside the safeguarding practice and culture that the diocese may be wanting to embed.

Further challenges arise with large mobile congregations (e.g. city centre churches) and consequent increased difficulty identifying offenders.

The dioceses vary enormously in terms of the resources they have available in general. However, auditors found in recent months and years resources were being provided in all dioceses to try and meet the need for the development of the safeguarding service. There remains the possibility though that the quality of the safeguarding service could be associated with the resources available as opposed to the needs of the congregations. The current wider context provides a driver to prioritise safeguarding, but it is conceivable that if safeguarding is under less national scrutiny (with less media and political interest and after IICSA has completed its work) the risk increases that poorer dioceses will be less able than wealthier dioceses to resource future needs of safeguarding services.

2.1.9 Cathedral

The extent of 'working together' between diocese and cathedral varies greatly. In some dioceses there was little evidence of any overlaps, whilst increasingly audits found recent moves towards increasing integration of systems and processes, including common training; Cathedral representation on diocesan safeguarding management groups and on the diocesan safeguarding group; the DSA providing consultation to the Cathedral; the Cathedral making use of the expertise of the diocesan communications staff. In at least five dioceses there was a service level agreement for the diocese to provide dedicated human resources (HR) and safeguarding advice and consultation and in many others such agreements were being developed or informal arrangements existed. It was evident in the second year of the audits that there have been increasing links between dioceses and cathedrals.

2.1.10 Support to non-traditional organisations

One diocese was notable in its support to the growing number of non-traditional congregations, such as Fresh Expressions and Messy Church, linking them into wider diocesan structures, including safeguarding. There was more generally a sense that these developments could pose safeguarding challenges and the need for the dioceses to consistently apply safeguarding measures across all aspects of church ministry.

2.1.11 Monitoring role of safeguarding in parishes

The monitoring role of safeguarding in parishes was commonly identified as a challenge arising from the large number and diversity of parishes, along with the lack of a 'command and control' management structure, in common with the entire organisational structure of the C of E.

A large part of this responsibility is understood to be part of the Archdeacon's responsibilities (see 7.1.3). However, this was often perceived as limited or a 'paper exercise' and does not provide data on the quality of safeguarding practice, or the extent to which those responsible for this in the parish understand or subscribe to the extensive new national practice guidance that has been introduced in recent years.

2.1.12 Good practice in safeguarding management

The following provides illustrations of good practice that have emerged in the audits:

- The Diocesan strategy explicitly addressing the need to further develop a safeguarding culture and a safeguarding roadmap, identifying developments that have taken place along with future planning
- Refusal to give or renew Bishop's License to anyone who does not attend safeguarding training
- Diocesan Operational Safeguarding forum involving the DSA, Diocesan Secretary and Bishop's delegated lead for safeguarding: this has the advantage of bringing together the safeguarding professional, diocesan management and clergy in regular meetings to share an overview of safeguarding issues and cases
- Safeguarding as a standard agenda item on senior management meetings / Bishop's staff meeting, with regular input from the DSA her/himself
- Diocesan Board of Finance to include safeguarding on its risk register

2.1.13 Changes implemented in response to considerations in previous SCIE audit overview reports

In the last two years, the Church of England has made considerable changes in national policy and NST safeguarding support to the dioceses, much of which has addressed the considerations posed to the NST in the two previous overview reports. The NST have provided the following update on progress in relation to leadership and management and the author of this report has provided additionally commentary in italics where appropriate:

Considerations in previous overview	NST update
<p>How to clarify the meaning of safeguarding leadership and its delegation, in particular around the operational receipt of concerns and the decision-making over referrals to statutory bodies: such responsibilities need to be with those who have no potential conflicts of interest and are the fundamentals of a professional safeguarding service.</p> <p>What form of escalation process is required to deal with disagreements about operational decision-making? Should this be through the National Safeguarding Team?</p>	<p>Safeguarding leadership strengthened and clarified in the new 'Roles and Responsibilities of Church Office Holders and Bodies Practice Guidance -which came into force in October 2017</p> <p>April 2017 an amendment to the Diocesan Safeguarding Advisors (Amendment) Regulations 2016 (the "DSA Regulations 2016") was agreed which clarified that a DSA could notify the police where an allegation (that a child or vulnerable adult has suffered abuse) is made against a bishop or other church officer, even if the bishop disagrees with the DSA's advice that police should be notified. It also offers an escalation process to the NST for support.</p> <p>The revised 'Responding to, assessing and managing safeguarding concerns or allegations against church officers Practice Guidance' provides clarity in respect of any escalation to the National Safeguarding Team (Responding 2017). Section 1.11 states the NST will 'Address any disagreements on how to respond to cases between a diocesan bishop and the DSA. If the advice of the NST is not followed the NST will</p>

	draw the issue to the attention of the archbishop/s and lead safeguarding bishop for resolution'
Is there a need to clarify how the parallel process of Clergy Disciplinary Measures (CDM) sits with safeguarding processes, and in particular when it might or might not be appropriate for an alleged victim to make the complaint to initiate a CDM?	The consultation on the effectiveness of the CDM process in safeguarding cases has now been completed. The results are currently being analysed. The current plan is to report the findings to the April 2018 NSSG and agree the process for any proposed changes.
Is there a need for DSAs to attend some senior management meetings in a diocese and, at a minimum, report on the safeguarding functions?	DSA attendance at senior management meetings is clarified in the new Roles and Responsibilities 2017', that was published and came into force in October 2017. Section 2.1 states that the Diocesan Bishop needs to 'Ensure that safeguarding is a regular item on bishop's staff team agenda and that the DSA is able to attend meetings, as required'

SCIE comment

Safeguarding leadership has been confirmed as lying with the Bishop with a helpful explanation of the responsibilities this entails.

However, this guidance does not address what exactly this means in terms of delegation of operational and management responsibilities of safeguarding, and if clergy should have any role in this at all, and if so, what that role should be.

Decision-making in relation to referrals to statutory agencies is now helpfully clarified as being the DSA's responsibility, but the escalation process to the NST on the referral process is not easily located (see discussion in 2.3 and chapter 3 – moreover the term 'escalation' is not used, so making it impossible to use the 'search' facility).

The current plan regarding the CDM process which the NST were reporting to the NSSG was not available when writing this report. It is not known if it will address the potential conflicts for some victims of abuse if encouraged to be a complainant to initiate the CDM process. Another issue to consider when reviewing the CDM process is the need to distinguish the role of CDM as a disciplinary process, rather than a complaints investigation: the former would benefit in some circumstances from the involvement of an investigator external to the diocese. Lastly is whether or not the CDM arrangements consistently ensure that there are no conflicts arising from the Bishop's involvement in both the CDM and the safeguarding process.

The NST response (above) in relation to DSA attendance at diocesan senior management meetings does not provide any consistency about either the role of safeguarding as part of the bishop's staff team agenda, or the role of DSAs in such meetings.

2.1.14 Conclusions

The NST have made changes to practice guidance which has helpfully clarified that the DSA makes the operational decisions in relation to referrals to statutory services. This is an important clarification.

Whilst there has been considerable change in terms of spiritual leadership on safeguarding in many dioceses as well as nationally, the underlying tensions about

where operational management responsibility for safeguarding remains. This is in part an intrinsic aspect of the organisational structure of the Church which does not provide a 'command and control' management structure, so there will inevitably be inconsistencies in safeguarding arrangements between dioceses and between parishes. This is discussed further in section 2.2 and considerations for action suggested.

Considerations for the National Safeguarding Team

- Is there still a need to clarify how the parallel process of Clergy Disciplinary Measures (CDM) sits with safeguarding processes with regard to:
 - a) [not] asking alleged victims to initiate the complaint;
 - b) the need for systemic provisions to avoid conflicts for the Bishop between her/his CDM responsibilities and any role in parallel safeguarding processes;
 - c) the adequate focus on a disciplinary process [as opposed to a complaints investigation] of the CDM and the potential use of investigators external to the diocese to investigate complaints
- How to further clarify the responsibilities for diocesan operational and strategic safeguarding management and leadership, including the role of the DSAs in management meetings in a diocese?
- Would a good practice model / exemplar of safeguarding management help inform diocesan decision making?
- Is there a need to further strengthen the NST role in relation to diocesan safeguarding, through a role in operational management (this is further explored in 2.2 below), so as to provide safeguarding expertise in operational management, as well as increasing the independence in investigations and responses

2.2 DIOCESAN SAFEGUARDING SERVICE

2.2.1 Roles and responsibilities

All the dioceses audited have at least one paid Diocesan Safeguarding Adviser/s (DSA) in post, (or a vacant post being covered temporarily by a DSA from another diocese). The DSA is not always full time, as recommended in national practice guidance⁴

There was variation in the hours worked, employment arrangements, professional background and experience, with many dioceses reporting a recent growth in the resources available, as well as a move, in some places, from a consultant to one or more employees covering different roles within the safeguarding service.

In an increasing number of dioceses the DSA functions have been split between different posts, and in one diocese there was, in addition, a separate Bishop's Safeguarding Adviser (BSA), whilst another had recently changed from having a

⁴ Appendix 1, Key Roles and Responsibilities of Church Office Holders 2017

BSA to a DSA, with the changed management arrangements this implies.

Where there is more than one professional safeguarding staff post, usually one is called a DSA (albeit in a couple of dioceses there is more than 1). Other posts are often managed and supervised by the DSA. The numbers in such safeguarding teams varied but in three dioceses there were four individuals in the safeguarding posts (plus an administration post), with different responsibilities and different job titles. Sometimes the different posts overlap in functions, and in other places there is a degree of geographic or functional specialism (e.g. risk assessments, youth adviser, domestic and sexual abuse adviser). In many dioceses, there is a specialist post with responsibility for training.

There is diversity in how the roles and responsibilities of the DSA are arranged, and in some dioceses, part of the core functions are undertaken by other members of the team, such as responsibility for training, writing policies and for the DBS system. Other places contract out parts of the work, for example the DBS processes, or use volunteers to help deliver training.

2.2.2 Employment arrangements

All DSAs are paid for their work, in line with national policy. In at least one diocese though, this is a relatively new position with the previous post-holders being volunteers.

Most of the DSAs are employees of the dioceses, but five commission one or more self-employed DSAs. Several dioceses had changed recently from self-employed consultants to employed DSAs.

Dioceses that prefer to use a consultant /self-employed DSA believe that this enables the DSA to be in a stronger position to provide independent challenge. The auditors were not convinced of this as self-employment can bring with it job insecurity and consequent disincentive for such challenge (although there was no evidence of any insecurity in these instances). In one diocese the self-employed DSA was responsible for finding her/his own cover when s/he had annual leave. This is a challenge: at the point of the audit no cover was available as the 'quid pro quo' arrangement with another DSA had ceased and no new arrangement had been agreed yet.

A model in one diocese is to commission the DSA role to a local social work charity with long established links with both the Church of England and the Roman Catholic Church. This has the benefits of the DSA working alongside a colleague undertaking this role in the Roman Catholic Church and as part of a team, with social work management and supervision. This arrangement was not considered by diocesan staff or the DSA as having a negative impact in terms of the DSA being less embedded in the diocese.

2.2.3 Resources

The wide variation in DSA time within a diocese ranged from one part-time DSA covering both vulnerable adults and children to an entire team consisting of four people with administrative support.

In order to provide flexibility of resources, some DSAs have additional hours they are able to claim to cover extra time as and when required.

The audits indicate that safeguarding resources have generally been increasing in

the last year or two, often more than doubling the provision, either through increased DSA time and other safeguarding posts, or through creative use of alternative sources of provision, such as the use of external agencies, to provide cover in the absence of the DSA or to undertake DBS checks; the use of other roles within the diocese to complete specific parts of the role, such as an events coordinator and communications assistant.

The use of volunteers features in the service in some dioceses, used for delivery of training, advising on domestic abuse or other specialist areas. The volunteers concerned are usually people who have professional experience in the field in which they are providing a service.

There was a recognition that for many DSAs the practice and training requirements, introduced recently, have added to their workload, and in particular DSAs mentioned the struggle to maintain records that are both up to date and in accordance with required standards. The introduction of the new Learning & Development Practice Guidance has also involved additional delivery of training.

Some DSAs and their staff spoke about the limited capacity to be able to get around parishes to support their safeguarding work. This is an under-developed area of work in most dioceses.

The DSAs have varying amounts of administrative support, some of which is dedicated to safeguarding and some not. There was a view that dedicated time worked better, as opposed to having to rely on the flexibility of individual administration staff. In one diocese there was no administrative support provided which meant that the professional safeguarding staff covered this and had less time for their core responsibilities, whilst in many others there was scope to increase administrative support so as to increase professional safeguarding time.

The auditors became increasingly aware of the differences in resources between dioceses, especially between the older and generally wealthier ones and the newer ones. One diocese, which has experience of historical abuse, had committed additional resources to the service, but achieved this through redundancies and restructuring elsewhere, as the diocese was running at a deficit. It was noteworthy that whatever their financial position, dioceses said that safeguarding is a priority and the resources are kept under review. Two dioceses in particular were considered to be currently under resourced with the DSAs in each frequently working additional hours and unable to take time off in lieu.

2.2.4 Management

Section 2.1 describes the variety of management arrangements that exists for DSAs and the safeguarding service, in particular if responsibility lies with senior clergy or senior lay diocesan management.

What is less clear is what line management of a DSA actually means in practice: what are its aims and purpose and what skills and expertise in safeguarding is needed by the manager, with many having no such knowledge or experience.

Some managers are deeply involved in the work of the safeguarding service, having regular one to one meetings with the DSA and being involved in operational management decisions. Others participate in team meetings, whilst others have no formal line management meetings at all with the DSA but are available as and when the DSA requires advice or support.

There appears to be an overall lack of clarity around what are the components of managing the safeguarding service as well as where in the organisation this management should be located. This risks what was seen in one diocese of an isolated safeguarding service, with the DSA drawing up her/his own development plans but without help or support from senior management, and not reporting progress into any management groups.

2.2.5 Isolation and team support

The isolation of many DSAs from other safeguarding professionals is a feature of the working life of many DSAs. When put in the context of longstanding challenges of safeguarding in the Church, linked to a culture of deference towards clergy and prioritisation of reputation, the image of a lone, isolated DSA is highly problematic.

With the growth in local and national resources the DSA increasingly has colleagues undertaking some of the roles in the diocese and now has more contact with the NST and fellow DSAs.

The diocesan increase in resources has enabled the growth of peer support within a team but has also meant some of the core tasks of the DSA role are being undertaken by those without safeguarding professional qualifications or experience. This peer support is a positive development for the team as a whole, with the DSA providing individual and group supervision to the team. However, the DSA's own needs are not so well addressed; any supervision will be provided externally and not integrated to management, with the latter unlikely to be provided by those with safeguarding expertise.

Another model is where the diocese contracts out the DSA role to a local charity (as described above), and the DSA is consequently part of a social work team receiving professional supervision of their safeguarding practice as well as peer support. This appears to work well, has real strengths in terms of supporting good practice and has the potential perceived advantage for some victims of being independent of the church.

2.2.6 Support from the National Safeguarding Team

The extent of support from the National Safeguarding Team (NST) was not a focus of the pilots but was included in the main stage of the audits. It is significant, because conversations with DSAs in the pilots highlighted their isolation and potential need for support and consultation, outside of the diocese. In exploring the use of available options, it appears that the national church had not historically offered this resource. The recent developments within the national team have provided opportunities to explore this relationship and how it could be developed, to provide greater liaison and support to the individual DSAs.

Isolation was mentioned less in subsequent audits, and participants spoke of having good links with the NST, in particular speaking of recent or anticipated visits by the National Safeguarding Adviser and DSA regional meetings. It is understood this is one of the many developments already implemented following the pilot audits. One DSA referred positively to the casework advice she receives from the NST, albeit this was linked to the DSA's consequent perceived lack of need for supervision on casework (as opposed to supervision about the emotional content of the work). The auditors view is that regardless of the increased availability of consultation from the NST, professional safeguarding supervision remains necessary.

2.2.7 Qualifications and experience

There is diversity in the professional qualifications and experience of DSAs, with more recent appointments coming from a professional background involving safeguarding, in line with the national guidance. The extent of safeguarding knowledge and experience varies both in terms of the profession of the post-holder and the level of experience in their previous jobs. Different dioceses have likings for specific professional backgrounds, for example one searched specifically for ex police officers. Others have nurses, probation officers, teachers, social workers, lawyers, education welfare officer and prison staff. The current national guidance⁵ recommends that the primary DSA should be a qualified social worker; however, this is a recommendation to the diocese as opposed to a requirement. It is not universally the case and, in some dioceses, there is no social work input whatsoever in the safeguarding team and in a few none in the Diocesan Safeguarding Group (see 2.3). This may be due to appointments pre-dating the current guidance (see 2.2.12 below). A lack of qualified social work input increases the risks that vital expertise is missing in the safeguarding service and response to victims and survivors.

A few DSAs have undertaken a safeguarding post-graduate course, to be better qualified for the role. Some performing DSA functions have no professional safeguarding background but have developed experience in the Church, working alongside a DSA with professional safeguarding experience. When there is more than one member of staff with previous professional safeguarding experience, they tend to have come from different professional backgrounds, which is perceived as a strength as it brings a wider perspective.

A challenge for all the DSAs as well as the diocese is how to encompass knowledge and expertise in both vulnerable adult and child safeguarding. In a few dioceses, this has been overcome with separate posts and/or separate supervision arrangements.

A further consideration is the need or not for prior management experience, given the level of decision-making involved in the job, as well as the ability to liaise and negotiate at senior levels with clergy and with other agencies. Such experience is not universal and is not a requirement for the DSA function. It would be helpful to consider whether this should be so, especially given the need for DSAs to be able to effectively challenge senior clergy and managers in statutory agencies. This has not been addressed in recent guidance (see 2.2.12).

2.2.8 Supervision

The auditors were told that supervision is left to the DSA to arrange, albeit paid for by the diocese. Some have difficulty in finding this and others do not consider that it is necessary.

Nearly half of the dioceses did **not** have adequate arrangements for the supervision of their DSAs at the time of the audit. Ten of the DSAs did not have supervision at the time of the audit. In a further seven dioceses, the supervision described did not meet the requirements of national guidance⁶ and in another three there was a

⁵ Appendix 1, Key Roles and Responsibilities of Church Office Holders 2017

⁶ Appendix 1, Key Roles and Responsibilities of Church Office Holders 2017

potential conflict of interest:

- In one case the line manager (Diocesan Secretary) was described as providing both management and supervision, albeit this was not professional supervision
- In two dioceses, instead of individual professional supervision, group supervision took place, led by the DSA/s
- In one diocese supervision was being provided over the phone by a friend of the DSA on an 'as and when' basis
- In three dioceses it was evident that the role of casework supervision was not understood, as opposed to a more therapeutic / counseling approach to deal with the emotional components of the job.
- In two further dioceses professional supervision was provided by members of the Diocesan Safeguarding Group (DSAP), in one case the independent chair: the auditors were concerned that this was a conflict of interest for those involved as the DSAP's role is partly to hold the diocese to account for its safeguarding practice (see 2.3)
- In another diocese the supervision was provided by the DSA's counterpart in the local Roman Catholic diocese; however, this poses a conflict of interest as the DSA also chairs the same Roman Catholic diocese's Safeguarding Group.

It is of note that in several dioceses (see 2.3) there is a sub-group of the DSAP which acts as a case discussion group and whilst not compliant with national guidance, and contrary to the function of the DSAP, the fact that this is wanted and appreciated by the DSAs concerned suggests it meets a supervisory and management need that is not met through the formal arrangements currently in existence. This is discussed further in conclusions in 2.2.13 below and the considerations for the NST in this section.

The DSAs without supervision largely spoke of the difficulty identifying a supervisor, although one of the DSAs had in fact tried supervision but decided that it did not meet her/his needs because an external supervisor did not have sufficient understanding of the particular issues that arise within a Church setting and the split between management and supervision was not helpful. This was a diocese where the sub-group of the DSAP provided case discussion.

The regularity of supervision varies, from monthly to three monthly, usually though providing for additional ad hoc arrangements if required.

Because the DSA sources their own supervisor, there is a tendency for the person to be someone from the same professional background as themselves, which risks the loss of provision of other perspectives, especially when the DSA comes from a professional background which has a specialist focus, such as working with offenders. Moreover, if supervisors are selected by the supervisee, they are potentially less likely to be able to effectively provide professional challenge. In dioceses without social workers in the safeguarding service, the use of a social worker as supervisor would bring this perspective and expertise. This has now been recommended as part of the 2017 new practice guidelines and the DSA regulations.

One of the dioceses in the pilot had particularly impressive supervision arrangements, with the commissioning of two supervisors, one with safeguarding social work expertise with children and the other with adults. DSAs will usually come

with only a children's or adult services background, so this is a particularly helpful supervisory arrangement to aid parity of response to adults and children.

Whilst the DSA usually has external supervision, other members of the safeguarding service often are supervised by the DSA her/himself, with varying degrees of frequency.

Because these audits have had a focus on compliance there has been focus on the existence of supervision with less consideration on whether the current expectations of supervision are in fact feasible in providing a quality supervisory experience. The reasons given by some DSAs for not valuing supervision or for making alternative arrangements with the sub-groups of DSAP suggest that this split between supervision and management is problematic.

2.2.9 Is supervision integrated into the work of the safeguarding service?

Across dioceses, supervision is commonly perceived as something that is for the DSA and left to them to arrange, as opposed to part of the safeguarding service, answerable also to the Church and evident on case files as well as supervision records.

In two dioceses, there were case records which demonstrated the supervision discussion, but this becomes the responsibility of the DSA and not the supervisor as would be the case in most other settings. Another DSA described the existence of supervision notes signed by both supervisor and supervisee.

There were little or no links between supervisors and DSA line managers. It is not known how concerns regarding professional conduct are addressed by supervisors, given that they are essentially commissioned by the supervisee. The one exception to this was in a diocese which commissioned out the DSA role to a social work charity: here the team manager provided both supervision and management to the DSA. This worked well in avoiding the split created by other arrangements.

In some recent audits there are references to plans for more links between supervisors and managers, especially in relation to input to appraisals; however, this relates to future plans as opposed to current practice. Also, there has been evidence in a few dioceses of contracts which identify the need for such links between supervision and management. In one diocese there was a formal contract covering recording, liaison with line manager, appraisal and annual review arrangements.

2.2.10 Conflict of interests for DSAs

A potential conflict of interests has become apparent with the appointment of DSAs who are also ordained ministers, lay preachers, parish priests etc. or who decide to become so after becoming DSAs. The potential for this leading to a conflict of interests had not been considered within the dioceses concerned in the early audits, perhaps because the national policy was not explicit about what could construe such conflict. The previous DSA in a recent audit had been a part-time vicar, and she and diocesan senior management had identified that this had posed a conflict of interest. This now adequately addressed in the 2017 practice guidelines⁷.

⁷ Appendix 1, Key Roles and Responsibilities of Church Office Holders 2017

2.2.11 Good practice examples

- The DSA post to be provided via an external organisation able to also provide management and supervision
- The DSA being an experienced and qualified safeguarding social work practitioner and manager
- Additional post-graduate safeguarding courses for non-social work qualified DSAs
- DSA supervising Cathedral Safeguarding Adviser
- Regular diocesan safeguarding newsletters for parishes, containing news, updates and changes
- DSA representation on Local Safeguarding Children Boards (LSCBs) and Safeguarding Adult Boards (SABs)
- Sufficient dedicated administrative support to enable the professional safeguarding staff to spend their time on their core role
- The services of an Independent Domestic Violence Advisors within the safeguarding team, able to provide support to victims of domestic abuse

2.2.12 Changes implemented in response to considerations in previous SCIE audit overview reports

The interim overview reports pointed out the lack of specificity in national practice guidance in relation to the expectations of professional qualifications and previous experience of DSAs; what would constitute conflicts of interest; the need to incorporate supervision arrangements and advice into records and with management arrangements.

The interim report suggested that social workers' training and experience provides the background that is most likely to equip DSAs with the breadth of knowledge and experience of both abusers (including offenders) and victims. The central core of social work involves working with other professionals and making referrals when required and also undertaking assessments of risk and provision of support where needed, not just for cases that meet thresholds for statutory intervention, but in the more complex area where thresholds are not met, but concerns remain.

The new *Safeguarding Advisors (Amendment) Regulations 2017* and the new *Key Roles and Responsibilities of Church Office Holders 2017*⁸ has now addressed these issues, albeit the need for social workers is only a recommendation, not a requirement.

Over the period of the audits the NST has worked hard to strengthen the engagement with DSAs through the provision of two/three annual DSA days; the development of regional network meetings; the introduction of Provincial Safeguarding Advisers offering advice/support to DSAs on case work; DSA Regulations that supports NST involvement in DSA recruitment; national DSA induction days for all new DSAs and the first National Safeguarding Summit in 2017.

⁸ Appendix 1, Key Roles and Responsibilities of Church Office Holders 2017

2.2.13 Conclusions

The NST has addressed all the considerations made in previous overview reports which have the effect of strengthening the diocesan safeguarding service and lessening the isolation of post holders.

Having made such improvements there remain problems in terms of:

- consistent provision and quality of supervision
- lack of safeguarding knowledge and expertise of management of the DSA and safeguarding service
- possible negative effects of split between management and supervision, leading to some DSAs feeling the need for case discussion to take place with members of the DSAP (see 2.3)

It is the view of the SCIE auditing team that a national arrangement for the appointment, management and supervision of DSAs has advantages that outweigh the benefits of local 'ownership' of the DSA in the current arrangements. A national safeguarding service will be better able to resolve the current difficulties relating to supervision and management, with the potential to also:

- share specialist resources, such as Independent Domestic Violence Advisors (IDVAs)
- be confident that resources match need, as opposed to being based on the wealth of any individual diocese
- increase supports to DSAs and decrease isolation
- guard against senior clergy having to be decision-makers in regard to their peers, when it can be more difficult to think the unthinkable
- provide a greater level of independence in the safeguarding service and divorce it from any considerations of the welfare of alleged abusers who may be friends and colleagues of diocesan decision-makers

Close collaboration from the House of Bishops would be needed to identify how local integration of DSAs could best be simultaneously achieved in the context of a nationally managed service.

Considerations for the National Safeguarding Team

- Is it possible to provide effective and safe casework supervision without it being integrated into the management system?
- Does the variation in resources, management and supervision provision facilitate a consistent quality safeguarding practice?
- Is it best practice for the management of safeguarding to lie with senior managers without professional safeguarding experience? If not, how can best practice be followed with the C of E?
- Would it be more effective and consistently safer for the DSAs to be managed and supervised as part of a national service, so as to provide a service managed and supervised by senior safeguarding professionals? If so, what posts need to be based within the diocese, and which ones could be provided

on a regional or area basis, so as to obtain benefits of scale?

- What further independence is desirable in the safeguarding tasks and when would it be best to be undertaken outside of the Church e.g. complaints about the safeguarding service, especially those from victims/survivors?
- If the DSA post remains managed by the diocese, is there a need for all those appointed to have had previous senior management experience so as to be able to be confident in challenging senior clergy and diocesan managers?

2.3 DIOCESAN SAFEGUARDING ADVISORY PANEL

2.3.1 Name and function

At the time of their audit, all but two of the dioceses had established a forum to provide strategy, scrutiny, challenge and monitoring of safeguarding policy and practice, albeit the name varies and includes Diocesan Safeguarding Steering/Commissioning/Strategy Group or Panel. For this report the term Diocesan Safeguarding Advisory Panel (DSAP) is used, as this is the term used in Key Roles and Responsibilities of Church Office Holders and Bodies (2017). In some places the Panel is relatively new and one diocese without a current DSAP had one till 2016, when it fell into abeyance, but a new group will start soon, and its independent chair has already been appointed.

In some places the term 'management' is used in the name of the forum. This is misleading as the group's function is not that of management, which usually rests with the Bishop's leadership group. It may be that this term reflects earlier perceptions of the role, which appears in the past to have involved consideration of casework.

In some places the forum is also additionally specified to have a quality assurance function.

What is less clear is how the strategic function of this forum inter-relates with the strategic functions of the Bishop and their management / leadership team/s and the extent to which it is able to hold the diocese to account. In a few dioceses a two-tier governance structure has been implemented involving a regular internal safeguarding management forum, which reports to the DSAP. The DSAP reports to the Bishop's Council, with regular meetings between the Bishop and the DSAP chair.

There has been growing understanding of the potential of developing the quality assurance functions of the DSAP with members themselves getting involved in auditing work, or in commissioning independent audits, in one case focusing on parish activity. Some dioceses are establishing audit sub-groups to take this work forward. The explicit statements about this function of the panels in Roles and Responsibilities 2017 will have assisted the development.

There is some acknowledgement by some DSAP chairs that they need to develop their role further in relation to adult safeguarding, as the focus in the past was largely on children.

The frequency of meetings varies, but was typically quarterly.

2.3.2 Potential threats to role of the DSAP

In several dioceses the DSAP had some involvement in operational management of

safeguarding:

- In three dioceses there was a sub-group of panel members constituting a risk assessment panel overseeing risk assessments and safeguarding agreements
- In nine dioceses the auditors were concerned that the DSAP and/or a sub-group was involved in case management as opposed to quality assurance e.g.:
 - Audits of live cases – as opposed to closed cases
 - Prior to each DSAP meeting a pre-meeting of the safeguarding team, the DSAP chair and the Lead safeguarding Bishop go through all current cases, and agree which to be discussed at the DSAP, selecting those with particular themes, issues to be considered or which pose particular risks
 - DSAP held in two halves, with the second half focusing on cases and making decisions about closure (which has the unintended consequence of lack of audit trail on the case file)
 - DSAP having a casework panel which included decisions about case closure
 - Several dioceses where the terms of reference including to 'look at cases as appropriate', 'to advise the DSA on complex and difficult cases'
 - A sub-group to provide casework scrutiny and guidance in 'difficult cases'
 - Case management and review group with membership including all the DSAP: role is to advise Bishop on action on individual cases, as well as reviewing cases to identify learning
 - Operational oversight group which 'signs off' the case as completed after reviewing files

The auditors were concerned that discussion of cases and risk assessments could lead to 'casework by committee', duplicate (or in one diocese substituting for) the work of core groups and threaten the independent role of the DSAP chair, as well as drawing the group into operational management as opposed to a scrutiny role. By contrast the DSAs valued the help and advice of the DSAP panel members, perhaps reflecting the systemic inadequacies in management and supervision arrangements, as discussed in section 2.2. Existing systems do not provide management by safeguarding professionals and split the case supervision from the case management.

The auditors also pointed out the possibility of potential concerns in relation to data protection if confidential case details are shared with members of the DSAP.

Such involvement in casework and risk assessments reflects the history of this group. 'Protecting All God's Children' (2010) called this group the 'Diocesan Safeguarding Children Management Group' and that name would have suggested its role was part of management processes. Over time it has developed into an independently chaired advisory group whose functions described in 'Key Roles and Responsibilities of Church Office Holders and Bodies' (2017) are advisory and specifically exclude case management. This guidance does allow for a sub-group to review the quality of risk assessments and safeguarding agreements.

2.3.3 Chair

All the DSGs have independent chairs, albeit for some this is a recent introduction and in one case the arrangement had yet to commence at the point of the audit.

In a few cases the auditors considered that the independent status of a few chairs was arguable either because of current or past roles in the diocese or because the chair had employment with a charity that was commissioned to provide services for the diocese. One DSAP chair was concerned that the diocesan use of him as a consultant could threaten his/her independence and was encouraging the diocese to find alternative sources of consultancy. The national guidance⁹ whilst helpfully trying to define independence, does not provide any specific advice as to what could constitute threats to the independence of the chair.

The role and time commitment of the Chair varied. Generally, this is a voluntary position, with expenses paid. In four dioceses the position is paid and in another four the chair receives an 'honorarium'. There was no evidence that being a volunteer has had a detrimental impact on the chair's input or performance. The auditors were mindful that the role, and hence the time commitment, varied. In one of the pilot dioceses it was particularly striking that the chair was providing considerable time to supporting the safeguarding function, and the auditors were concerned that in the long run this may not be a sustainable position for a volunteer.

The background experience of the chairs differs, although a legal background was a frequent feature and, according to NST data, currently over 50 per cent are from a police background.

2.3.4 Membership

Membership of the DSAP varies, with most having or aiming to have involvement of external agencies. This is a challenge in some locations, especially the larger dioceses which have to liaise with several local authorities. One such diocese obtained professional input through paying for consultants. However, whilst giving professional expertise, this does not replace the need for the representation of statutory agencies in this group.

Also missing, in a few dioceses, was any children's social work expertise at all in the group, but the newly appointed DSA in one would, in the future, attend the meetings and bring this expertise. Another diocese is of more concern, as it had neither social work expertise nor representation from statutory agencies or professional consultants. The emphasis instead is on legal and ecclesiastical membership.

Only one DSAP included a victim/survivor of abuse and this would seem to be an omission. Such a perspective would add to the panel in all its functions, especially in relation to quality assurance and scrutiny of risk assessments. It is of note that nationally survivors are represented on C of E's National Safeguarding Panel, which would seem to be a good example to be followed.

Some DSGs included DSAs as part of the membership of the groups and others distinguished between membership of the group and those officers attending to provide information and support functions. Usually the DSA's line manager is part of the group, but this is not so universally. The auditors considered that the line manager needs to be a member of this group, or to attend as an officer, as that role is responsible for the DSA and the diocesan safeguarding service.

A few bishops are part of the group, and this was perceived within the dioceses

⁹ 'Key Roles and Responsibilities of Church Office Holders and Bodies' 2017

concerned as a positive reinforcement of the importance of safeguarding, as it demonstrates the importance the panel has to safeguarding. It can though also be perceived as a conflict of interests: if the Bishop is the lead for safeguarding, to whom the chair reports, the Bishop's presence could intimidate panel members in their scrutiny role. This needs a steer from the NST.

Cathedrals are represented in a few dioceses, but this is by no means standard practice. It was viewed as a positive development in working together on safeguarding.

A weakness for the chairs in the pilots was the lack of active involvement in forums with other independent chairs. However, in subsequent audits, chairs have spoken positively of having attended such meetings. These are positive developments.

2.3.5 Good practice examples

There is a variation in how the groups function in different dioceses and each had developed their own individual characteristics. Examples of good practice include:

- involvement of a victim / survivor on the group
- involvement of a Parish Safeguarding Officer in the group
- members attending parish events on behalf of the group
- use of annual strategic plans, regularly updated and shared with the other strategic management groups within the diocese
- Cathedral representation on DSAP
- safeguarding survey of parishes to inform planning
- sub-group for quality assurance / case reviews which commissioning of independent audits and case reviews
- provision of 'data dashboard' each meeting outlining safeguarding activity e.g. number of referrals, risk assessments, training stats

2.3.6 Changes implemented in response to considerations in previous SCIE audit overview reports

The NST has addressed the need to provide support to the independent chairs of the DSAP through the introduction of an annual National Chairs' Network meeting, the promotion of regional network meetings for chairs and their participation in the Safeguarding Summit in September 2017.

The new Roles practice guidance¹⁰ has clarified the function of the DSAP and makes it clear that the DSAP should not be involved in case management, albeit can have a sub-group to monitor the quality of risk assessments and safeguarding agreements.

Comment: *There is a separate provision that the Panel should only have anonymised case information, but it is not clear to if this applies to the sub-group monitoring risk assessments and safeguarding agreements, albeit that was the NST intention.*

Whilst the role of this sub-group may be perceived as quality assurance, it could also potentially become part of the case management process in relation to risk

¹⁰ 'Key Roles and Responsibilities of Church Office Holders and Bodies' (2017)

assessments and safeguarding agreements.

2.3.7 Conclusion

The auditors have observed the development of independently chaired DSAPs during the last three years, with all but one diocese now having such a Panel or planning to do so imminently in one case. The new guidance¹¹ has helpfully clarified the function and membership of the Panel, and that it should not have involvement in case management. However, it is not clear if this latter provision is still possible in relation to risk assessment and safeguarding agreements. There is also a need to further clarify the membership of panels in relation to potential inclusion of victims, DSAs line managers and whether the Bishop's attendance is or is not desirable.

Considerations for the National Safeguarding Team

- How to clarify the role of any sub-group of the DCAP in relation to its monitoring of all risk assessments and safeguarding agreements: how will such discussions retain a focus on quality assurance as opposed to case management?
- Does the practice guidance require further clarification around whether the requirement for anonymised information applies to the quality assurance role of the panel in risk assessments and safeguarding agreements?
- How to clarify membership of panels in relation to attendance / membership of DSAs, DSA line manager, victim/survivor representation?

¹¹ *ibid*

3 POLICY AND PRACTICE GUIDANCE

One of the major achievements in the last three years has been the total revision of national practice guidance. This section covers the:

- 3.1: Overall framework of national practice guidance and whether there is a need for local guidance
- 3.2: Are there gaps in national practice: code of conduct, complaints and whistleblowing?
- 3.3: Discussion about diocesan practice in relation to particular practice guidance in responding to concerns, undertaking risk assessments and safeguarding agreements
- 3.4 Changes implemented in response to considerations in previous SCIE audit overview reports and if applicable other learning projects / reviews
- 3.5 Conclusions
- Considerations for further action by the national church and its National Safeguarding Team (NST)

Examples of good practice are within 3.1 and 3.2.

3.1.1 The overall structure of national practice guidance

In the last few years the NST are to be commended in their review of all existing practice guidance and rewriting of them. The new documents are a major advance on previous versions, with an attempt to make the guidance more accessible, streamlined, comprehensive and coherent.

This SCIE audit has not involved any assessment of the quality or content of this guidance, except in so far as establishing the extent of compliance and trying to get to comprehend the reasons behind noncompliance. However, in trying to check exactly what processes should be followed at any time, the author has encountered some difficulty always identifying the processes which must be followed.

The underlying difficulty is the overall C of E's overall use of the term 'practice guidance' to cover a variety of policies, procedures (i.e. instructions of what must be done) and guidance (what is best practice, research evidence etc). It is not always evident which parts of the processes contained within the practice guidance must be followed, which should be followed but allow for local discretion, the rationale for being allowed such discretion and what content is further guidance. Some procedural issues, such as what to do if dissent, are hidden within footnotes for the Bishop's role or the NST role, but not where a DSA is likely to access it. This means that it is not always easy to locate the specific process to follow.

3.1.2 Is there any need for local policies and practice guidance?

All the dioceses have already, or plan to, adopt the House of Bishops' Policy and Practice Guidance.

There is a variety of practice in relation to the need or not for the production of local policies, guidance and procedures. Many dioceses have always provided these and had experienced challenges in maintaining these due to:

- Constructive delay whilst waiting for the production of up-to-date national

safeguarding policies and procedures

- Debate about the need or not to produce local versions of national policies
- The recent pace of change with numerous new policy documents and consultations on further new policy making it difficult to maintain up-to-date local versions
- This area of work tends to be given less priority by the DSA than casework and training

In the pilots, there was evidence of local effort being put into writing diocesan policies, without the knowledge of imminent new national guidance being produced. As a result, there were examples of wasted time and effort locally. This was not an issue from 2016, indicating better communication centrally around forthcoming consultations and new policy development.

The current volume of new national policy and guidance being produced is a challenge within the dioceses in terms of comprehension and dissemination.

There are different views on the need or not for local policies and practice guidance. Some see this as a duplication of effort and provide no or limited added value. Local adaptations could also risk potential confusion if they are inconsistent with national documents and are not up to date. Some examples seen predated the Care Act 2014, Working Together 2015 and the introduction of the offence of controlling or coercive behaviour in the Serious Crime Act 2015.

Others appreciate local versions. Parish representatives in one diocese spoke positively of the fact that key documents had been broken down into an easier to understand format, as the national documents are often not in their view easy to comprehend. Parish representatives in another diocese mentioned the lack of guidance regarding safeguarding record storage on a local level.

Whilst there should not be a need for local practice guidance, it is understandable that there are local needs to produce more streamlined accessible documents, albeit there is the risk of duplications of efforts and potential local variations and consequent inconsistency.

EXAMPLES OF GOOD LOCAL PRACTICE

- Introduction and endorsement in local guidance by the Bishop
- Links on diocesan website to the national policies and practice guidance (and would be improved with information on local organisations e.g. police, social care)
- Some particularly impressive local diocesan policies e.g. on preventing bullying and harassment
- Use of newsletters/ ebulletins to provide information of new policy and on major changes, including electronic links to the material
- Use of 'toolkits' on the website to break down national policy into navigable elements
- Good practice guidelines posters for parishes
- Development of social media policies
- Development of lone working policy in one diocese

- Safeguarding handbooks for staff
- Development of safeguarding procedures to address specific circumstances, such as choir festivals

3.2 ARE THERE GAPS IN NATIONAL PRACTICE?

This section considers whether there are gaps in national practice because it has largely been left to local dioceses to develop (or not) their own individual approaches.

3.2.1 Are national complaints and whistleblowing policies, procedures and practice needed?

There was a great variety of diocesan practice in relation to complaints and whistleblowing, the existence or not of any procedures and the content of these when they existed.

As stated in the interim overview report (April 2017), from available evidence in the records and in local policies, there is a lack of clarity around the distinction between a 'complaint', a 'grievance' and a safeguarding concern. There is also insufficient understanding of how these fit in with Clergy Disciplinary Measures. This lack of clarity also applies to the difference between whistleblowing and complaints, who is able to make these, what they might be about and the exact process for initiating either action.

Critically, some senior clergy did not appreciate the challenges involved here for some individuals and were over-optimistic about people being able to take up their concerns if they are dissatisfied about the support they had received.

The case audits did not provide sufficient information on the outcomes of complaints and whistleblowing, but there did not generally appear to be processes to extract learning from these. The transparency and accountability of these processes is an important part of a safeguarding culture.

COMPLAINTS

Arrangements vary around the provision of a diocesan complaints procedure and what this covers. If it exists (and this is by no means universal), it was often very brief and partial, for example only covering particular aspects of safeguarding work, such as the service from staff at the diocese office, or the DSA specifically or for parishes or for offenders refused employment. Others are general complaints policies, and do not make mention specifically of the safeguarding service.

In casework in some dioceses, there were examples of complaints to the Bishop about the safeguarding service being treated as part of the casework and not being identified as a complaint. This is a major concern as it means that those making the complaint do not get their concerns addressed other than by the safeguarding officers about whom they are attempting to complain about. It is likely that the direct participation of victims / survivors in the parallel project will provide more information on this obstacle in getting complaints addressed (see Part 2 of this report and the executive summary).

The scope of the complaints procedures seen earlier in the process did not allow for different approaches to include the use of an informal stage to resolve the majority of

complaints, but then a formal independent investigation stage if this does not resolve the concerns, or for more serious circumstances, and a final appeal process. Most did not provide explicit expectations of the process, such as a timescale and expected responses. In more recent audits, three stage processes have been increasingly identified in complaints procedures and in some it was apparent that this was a newly developed process, not yet applied.

Another weakness is the challenges in being able to locate the complaints procedure and it not coming up in the search engine on the website. The auditors often failed to locate the procedure without help from diocesan staff. Its accessibility is often then a further obstacle for would-be complainants. Lastly, there can be a reliance on formal written complaints and not allowing email or telephone contact in the first instance so making it more difficult rather than easier for someone to initiate a complaint.

Even when there were examples of complaints and the subsequent investigation, there was no evidence of the recommendations being acted upon.

Examples of good practice

- Three stage complaints process, with clear timescales and explanation of process involved
- Information on how to complain openly available within the safeguarding section of the website
- Clear instruction of how to make a complaint, including contact details
- Provision of options in first instance including letter, email and telephone call
- Within complaints procedure an undertaking to report to the DSAP twice a year the number and nature of complaints: the aim here is to identify, understand and address possible themes with wider significance
- Statement by the diocese in the procedure and on the website that complaints are an opportunity to learn and improve practice

WHISTLEBLOWING

The picture with regard to whistleblowing procedures is equally variable: many dioceses have none, others have ones for specific groups of staff (e.g. Board of Finance, Cathedral employees) or specifically for safeguarding concerns or complaints and increasingly others are in the process of developing a process. In several instances the process is not applicable or available for volunteers; this is an omission. However, like with complaints it was evident that dioceses were learning from earlier audits and had recently developed whistleblowing processes.

In one diocese, members of the parish focus group spoke about an environment that was not conducive to whistleblowing and referred to the existence of bullying.

EXAMPLES OF GOOD PRACTICE

- Comprehensive and accessible procedure published in staff handbook or as a standalone document and available on the website
- Explanation in procedure of distinction between complaint and whistleblowing
- Clear contact details of how to whistleblow, with role of the responsible person

and their contact details

- Reference to an independent source of advice (Public Concern at Work) – albeit when this was provided the contact details were incorrect or out of date

3.3 SPECIFIC ISSUES IN RELATION TO NATIONAL POLICIES

3.3.1 Responding to, assessing and managing safeguarding concerns or allegations against church officers

The interim overview report (April 2017) undertook an in-depth analysis of aspects of *'Responding to Serious Situations relating to Church Officers'* (2015), in particular in relation to the differing understandings there were of critical parts of the process, around taking and accepting referrals, making referrals to statutory agencies, the role of the Bishop *vis a vis* core groups. The problems arose in part to the lack of clarity in policy and guidance around defining who was responsible for case decision-making, and what to do when there are disagreements about the action required in the diocese (as occurred in two dioceses).

The analysis and considerations for the NST fed into the rewriting of that particular procedure, which has now been replaced by *Responding to, assessing and managing safeguarding concerns or allegations against church officers* (2017), which has clarified the issues raised.

The new practice guidance and regulations in 2016 and 2017 has been a major step forward in establishing the roles and responsibilities in managing safeguarding concerns. It is now clear that the DSA has the responsibility to decide if and when to make referrals to statutory agencies and the core group makes its own decisions as opposed to recommendations for the Bishop to agree or not.

An escalation process has been introduced, as advised in the interim report. However, the author of this report found it extremely difficult to locate this process and there seem to be internal contradictions in the guidance documents:

- The DSA Regulations 2016 (point 4 j)¹² tells the DSA to report matters to the Archbishop's Council if they cannot be resolved in the diocese and makes no mention of the NST role – the 2017 amendment also does not do so.
- The 2017 *'Responding to, assessing and managing safeguarding concerns against church officers, 2017'* escalation process in relation to referrals (is not in the process section on referrals (section 2) but as a footnote in 1.1, the Roles and Responsibilities of the Bishop or Archbishop and in 1.11 under the NST, but NOT in the DSA roles and responsibilities
- The 2017 *'Responding to, assessing and managing safeguarding concerns against church officers, 2017'* does give an escalation process in relation to core groups (1.6.2 under role of core group)

It is understood that the discrepancy in the processes arise from the fact that the archbishop's council is a legal entity and the NST is not. In consequence the regulations (first bullet point above) have to refer to the legal entity, whilst the

¹² DSA regulations 2016

guidance does not need to do so. However, this means that the regulations provide instructions that are not in practice the ones to follow.

Moreover, the actual escalation process, should a DSA locate it, involves an interim step prior to involvement of the NST. The instruction provided is to refer the case to the chair of the DSAP. This seems contrary to the new clearer role of the DSAP described above (2.3), to NOT be involved in case management.

3.3.2 Risk Assessment for Individuals who may Pose Risk to Children or Adults (2015)

There was wide variation in the extent to which dioceses were compliant with all aspects of national practice guidance on risk assessment. Partly this reflected only recent implementation of systems since the guidance was published in 2015, but also for a few dioceses reflected questioning of the suggested templates and the clarity of parts of the guidance.

One diocese, whilst undertaking good risk assessments (or participating in these provided by other agencies), felt unable to provide these to the parishes responsible for implementing the subsequent risk management plan (or safeguarding agreement), because of concerns about data protection. This is discussed in the individual report. The SCIE audit team view is that it is harder for a parish to implement the subsequent plan without a full understanding of the risks and that this needs to be a clear procedural requirement.

The quality of the risk assessments seen and the obstacles in full implementation in a few dioceses are addressed in chapter 4.

3.4 CHANGES IMPLEMENTED IN RESPONSE TO CONSIDERATIONS IN PREVIOUS SCIE AUDIT OVERVIEW REPORTS

FRAMEWORK OF NATIONAL AND LOCAL GUIDANCE

In the interim report the NST was asked to consider the need for the national team to provide DSAs with clarity about the need (or not) of any local guidance, policy or procedures to complement national editions, and whether or not it is possible to retain local procedures which are preferred to national ones. Sections 5 and 6 of the Safeguarding & Clergy Discipline Measure came into force on 1 October 2016. This introduced a duty to have due regard to House of Bishops Safeguarding policy and guidance. The House of Bishops' guidance is now supported by good practice reference materials and templates that can be adapted for local use.

The diocese now receives regular policy updates from the NST

The previous reports asked the NST to consider the need for open discussion within the Church about the implications of the inevitable blurring of personal / professional boundaries in Church life: implications of 'duty of care' of clergy, clarity over management responsibility of situations and conflicts of interest. The NST (in Roles and responsibilities of Church Office Holders and Bodies 2017¹³) provides greater

¹³ 'Key Roles and Responsibilities of Church Office Holders and Bodies' (2017)

clarity about respective safeguarding roles in the Church e.g. a Church Warden and/or an Incumbent. Additionally, the Core Safeguarding training modules (C3 and C4) aimed at Incumbents and diocesan senior staff teams does address potential conflicts of interest, but the NST also is giving further consideration to developing a policy around conflicts of interest.

The NST is currently in the process of completing its actions in response to the previous SCIE overview reports as outlined below:

- The new 'Safer Environment and Culture Practice Guidance' will strengthen the detailed guidance in relation to complaints and whistleblowing processes, including offering a good practice templates – due to be finalised, agreed and implemented in 2018
- The importance of dioceses publicising complaints and whistleblowing processes is highlighted in the new Church of England policy Statement 'Promoting a Safer Church' 2017.
- The further development of whistleblowing processes is part of NST Business Plan for 2018.

The previous reports asked the NST as part of the revision of Responding to Serious Situations relating to Church Officers, consideration be given to further clarification about the threshold for referral to statutory services, and the use of consultation processes with adult services, as well as children's social care to enable a fast resolve of disagreements. The NST has addressed this in the 2017 'Responding to concerns and allegations relating to church officers practice guidance'.

3.5 CONCLUSIONS

The new practice guidance in 2017 has been a major step forward in establishing the roles and responsibilities in managing safeguarding concerns, especially in clarifying the DSA and core group decision making role in relation to the decision-making role retained by the Bishop.

However, there remains scope to improve accessibility and clarity of national procedures and guidance, with distinctions between what is required (procedures) and what is best practice.

The existence and quality of procedures for complaints and whistleblowing was variable over the dioceses. However, it was clear that as time went on many had newly developed processes implemented and about to be implemented, and that the quality of the content was increasingly consistent with the in previous SCIE reports. However, to have national procedures relating to these two areas would facilitate consistency and minimise risk of inadequate processes and responses to whistleblowing and complaints. Also important is the learning from these processes.

A national code of conduct would enable more clarity around the difficult areas of personal relationships within Church life and what is and is not acceptable and appropriate.

Considerations for the National Safeguarding Team

- How to further clarify practice guidance and regulations so that it is easy to distinguish between and access the procedures which must be followed as opposed to general guidance on best practice.
- Would a written code of conduct for church officers set standards for behaviour and professional boundaries and assist those who find this a difficult area?
- How to facilitate universal clear and explicit policies and procedures for both complaints and for whistleblowing as an integral part of safeguarding practice within each diocese: these need to be accessible to the staff and the public, explain the scope of what is covered, provide for a staged complaints procedure and a distinct whistleblowing procedure.
- How should dioceses and the NST follow up complaints and whistleblowing so that recommendations are acted upon and the learning from them is disseminated and incorporated into practice?

4 QUALITY OF SERVICE PROVISION

4.1 RECORDING SYSTEMS AND IT SOLUTIONS

Many dioceses are in the midst of considering or implementing new IT solutions to meet the need to maintain a single, secure and up-to-date recording system. Some use electronic recording systems, some use paper files and others use a mixture of both.

A number of recently appointed DSAs referred to inheriting chaotic and idiosyncratic recording systems, in one instance consisting largely of post-it notes. Consequently, the development of recording processes has been a major part of their role and of the challenges faced coming into post.

There is evidence that more work is required to achieve all safeguarding records becoming part of the diocesan document management and secure storage systems, in line with national practice guidance and data protection requirements. This has been a particular issue for some DSAs who are/were home-based and/or whose recording is stored on an individual laptop computer, as opposed to a diocesan recording system. This was the case for at least two dioceses at the time of the audit, with a few more having made changes to this prior to the auditors' arrival (perhaps following previous diocesan audits highlighting the need for secure record storage). Moreover, in several dioceses the DSA records were not accessible to anyone other than the individual DSA, so in practice they were a personal recording system as opposed to one for the diocese. It is notable that this issue has not arisen in later audits.

Overall the audit demonstrated recent improvements in case recording practice, albeit the standards are variable. Particular weaknesses seen were a lack of front information sheets; illegible undated, unsigned hand-written records; records referring to individuals only by name and not by role; records not closed off in a timely manner and missing details of contacts made. It was felt that if files were structured by type of document, they would also be more accessible e.g. safeguarding agreements. Evidence of historic information, prior to the arrival of some current DSAs is problematic in a number of dioceses, with scant information available.

The lack of written risk assessments was a particular weakness in a few dioceses and the use of different formats for the assessment in another diocese.

The secure storage of safeguarding concerns relating to clergy in Blue Files was of concern in a number of dioceses, with it sometimes not filed and loose, and other times filed inappropriately e.g. in the finance section. An auditor commented that 'Blue Files do not readily lend themselves to the storing of safeguarding papers....'.

Capturing the training completed and the date DBSs are due within the parishes is a challenge, and has only been attempted in recent years. Such performance management functions are at an early stage of development, but most dioceses are making progress. The commissioning out of the DBS process has been viewed as being particularly helpful where this has occurred.

There was a suggestion from one diocese that the records are focused around

perpetrators which can make it more difficult to focus on the needs of the victim. A system which provided records for both, with cross references, could aid improved attention to the victim's needs.

4.1.1 Examples of good practice:

- Storage of files in locked cabinets
- Use of case summaries and chronologies
- Incorporating historical paperwork (of previous DSAs) into current filing systems
- Dating of any retrospective edits to case files
- Maintaining record of queries / contacts which do not develop into cases.

4.1.2 Changes implemented in response to considerations in previous SCIE audit overview reports

The NST is currently purchasing and developing a national casework management system. It will be piloted this year and rolled out from autumn 2018.

Good practice will be explored and shared as part of Safeguarding Progress Reviews. Additional improvement support will become available to those dioceses identified by the NST as needing targeted support.

An intranet will form part of the electronic safeguarding tools in the Church (Safeguarding Hub) - planned for 2019.

All the above responses relate to actions the NST have taken and are in progress in response to the interim overview report. The considerations remain below as these actions are not yet completed.

4.1.3 Conclusion

The audits have identified common issues with regard to recording and IT systems arising from the history of the safeguarding service within each diocese and how it was organised e.g. a lone DSA based at home, a volunteer or a DSA based within the diocesan management structure. What has been evident is that during the period of the audits many dioceses have made major improvements to their own recording systems and processes and the NST have commendably grasped the challenge and are introducing a national case work management system along with national safeguarding tools and an ambitious national safeguarding hub.

Considerations for the National Safeguarding Team (NST)

- How the NST can support dioceses in implementing safeguarding recording systems which are adequate, consistent with both national guidance and data protection requirements (particularly in relation to home working, risk assessments and historical record).
- How to share good practice between dioceses, so as to assist those areas still struggling to implement robust systems.
- Is there scope for any further development of common web-based recording resources, such as templates?
- Would it aid focus on victims / survivors needs if they were the subject of case

files as well as the alleged perpetrator – if so does this need to be incorporated in procedures on recording?

4.2 CASEWORK, RISK ASSESSMENT & SAFEGUARDING AGREEMENTS

Generally, the quality of casework was judged by auditors to be good in many dioceses. It clearly demonstrates progress over time, particularly with regard to improvements in information sharing with statutory agencies and an understanding of when referrals need to be made.

4.2.1 Response to allegations against church officers

In general, case audits demonstrated a change over time in responses to allegations, with increasing recognition of what is a safeguarding concern as opposed to a pastoral issue or complaint. Older records demonstrated more worrying practice, and the auditors picked up individual cases where there remained outstanding action still required, which was provided to the diocese concerned during their audit.

This improved safeguarding practice was judged to be both a reflection of:

- the increased quality of responses of DSAs (which may be associated with increased professionalism of the DSA role) and
- the increased understanding by clergy of the need for safeguarding priorities to work alongside canonical duties.

This change over time is evidenced in terms of improvements in timing, actions, collaborative working and outcomes.

Core groups have been introduced during the period of this audit and are being experienced as a helpful process in managing responses. The use of such groups has contributed to a sense of team work. Sometimes there were delays in convening these and in a few dioceses not using them fully due to some level of uncertainty around criteria arising from different interpretations of what constitutes a church officer. However, there were also some dioceses who used a broad definition of this and some who having found the core group process useful, were extending its use to complex cases, even when a church officer was not involved.

Records demonstrate the complex nature of the DSA role and the need for the post-holder to be able to stand their ground when challenged, as well as to make effective challenges to senior clergy.

Parish representatives largely described the helpful and supportive experience of working collaboratively with the DSAs, and particularly mentioned their speedy responses, even in evenings and week-ends.

When feedback to the audit was received from statutory partners, positive comments were made about the involvement of the DSAs in making appropriate and timely referrals, and their involvement in strategy meetings.

One of the themes repeatedly expressed in the audit is the vulnerability of the diocese, when concerns arise in circumstances outside its direct management e.g.

school chaplains, clergy employment outside the Church. In these situations, the dioceses may have limited scope to swiftly respond and address the concerns.

Despite the general good quality of responses, there were areas that need improvement in one or more dioceses:

- Lack of clarity around cases being closed and final outcomes
- Lack of response when the Cathedral was recipient of allegations (one case)
- Understanding when to inform the NST, e.g. if a local case has links to a national case (it is likely that this will have improved with the embedding of the larger NST and provincial advisers)
- Indications that adult safeguarding concerns may not yet be identified sufficiently for referral to DSAs
- Under-reporting to DSAs of domestic abuse concerns, which subsequently emerge as being known about if allegations are subsequently made
- Lack of taking account of the full history and previously identified risks in deciding required interventions
- Need for more consultation with the Local Authority Designated Officer in situations which are less clear-cut and/or following outcomes of risk assessments
- Letters or records from senior clergy / DSA in two dioceses, to those who are the subject of concern, that may be construed by victims to be hurtful or to minimise the alleged / actual offences

4.2.2 Risk assessments and safeguarding contracts/agreements

At the time the audits were undertaken several dioceses did not have any written risk assessments and spoke of relying on statutory partners to have such an audit trail as the assessment was perceived to be their responsibility. The subsequent safeguarding agreement consequently existed without any audit trail to provide understanding of the risks it is designed to address. This could provide problems in the future as it would be too easy for a parish to lose sight of why there is a safeguarding agreement in place. It also means that there is no structure for undertaking risk assessments, in the absence of statutory partners undertaking and sharing such an assessment. Other dioceses had only recently implemented risk assessments, with a change in DSA and/or the publication in 2015 of national guidance.

More recent audits have demonstrated more consistency in the use of risk assessments and safeguarding agreements, including in cases where risk was presented and in absence of a conviction. This is in line with the October 2017 practice guidance¹⁴. This guidance has changed the title of risk assessments from 'A' and 'B' to 'standard' and 'independent'. The following uses the previous terminology as this was what was audited

¹⁴ Responding to, assessing and managing safeguarding concerns or allegations against church officers (October 2017)

Whilst the individual concerned is included in the assessment process, in one diocese the auditors noted that the parish is not involved and therefore does not understand the risk factors that led to the subsequent safeguarding agreement. This had not arisen in other audits.

There was growing evidence over the audits of the use of Type B Assessments¹⁵, by an independent assessor. In others this level of assessment had not yet been required, but the plan was to either use a DSA from a neighbouring diocese or, if this was not possible, to commission a consultant. There was though some concern whether they would be able to identify a suitable consultant if needed. In recent audits the provision of a national list of such consultants has addressed this problem – in line with recommendations in previous overview report.

All the sites provided evidence of safeguarding agreements of known offenders, albeit with variations of quality. Some parishes have developed their own individual practice, as opposed to a centrally determined process, and in other places all assessments are undertaken centrally. Overall, there was evidence of increasingly robust agreements in the last few years, with clear expectations specified. However, older ones often remain in force. DSAs did not always sign agreements, leaving this for the parish concerned – the auditors concluded that this weakened the status of the agreement and suggested this practice needed to be changed.

Dioceses provided annual (or earlier if needed) reviews of these arrangements, but this was not universally applied and not consistently undertaken to the same high standard, with older well-established agreements more likely to be undertaken by email. Whilst compliant with guidance, the auditors had concerns whether this was desirable. There were also examples of the lack of new risk assessments and reviews of safeguarding agreements, following a change in circumstances, such as re-offending.

In one diocese the assessments highlighted the difficulty that some senior clergy have in fully understanding the need for such detailed assessments and agreements, and the importance of balancing the pastoral needs of offenders with risk management and with the needs and views of survivors. It also showed that there is a risk the DSA is not always informed promptly of all relevant cases needing such assessment.

In another diocese, there was discussion within the focus group of the challenges they face and the lack of clarity around the practice guidance with regard to specific situations such as:

- action when an employed lay officer is found to have an offence in the past
- whether a convicted offender should ever be given a position of responsibility as a volunteer
- available action if a member of the clergy declines to cooperate with a risk assessment on the grounds of no prosecution due to lack of evidence.

¹⁵ A Type B Risk Assessment (called 'independent' in 2017 guidance) is commissioned by the diocese or responsible body and referred to an independent agency or professional person qualified and experienced in safeguarding risk assessments. A Type B Assessment will only be undertaken in relation to a church officer, whether ordained or lay, and on completion of a statutory investigation.

4.2.3 Consultation with NST

There was little evidence on files of consultation with the NST around complex cases. It may be that this is not recorded, or that the past culture did not encourage consultation. The NST has informed SCIE that it is now dealing with a great number of queries.

4.2.4 Good practice examples

- Focus on engaging with victims/survivors, demonstrated by opening case files for them, not just in name of (alleged) perpetrators
- Identified day and time every week put aside for core groups, so enabling meetings to be held within 48 hours.
- Use of core groups for complex cases which may not meet criteria for such a group
- DSA providing specific training within parishes to assist in the implementation of individual safeguarding agreements on basis that such an agreement is only as good as the network in place to enforce it
- DSA signing all safeguarding agreements to demonstrate diocesan leadership
- Involvement of probation service in assessment/safeguarding agreement
- Clear and concise risk assessments which evaluated both past and current risk
- Safeguarding agreements explicitly linked to the risk assessment
- Use of early reviews (e.g. after one or three months) for new agreements and reviews brought forward due to changing risks
- Routine reviews twice a year, only moving to annual if the subject had demonstrated compliance over time
- Overt support by senior clergy in face of demand to 'soften' requirements
- Reliable database for scheduling reviews
- Use of chronologies and regular case summaries making records accessible to readers

4.2.5 Changes already implemented

The overall review of all national policy and practice guidance has enabled the NST to clarify and strengthen consistency of practice in relation to casework as follows:

- Sections 5 & 6 of the Safeguarding & Clergy Discipline Measure came into force on 1 October 2016 – this introduced a duty to have due regard to House of Bishops Safeguarding policy & guidance.
- The Risk Assessment Regulations (clergy) came into force on 1 March 2017 to strengthen consistency of practice. This is supporting by 'Responding 2017'¹⁶, with all risk assessments in relation to clergy and licensed officers now undertaken independently from an assessor on the National Preferred Risk

¹⁶ Responding to, assessing and managing safeguarding concerns or allegations against church officers (October 2017)

Assessor Supplier List. This also introduces a process where all independent risk assessments will be quality assured, with status on the list be dependent on the quality of the work.

- National risk assessment training for DSAs is planned for 2019
- 'Responding 2017' requires the DSA to notify and consult the NST in relation to any safeguarding concerns or allegations against a church officer., which is supported by a case work protocol (January 2017) and the role of the Provincial Safeguarding Advisers.

4.2.6 Conclusion

Generally, most dioceses evidenced good quality in their current casework and current risk assessment practice, with changes evident to auditors over time as the NST provided clearer practice guidance which addressed the SCIE 'considerations' in the previous overview reports.

Additionally, the introduction of core groups has been one of the major changes in this period, which has supported the work of the DSA and given a helpful structure to the process. In a few dioceses there has been some confusion around when to implement such a group as the practice guidance does not define the meaning of 'church officer' and this is subject to different interpretations. In some dioceses, core groups have been applied more widely and even if the concerns do not involve someone considered to be a 'church officer'.

Considerations for the National Safeguarding Team (NST)

- Clarification of the October 2017 practice guidance¹⁷ on the meaning of 'church officer' and the advisability of using core groups in other complex cases.

¹⁷ Responding to, assessing and managing safeguarding concerns or allegations against church officers (October 2017)

4.3 INFORMATION SHARING

The quality of information sharing by the diocese is related to the overall level of understanding about safeguarding. It was evident that this has improved in recent years, although there remained some obstacles.

4.3.1 Information sharing with statutory agencies

Generally there was good information sharing with police, probation and MAPPA and the Local Authority Designated Officer (LADO). However, in a few dioceses the evidence of the latter was not on the files.

Larger dioceses face bigger challenges in terms of building relationships that support information sharing, especially in relation to the many different points of contact to be identified.

There was a perception in one diocese that information is not consistently shared by the statutory authorities, with particular mention of the police, and in another that this had previously been a problem. In others the probation service was identified as problematic, due in main to the service being in a state of flux.

There was evidence in one diocese of delays in communication to statutory agencies over allegations against clergy, due to the perception of the high level of evidence required to make such a referral. The changes in practice guidance making this a clear responsibility of the DSA should now mean that this should no longer happen.

4.3.2 Information sharing within diocese

Information sharing within each diocese is generally good, but there were some exceptions:

- With DSA responsibility split between different posts responsible for children and vulnerable adults, there is a risk of insufficient communication between each other e.g. when a children's case involves a vulnerable adult offender.
- There were delays in communication to the DSA of allegations against clergy (one diocese) and historic delays in such communication (another diocese) associated with the use of Clergy Disciplinary Measures (CDM).
- There was occasional confusion around who needs to be informed of a case, with one example of the clergy lead for safeguarding not being informed of a potentially high-profile case.

It is of note that the above examples all occurred in the audits undertaken within the dioceses audited prior to the interim overview report and no major information sharing instances were subsequently identified.

Good practice examples

The following were innovative initiatives aimed to improve information sharing practice:

- The DSA is informed whenever an incumbent leaves a church where there is a contract in place, so enabling the DSA to formally inform the new priest of the existence of the contract
- Information-sharing protocol between senior clergy and other staff in the diocese

4.3.3 Information sharing between dioceses and with other denominations

The transmission of information about individuals of concern between dioceses usually works well if the whereabouts of the individual are known, along with where they choose to worship. When this information is unknown this is more problematic, with no system nationally to circulate details of such individuals amongst dioceses and denominations.

4.3.4 Information-sharing protocols

Some dioceses have agreed information-sharing protocols or local guidance with statutory agencies, but this is a challenge for those covering a wider geographical spread, due to having to negotiate with several different authorities, their Safeguarding Boards and a multitude of agencies. In a few cases, the diocese is signed up to the LSCB information sharing protocols and the local MAPPA ones. This would seem to be the best route to take, rather than trying to initiate a protocol by the diocese itself.

There is little evidence that a lack of information-sharing protocol has any adverse effect on information sharing between the Church and statutory agencies. It may be though that in some places the information-sharing weaknesses are more likely to have arisen between members of the Church themselves, usually involving a delay in reporting concerns to DSAs.

One diocese, however, mentioned the lack of information sharing by the police – it is possible that a protocol might improve this. In a second diocese where this was also a problem, such a protocol has been developed with police and probation services, and in a third it is being developed.

There was some frustration in the dioceses about the need for national input into agreeing information-sharing protocols with national agencies, in particular the National Probation Service. The NST has advised SCIE that the Church of England is not able to do this.

4.3.5 Changes implemented in response to considerations in previous SCIE audit overview reports

An information-sharing protocol template for use by dioceses with statutory partners and other denominations will be included in new practice guidance '**Safer Environment and Culture**'. This will be available in early 2019.

The Church is in the process of developing and trialing a national information-sharing protocol between dioceses, cathedrals and NCIs. This will be mandatory and be rolled out early in 2019 to support compliance with GDPR.

4.3.6 Conclusion

Information-sharing practice overall was good, with particular issues within a few dioceses around internal information sharing. However, this has not been a problem in later audits.

There was little evidence of any problems in relation to the sharing of information with statutory agencies, except in one diocese around delays in making referrals. This should not happen in the future as the practice guidance is clearer about responsibility for such action.

Several dioceses have experienced some problems relating to the sharing of

information by statutory agencies, in particular the probation service and/or police service. It maybe that specific information-sharing protocols will assist this, as being developed by the NST. However, the more effective strategy may be for the Church to be a signatory to local Boards procedures and information-sharing arrangements – currently a few dioceses have already done this and saw no need for any additional protocols.

The previous considerations in the interim overview report have been addressed by the NST responses, but a new consideration has been provided in relation to signing the local Board information-sharing arrangements, wherever possible. This would underline that they are part of all agency local safeguarding arrangements.

Considerations for the National Safeguarding Team

- That dioceses become signatories of local information-sharing arrangements under the auspices of the LSCBs (and their successor partnership arrangements) and SABs.

4.4 SUPPORT SERVICES FOR CHILDREN AND VULNERABLE ADULTS

4.4.1 Authorised Listeners

Whilst most dioceses had in place some arrangements to provide some support for victims and survivors of abuse, the form this took varied. Also, some dioceses questioned the Authorised Listener service as identified in national policy because of queries about:

- whether victims / survivors might prefer support external to the Church
- the difficulty of identifying the specific need for Authorised Listener as opposed to counselling
- the appropriateness of undertaking what can quickly develop into a counselling role and the need then to switch to an alternative provision
- the difficulty resourcing a service for which the demand fluctuates
- the off-putting nature of the actual term 'Authorised Listener'.

Less than half of the dioceses had appointed one or more Authorised Listeners, in one case using one of the individuals who is also both a member of the clergy and part of the safeguarding team, and in another having an arrangement to use (if needed) listeners from a neighbouring diocese. Some dioceses have made no or limited use of this service, despite in some cases consistently offering their services.

Nearly a quarter of remaining dioceses had commissioned this provision via an external provider, who is also able to provide any necessary counselling services. Two more dioceses are in the process of making a decision to commission the service from a Christian counselling service. The advantage of outsourcing this service is identified as being able to use trained counsellors who are supervised. One of the dioceses currently using Authorised Listeners is considering switching to a charity, so that staff will receive regular training and supervision.

Most (but not all) of the dioceses without Authorised Listeners or service agreements with external providers mention the provision of counselling provision via local voluntary groups or through ad hoc funding as required. Counselling was additionally funded by some dioceses with Authorised Listener provision, when it was considered to be required.

It was of note that parish focus groups were quite often unaware of the role of Authorised Listeners and it may be that this contributes to their lack of use.

In addition to Authorised Listeners, some dioceses have developed counselling and other support services for children in particular, but in some cases also adults who were abused as children or vulnerable adults. Examples include:

- the provision of support to young people through youth workers and safeguarding representatives; the youth workers speak sometimes of fulfilling the role of advocates, but this is not specifically part of their job
- provision of 10 unpaid counsellors through a diocesan Committee of Social Responsibility
- a diocesan group to support people with mental health issues (Open Minds)
- promotion of local domestic abuse support services

- complementary service of 'Bishop's Safeguarding Supporters for those wanting pastoral and theological support (provided by clergy and lay ministers)

Good examples

- Posters promoting the Authorised Listener service
- Use of Authorised Listeners as a resource for anybody who had experienced abuse in any context, not just for abuse committed within a Church context
- Outsourcing the service so that the 'listener' can receive support and supervision, the provision is external to the Church (which may be more attractive to many victims/survivors) and can lead to counselling if required – is also easier to resource such a fluctuating demand service
- Development of an agreement which specified the boundaries of confidentiality in terms of what information is to be provided to the DSA – this could usefully be adopted in national guidance
- Availability of a sexual violence independent advocate
- Availability of advice leaflets co-produced with Victim Support for victims/survivors of non-recent abuse

4.4.2 Listening to the views of children and vulnerable adults

The extent to which children's and vulnerable adults' views are sought and listened to varies. Some places retain children's 'champions' (in one case having about 350 of them), but others no longer use them. In some places it is wholly dependent on the individual parish whether or not there is any provision for such a service.

Good examples of listening exercises

- Listening exercise with older people attending luncheon clubs and evening groups
- A dementia specialist project officer to develop support for worshippers with dementia
- Various training and awareness raising forums designed to improve understanding of and support to worshippers with mental health needs or with learning difficulties or who are on the autistic spectrum
- Listening exercises with children about how safe they felt in the Church undertaken via a specific exercise in parishes in several dioceses (albeit it is not clear the information is subsequently collated and analysed)
- A diocesan adviser for the children's ministry and a diocesan youth worker who take the lead in hearing the views of young people
- Survey monkey to obtain views of young worshippers
- 'Growing Younger' facilitators working directly with parishes to reach out to children
- Parish children's advocates and 'Leads for Adults'
- Provision of an advocate for children to better promote the voice of the child
- Bishop's Youth Councils
- Consideration of how to include aspects of work being undertaken against

domestic abuse into marriage preparation sessions

4.4.3 Changes implemented

The NST has commissioned SCIE to undertake research into responding well to survivors. This research project will report in 2018. The outcome of the project will inform future proposals for how the Church will support survivors.

A project manager has been appointed in January 2018 to accelerate the pace of development for the Safe Spaces project. Part of this will be the development of an independent advocacy service for adult victims/survivors

4.4.4 Conclusion

Whilst there is increasing recognition of the need to provide support services for victims and survivors, the current NST expectation that this is undertaken via Authorised Listeners and then the subsequent possibility of counselling provision by an alternative provider is not universally accepted as desirable. Some dioceses have overcome this through the commissioning of an external provider able to provide suitably trained and supervised therapists able to undertake both the limited 'Authorised Listener' role and that of a counsellor. Unfortunately, there is no universal provision and the services available for victims and survivors vary, depending on what each diocese has decided to do.

Considerations for the National Safeguarding Team

- Taking into account the differing views of the appropriateness of Authorised Listener service and the forthcoming SCIE research findings, the NST to consider how to respond well to victims / survivors. Such consideration to include how to provide a consistent *minimum* service nationally, regardless of the resources or particular perspectives of individual dioceses – albeit *additional* local arrangements may be appropriate, depending on individual contexts.

5 TRAINING

The delivery of safeguarding training has been one of the biggest challenges for all dioceses and the progress that can be seen since 2015 is considerable. Many DSAs faced a challenge in providing training to all who require it, especially in the face of backlogs from previous years, the need to establish refresher training input and the implementation of the national training and development framework from September 2016. The latter has been a driver in some dioceses to develop more training delivery resources.

The challenge was immense for most dioceses, especially as there were few adequate databases to provide information on what training had been provided, who had attended, who needs still to attend and who needs refresher training. Over the last three years dioceses have been developing such databases and have identified priorities for training, usually the clergy, those with Permission to Officiate (PTO) and lay ministers. Generally, this targeted approach has been successful. The role of senior clergy is critical in facilitating the uptake of training. Escalation processes to the Bishop have been effectively used in one diocese to increase uptake by clergy. In several dioceses, no one applying for PTO is accepted until they have completed the safeguarding training provided by the DSA. Such training aims to meet the learning needs of new clergy in the diocese (including new curates), other applicants for PTO and lay readers. This strong lead from the Bishops concerned provides a clear message of the essential nature of safeguarding training as part of the ministry.

What remains problematic is to identify all who need training within the parishes and devising strategies to cope with the numbers involved. Sometimes this has to be accomplished in the face of views about training in parishes (according to a few focus groups) being a burden that must be done and having to repeat training due to changes in content and/or because training having to be done for different roles e.g. volunteers who had been trained in their substantive employment.

The large number of people requiring basic training has led to increasing use of e-learning. However, one diocese has raised concerns that the online version of 'CO' module of safeguarding training is too easy, with people passing despite getting questions wrong. Others have raised concerns about the number of people who do not have access or are not technically able to use e-learning.

The balance between e-learning and face-to-face training varies, with the latter recognised as being more effective in terms of positive feedback and links made with key people at parish level. However, providing this for all that need it is a challenge and the DSAs / dioceses have initiated varying strategies to be able to achieve this task, such as:

- Some dioceses provide e-learning for all Church staff, as an introduction, with the provision of face-to-face training dependent on role
- The use of experienced safeguarding professionals as volunteers delivering training
- Buying in additional training capacity or using the LADO
- Outsourcing some or all training to a charity experienced in Church safeguarding
- Delivery of basic training to very large groups

The position around responsibility to provide training for religious communities is less

clear. One DSA mentioned this being provided on request for one of the three theological colleges in the diocese.

The introduction of the new national training framework is perceived as a positive opportunity to move from sometimes outdated training to a more contemporary approach and the inclusion of adult safeguarding. There is though some confusion around the level of flexibility that can be applied i.e. whether the framework is to assist trainers, or if it has to be delivered in its entirety as laid down by the NST. Also, not clear is whether or not those who have been retrained in the last three years need retraining now, or when their refresher training is due.

5.1.1 Good practice examples

The following provide particular initiatives to increase take-up and / or effectiveness of training:

- Inclusive training by diocese for Cathedral staff, property maintenance staff and other frontline workers who could be the first people to spot concerns
- Parish groups or whole congregations to do basic training (CO) together
- Delivery of training within each parish: whilst resource intensive, it increases uptake
- Bishop attending / introduces training courses to provide affirmation - sometimes through use of the Bishop in video clips
- Joint training by the DSA and senior clergy e.g. Archdeacons using the theological element of the Chichester Report to stress the place of safeguarding within the whole context of the gospel message and living
- Training administered by Ministry Development team assists safeguarding being seen as part of core business
- Development of written training and monitoring plans to achieve 'buy in' from senior management within the diocese
- Development of additional bespoke training covering for example mental health issues, child sexual exploitation or 'grooming' awareness for clergy, age of consent and female offenders
- Development of specialist training by an 'expert' for senior clergy and rural deans in speaking with victims
- Development of monitoring systems to have an accurate picture of who has and has not been trained / attended refresher training
- Annual refresher training for staff and volunteers at parish level, on the initiative of a parish safeguarding officer
- Safeguarding surgeries by the DSA within parishes: whilst not badged as training, have been accepted as being very effective in the transmission of safeguarding knowledge and good practice.
- Provision of a second trainer to enable provision of support to individuals who may be distressed / affected by some issues that arise
- Provision of support for those requiring help to access e-learning

5.1.2 Changes implemented

The need for a national position around the completion of safeguarding training prior to being accepted for PTO will be met by the revised PTO guidance to be presented to the April 2018 NSSG. It will offer a clear statement that PTO cannot be granted without updated safeguarding training.

Clarification of the levels of flexibility in the content of the new training and whether retraining is required for those already trained, prior to the time their refresher training is due, was addressed in the Training & Development Framework' approved published in January 2017. This also promotes the engagement of senior clergy in training delivery, especially in relation to clergy. Information on the grooming process is included in the core modules, but there are plans to develop a Specialist module (S4) 'Grooming', as part of Training & Development Framework in 2018.

The revised 'Training & Development Framework' supports a consistent approach to training across Church Bodies, including cathedrals and religious communities. With the diocese as the provider of core modules in line with nationally developed materials. Church schools lie outside the scope of the House of Bishops guidance and under the responsibility of Church of England Education Office.

5.1.3 Conclusion

Implementing a fit-for-purpose training service has been a major task within all dioceses and remains an ongoing challenge for most.

It has been apparent over the span of the audits that as time went on the dioceses made considerable progress in establishing databases for training attendance and implementing the new national training framework. To do so has involved increasing training resources within dioceses, through a mixture of paid staff and volunteer trainers. Integral to this achievement has been the support of senior clergy to be able to set an example and provide affirmation to clergy in particular.

Great progress has been made on delivering training to members of the clergy, and those with PTO. However there remains concern in many dioceses about outstanding numbers of parish staff and volunteers, and the potential unknown numbers of these needing training.

The NST commendably have commissioned an independent review of the effectiveness of the training and development framework.

Considerations for the National Safeguarding Team

- Does the current review of the effectiveness of the training and development framework provide enough information on its impact on of the quality of safeguarding practice within the C of E, as well as on the quantitative data of the numbers trained in each diocese?

6 SAFE RECRUITMENT OF CLERGY, LAY OFFICERS AND VOLUNTEERS

Safe Recruitment has been subject to considerable change and development in recent years, with appointments now involving application forms, DBSs and references. This was not always the case some years ago. Its inclusion in modular training is a helpful way of disseminating awareness.

Overall, there has been a great change in the recruitment processes, but in two dioceses, at the time of the audit people (including clergy) were still being appointed prior to their DBS and/or references being received, despite the policy that prohibits this. More widely there were shortcomings in some clergy files, which did not consistently include references when these had been emailed through (as opposed to being sent as hard copy).

Also observed frequently in all files was a lack of a routine front sheet to access basic information and loose pieces of paper, risking the loss of important documents. Often there were missing documents in records due to parallel filing systems, for example references not being on the individual's file nor the fact of the DBS check which was maintained in a separate folder. Proof of identity was sometimes available in the file, but this was not consistent.

6.1.1 Blue Files

The standard of the Blue Files (of clergy) seen by auditors was variable. Some pre-dated Safer Recruitment (2015) practice guidance and offered little evidence historically of Safe Recruitment practices. More recent files are generally better organised and subdivided into sections, but in one diocese two recent Blue Files did not reference a safeguarding concern that had been dealt with previously.

The recruitment process was not always consistently evidenced on the files, with missing applications forms and/or one or more of the three references. In a few instances, there was no evidence of an application or interview process and no mention of references. The challenge of implementing Safe Recruitment practices for clergy was particularly striking in this one of these dioceses, as this is one where the Bishop is particularly aware of the need for this and safeguarding is a high priority in the diocese. In another diocese where there was a lack of application form for a recent appointment, there had instead been a letter from the Bishop proposing the individual as a suitable candidate.

A potential weakness within the system nationally is that a new diocese only receives the Blue File after clergy have been appointed, and sometimes after they have started work. The Current Clergy Status Letter (CCSL) is received from the previous Diocesan Bishop – this is effectively a reference, stating if the individual is suitable to minister. However, one case in one diocese and individual conversations within others suggest that the contents of the Blue File may not always be represented adequately in the letter. One Bishop suggested that Blue Files should be electronic, so that they are accessible as part of the recruitment process.

There remain difficulties in always being able to identify previous safeguarding allegations within what are often poorly organised files. In some, this information was held within sealed envelopes and in others in a separate Red File. This is risky, unless the Blue File shows clearly the fact of there being a separate file / envelope

with such information. A recent innovation in one diocese was to attach a red card securely to the front of the file when there had been a safeguarding concern and in another a sticker on the front cover. Another diocese uses a lilac sheet at the front of the Blue File to advise the reader to refer to the safeguarding team. However, the Blue File structure does not contain an obvious place for safeguarding concerns, hence the potential for the variety of local solutions and the increased risk of documents not being easily located or even being lost.

6.1.2 Volunteer appointments

Members of some parish focus groups mentioned a level of uncertainty about the checks for volunteers and an Archdeacon spoke of her/his concern because this aspect of safe practice is alien in congregations who have known each other for years and where the volunteers have been undertaking this role for a very long time.

6.1.3 Appointment of chaplains

A particular weakness remains in relation to the appointment of chaplains in schools, prisons, etc. Recruitment is undertaken by the organisations concerned, and the diocese has no automatic right to have a say in the appointment, despite an assumption that the Bishop will license the successful applicant.

6.1.4 Disclosure and Barring Service (DBS) checks

Generally, over the time of the audits, the position with regard to DBS arrangements has improved with an increase in electronic and outsourcing arrangements, which appears to be efficient. There are more complaints about paper-based systems.

There remains in some parishes resistance to DBS checks for long-standing volunteers, because of a perception that doing so is an insult to people who have been doing this for a long time, and because the process is viewed as bureaucratic.

DBS eligibility and the acceptability (or not) of portable DBS remains problematic in several dioceses, despite use of House of Bishops' guidance and FAQ. One diocese spoke about the loss of free advice from the Churches Child Protection Advisory Service contributing to this challenge. Another spoke about volunteers with contact with children and/or vulnerable adults having been deemed as ineligible for DBS.

Each diocese seems to have developed their own process to respond to blemished DBSs, usually (but not universally) involving some form of risk assessment. However, there is no consistent methodology.

Waiting times for DBS clearance are a particular problem in the Metropolitan Police Service area. Because of this one diocese reminds clergy five months before their DBS expiry date, and if they do not apply in time will have to step back from their duties.

6.1.5 Good practice examples

- An Independent Reviewer who scrutinises Blue Files to check that documentation correct, and identify any causes for concern, gaps and conflicting information
- Use of a standard checklist at front of file, including date of DBS
- Routine questions about both children and vulnerable adult safeguarding in the interviews for clerical and other relevant posts

- Production of helpful leaflet on what is entailed in recruitment of volunteers and when a DBS is required
- Quarterly bulletins disseminating awareness of the need for Safer Recruitment
- Blue Files sub-divided into sections, so information is accessible and any allegations are easily located
- Use of Clergy Current Status Letter for every member of the clergy, not just those applying for posts from outside the diocese
- DBS clearance received prior to announcement of a new appointment (as opposed to before take-up of post)
- PTO given for limited period (three years) with a new DBS each time (as opposed to indefinitely)

6.1.6 Changes implemented

The NST has taken actions since the interim overview report which are in the process of addressing the considerations in that report as follows:

- The new revised Clergy Files Guidance was published in February 2018 which strengthens guidance in relation to the CCSL processes.
- Training on 'Blue Files and record keeping' was delivered to Bishops' PAs in 2017.
- The Church is developing an electronic national Human Resource system which will hold all clergy, staff and volunteer personnel information. It will roll out in 12–18 months' time.

6.1.7 Conclusion

Recent changes have been implemented by the NST which should address the weaknesses found in clergy recruitment processes and the Blue File structure and content. The effectiveness of these will need to be tested given the core role this plays in the safeguarding of children and vulnerable adults.

No action was taken by the NST on the consideration 'What actions can be taken to promote Safe Recruitment processes into the appointment of chaplain to schools, hospitals, prisons, universities, etc.'. The reason for no action is that these appointments relate to recruitment processes that are the responsibility of other organisations e.g. a hospital trust for a hospital chaplain, the Prison service for a prison chaplain etc. They are not the subject of any oversight by the NST. SCIE takes the view that whilst this is true, the NST has a responsibility to consider what action it can take to influence such organisations to demonstrate recruitment standards are in line with that of the Church, prior to the Bishop licensing successful applicants. For that reason the consideration is repeated, albeit in a changed form.

Considerations for the National Safeguarding Team (NST)

- What needs to be done, and when, to examine the effectiveness of the practice guidance changes in relation to clergy recruitment and Blue File structure and content?
- Is a Bishop in a realistic position to be able to safely license a chaplain if they have not had a part in the recruitment process? What actions can the NST

take to be assured of Safe Recruitment processes into the appointment of chaplain to schools, hospitals, prisons, universities, etc?

- How to provide a reliable response to blemished DBS across all dioceses.
- How to evaluate the progress made in the development of a national HR recording system for all clergy, staff and volunteer data.

7 QUALITY ASSURANCE PROCESSES

The NST commissioned this national audit as part of its quality assurance activities, which will provide a benchmark for each diocese so as to be able to subsequently review its progress in implementing learning and undertaking future audits. The NST now plans to undertake a similar benchmarking national audit of the safeguarding in Cathedrals.

All dioceses undertake a self-assessment audit for the NST and the Archdeacon's Articles of Enquiry (see below) provide a process which can also contribute to the monitoring of safeguarding in the parishes. Most DSGs have quality assurance as one of their main functions, accomplished largely via the DSA's reports to the meetings.

Over and above these universal systems of quality assurance several dioceses are developing their own individual processes to monitor the state of safeguarding within the diocese. Examples include:

- independent audits of safeguarding arrangements, processes and casework
- independent case reviews
- case peer review between neighbouring DSAs
- participation in section 11 audits as part of LSCB involvement
- audits and self-audits of parishes.

7.1.1 Role of DSAP

As mentioned in the previous section, many DSAPs are involved in quality assuring safeguarding processes and practice including the quality of risk assessments and cases.

Several dioceses and DSAPs referred to the preparations for the SCIE audit as initiating quality assurance activity, which they intend to follow up with further measures, such as dip sampling and case reviews.

7.1.2 Learning Lessons Review

The Learning Lessons Review, written by the chair after each core group finishes its work is an effective way to inform local changes, looking at what processes worked and what might be done differently.

7.1.3 Safeguarding in parishes

The large size of the Church and its constituent organisations provide a major challenge in knowing how well safeguarding is understood and applied, especially in relation to the number and diversity of the parishes. DSAs and Archdeacons mention that 'you only know what you are told' and consequently this is an area of unknown risk.

The lack of a 'command and control' management structure within the Church means that by and large changes are implemented through education and persuasion.

The Archdeacons were aware of their responsibility to monitor safeguarding in the parishes, usually to address safeguarding of both children and vulnerable adults through the Articles of Enquiry prior to a Visitation, albeit not universally applied in each of the Articles. In one diocese there is a preference for the use of Survey

Monkey for specific questions, instead of what is viewed as the 'paper exercise' of Articles of Enquiry.

Whilst being able to collect factual information, it was identified that it is more challenging to understand the safeguarding culture in each parish and the quality of the work of the Parish Safeguarding Officers (when they exist). There was also recognition that the information collected about each parish is not analysed, in a systemic way, to assist planning.

Sometimes the lack of answers to factual questions provided evidence, but the subtler attitudes towards safeguarding tend to only be discerned via cases. DSAs are very aware that within available resources it is not possible to know where each parish is on its safeguarding journey and that such understanding is at an early stage.

Sometimes concerns are identified via issues raised in safeguarding training. Also some Archdeacons pointed out that often it emerges due to other issues, and that concerns around the parish falling short in general often include poor safeguarding performance.

Of particular concern are the parishes without a safeguarding officer, or this role being undertaken by the incumbent or their partner. Those incumbents with freehold (as opposed to common tenure) can prove a greater challenge, as it is more difficult to demand compliance.

There is wide recognition that the safeguarding of vulnerable adults is more complex and less well understood within parishes, and consequently provides the greater challenge.

7.1.4 Examples of good practice

- Safeguarding audit of all benefices
- Parishes being asked to complete comprehensive safeguarding checklist or self-audit
- The use of 'Simple Quality Protects', an online QA tool for community organisations based on requirements and standards – it is approved by local LSCBs and the diocese paid to use the tool and was piloting it in six parishes
- Use of both factual tick box questions and open questions as part of Articles of Enquiry and parish safeguarding list (e.g. existence of safeguarding policy and 'what else would be helpful in terms of safeguarding?')
- Parishes asked to undertake a self-audit to provide detailed baseline information
- Members of the DSAP undertaking quality assurance training
- DSA maintaining databases of parish information to share with Archdeacons e.g. DBS checks, status of training
- Archdeacons using informal networks to understand better the state of safeguarding practice, such as church wardens, rural deaneries
- Archdeacons involvement in core groups relating to cases and in the process for individual safeguarding agreements in parishes
- Regular e-bulletins / newsletters / Facebook groups: tools for DSAs to keep parishes up to date and to develop links between each other

- Building up awareness in parishes of dementia as source of adult vulnerability
- Archdeacons conduct exit interviews on safeguarding issues with departing incumbents, to have better understanding of local challenges

7.1.5 Changes implemented in response to considerations in previous SCIE audit overview reports

The interim overview report (April 2017) asked the NST to consider the development of national guidance around the components of a diocesan quality assurance framework, to encompass safeguarding practice in the diocese and the parishes. In response:

- The NST has outlined key components of Diocesan QA, namely annual self-assessment, independent audit.
- Plans are progressing to pilot safeguarding progress reviews with three dioceses, in April/May/June 2018, as a follow up to their independent audits. With a view to roll out to all Diocese in 2018/2019.
- The NST is developing a Parish and Diocesan QA framework

This remains work in progress, so the previous consideration remains

7.1.6 Conclusion

Other than the individual initiatives in several dioceses, the auditors considered that the quality assurance function is at a relatively early stage of development, and tends to focus on collection of statistical data, but does not get to the qualitative information that would be able to test what actual understanding there is of safeguarding and the reason behind any identified problems in practice. Moreover, there seems to be a tendency to collect data, but not to analyse it and develop actions in response to that analysis.

Whilst there is awareness of the need to quality assure parishes (see below) there is less focus on the challenge of how to quality assure the safeguarding work of Fresh Expressions and Messy Churches.

Considerations for the National Safeguarding Team

- Consider the development of national guidance around the components of diocesan quality assurance framework, to encompass safeguarding practice in the diocese and the parishes.
- Consider the benefits of exploring collaborative, systems approaches to quality assurance (QA) that engage those whose practice is being assessed in order that:
 - a) they learn through participating in the process and
 - b) the QA process sheds light on what is helping good practice and what is getting in the way

GLOSSARY OF ABBREVIATIONS AND TERMS

CDM	Clergy Disciplinary Measure
C of E	Church of England
DSA	Diocesan Safeguarding Adviser
DSAP	Diocesan Safeguarding Advisory Panel
IICSA	Independent Inquiry into Child Sexual Abuse
IDVA	Independent Domestic Violence Advisor
NST	National Safeguarding Team
NSSG	National Safeguarding Steering Group
PtO	Permission to Officiate
'RAG' rating	System of ascribing red, amber and green to describe level of risk, or of progress in completing actions on an action plan
SCIE	Social Care Institute for Excellence

PART TWO

Improving Church responses to victims and survivors of abuse

1 INTRODUCTION TO THE IMPROVING CHURCH RESPONSES REPORT

1.1 THE REPORT

This report presents the learning from an independent, confidential survey run by SCIE seeking the views of anyone who has received or expected to receive a response from the Church of England related to safeguarding. People may have turned to the Church of England to disclose abuse, share concerns of unsafe people or practice, or needed help to keep safe for any, or they may have been approached by the Church. The aim of the survey was to learn from people with first hand experiences, about what a good response from the Church should look like. It concludes with drawing out some systemic issues for the national Church to consider in order to make it easier to achieve the vision of good practice that survey participants have created.

1.2 CONTEXT

This report forms Part Two of the final report of the programme of independent work focused on diocesan safeguarding arrangements and practice, conducted by SCIE.

Part Two of the report introduces the additional work conducted to ascertain the views of people who have first-hand experience of Church responses, including survivors of clergy and Church-related abuse. The rationale for choosing this work as the more meaningful option for engaging with people with first-hand experience, rather than seeing people with experience of Church safeguarding responses as part of individual diocesan audits is explained in the Overall Introduction to the report.

1.3 AIMS & ETHICAL CONSIDERATIONS

1.3.1 A future-oriented focus

In setting up a supplementary piece of work seeking the views of people with first-hand experience of Church safeguarding responses, ethical considerations were paramount. Our working assumptions were that there would be an emotional cost to everyone who took part in the survey and the possibility of re-traumatisation. In determining the aim and focus of the work therefore, we aimed to:

- build on existing evidence and avoid re-inventing the wheel
- make tangible how the results are designed to support improvements on the part of the Church

In line with the principles underpinning our collaborative, systems approach to the audits, we also aimed to:

- avoid fostering a blame-culture by scapegoating particular individuals or roles when more complex explanations are required

Consequently, we decided not to focus the work on understanding people's experiences to-date of reporting cases of abuse to the Church or sharing concerns about unsafe people or practices. These are the focus of prior research, including a

major study by MACSAS¹⁸, a recent compilation of survivor's experiences of Church responses¹⁹ as well as more recent evidence given to IICSA in March 2018.

Building on that research, this work instead has a future-oriented focus. The aim is to improve understanding of how the Church should respond to people who come forward to share information about abuse or safeguarding concerns. What should happen in order to meet people's needs? Key questions include:

- What are the ingredients of a good Church response?
- What does a respectful and timely response to concerns or allegations about abuse, neglect or vulnerability look like?
- What does it take to achieve a compassionate, supportive and healing response?

We wanted to gather views of people with first-hand experience, on what should be done by people with roles in the Church that give them certain responsibilities for safeguarding. We also want to understand what fellow Christians / churchgoers can best do to help.

This focus, should make it relatively straightforward, for the survey results to allow the Church of England to improve how it supports survivors and victims of abuse and neglect, as well as protecting people who need help from the Church to keep safe. We hoped that the focus also reassured participants that the cost of taking part was likely to be worth it.

1.3.2 A wide focus

The Church has an obvious responsibility for anyone who has been abused by people who work for the Church, whether clergy, lay officers or volunteers. The survey might therefore have focused exclusively on learning about what a good Church response looks like to survivors of abuse by clergy and people in Church-related roles. However, the Church also has a wider commitment to keep everyone involved in Church activities safe, including people who have been abused outside Church settings and turn to the Church for help and support, and those who feel or are unsafe for any other reason. Lastly, creating safe and reliable safeguarding arrangements also requires the Church to respond well firstly, to those who are not in need of safeguarding themselves, but come forward proactively to flag risks and hazards so that they might be addressed before anyone is harmed. Secondly, the Church also needs to respond well to anyone who wants to highlight where Church responses have been poor or absent, in order that the situation can be rectified and lessons for the future learnt.

We therefore took a wide focus in terms of Church safeguarding responses, aiming to learn about good Church responses in a range of different safeguarding scenarios including where the person has:

¹⁸ Anne Lawrence. *The Stones Cry Out: Report on the MACSAS Survey 2010*. http://www.macsas.org.uk/MACSAS_SurveyReportMay2011.pdf

¹⁹ Andrew Graystone *We asked for bread and you gave us stones. Victims of abuse address the church in their own words*. <http://abuselaw.co.uk/wp-content/uploads/2018/02/Stones-not-Bread.pdf>

- Been abused or mistreated by clergy or someone in a church-related role – be they lay or clerical, paid or volunteer
- Turned to the Church about abuse or harm that happened in other places – for example in the family, at work, or in another organisation
- Raised concerns about unsafe situations in the church, where they have feared children or vulnerable adults may be at risk of harm or abuse due to hazardous church activities or the presence of known perpetrators of abuse taking part in Church services or activities
- Needed help to keep safe because of circumstances – such as bereavement, relationship breakdown, redundancy, physical or mental ill health, drug or alcohol dependencies, physical disabilities, learning disabilities, old age, or emotional distress – that led the person to seek or need support from the Church
- Needed to complain about how one of the above concerns was handled by the Church

1.3.3 What it is not

As the description above makes clear, the focus of this work was not ‘best practice’ in terms of evaluated effectiveness. We did not set out to conduct a systematic literature review of the international research evidence on good practice in Church responses to abuse survivors. Instead, the focus was inextricably linked to the gap in the diocesan audit programme, which created a need to focus on the views and experiences of people with lived experience of Church safeguarding responses.

1.3.4 Engaging with different view points

In line with the principles of working with the Church to support progress in their safeguarding improvement journey, we were keen to engage Diocesan Safeguarding Advisers in the work as it progressed, and to start the process of triangulating their views and experiences of responding to abuse survivors and safeguarding concerns, with those created through the survey. A group of DSAs supported the SCIE team in the initial formulation of the work. We met larger groups of DSAs on three further occasions:

When	Where	Why
March 2017	DSA day – 1 day workshop	Introduction to the additional piece of work; input on DSA views of what working well and what they are struggling with.
September 2017	X2 workshops (90 min) at National Safeguarding Conference	Introduction to the five stages of engagement model, and exploration of DSA views of ‘good’
October 2018	DSA day – small part of a 1-day event,	Discussion of survey analysis (levels of dissatisfaction & need for keeping the person at the heart of the process)

We intend to return to this engagement once the report is published and any implementation plans are in consideration.

1.4 METHODOLOGY & ETHICAL CONSIDERATIONS

1.4.1 Survey design

As with the aims and focus, ethical considerations were integral to the approach we took to developing and designing the survey itself. We deemed it important that the framework we used for the survey was anchored in what is already known about what goes to make up a Church response from the perspective of survivors while seeking to better understand the very same thing. In this we were very much helped by the only survivor who the SCIE team met during the audit programme, Dr Josephine Anne Stein, who took the initiative of sharing with the auditors a special issue of the Christian ethics journal *The Crucible*, on the topic of safeguarding.

The framework we have used for this survey is published in this journal, and was created by Dr Stein²⁰, an independent researcher and policy analyst, and a survivor, with whom we discussed the survey design. It distinguishes five different stages of potential engagement in the Church's response to allegations of abuse and safeguarding concerns as shown overleaf.

For each stage, a similar set of open questions was posed. These aimed to generate detailed and nuanced information from participants. They included:

- What are the key things that you think need to happen in this stage?
- What is most important in the Church's treatment of people during this stage?
- What needs to be avoided from the perspective of the survivor, the person raising safeguarding concerns or person at risk of harm?
- Are there particular situations that need to be recognised in determining the response and help?

²⁰ Stein, J. A. (2016). "Surviving the Crucible of Ecclesiastical Abuse." Crucible: The Journal of Christian Social Ethics July: 23–35.

Table 1. Five different stages of potential engagement in the Church’s response to allegations of abuse and safeguarding concerns

<p>Stage 1: Making it easy to tell someone</p>	<ul style="list-style-type: none"> • Enabling everyone involved in Church related activities to identify concerns about abuse and risk of harm, and tell someone in the Church • Making it as easy as possible for victims of abuse to tell someone.
<p>Stage 2: When initially told</p>	<ul style="list-style-type: none"> • Immediate responses and support to the person when someone in the Church is initially told about abuse or worries about a person's safety and welfare.
<p>Stage 3: Throughout processes that follow, both formal and informal</p>	<ul style="list-style-type: none"> • Communication and support to victims of abuse during the Church's own and/or police investigations, criminal proceedings, civil claims, compensation processes etc. and direct negotiations with the Church; • Communication and support to people during interventions to address the source of people's vulnerability.
<p>Stage 4: Grievances and complaints</p>	<ul style="list-style-type: none"> • Reactions to people when they tell someone in the Church that their previous disclosures of ecclesiastical abuse or safeguarding concerns have not been acted upon adequately.
<p>Stage 5: After processes have ended and longer term</p>	<ul style="list-style-type: none"> • Responses and engagement with individuals when processes of disclosure, investigation, and where appropriate, prosecution and/or compensation, have concluded • Responses and engagement after the person has given up and gone away without a satisfactory conclusion.

There was also a shorter, part one section of the survey, which asked basic details of each participant’s experience of coming forward or being approached by the Church regarding safeguarding. These were primarily closed ‘tickbox’ questions, with the optional space provided for people to add more if they wished to.

The survey has a long introduction in which we tried to flag-up the issues around re-traumatisation and support.

The survey was designed in consultation with the survivor support organisation MACSAS (Minister and Clergy Sexual Abuse Survivors) with Jo Kind and Phil Johnson providing detailed feedback on developing drafts. This included doing 'cognitive testing' in which the person conducts the survey in the presence of the researcher, talking aloud their thoughts, understanding and reactions as they do so.

The full survey document is available on request.

The survey was available to complete in a Word document or in PDF format. Participants were asked to email their completed forms back to SCIE. The rationale for this was to enable participants to have as much control as possible over the process of completing the survey, including complete the survey at a time, place and pace that worked for them, and when any support people wanted to draw on was available.

The survey was open for seven months, from the beginning of June 2018.

1.4.2 A wide audience of participants

Given the potential vulnerability of participants, we opened the audience to people with first-hand experiences of Church responses either personally or as a family member or friend of someone who had had or expected to have had a Church response. If we assumed that some survivors of abuse would not be in a position to take part without jeopardising their safety and wellbeing, we judged it to be a moral imperative to be able to hear from those close to them.

We were interested in hearing from clergy as well as lay Church officers who fall into either of the above categories.

1.4.3 Raising awareness of the survey

We sought support from a range of Church and non-Church roles and networks and organisations to publicise the project and seek representation from people to cover the range of different safeguarding scenarios. These included:

- NST
- Diocesan Safeguarding advisors
- MACSAS and other victim/survivor support and advocacy organisations who are members of the Survivors Trust
- The Association of Child Abuse Lawyers (ACAL)
- SCIE ourselves

Ethical considerations were key to questions of how best and safely to raise awareness of and distribute the survey. The more people with first-hand experience that took part, the stronger the picture could be of what is needed from the Church. Equally, for some people simply knowing of the survey might at best have a negative impact on their wellbeing and/or recovery, and at worst be re-traumatising. We aimed to strike a balance between giving as many people as possible the opportunity to contribute to a composite picture of what a good Church response looks like to people who come forward to disclose abuse or share concerns and avoiding inadvertently approaching individuals who were not in a position to consider taking part. We did so by focusing predominantly on getting information about the survey on websites, twitter, noticeboards and newsletters. We did not promote a broad-brush targeting of individuals. We suggested direct approaches to individuals only by people who were in positions to be able to make the necessary and careful

consideration and judgement about whether or not, for any individual, such contact was appropriate – e.g. DSAs and lawyers. People needed to have a right to be in touch with the person under GDPR, and consider that the person might be interested in taking part and be someone they considered robust enough for the approach not to cause harm.

1.4.4 Ethical considerations

As indicated in the above sections, ethical considerations were discussed at length throughout the process of setting up the survey and its administration. Given the sensitivity of the topic area and vulnerability of many of the participants we were seeking to hear from it was imperative to identify best ways of minimising risks to participants. Key steps are summarised below.

We decided early on in the planning that engaging directly with children and young people is important but beyond the scope of this project. Therefore we did not market the survey for children and young people. Enabling children the option of participating and making it safe for them to do so is especially challenging in a reasonably small project. However, we hoped to hear from adults who were abused as children. We are also keen to hear from parents or carers of children and young people who have been abused, neglected or been vulnerable in a Church context. We agreed nonetheless not to exclude any young people who did participate in the survey.

In the survey document, we:

- gave a long introduction in order to provide a detailed description of the work, and the structure of the survey and different types of questions participants are going to be asked, before people arrive at the survey proper
- clarified the confidentiality of people's submissions and included a privacy statement at the end with options about what people wanted SCIE to keep in touch with them about or not
- highlighted and encouraged self-care before, during and after the process
- sign-posted appropriate support services
- flagged that what questions people complete, to what level of detail was up to them to decide.

In choice of format, we opted to have the survey available as Word/PDF in order to enable participants to have as much control as possible.

In the structure and substance of the survey too, we drew on work by survivors – both a previous survey for survivors by MACSAS, and a framework created by a survivor of ecclesiastical abuse – in order to maximise the resonance of the survey with people's experiences and try to convey a sense of our integrity and trustworthiness as regards the work.

We have also worked closely with MACSAS to check the sensitivity of the survey wording, about advertising and disseminating the survey, and availability to answer queries and get support.

In the approach to raising awareness of the survey we requested direct approaches to individuals were made only by those with the relationships to be able to make the necessary considerations and otherwise sought to share information widely that

signposted people to the survey.

After the survey went live we sought to respond promptly and personally to acknowledge receipt of completed surveys. We also continued to work closely with MACSAS once people began to respond, for support in making judgements about how best to respond to any queries, concerns or requests.

In regard to any potential disclosures made in the survey responses, where possible to do so, we were to follow SCIE's usual safeguarding policy sharing information with the relevant local authority if we were concerned that the survey respondent has identified ongoing and active abuse or is at risk of serious harm to themselves or presents a serious risk to others.

We did not take the survivor survey work through a formal research ethics committee. While this is not a formal requirement for this, confidence in the ethical conduct of the work would have been enhanced if we had done so. This is a lesson learnt for any similar future work.

1.5 STRUCTURE AND CONTENT OF THE REPORT

The report is structured to reflect the different stages of engagement that formed the structure of the survey as follows:

- Section 2: **Who took part**
- Section 3: **Stage 1.** Making it easy to tell someone
- Section 4: **Stage 2.** When initially told
- Section 5: **Stage 3.** Throughout the processes that follow
- Section 6: **Stage 4.** Grievances and complaints
- Section 7: **Stage 5.** After processes have ended
- Section 8: **Systemic issues for the Church to consider**

2 WHO TOOK PART

2.1 INTRODUCTION

This section provides some details of the survey participants. The purpose is to give an indication of the experience base upon which people have drawn in order to articulate their perspectives of what Church responses should look like – that we present in the following Section 3.

Participants gave generously in the survey and provided much more detail about the specifics of their past experiences of abuse and of Church responses. It is important to put this data in the public domain and that the Church can reflect and learn from it. This is going to be written up as a separate piece of work, including journey mapping, creation of survivor experience profiles as well as case studies. We have decided not to place it in this section, in order to allow the focus of Part 2 of this final report, to be future focused, capturing the perspectives people shared about what ‘good’ looks like, and how this can inform national Church improvements.

2.1.1 Survey participants

How many people took part?

Fifty-eight survey submissions have been analysed for this report.

A further two have been received in January and checked for any additional issues to add to the themes before publication.

Why had participants turned to the Church for help?

We aimed for a wide audience of people for the survey. This included both survivors of Church-related abuse and those survivors of abuse outside a Church context, who nonetheless turn to the Church for help. We also opened the survey to people with vulnerabilities who have turned to the Church for help to keep safe, as well as people who have flagged up unsafe practices or people to the Church. However, participants in the survey did not cover the range of experiences.

By far the largest number of participants (47) reported being survivors or victims of ecclesiastical abuse – abuse perpetrated by clergy and others with specific roles within the Church.

Of the others, 10 people reported being victims or survivors of abuse not related to the Church (e.g. at home, school, work or while being cared for). Three people reported that they had shared with the Church concerns about unsafe Church-related people or practices. Two reported vulnerabilities due to personal circumstances that led to seek help from Church. Six of the total said they were friends of a victim or survivor.

Eight participants selected one or more categories in response to this question therefore numbers do not equal the total number of participants.

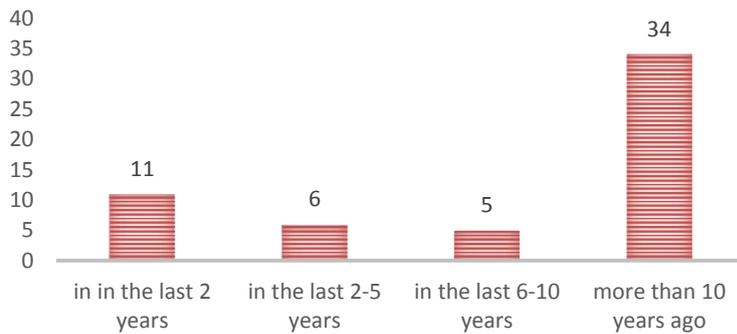
Clergy and Church-related abuse

The largest category of Church-related abuse was sexual abuse (n=29), of which seven were abused while choristers. Two participants reported domestic abuse by clergy against their spouses. There were a wide range of other abuse scenarios and participants rarely document just one type of abuse, but indicated they had suffered multiple types of abuse.

There was however no clear ‘them’ and ‘us’ divide between Church perpetrators and congregation victims. Fifteen of the survey participants victims/survivors of abuse were themselves clergy or in Church-related roles such as lay readers and ordinands.

How recent were people’s experiences?

The largest group of participants reported that their abuse occurred more than 10 years ago. Of those, 23 were children when they were abused (under 18), and 11 were abused as adults (over 18).



Participants brought more recent experiences of abuse as adults (under 10 years ago), compared with experience of abuse as children. Four participants reported experience of abuse as they transitioned to adulthood within the last 10 years.

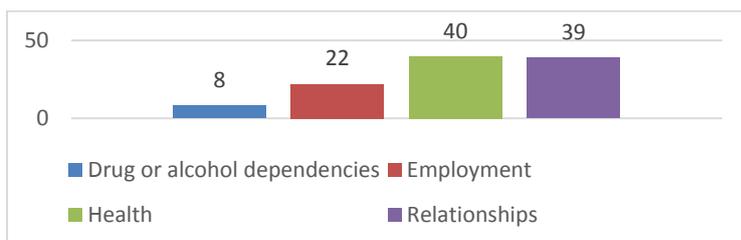
	0-18 years old (child)	18+ (adult)	Child to adult
More than 10 years ago	23	11	0
Less than 10 years ago	0	18	4

Twenty-five participants disclosed ‘whilst abuse was still going on’, whereas 20 participants disclosed more than ‘five years after it happened’ – with a range from 10 years to 30 years ago, with one participants disclosure dating back to 1975.

Eighteen people said their cases with the Church are ongoing.

Impact of abuse

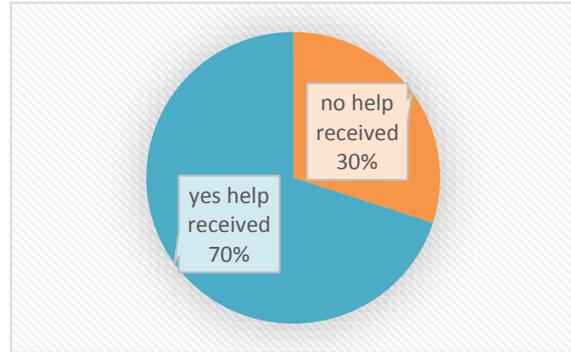
The impact of the abuse is multifaceted with 26 participants reporting three or more instances of long-term, negative impact. General patterns of negative impacts were recorded to be: health, employment and relationships. Participants who selected other suggested their relationship and trust with God and/or the Church clergy had greatly suffered. Zero participants selected that they had no negative impact.



Response from the Church

Thirty-five people reported that they received help from the Church, 15 said they did not. Some participants did not complete this question.

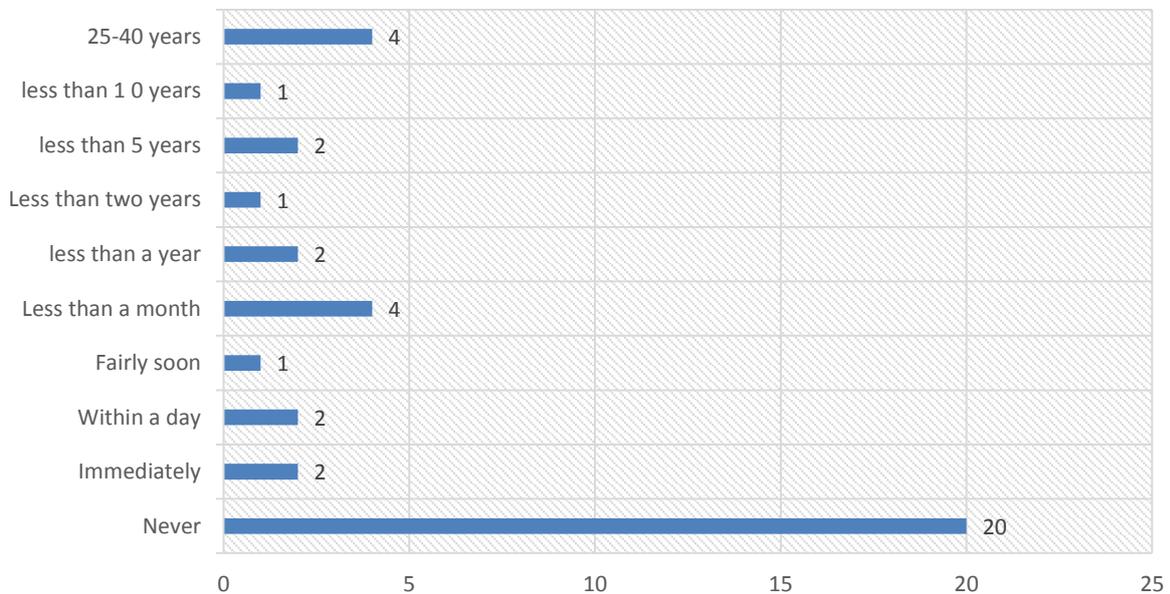
Eighteen people said their cases are ongoing.



Satisfaction rates

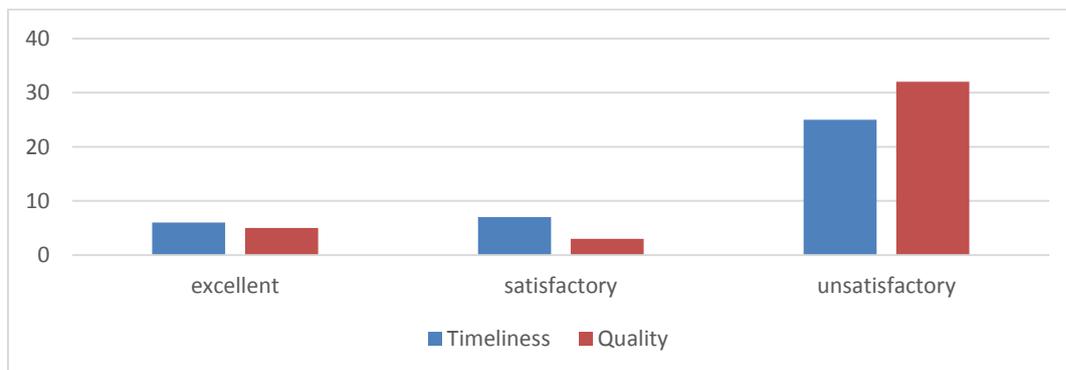
Two of the survey questions are relevant to understanding how positive or negative participants are about the response they have received from the Church.

When asked ‘how long after someone in the Church first knew about the response/neglect or vulnerability was a meaningful response received?’, by far the largest group reported that they had *never* received a meaningful response.



Seventeen participants left this section blank.

When asked directly how satisfied they were with the timeliness and quality of Church responses, participants who replied, were overwhelmingly unsatisfied.



2.2 WHAT COMES NEXT

In sections 3 to 7 that follow, we present findings from the survey about what Church responses to abuse survivors and others coming forward to the Church with safeguarding concerns, should look like. The sections deal with one of the five different stages of Church engagement in turn. Each section contains a table of themes from the survey capturing features of good practice from the perspective of survey participants. Each row represents a theme. The theme is summarised in a heading in in bold text. Underneath illustrative quotes from survey are presented.

The themes for each stage/section are organised in three different ways: a) What is important; b) What to avoid; c) Any particular circumstances to take into account.

3 STAGE 1. MAKING IT EASY TO TELL SOMEONE

3.1 WHAT'S IMPORTANT - MAKING IT EASY TO TELL SOMEONE

Communicate widely across the Church how survivors are expected to tell someone and what help will be offered

Have a dedicated C of E website or area on the website that signposts what to do on first contact, emphasises how victims may be feeling, highlights what the C of E is doing and sets out a clear goal – to eradicate all abuse in the C of E and help every victim find healing and restoration. Zero tolerance. Many construction businesses have a goal of zero accidents on site. The C of E should have a goal of zero abuse.

Know you'll be heard and believed and help and support will be available.

Repeated messages from the Church that it is not the victims' fault. I felt too ashamed to tell anyone for 20 years.

The Church's safeguarding training needs to make the needs of, and support for, the abused, its prime focus.

I only considered disclosing my abuse because, for the first time, we have a primate that appears to take safeguarding seriously.

Provide assurance that support will be resourced adequately for all victims, irrespective of their position in the Church or their position outside the Church.

Make clear the offer to fund independent counselling for victims and survivors, with counsellor to be chosen by survivor.

Be explicit that you as a diocese you are aware how damaging abuse is.

If everyone is aware that safeguarding is taken seriously and abuse is not tolerated then it makes it easier for a victim to come forward.

Survivors can feel 'safer' suffering alone in silence than taking the perceived risks of the consequences of telling their story.

Have and make readily accessible a clear process of what follows a disclosure

A free, easy-to-understand, information pack or guide to accessing support that is available and explaining their rights and entitlements and what to expect from an investigation.

Because one is stepping into the unknown on a risky and journey of vulnerability, I think it would be really helpful to discover what the journey was, how long it might be, what the various steps were, and what it might involve.

Regular, overt messaging that abuse will not be tolerated, that there is a formal process for investigating concerns, and abusers will be made to answer for their actions

The whole safeguarding issue needs to be highlighted so that everyone is aware

of how important it is. If everyone is aware that safeguarding is taken seriously and abuse not tolerated, it makes it easier for victims to come forward.

Give confidence and reassurance that despite an abuser being a member of clergy, the Church will be rigorous in investigating and seeking the right outcome.

It is most important that you can trust in the person and trust in the organisation they represent.

Remove Permission to Officiate (PtO) more readily from clergy who are known to abuse power.

Have a clear and public anti-racism policy and racist abuse, including against BMEA clergy, will be taken seriously, investigated and action taken.

Routinely portray survivors as valuable members of the Church and disclosures of abuse as a valuable, and valued service given generously by victims/survivors

Such portrays are needed in order to tackle the stigma attached to survivors of abuse.

Children need to routinely be listened to and treated respectfully

Tackle constructively views that safeguarding has ‘gone too far’, ‘everyone’s jumping on the bandwagon’, ‘can’t even pray with a hand on someone’s shoulder now’ etc.

Demonstrate expertise about perpetrators of abuse and how they work

Demonstrate understanding of the highly manipulative behaviour of sexual predators, and that you understand the psychology of this type of abuser, and their skill at hiding their true nature and abuse they perpetrate.

Show awareness of the many different forms of abuse and that they can happen to anyone and that perpetrators will not wish the truth to be unearthed and can be manipulative of others, including professionals, in order to avoid this.

It is vital that anyone in apposition of pastoral leadership should be made fully aware of how abusers groom their victims. Of course, we need to do the basics of safeguarding but I don’t think there is enough training on spotting the signs of grooming, whether related to bullying, domestic abuse or sexual misconduct.

Talk about the need to reconcile that good parish priests can still do bad things; that people can be good and bad. Be explicit that the good of an abuser, can never justify the abuse they have perpetrated.

It is really important for people in the Church, not just ministers and others who attend safeguarding training days, to be aware of abuse within the Church and the forms it can take. It is hard to accept that abuse has taken place when a priest is a trusted figure. I didn’t even recognise what had happened to me as abuse till sometime later, when I’d heard other survivors’ stories.

Debunk the myth that clergy/authority figures cannot be guilty of abuse

Openness about situations from the past

Training for clergy in spotting the danger signs within themselves/ emotional issues that could make them vulnerable to becoming abusers and how/where to seek help e.g. psycho-sexual issues that the person seeks to work out through serial seductions and one-off sexual encounters. Emphasis on ongoing and reviewed 'personal growth work' for everyone in clergy and Church-related roles to support people in seeking help for root issues that could lead to development of inappropriate behaviours from potential abusers/ perpetrators.

Make it routine that newly appointed priests have close supervision and involve PCC members in performance reviews.

Educate everyone about abuse within the Church and the forms it takes

Educate everyone to understand that a concern that may initially appear to be a 'pastoral' issue, needs to be recognised as potentially an early piece of the safeguarding jigsaw.

Make everyone aware of signs of emotional abuse by a parent of their child

Make detail available about how thorough investigations are

Make clear that investigations will include into the person's past Churches, in order to see if a pattern exists. This will help address the fear that you won't be believed.

Enable victims

Provide pastoral care and encouragement toward taking further action.

Demonstrate understanding of the importance of people receiving disclosures to have the right pastoral skills, experience and expertise.

Demonstrate how it'll be in safe hands, and the person will be listened to.

Have availability to listen.

Be 'trauma informed with a careful use of words in worship – don't assume a shared positive understanding of what words used in worship mean e.g. father, family, love. Fellow Christians need to understand something of the perceptions of God, Christianity, family etc. that a survivor of abuse has been given so that they do not inadvertently continue the perpetrator's line of argument and patterns of control. Training needs to be widely spread so members of the Church can also choose their level of engagement and understand something of the complexity. Most people seem to have this awareness when bereavement occurs.

'Openness to brokenness'

Remember survivors do not trust people with titles and labels and authority just because they have that title. The person's trustworthiness and role has to be communicated clearly to reassure.

Encourage anyone leaving a parish/church to share their reasons – akin to an exit interview in a work context. This would alert the Church of any concerns previously not reported (where the person is moving rather than reporting a concern) and provide additional information that might add to a growing picture.

Someone there solely to represent survivors and be on their side at all times

Have the right personnel

Access to a trained, approachable, empathetic, person-centred person.
Knowledgeable, good listening skills and compassion, patience and acceptance.

Knowing who to speak to

Identify who you can speak to through an information poster on a notice board
Every parish should routinely put on its pew sheet the names of the designated safeguarding person / and the diocesan safeguarding contact number.
Increase the profile of the lead safeguarding person so referral to them happens quickly and consistently by anyone who raises an issue or receives it in the Church.

Make clear that all information is passed to a central, designated person at either parish or diocesan level, so pieces of the jigsaw can be put together where relevant and the whole picture can be seen

A well-advertised, independent help line

Privacy, secrecy – telephone numbers on back of toilet doors etc.
A helpline where people can talk anonymously, is possibly safer than talking to someone you know. And the person can then help you to report.
An independent, free-to-contact, easy-to-access service where people can raise concerns (such as something provided by NSPCC for children and something similar for vulnerable adults).
A whistleblowing number where people can raise concerns if they suspect that someone is acting suspiciously, or someone is being abused, or someone has not responded appropriately to an allegation of abuse or for them to get advice if they don't know what to do about it.
There needs to be a way of reporting abuse and concerns that is outside and independent of the Church.
At parish level, provide someone other than the incumbent and Church Wardens and not a member of the PCC.
Make sure there is a clearly publicised and defined confidential route for victims, abusers and church goers to be able to report any concerns they may have about possible victims or abusers.
A helpline may be a safer place to talk for the first time than to someone you know and will continue to have contact with.
There should be some kind of helpline / advice line (like the Samaritans) where people can talk to someone anonymously – who would then help them to report it if they wanted to.

Easily accessible modes to report concerns – online, in person, on social media applications, and directly and indirectly i.e. via third person or

organisation

A campaign about reporting abuse and concerns being everybody's responsibility to report and how to report concerns

An easy-to-understand, widely distributed, leaflet and statement from the Church explaining and encouraging everybody attending or connected with the Church to report concerns, and that people do not need to know for sure that something is happening before reporting.

If you've ever thought 'That's awful, I've a good mind to / I should report it ... do – report it to a safeguarding specialist without breaking confidentiality and ask what you should do next.

Availability of a safe space

A private suitable environment.

A safe space showing God's love.

Discretion – the person may need to ensure the person they are afraid of is not aware they are seeking support.

Messaging about safety and confidentiality

Explain how they will be safe after disclosure.

Assurance of confidentiality.

Allow a companion.

Gain the confidence of survivors

Of the 10+ survivors I have knowledge of, zero currently have any confidence in NST. That could easily be changed.

3.2 WHAT TO AVOID - MAKING IT EASY TO TELL SOMEONE

Avoid promoting clergy who are known to abuse power

This person was well known to be an abrasive bully who couldn't keep his hands off women. And yet, he was repeatedly promoted. The Church far too often promotes people who are known to abuse power.

Avoid treating someone who emotionally fragile/ distressed and behaving erratically as if they are simply overemotional, unreliable, 'flaky' when they may be an abuse victims/survivor and not able to explain why. The impact of their distress can find it very hard to find someone to hear what has happened to them and take it seriously.

Avoid assuming mental health problems/crises explain someone's behaviour; it may be the rational consequence of abuse that they have not yet disclosed and trauma not yet supported with

Avoid closing a supportive relationship on the basis of not being qualified to technically provide support e.g. on grounds of mental health needs of the person.

Avoid a culture where sex and sexuality are not talked about

Avoid only being able to report to clergy

Ambiguity or a sense that disclosures of abuse are not important or will be brushed aside

Avoid impression that concerns are all dealt with internally by friends and colleagues

Avoid impression that cover up and denial is best for reputational management

3.3 PARTICULAR CIRCUMSTANCES TO TAKE INTO ACCOUNT - MAKING IT EASY TO TELL SOMEONE

SURVIVORS WHO ARE CLERGY OR IN CHURCH-RELATED ROLES

They are highly likely to have relationships with people in safeguarding roles which will make maintaining confidentiality impossible, heightening the perceived need for a way of reporting that is independent of the Church.

SOMEONE IN THE EARLY STAGES OF DECIDING WHETHER THEY ARE CALLED TO ORDINATION

They know that once you reveal yourself to your parish priest, you are already under scrutiny and you are aware that your behaviour is going to be noted. This can act as another disincentive to reporting.

WHERE SURVIVOR IS CLERGY IN MORE JUNIOR ROLE TO THEIR CLERGY ABUSER

Need extra assurance that there will be no risk or penalty for having told. One survivor told by Bishop to whom the abuse reported and refused to act and the Bishop said: 'The scent of failure will follow you throughout your ministry'.

Clear messaging is needed that an independent investigation not an in-house one is available.

SPOUSES OF CLERGY IN SITUATIONS OF DOMESTIC VIOLENCE AND

ABUSE

Recognise the powerlessness that clergy spouses feel when they have marital problems including domestic abuse, and how difficult it is to tell anyone what is happening, or even acknowledge it to yourself. There is a huge power imbalance in any clergy marriage. This is compounded by the relationship the member of the clergy has with the Church and its hierarchy, the impression that the member of clergy is more likely to be believed than the spouse and the unhelpful process of the Clergy Disciplinary Measures which can dissuade a spouse from coming forward about the abuse happening because they do not want their partner to lose their job.

OCCULT PRACTICES AND NON-CHRISTIAN STATEMENTS

This is no doubt rare but if not acknowledged as in the range of possible abuse scenarios, will make it harder for victims to recognise and report it.

4 STAGE 2. WHEN INITIALLY TOLD

4.1 WHAT'S IMPORTANT - WHEN INITIALLY TOLD

Recognise the enormity of disclosing abuse; understand how hard it is to come forward

Recognise the magnitude of courage they have needed to report what they have and give assurance that they have done the right thing.

Recognise how much time and emotional energy it takes to come forward and communicate about past trauma and abuse especially if the abuser is clergy and well loved.

I had spent a long time thinking 'Shall I? Shan't I?'

Recognise the person may love the abuser but hate them for what they have done.

Be aware that the victim is traumatised and that even talking about things is distressing.

Even after all these years, my training and experience, and my available personal support network, I have found stepping out and reporting the abuse a challenging personal journey. Stressful, emotional and stirring up stuff that I would have been pleased to leave fallow.

It's important that the person understands the range of emotions that the survivor has been through by the time they call.

Say thank you for doing this, recognise how much courage and bravery it takes.

I wrestled with and still wrestle with the issue of forgiveness – does forgiving someone mean not reporting them and not getting someone into trouble.

Take what children and young people tell you about abuse at face value and always follow-up

I told a member of clergy years ago what had happened. He interpreted that I had run away and told me to go home. He never checked to see if it was a safe place.

I tried to talk to members of the Church and my mum at the time. However the response I usually got as I started to talk about being made to feel uncomfortable by the perpetrator was that 'it was just his way' and that 'he was just joking'. I therefore never made a full disclosure at the time as in my mind this behaviour became normalised.

Agree a safe place with the victim to speak

Not in the place where the abuse took place.

A confidential space in which to talk at a convenient time.

Discretion – the person may need to ensure the person they are afraid of is not aware they are seeking support.

Ask if the person would prefer a male or female person or both to speak to

As an adult male, it is difficult telling another male about abuse perpetrated by a choir master – somehow more embarrassing.

Abusers usually like to get their victims alone, and go to extraordinary lengths to do that, by gaining trust and winning over the people around them. It is far better to have at least two people listening to the person who was abused, which protects both the listener and the abused, without them feeling threatened.

Don't expect a person to be happy to discuss their experiences with a lone male, if it was a male that subjected them to abuse – this would make them feel incredibly vulnerable again.

Articulate the Church's zero-tolerance policy about abuse by clergy and people in Church-related roles

The Church needs to acknowledge that the person abused their position of authority and that they therefore had no right to be in that position. Authority and hierarchy in any institution count for nothing when a person abuses. They become lower than the lowest in the hierarchy.

Victims and survivors need to know that those in authority don't believe silence to be the better option.

Express a strong indignation from the Church and that they will do all they can to bring about justice, healing and preventive measures. Not a hint of justification of criminals.

At this stage it's helpful to know the definitions of different offences as it labels the offence. Actually hearing the term 'indecent assault' etc. gives it weight. It is not called fondling or touching, it's assault. It helps to hear the definitions from the outset; the person committed a crime.

Explain that the police may need to be involved, that the person is the victim and that whatever the over-riding emotional response of the person is, e.g. shame or embarrassment, is a consequence of the abuse and not their fault.

Give overt assurance that the person is doing the right thing, that telling about the abuse or concern is welcomed, that the Church is grateful.

Guard confidentiality with great care

The Church must ensure the safety and anonymity of the complainant in the first instance.

Make sure it is kept confidential i.e. action is taken as appropriate but it is not gossiped about and the person's identity is not published to the congregation.

I've had two major breaches of confidentiality by NST and Lambeth for which they have not even yet properly apologised for.

Reassurance of 100% anonymity throughout.

Take what you are told seriously, report to statutory partners

Someone disclosing abuse or concerns needs to be believed no matter how unlikely the situation sounds. [Whatever it is] must be accepted and followed up,

not ignored and disbelieved

Acknowledge hearing the disclosure and let the person know that they are believed and their complaint will be treated seriously.

Take it seriously and follow a set process that has to be followed whenever abuse is disclosed, regardless of how serious the person being told thinks it is. Process and protection has to come before reputation of the C of E.

A non-judgmental attitude – listen and do not make assumptions.

Listen and hear, accept and investigate allegations with integrity and openness.

Victims and survivors need not to feel any sense of being judged, dismissed or fearful of the consequences to themselves or others.

Lay aside any assumptions about people who abuse

It is not uncommon for those perpetrating to appear most unlikely to be the sort of person who would do. This should be kept in mind. Abuse can happen to anyone, of any age, from any background or walk of life. The same is true of perpetrators.

Understand the continuing power to harm when a perpetrator is being faced with disclosure and the intense vulnerability and fear of repercussions of the victim

The vulnerability at this stage for me was immense and very unexpected.

Recognise the imbalance of power between the perpetrator and the victim.

The victim is likely to be terrified of reporting for fear of repercussion from the abuser.

Where the victim has been targeted by the abuser because of emotional vulnerability, the fear of character assassination is huge.

If the victim's home belongs to the C of E, and they are reporting abuse by clergy or someone in a Church-related role, the victim is extremely vulnerable.

Put the victim's safety and wellbeing before anything else; agree and provide immediate protection

Take immediate and effective action to avoid leaving the person in a dangerous situation – and keep them informed.

Assess the seriousness of the abuse and response that is appropriate.

Agree procedures to protect the victim from further abuse.

Acceptance and understanding of what makes them feel safe.

Do a wide-ranging risk assessment to ensure the survivor feels safe from harm, and safe in the process of disclosure and its consequences.

A safe house, food, emotional support.

Provide advocacy

Someone unequivocally on my side.

Provide a support person from outside the parish or the Church structure –

someone trained to recognise the issue of clergy behaving inappropriately and also telling lies.

Direct to MACSAS and other support agencies.

Be person-centred and enable the person to shape what immediate support is needed

Listen to what the person is saying they need to be supported.

Provide understanding, empathy and an ability to respond flexibly and appropriately.

Offer to provide support how they want it.

In non-recent abuse, talk through the consequences of any planned response for their life situation and relationships.

It is vital that whoever is the initial contact should have sufficient knowledge and training to be able to lead me and walk with me in the way that suits me, rather than in the path defined by their processes.

Agree with the survivor what actions can or will be taken, and the consequences.

Ask the person what they want to do about it, if anything, it might be that they want to share it, but are not ready to do anything about it at the moment e.g. going to the police.

The person must be supported, not pushed and the support must remain in place throughout and once the process is completed.

Provide pastoral care but encouragement towards possibly taking further action.

Talk about partners in long-term relationships

If they don't know about the abuse, what support does the person need in addressing the process of disclosure and consequences with their partner?

If the partners does know, what support does the person need to assess whether their partner's response has been supportive or if their vulnerability has been played on in anyway?

This is especially pertinent for non-recent abuse.

Be professional, organised and systematic from the off

Make notes of the meeting, a plan of action, time frames.

Make a recorded 'paper trail' of what happens next recorded for reference, including response to the person coming forward, even if no further action is taken. They then know it has been recorded for future links, to allow potential for patterns to be identified.

Give the person a clear path forward.

Act on the information in a timely manner – things in the Church seem to move at an extraordinarily slow pace.

Be clear that if police and/or social services have failed to investigate in the past, where necessary the Church will escalate their concerns within the

4.2 WHAT TO AVOID - WHEN INITIALLY TOLD

Don't insist on Church hierarchies

It's hard enough to make up your mind to talk to someone and to choose someone you trust, without being told they are not the right person ... And its particularly difficult to follow protocol when the abuser is local and/or well known to the people you might normally be expected to speak to e.g. parish priest.

Avoid sending the person round the houses

Don't tell the person they need to go to the diocese where the abuse took place.

Avoid expressing disbelief or judgment

E.g. 'I don't think X would do that', 'Really? Are you sure?'

The rejection of disbelief was something that I found to be hugely diminishing.

Avoid any semblance of judgment.

Avoid questioning and doubt to what is being said.

Avoid any expression that makes a judgment on what the person has endured or their reaction to it.

Avoid minimising the abuse

Avoid suggesting any abuse in minor. All abuse is a big issue for the victim.

Don't assume that clergy/accredited workers are above such behaviour

Avoid assuming that behaviour of someone known to be a 'maverick' is not dangerous or abusive

Don't make the person feel powerless

Avoid any insistence of 'how things need to be done'.

Don't speak to anyone else before checking it is appropriate and informing the person disclosing that this is what you are doing and why.

Do not insist that further action is taken (unless the situation overrides the person's wishes).

Avoid putting pressure on the person to report. The person must be supported not pushed.

Avoid putting pressures on the victim.

Avoid the person having to give the names of the perpetrator if they are not ready to.

Don't force the person to take action if they are not ready. BUT follow any

safeguarding advice that may override this.

Don't question survivors' behaviour; everyone reacts differently to be assaulted. Not everyone is ready to talk to the police (or someone else) straight away.

Avoid preconceptions, judgmental attitudes, attempts to 'resolve' simply – there are no easy answers!

Avoid waiting for the survivor to ask for help

I didn't know I had to ask for help; I presumed that if I disclosed abuse, help would be offered.'

Avoid victim blaming

Avoid the person being labelled and viewed suspiciously.

Avoid any suggestion that you are causing trouble by complaining.

Don't ask the victim to have ongoing contact with the perpetrator

Do not ask the victim to pray for the perpetrator

Don't fob a person off by telling them to arrange a meeting with you in a couple of weeks when you have no intention of doing so

Avoid lack of clarity

Avoid saying 'leave it with me' and then not being clear about the process.

Do not anoint the person or do a laying on of hands if they agree to pray

Do not assume that if they are not asking for help, that they do not need it

Avoid creating a sense of the victim being alone and unsupported

Do not panic, over-react or attempt to sort the situation

Instead refer/ sign-post to relevant expertise.

4.3 PARTICULAR CIRCUMSTANCES - WHEN INITIALLY TOLD

SPIRITUAL ABUSE

Support for the person who is reporting is especially pressing in cases of spiritual abuse as it is implied that you are 'not of God' / an evil person and disruptive of the Church's vision if you challenge an anointed vicar, called by God to his roll.

DANGEROUS OR 'OCCULT' SPIRITUAL PRACTICES. In this case, the victim may be, or be worried that they are, under serious spiritual danger

They may be seeking to get the issue taken seriously, understand what has happened to them in terms of occult issues and in general spirituality, understanding the relationship or boundaries between mental health and spiritual health; advice and support about being a survivor of abuse and how this might affect me and how best to cope!

WHEN A VULNERABLE PERSON IS BEFRIENDED BY CLERGY WITH THE GOAL OF CONVERTING THEM

This can constitute an abuse of power if the vulnerable person is abandoned when it becomes clear that conversion is not forthcoming. The abuse is exacerbated if the abandonment is then blamed on the person's mental health problems.

WHERE BREACHES OF CONFIDENTIALITY BY CLERGY IS PART OF THE ABUSE OF POWER BEING REPORTED

It is especially important to explain the next steps and to whom information would be shared before doing so.

WHERE 'LOWER LEVEL' CONCERNS ABOUT E.G. PATTERNS OF MINOR BULLYING BEHAVIOUR

It is vital to listen, treat the person as an adult, provide reassurance that they have done the right thing.

WHERE THE PERSON COMING FORWARD HAS PREVIOUSLY RAISED CONCERNS OR HAS 'A HISTORY' OF RELATIONSHIP BREAKDOWN WITH THE CHURCH

Take what is being said seriously, don't make assumptions and pass on to the relevant person for assessment of ongoing risks.

'It was openly conveyed that I was the problem, not the abusers. Therefore as the "victim" I was side-lined by the powerful, so Church engagement was limited, whilst the abuser continued as a fully paid-up member.'

Avoid reputational damage to someone sharing concerns, such that they struggle to find a new role in the Church.

IN SCATTERED RURAL COMMUNITIES

Maintaining confidentiality is not easy within the community and far harder within the Church where people in Church roles are few in number.

WHERE THE ABUSER IS AN INTEGRAL PLAYER IN NUMEROUS ASPECTS OF CHURCH LIFE IN THE LOCALITY WHERE THE SURVIVOR LIVES AND WORKS

Avoiding them and flashbacks is not simple to achieve.

ADULT SURVIVOR OF CHILDHOOD ABUSE

When you are that age you don't understand the damage done – just that something is wrong, so the desire as an adult was to be taken seriously and have some support to get over it.

NON-RECENT ABUSE

Avoid detailed questioning about exact age as it was many years ago – age ranges are easier

Avoid explaining away what happened or saying 'it was all a long time ago'.

WHERE PERSON DISCLOSING ABUSE IS CLERGY OR HAS CHURCH-RELATED ROLE

Protecting the person from harm may mean a job transfer.

CLERGY SPOUSE REPORTING DOMESTIC ABUSE.

The vulnerability of the person coming forward needs careful consideration because a clergy spouse may not be safe to return home if her husband finds out she has reported him. Children will be adversely affected if there is a sudden withdrawal from clergy housing and they may not be provided for financially.

ORDINANDS REPORTING TO TUTORS CONCERNS ABOUT ALLEGATIONS MADE BY OTHER STUDENTS ABOUT MEMBERS OF CLERGY AND SEXUALLY INAPPROPRIATE BEHAVIOUR

As a woman and an ordinand, reporting about clergy and reporting within the organisation can be especially challenging.

Their placement will need to be considered.

Seeking help for the clergy member may dissuade them from disclosing their own sexual assault.

CLERGY DEALING WITH THEIR OWN ABUSE IN CHILDHOOD BEING LINKED TO MARITAL BREAKDOWN.

If the marital breakdown is treated as a disciplinary matter, in effect the clergy survivor is then being punished for being an abuse victim.

CLERGY REPORTING RACIST ABUSE

For an ethnic minority clergy, it is very difficult to accuse another member of a local church of racism, especially if one of the perpetrators works for the diocese (though not clergy is a senior official) – it becomes a question of one person's word against another. Secondly, it's very hard to prove racism as the racist abuser can say that they did not intend abuse by their words. Thirdly, if an ethnic minority

clergy has a senior member of his senior local church leadership who he suspects as racist, it is very hard to take it up with archdeacons and bishops.

ORDINANDS WITH MENTAL HEALTH PROBLEMS

They need to be supported to continue to follow the advice of MH professionals and the medication/therapy regime that keeps the person well. They should NOT be told not to go through with ordination until off all medication as this creates a lot of pressure on the person to get off and stay off their medication which may not be advisable or realistic.

5 STAGE 3. THROUGHOUT THE PROCESSES THAT FOLLOW

5.1 WHAT'S IMPORTANT - THROUGHOUT THE PROCESSES THAT FOLLOW

Remember reporting abuse is extremely stressful; keep in touch with updates on an agreed and regular basis

Being kept up to date at every stage is vital.

Appreciate how challenging the ongoing process is for someone unfamiliar to it

Provide regular updates. Clarity of process. Clarity of outcomes and decisions.

Keep communicating even if processes take longer than expected. At least an email every couple of weeks to say 'no news yet. This is the stage we are at. This is when you'll next hear more'.

Improve the clarity of information flow. I recently discovered that Ecclesiastical insurance pursues the perpetrator for contribution. This is not ideal to learn. We should know the process from the outset.

Somebody from the diocese needs to be in regular contact throughout a police investigation. And the victim should be kept informed at all times.

I felt in the dark at times as to what was happening in the process and I had to chase up to find out what was happening. I don't feel I was contacted by the support person very frequently. I feel I only survived the CDM process with the support of my family and close friends. I was a very stressful and difficult time.

The process is confusing to someone with no experience of legal proceedings or this sort of process. It was also overwhelming given the nature of the complaint and the distress it has caused.

If the person coming forward is told that the issue is being dealt with on behalf of others, have a clear progress reports – who is informed by whom in what timescales?

Provide early confirmation to the survivor about what has happened as a result of their report e.g. if the abuser has been cautioned by police, or removed from any active by the Church.

Involve the discloser throughout the process as, even if these allegations are untrue, this highlights vulnerability and the need for support of another form.

Reassure the victim that the care of others is deemed important and immediately suspend the alleged perpetrator

A key concern of the victim is the safety of others and the impact of the disclosure on other victims.

'Throughout the process the emphasis was on my wellbeing, to the extent that the need to protect other people, the safety of anyone coming into contact with the priest in the present or future, was given minimal significance. This really worried me and continues to worry me that nobody seemed to be concerned about this.'

If you down-grade or minimise the concern, you leave others at risk.

Remove the person immediately from public positions so do not pose a risk to anyone else.

If there is a known accusation then the perpetrator should be removed from public positions such as church warden and communion assistant.

The perpetrator should be immediately suspended in order that they don't pose a threat to anyone else.

'He didn't just abuse me and I didn't report the abuse for just myself. I reported it to stop him doing it to me anymore, to stop him doing it to the others and to prevent him from doing it to anyone else.'

'I was also reluctant to seek help via the Church, because people had repeatedly suggested that I seek counselling, as if this would make everything ok. Given that my main worry was whether other people were protected, no amount of counselling for me what going to fix this.'

Act on evidence to safeguard adequately.

Consider more seriously the possible risk to others when abuse by clergy has been reported; take sexual assault by clergy seriously whenever it occurred.

Take the duty of care to victim very seriously; treat them as you would your own son, daughter, family member

Be willing to listen and listen again if necessary

Keep checking if the person is ok and keep asking their opinion.

Provide gentleness and patience. Be aware of the difference between head knowledge and heart knowledge in the survivor.

Give prompt responses if the victim contacts the Church

Believe, support and care for the person.

Provide assurance the person will be kept safe.

The Church needs to respond in love. It's all about Jesus and people, not policy and procedure. The NST needs to be seen as part of the body of Christ not just part of the institution of the Church.

Provide continuity of care if the person moves house or area.

Provide sensitive communication and emotional support.

Explain, explain, explain

Ensure there are no grey areas. The victim should have the process clearly explained to them and also the penalty for the abuser. Take into account the distress of the victim. They may not be able to process everything all immediately. Answer questions clearly and directly and don't side-step questions.

Communicate to give clarity AND compassion

Be sensitive, appreciative of impact, supportive, responsive.

Communication should not be just factual but should recognise how the news might make the person feel, and check if they need support.

I needed compassion, time, empathy, consistency from the DSA – when told I would be phoned she never rang. Make sure arrangements are followed up.

Be person-centred

Treat each person as an individual and give a person-centred response.

Always consult the survivor regarding actions, processes and explain consequences and who will know about what they have disclosed.

Within the requirements of law and policy, the Church's response needs to be a bespoke response to each individual and circumstances.

Protect the victim from having to be in the vicinity of the abuser; take measures to avoid that happening

Recognise the duty of care to the community; enable them to believe the victim

[Help people] be aware that perpetrators of abuse can appear decent and respectable people. Abusers can seek to obtain positions in order to have easy access to potential victims. In my experience, people will give statements to the police saying that the abuser would not behave like that, even when they were not a witness and don't know what happened. People don't seem to recognise, just because a person appears good and respectable, that they may be hiding their true nature.

Thought needs to be given to what the parishioners are to be told about what is happening. How they are told needs to be true but not necessarily comprehensive. How this case is handled could influence whether or not another person discloses information currently or in future.

Remove the stigma and taboo associated with abuse in the church congregations by careful use of language and training so that more people understand that a survivor's view of the world is different from theirs but that they are no less valuable. Survivors are part of diversity.

ADVOCACY AND SUPPORT

Provide advocacy and support via a named contact

Make sure the victim is allocated one, named, point of contact/supporter in the Church, who they can access easily and directly, who is adequately trained, qualified and supervised and who is not a potential witness in the case. That person should then be responsible for ensuring that the victim is communicated with appropriately and regularly by the Church. This is a long-term commitment, so the named contact / supporter should be committed to this. That person can find out about and feedback to the victim on any issues the victim should be updated on and help the victim access further support from the Church and other agencies

if they wish.

Give support role clarity of function and boundaries

Support roles needs to be carefully spelt out and have agreed boundaries for safety of all concerned, and so any important information is not wrongly attributed.

Provide a specialist team of people to support victims going through the investigation process

PROFESSIONAL, EFFECTIVE AND FAIR SYSTEMS

Work actively to minimise biases that disadvantage the victim

Churches are often tightly knit social networks. This can make it difficult for victims to get justice, especially if victims are new to the area and/or if victims are single or their family members do not attend church.

Be impartial. Be aware that wrongdoers will (more likely than not) be trying to cover up their own behaviour and trying to make victims look bad.

Police your own biases: the Church tends to favour people who have many years of service in that church, even if the individual has been using their church roles to gain access to victims and to gain the good reputation that makes them appear to be trustworthy (even though they are not).

Make explicit any potentially prejudicial / discriminatory views – e.g. that married men are more trustworthy than single, childless women, particularly if they have any with health/ mental health conditions.

Match what is assured on initial disclosure with what is actually delivered in follow up

Seek to respect and help the survivor over and above protecting the reputation of the Church

To keep the person sharing the concern paramount and first consideration when progressing matters.

Listen to victims, don't be so defensive and just seek to minimise damage to the Church.

Support the survivor by calling out the abuser. The Church has a responsibility for justice.

Have a fair and balanced process

I was given no right of reply to the vile and untrue statements written about me in the perpetrators response to my complaint.

I was very upset to find out the CDM had taken the form of a 1:1 meeting with the Bishop and was confidential. ... is it not usual in any disciplinary hearing in any place of employment to have at least two people representing the management (and of course the 'defendant' able to bring a supporter)? I had assumed that after a formal hearing, I would have been made party to most of the detail and certainly anything relating directly to my specific allegations.

All questions much be asked and answered

Why was the abuser not checked if their behaviour was known about

Deal with the reports swiftly

It took five months for the chair of the tribunal to decide that the case has been deemed 'out of date' because the attempted rape occurred over a year ago; this is unacceptable.

Action needs to be swift and effective. They need to be kept safe, they need to feel they have been believed.

Achieve a parity of support and protection between survivor and the accused person and transparency about this**Maintain confidentiality**

Anonymity

Create organisational memory through record keeping

Keep records that can be passed on when necessary, so that whoever engages with the survivor has an accurate story of the Church's response to date and any conditions set by the survivor. This will avoid the survivor feeling let down that their input has not been passed on, and avoid initial meetings with new staff getting off to bad starts.

Recognise the relationships established between survivors and people in national safeguarding roles in anticipating staff turnover

'I felt very upset and angry that once again someone who seemed both professional and concerned for me, had left me with no information for months and then passed me on to yet another stranger, with no opportunity to discuss what would happen with aspects of my case that were still with her, no apology, and apparently no concern that I might find this upsetting.'

An appeals process for somebody who is not clergy, through which to bring the case to an independent body to review the response to the disclosure

Under the Clergy Discipline Measure, the respondent can appeal but the complainant cannot. This is therefore not fair to both parties but is balanced in favour of the clergy.

At the conclusion of the CDM I was left feeling that after 10 years (since the original distressing events) and a great deal of courage and emotional stress on my part, I was: no nearer to gaining an understanding of what had happened to me; no nearer feeling reassured that others would not be at risk from this priest; and no nearer getting any meaningful support for myself as victim.

HELP AND REDRESS

Provide timely access to support

It is important to get that person ALL the help they need – if agreed by them.

e.g. Make sure the victim is able to access support from the Church (if they wish) and independent support (if they wish). Bear in mind that a lot of services are underfunded so there may be a waiting list for the victim to access external support services and they may not be able to get through on helplines. While they are waiting to access support services the Church should make sure that they provide suitably trained support workers themselves.

In length criminal investigations and court processes consider what kinds of trauma therapy can be made available to victims, that will not affect the legal process.

Provide a safe place for them to express their pain.

Provide counselling and pastoral support.

Have workable, flexible structures e.g. a central fund which people can access to pay for counselling, travel expenses etc.

I was told to go the diocese where the abuse took place; that doesn't work for me.

Provide clear information about what a victim's options are

e.g. links between financial claims, police investigations, going to court

Information needs to be available on what the victims options are e.g. I can't make a financial claim because the police have done an investigation and are waiting for me to decide if I want to make a statement. If I went to court, different outcome for compensation may exist. I just need money to get on with my life.

Enable people to access compensation

Provide clarity about the option to claim compensation and a caring and empathetic responses in relation to any such claims.

Quick settlement of claims.

Address spiritual needs where this is sought

With hindsight I would have liked someone to walk the journey with me, to bring healing and unpack the 'spiritual issues'. This is not counselling.

Offer a wide variety of types of service, including opportunities to pray without words, silence, privacy or sharing.

If someone requests Christian support, someone to talk to about theological and spiritual issues and to pray with, it's important that it happens, instead of provision that is completely inadequate. If the provision requested cannot be found, other provision needs to be sought.

Sign-post to whom the person who has shared allegations can speak to or go to for their ongoing spiritual needs to be met.

I disclosed because I had an encounter with God and experienced His love for the

first time. The spiritual needs have never to this day been met. I have had to seek this help myself.

It was helpful to meeting with the Bishop but I am surprised he didn't offer to pray for me at the end of the meeting. I wouldn't have been offended and it would have helped, even if I had said no.

AROUND THE EDGES OF THESE PROCESSES

Supportive clergy

Having supportive clergy as friend or champion has been very helpful to me.

Fellow Christians/ Church goers

Show you are there for the victim even if not allowed to talk about what happened until the criminal justice process is completed; spend time talking about other things and help with practical things like appointments.

Keep an eye on them. It is probably the most difficult thing they have faced up to and it may affect the rest of their lives and their family/friends relationships.

AT THE END OF RESULTING PROCESSES

Have effective discipline of clergy offenders, however senior

Talk openly and at all levels about the abusive behaviour of the abuser

Survivors have no choice but to remember the good and bad about the abuser. If the Church is to take responding well seriously, they have to do the same.

Provide transparency of outcomes

Share the risk assessment and what safety measures are in place with the victim so they can believe others are safe.

Provide reassurance that the person is not able to work with children.

Victims should be told whether the perpetrator has been charged for offences against them, and what the outcome is of the criminal case, and how are future people being protected from him/her – not left wondering.

Keep survivors up to speed about decision-making within the Church follow successful criminal convictions i.e. that the perpetrator, having been imprisoned for abuse, will be barred from ministry for life, and that this will be communicated to others.

Publish the Archbishop's list, like other institutions publish results of disciplinary procedures.

Check if the victim wants to know anything about how the perpetrator / alleged offender is responding. E.g if the perpetrator is given support to get to a place of remorse. Does he want to seek forgiveness from God or me? Is he given the opportunity to write a letter? NB. Be aware of the risk that telling the survivor that the perpetrator is asking for forgiveness this can make it appear that the Church is siding with the perpetrator and/or minimising the impact of the abuse on the victim.

Keep the person informed, and keep checking where they are at in the proceedings, including any final end conclusions i.e. 'case closed'. This is to stop it 'hanging over someone's head' for years, if that is not helpful to them.

Give a personal apology from the relevant diocesan bishop to the survivor(s) of clergy or Church-related abuse, as promptly as possible at the conclusion of an investigation/ trial

Offering apologies via press statements alone, without following up with anything personal, feels like it is about protecting the Church's reputation rather than an actual apology.

Tell the truth in press releases

5.2 WHAT TO AVOID – THROUGHOUT THE PROCESSES THAT FOLLOW

Don't respond in fear and defensiveness

Recognise the Church is like any other institution where abuse happens.

Avoid being bureaucratic and impersonal

Don't be afraid of the victim. They are the expert in what has happened and you need them.

Avoid hiding behind process and not getting personal.

Avoid responding formally to victim in response to complaint via CDM, without anything personal.

Avoid passing the survivor along the pathway – pass the disclosure along

They passed me around and made me redisclose at every stage of the safeguarding procedure.

Avoid exposing the victim to more abuse by increasing the power of the abuser

I was left under the power of the abuser again – the power to ratify my disclosure was given to him and effectively left with him for five weeks. The impact on my mental health and wellbeing was almost catastrophic. I had no idea whether he would try to contact me or my parents (they were friends), whether he would turn up at my house in a rage, whether he admitted anything, whether he wanted to apologise. Nothing.

Avoid leaving the clergy to practise during the process of investigating and allegation of abuse. This gives the impression that he is 'getting away with it' and risks giving further confidence to the abuser.

Do not gossip

Avoid gossiping about victims.

Avoid being abusive to the person who has come forward

Avoid yelling at victims.

They have been belittling, condescending and extremely difficult to deal with. Every time you talk about the abuse, they butt in with words like 'alleged abuse' and this despite my abuser being in prison.

Avoid Church community and senior staff seen to surround and protect the abuser

Avoid ecclesiastical pulling together to cover up.

Avoid loss of control of the process for the survivor

Only the survivor knows what they can bear and what they fear.

Avoid victim blaming

Avoid every suggestion that the victim is in any way to blame.

Gossiping, shaming, blaming, treating us like we have nothing to offer, treating us like we are untrustworthy.

Don't cause the person to feel they are a trouble maker or a nuisance

A message came back: tell her she mustn't go running around bothering Bishops and Archdeacons all over the place; they are busy people in senior positions.

I was left feeling that my welfare was not her main concern at this meeting – but to get this matter wrapped up, and for the Church to be caused no further trouble or expense.

Avoid discussing the victim and having meetings about them without their involvement or their trusted representative

I've been told I can't know who sits on the Core Group, let alone join.

Avoid losing sight of the survivor's interests

I felt the DSA had their own agenda of a file review not my interests at heart at all. As long as the Church is its own custodian of safeguarding then it will, in my view, tend to appear to put its own needs first.

Avoid a lack of resources inhibiting the support available for victims who come forward**Don't leave the victim to chase for updates**

Long periods with no contact creates anxiety.

Long delays of apparent inaction – even an 'inquiries continuing' message can be reassurance that it isn't being ignored.

Don't simply leave the complainant to provide proof

Avoid the requirement to provide a signed statement and a warning that they may have to give evidence in court

Avoid normalising or minimalising the abuse

Don't say things like 'I'm not taking sides. It's so sad that you had to go through but I'm not taking sides'.

Avoid using assumptions about gender/sexuality as a basis for not responding to concerns shared

I was advised that I needed prayer ministry to be healed of my problem with men.

Don't not answered when the victim is seeking help

Avoid long delays, stone-walling, lies, obfuscation ... hoping the survivor will go away

Silence, blanking, not acknowledging emails or messages, protection the Church with no concern for facts.

Don't blank victims, they are your greatest resource.

Avoid complacency, indifference, lack of information and the person making the complaint feeling unsupported or not kept informed.

Avoid independent Health Assessment, that is part of Civil Claims Process, being shared with perpetrator

It was like handing power and control back to the abuser.

Avoid conveying findings of investigations in a casual manner, in inappropriate settings

Don't leave the survivors feeling ignored after the horrors of a trial

5.3 PARTICULAR SITUATIONS TO BE RECOGNISED – THROUGHOUT THE PROCESSES THAT FOLLOW

WHERE THE PERSON DISCLOSING IS A CHURCH EMPLOYEE, SHARING CONCERNS ABOUT A MEMBER OF CLERGY WHO IS ALSO THEIR MANAGER

Replacement line management needs to be sought, arranged by the PCC, even someone from a neighbouring church.

WHERE A CONCERN IS RAISED IN A PARISH LEVEL AND THE PARISH SAFEGUARDING OFFICER IS A NAMED LAY PERSON

How can they have adequate access to what is going on with clergy, other staff, PCC etc.?

CLERGY SPOUSES IN SITUATIONS OF DOMESTIC ABUSE

Avoid allowing the member of clergy to tell his/her story while the spouse is told by the Church hierarchy to say nothing.

The clergy person should be suspended immediately otherwise he has the opportunity to influence and manipulate other people to support him. Suspension should mean not being allowed to meet with colleagues especially those lower down the hierarchy who are answerable to him.

Where a clergy spouse leaves the matrimonial home after disclosing domestic abuse, the Church should visit to make sure they are where the clergy person has reported them to be and that they are safe and well.

Anonymity and confidentiality need to be addressed – clergy spouses are particularly vulnerable to gossip and interest. They need to be given some level of protection and advice.

CHORISTERS

Choristers need special policies for making complaints against cathedral and music staff, and should not be put through adult cathedral procedures

PAST CASE REVIEWS

It is important to provide validation of impact, pain and suffering from the past and support to deal with the re-opening of the past which can be experienced as re-abuse.

Don't oversimplify the outcome i.e. assume this resurrection of the abuse will be healing. Recognise impact is far-reaching as the abuse was never resolved adequately. The original abuse and betrayal by Church not accepting allegations had to be buried for any future to lived. This 'exhumation' will not only be resurrecting past abuse but also calling into question present as it has had to accommodate the 'skeleton'. The 'clean up' act has, in fact, served to open up all my old wounds and served to dump the responsibility back in my lap to act/deal with the fear of others suffering / manage with my own unrealised vocation etc. etc. – all with the goal of 'looking good' that the organisation is cleaning up its act! At whose expense is my question. The resurrection of issues which then creates a vacuum – this experience can seem like re-abuse and should be avoided.

6 STAGE 4. GRIEVANCES AND COMPLAINTS

6.1 WHAT'S IMPORTANT - GRIEVANCES AND COMPLAINTS

Listen

Find out what has gone wrong, listen, answer in truth not fear.

Key is to clarify what has happened if known and what the person wished to happen that seemed inadequate.

Key questions must be answered with urgency and thoroughness

e.g. If many people knew of the abuse, how did the abuser go unchecked?

e.g. The Church has totally failed to explain how [key figures] failed to investigate when the first whistleblower came forward ... A single phone call [to any of a number of individuals] would have revealed everything subsequently uncovered They simply showed no interest or concern.

Aim to meet current needs

Listen, apologise, respond to emails, most importantly ask the person what they need and fulfil if at all possible.

The Church needs to respond in love. It's all about Jesus, not policies and procedures.

Accept what the survivor says, empathise with how it made them feel. Do not challenge their view or impact. Aim to meet their current needs.

Proactively offer counselling and/or pastoral support.

Provide assurance that it is not a waste of time to challenge

Have an effective structure for complaints against bishops

Deal with complaints about historic and current abuse with the same importance and with the same seriousness

A professional and independent service

The Church needs to look honestly at its own behaviour and not cover up the cover-up

Positive judgements from courts of law should be accepted without question as evidence e.g. findings from divorce courts on threats to kill and physical abuse proven.

Penalties need to be consistent across diocese. Currently a bishop in one diocese can hand out a completely different penalty to a bishop in another diocese, for the same offence.

Honesty about where power in the Church lies and where change is possible

Have a person who solely represents survivors

Members of clergy should be asked to step aside during the investigation of complaints

Overt acceptance and institutional repentance

Say sorry and work with the victim to identify what needs changing to avoid the same things happening to others in the future.

Acknowledge mistakes, admit shortfalls in best practice and be open, honest and transparent to the person about past failures and responses.

Apology, evidence of how things have changed, openness and transparency about new processes to avoid future recurrences of abuse and clarity about how those affected can be supported and still feel part of the Church community – if they wish

6.2 WHAT TO AVOID - GRIEVANCES AND COMPLAINTS

Avoid telling the person sharing information about poor handling of previous attempts to share concerns, that they need to forgive, receive 'healing' and move on

Avoid a tardy response to serious issues

e.g. Knowledge that confidential information in Independent Health Assessment of victim/survivor, that is required as part of civil claims process, has been shared with the abuser.

Avoid rehashing of defensive, unresponsive and untimely progress

Not responding.

Further lack of response or simply repeating the same things.

Don't say 'it was different back then', that simply doesn't help. Acknowledge the response was wrong, and we are sorting it, is a better message to hear.

Avoid taking an adversarial approach just because of the potential liability concerns that may be present

Avoid shutting down communication and cutting off support when a complaint process starts

Avoid isolating and victimising the survivor/victim in complaints process

Circling of the wagons so the Church looks after its own and complainant is left out of discussions and made to feel in the wrong.

It ends up replicating behaviour of the abuser – silencing, isolating, making the person feel unimportant, hurt, dismissing the person.

Avoid telling survivors/victims that a complaints procedure does not exist

Avoid leaving the person not knowing what is happening behind the scenes

Too many legal loop holes

e.g. saying the event must have occurred in the past two years.

Avoid reference to the status of the alleged abuser

I was reminded to 'remember the high-profile nature of his position. This was like re-living the original experience, implying that his role put him above and beyond the possibility of such misdemeanour.

6.3 PARTICULAR CIRCUMSTANCES THAT NEEDS SPECIAL CONSIDERATION - GRIEVANCES AND COMPLAINTS

WHERE BISHOPS AND ARCHBISHOPS ARE INVOLVED OPTIMISE OPENNESS AND TRANSPARENCY

By a Bishop's own admission at IICSA, the Church assumes clergy are right. As the Peter Ball case proved years ago, this is even more true once Bishops and Archbishops are involved. The current two Archbishops and the previous two Archbishops of Canterbury have all failed to be open about major safeguarding failures.

7 STAGE 5. AFTER PROCESSES HAVE ENDED

7.1 WHAT'S IMPORTANT - AFTER PROCESSES HAVE ENDED

LONG-TERM CONTACT, SUPPORT AND REDRESS

Accept the long-term impact of the abuse remains long after the process is finished and provide accessible emotional and pastoral care and support for as long as the survivor/victim needs it

Little triggers can occur from time to time ... having a permanent contact to whom one can go to air those feelings would be valuable whether it's 5, 10, 40 or more years after the abuse.

Provide ongoing support if needed and advice and guidance on managing fall-out for wider circle, e.g. family members.

A framework for ongoing support and care – 'after care' because long after the case is dealt with the victim remains damaged.

Be victim/survivor-centric and willing to provide support, even if it is many years afterwards.

Discretion, support, understanding, it can take a very long time to come to terms with what has happened and often, to sort the practicalities that have resulted. The effects can and often are psychological, emotional, physical, financial and so on. The person may have lost trust, especially if they have not been taken seriously before or by other agencies. They may be dealing with the impact of not being taken seriously on top of the original abuse.

Keep doors open; don't forget them. Welcome contact from a survivor

Being available if the survivor needs to keep in touch.

Say 'If you ever need to talk further, we are here".'

Don't forget them because the damage lasts a lifetime, the distress does not stop just because the process is over. Keep in touch to see how they are getting on / coping.

Include options of Christian support, availability of prayer and healing

Someone to talk to about theological and spiritual issues, to pray with.

Have appropriate support in place for healing and spiritual growth.

Secular professional resources like counselling can repair the individual but the Church nationally needs to identify the places where real spiritual healing can take place and make those resources available to victims free of charge. The place an individual is sent needs to be appropriate for where they are spiritually and the nature of their practice of the Christian faith.

Be trauma-informed

Talk to the survivor/victim about how Church can be a safe space for them; identify together triggers; be sensitive to language and potential triggers.

Explore options including 'healing of the memories'.

If the survivor of abuse moves to a new church / congregation be led by them as to how best to continue to support them in the early days and over time – identifying a new support person and passing on information about what happened, or their existing supporter continuing to provide support

Even though it's not their fault, some may not want the stigma of abuse to follow them so may not want others to know. Some may need pastoral support so it might be important for the new priest to know. It needs to be handled with care and sensitivity. The victim may be fearful of judgment and victim blaming. They may be worried about being seen as a trouble maker. The Church needs to support and reassure victims if they do move, but it does require them to have someone in the know, to oversee their move.

Make sure the person knows where to seek support if need be.

Ensure that financial responsibility travels if a survivor moves diocese

I have lost Church financial support for therapy since moving to a new diocese.

Provide publicity and awareness about the possibility for survivors to provide support to other victims**Gentleness and patience**

A willingness to go with what the survivor can offer at any time – despite a confusing ebb and flow.

Meaningful support networks

There don't appear to be any.

Maintain confidentiality

Anonymity is key.

If the support came from an independent source then 'the Church' in the local sense need never know. Why is it their business?

Recognise that victims/survivors are not defined solely by the awful behaviour of someone else

Victims/survivors have a lot to offer, including spiritual gifts for the building up of the Church; some victims/survivors have a calling to ministry.

SAFETY FOR SELF AND OTHERS**Ascertain what is needed to keep the person safe and keep it in place**

E.g. Details like not disclosing somebody's address or contact details. Even writing their address on a magazine or envelope at the back of the church can put

someone in potential danger.

Concrete assurances of full and adequate risk assessments and safety plans around the abuser

If a member of clergy is being given a 'fresh start' in a new congregation, the victim of their past abuse needs to know that systems are in place to enable early detection of any patterns emerging e.g. any female employees are given external support from someone who has been fully briefed on what to look out for, to allow rapid response if the same behaviours exhibited in the new context.

Reassurance and information to confirm that if they move to a new parish, the new parish will have processes in place to ensure the risk to others is known and managed.

Decide with the survivor what, if any, ongoing information about the perpetrator they want and what is legally possible e.g. to be informed if they move church

I was told to have nothing to do with the perpetrator. This meant I did not know his location so chose to stay in the location where the abuse took place as I knew he wouldn't come back here. This is a very poor response and there must be an alternative to encourage and enable people to flourish and not live in fear.

ORGANISATIONAL LEARNING AND IMPROVEMENT

Talk about the abusers, the abuse they perpetrated and give overt demonstration that the Church has learnt from the survivor/victim's abuse, about grooming and common behaviours of particular types of abuser

I need to hear that the Church recognises and understands this type of manipulative and cruel behaviour and acknowledges the lasting damage it does.

Make clear what the abuser did, how he groomed and how you as a diocese have learned from this.

Demonstrate that past mistakes however long ago are not forgotten

It's important to hear that the processes are improving and that the leaders are genuinely focused on not resting until not a single person is ever abused, and every victim is helped.

Provide evidence of the Church acting on the evidence provided and tracking over the following months/years to monitor impact.

Overt demonstration of preventative work being done routinely as a consequence

E.g. 'Established members of the Church with any role should be reassessed for their suitability to that role, so that methods of control that a perpetrator has established are revealed or challenged'.

7.2 WHAT TO AVOID – AFTER PROCESSES HAVE ENDED

Avoid ending contact, communication, support and financial support once the case is closed for whatever reason – financial settlement, death of perpetrator, criminal case not progressed

This risks leaving the survivor feeling abandoned – that the Church has ticked a box and the matter is closed and the individual no longer has any voice or anywhere to go.

People shouldn't feel that the Church has filed them as 'done'.

Avoid thinking that now it is all over, they are ok.

Avoid silencing the victim

'The member of clergy admitted the abuse, lost his job and I received a letter through the post, thanking me for my help and told me not to tell anyone.'

'I expected empathy, non-judgmental response and everything out in the open so the clergy can have the skills to pastorally steer the victim/s and congregation to healing. I am still silenced.'

Avoid pretending nothing has happened

Avoid offers of support e.g. counselling that are unworkable due to distances, child care and other responsibilities

Avoid distinguishing the Church from the abuser

I've been told by a senior clergy person that it wasn't the Church that abused, it was the man. And that made me feel like the whole thing that happened to me didn't matter.

Avoid self-justification and defensiveness

Never seem to be protecting your own. Abusers should not be protected. God is the judge of all.

Avoid being prescriptive about recovery or make assumptions about impact

Don't expect victims to behave in a certain way or recover in a coherent rational fashion – we are not robots.

That recovery can and does happen, is individual to each person and their circumstances, that people may or may not have a continuing need to talk about what happened, about their progress or be ready to leave it in the past and feel their life is safe and in their own control once more.

Avoid making any assumptions about the person or the impact the abuse has had on them.

Don't break confidentiality

Avoid the person being identified in any way.

Avoid dominance

If the person who has shared concerns moves to a new church, don't send a message that the person is a trouble maker, to be watched carefully etc.

7.3 PARTICULAR SITUATIONS TO BE RECOGNISED

HOUSING OF CLERGY SPOUSES WHO HAVE BEEN ABUSED.
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Their living standards should not be lower than those of the former spouse who keeps his job and his home.
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8 SYSTEMIC ISSUES FOR THE CHURCH TO CONSIDER

8.1 INTRODUCTION

In addition to the programme of independent diocesan safeguarding audits, SCIE conducted further work aimed at supporting the Church to improve responses to abuse survivors and others who turn to the Church about safeguarding issues. The aim was to engage with people with first-hand experience of Church safeguarding responses in order to better understand their views of how people in the Church should respond. We also wanted to contextualise that input with Diocesan Safeguarding Advisers' (DSAs) reflections on their own work – what is working well, and areas they feel they are struggling with in engaging directly with people who come forward. The work was designed to complement and supplement learning from the diocesan safeguarding audits, which did not involve direct engagement with people with first-hand experience of a Church safeguarding response.

In the preceding sections of Part Two of this report, we have presented themes from the survey that highlight features of good practice from the perspective of people with experience of coming forward. In this concluding section, we turn to the question of whether there are any identifiable barriers and enablers to achieving those features of good practice. The survey itself does not provide this data. We have used the understanding of diocesan safeguarding requirements, arrangements and practice that has been generated through the diocesan audit programme, to identify systemic issues that will make it harder for the Church to achieve the features of good practice that abuse survivors and others have identified through the survey.

8.1.1 Posing questions for consideration

Analysis of the survey results has indeed put aspects of national Church safeguarding arrangements in a different light, that did not emerge through the diocesan audits, and do not therefore feature in the systemic issues drawn out in the overview report that forms Part One of this document. Conversely, we feel better able to understand these issues, with the understanding that we have garnered from the audits themselves. In this section, we draw out those additional systemic issues to those we identified from the diocesan audits and have captured in Part One of this report. Where possible, we draw out the extent to which these systemic issues are ones that DSAs are already alert to.

In line with the SCIE's Learning Together methodology, we do not make concrete recommendations but instead pose questions to help the Church decide how best to address the findings presented. This creates the opportunity for the Church to engage survivors of abuse and others in what the best solutions might be and generate ownership within the Church of the strategies and actions agreed.

8.1.2 Summary of systemic issues

This section therefore raises issues that will make it harder to achieve the good practice identified by survey participants. Some are not new, and so reasonably predictable, such as the lack for a national framework for long-term support and redress (e.g. Finding 5). Some are practical and reasonably straightforward to address, such as gaps in national guidance that the diocesan audits (e.g. Finding 3), with less data about the experiences and perspectives of abuse survivors, could not have identified and indeed, did not raise. Others touch social and cultural issues

about the narratives the Church tells, and the kind of public discourse the Church fosters and promotes – about the Church’s safeguarding journey (e.g. Finding 8), about abusers in Church contexts (e.g. Finding 7), about being personally open about getting things wrong (e.g. Finding 6). In relation to these, we raise challenges about the kind of leadership that is needed.

Given the experience of participants in the survey, it is not surprising that the findings relate predominantly to responding to survivors of abuse by clergy or people in Church-related roles, and those who come forward to share concerns about unsafe practices or people within the Church.

This section does not repeat all the themes identified in the survey material.

A summary of the findings are presented in the table below:

	Category	Area	Finding
1.	Leadership and culture	Valuing the service of abuse survivors – creating accurate histories of the Church’s safeguarding journey	Public narratives the Church tells about its own safeguarding journey of improvement do not adequately recognise the contributions of survivors of Church-related abuse. This makes it less likely that good practice is achieved in recognising people disclosing abuse and sharing concerns as playing a valuable service to the Church.
2.	Leadership and culture	An open learning culture – talking about known abusers in Church contexts	Currently stories of people who have abused in Church contexts are used as case studies in safeguarding training. It is far less common to bring real life tales into a broader public sphere, at parish, diocesan or national level. This increases the chances of causing further distress to survivors who do not see the reality they have to live with reflected by others. It also makes it harder to create the right conditions for a safe Church that is appropriately vigilant about abuse and feels trustworthy for anyone thinking of coming forward.
3.	Leadership and culture	An open, learning culture – personally holding your hands up to past failures	A lack of role models and leadership about how to hold your hands up to personal mistakes in responding to disclosures of abuse or safeguarding concerns, makes it more likely that people who come forward to flag up mistakes in the past will experience defensive responses when they raise poor past responses by people in the Church.

4.	Quality of service provision	Support and redress – a long-term framework	The impact of abuse by clergy and people in Church-related roles is often profound and lasts a lifetime, emerging and fading at different times over decades. This is not matched by current thinking and provision of support by the Church.
5.	Policy and practice guidance	Person-centred responses – an abuse survivor audience	Abuse survivors and people who come forward to share safeguarding concerns are currently only addressed indirectly in House of Bishops' policy and practice guidance. What exactly the Church has committed to, in terms of its response, is not therefore clear or accessible either to abuse survivors themselves or those responsible for implementing policy.
6.	Policy and practice guidance	Person-centred responses – the golden thread	Recent revisions to policy and practice guidance include specification of what is required in responding to abuse survivors and people who come forward to share safeguarding concerns. They do not yet constitute a strong golden thread about keeping the person who has come forward at the heart of everything, limiting how specific or helpful they are to people in Church roles who are trying to respond well.
7.	Policy and practice guidance	Person-centred responses – allegations management	Church processes for allegations management do not currently support a person-centred approach, keeping the survivor of abuse, or person who has come forward to share safeguarding concerns, central to Church responses to disclosures of abuse or hazardous people or practices.
8.	Quality of service provision	Support and redress – support vs advocacy	The requirement to offer everyone who comes forward a Support Person is a positive development. The specification of role does not yet convey the Church's positive valuing of the person coming forward, or reflect a clear commitment to keeping the abuse survivor at the heart of all Church safeguarding processes.
9.	Quality assurance	Seeking routine feedback including	There is not a requirement to routinely seek feedback from people who have received a safeguarding response, nor a

		complaints	common culture of proactively identifying complaints about the safeguarding service. This lessens the chances of understanding where improvements are needed at diocesan or national level and increases risks of leaving people suffering, with little hope of resolution.
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8.2 TELLING DIFFICULT STORIES ABOUT ABUSERS AND ABUSE (LEADERSHIP AND CULTURE)

Input via the survey highlights the need, from the perspective of survivors, to talk about people known to have abused in Church contexts, once criminal or other processes are complete: who they were and their abusive behavior, how they groomed individuals and communities.

To do so supports good practice at the initial and final stages of engagement of our framework as identified in the survey: Stage One, making it easier to tell someone and Stage Five, longer-term support.

In Stage Five, once formal processes are completed, good practice from the perspective of some survivors, involves finding ways to bring into the public domain, details of the abuser, their abusive behavior and how they managed to avoid suspicion (where relevant), for example. This serves to break the secrecy that was often integral to the abuse itself. Without these stories, the survivor(s) of any particular abuser(s) are left to carry the story of the person's abusive actions in isolation, often while others around them continue to assume that the good facets of the individual they knew, constitute the whole picture of the person.

Conversely, input from the survey indicated that these tales also serve a preventative purpose, in Stage One of the process. Firstly, telling these stories demonstrates publicly a level of knowledge about the dynamics of abuse and abusers, supporting confidence in the Church for other victims. It bolsters a sense of trust for people thinking of disclosing abuse or sharing concerns, which makes it easier for them to come forward.

Secondly, telling difficult stories of abuse that has occurred in Church contexts also helps everyone involved in the Church to maintain vigilance about potential grooming and abuse in their particular contexts. This is vital because the relative rarity of most types of abuse in a Church context, and the culture of silence around prevalent forms such as domestic abuse (Aune & Barnes 2018)²¹, makes maintaining vigilance a huge systemic challenge. While the work of IICSA shows that it is far too common, for any parish, diocese or religious community it remains a rare occurrence. Staying vigilant against this abuse is therefore difficult. And the chances of any organisation

²¹ Aune, Kristin & Barnes, Rebecca (2018) *In Churches Too: Church Responses to Domestic Abuse – A case study of Cumbria, Coventry*: Coventry University and Leicester: University of Leicester.

therefore cutting corners on key safety operations and making them less of a priority than other functions are high.

The risks are compounded by the fact that the relative rarity of abuse also means that for an individual, the probability of being involved in worship or Church-related activities with a person who abuses, is low. First-hand experience of identifying and acting on suspicions, responding to disclosures or sharing of safeguarding concerns, is rare. The vast majority of people who might play a key role in this important task are therefore novices (beyond the DSA and team). Telling stories about when and how abuse happened in the Church, helps keep a focus on the fact that it can happen and it does. So they further support prevention, early detection and taking seriously anyone who comes forward.

This raises the question of what stories the Church tells about past incidents and occurrences of abuse in Church contexts, when and where these stories are shared. How are clergy, and others in Church-related roles, who abuse remembered as part of the Church's history and the stories of their abuse reconnected to the history of the Church as told today? How are other stories of abuse in Church contexts crafted and shared?

There is much the Church does do in this regard, for example, with lessons learnt reviews, and drawing on real life case studies in Church safeguarding training. This finding, questions whether more can be done to bring such stories out into more everyday Church settings at parish, diocesan and national levels. Can the telling of these difficult stories for the right purpose, be made more routine across a range of more public Church forums?

Finding 1 summary:

Currently stories of people who have abused in Church contexts are used as case studies in safeguarding training. It is far less common to bring real life tales into a broader public sphere, at parish, diocesan or national level. This increases the chances of causing further distress to survivors who do not see the reality they have to live with reflected by others. It also makes it harder to create the right conditions for a safe Church that is appropriately vigilant about abuse and feels trustworthy for anyone thinking of coming forward.

Questions to consider:

- Where could the Church best turn for support in ascertaining best practice in how to create stories and talk publicly about past cases of abuse in Church contexts?
- Are there examples of good practice within the Church that could be shared?
- How might the Church's communications resources be used to support more telling of difficult stories of abusers for the right purposes?
- What would strong leadership look like regarding this finding?

8.3 RECOGNISING THE CONTRIBUTIONS OF SURVIVORS IN PUBLIC NARRATIVES ABOUT THE SAFEGUARDING JOURNEY OF THE CHURCH (LEADERSHIP AND CULTURE)

Input via the survey highlighted that good practice in responding to people who come forward, involves recognising first and foremost that they are providing an invaluable service to the Church. In disclosing abuse particularly by clergy and people in church-related roles, sharing safety concerns or challenging poor Church safeguarding responses, people are helping to protect others and to create a safer Church. Good practice in engaging with people who come forward, sees the value of their service reflected in all aspects of how they are treated.

The Church currently makes efforts to acknowledge this service in some ways. There is an expectation that thanks is extended abuse survivors and others who have come forward in individual cases. Collectively too, actions such as inviting survivors of clerical abuse to engage in person with members of General Synod for the first time in July 2018, can be seen as steps in this direction. However, this finding highlights an important gap in terms of a public Church narrative.

The Church often uses the analogy of a 'journey' to describe the process of change and efforts that have been made over time, to improve safeguarding and create a safer Church. The contribution of survivors who have worked as part of the Church safeguarding structures was recognised in the National Safeguarding Steering Group's safeguarding paper for General Synod July 2018 (reference GS2092):

A small number of survivors have contributed enormously to the improvements that the Church has made via their engagement with the National Safeguarding Panel (paragraph 21)

But further than that, to-date, the history that the Church crafts about its safeguarding journey does not adequately reflect the role that individual survivors of clergy and Church-related abuse have played, or validate their roles as a valuable service. A small number of individuals have been at the vanguard of bringing safeguarding issues within the Church to light, sometimes against strident resistance and at great personal cost. Yet so far they have not featured in the story the Church tells about its own safeguarding journey, in this regard.

This represents a systemic barrier to good practice. If people thinking about coming forward in the present, look to examples from the past of how the Church has treated those who came forward, they will not find the kind of public acknowledgement of a valuable service, that would foster confidence in their disclosure being welcomed. It creates a barrier too for people providing contemporary Church response and who want to acknowledge to the survivors of abuse they are working with, the value of their service. There is no legacy of such acknowledgement for them to build on.

Finding 2 summary:

Public narratives the Church tells about its own safeguarding journey of improvement do not adequately recognise the contributions of survivors of Church-related abuse. This makes it less likely that good practice is achieved in recognising people disclosing abuse and sharing concerns as playing a valuable service to the Church.

Questions to consider:

- What are Church mechanisms for creating shared narratives of the past? Could they be used to craft a history of safeguarding developments that recognises the service played by survivors individually and collectively?
- What else would support such narratives of the Church's safeguarding journey e.g. some kind of award scheme or annual day of celebration.

8.4 POSITIVE SENIOR ROLE MODELS OF HOLDING YOUR HANDS UP TO HAVING GOT IT WRONG (LEADERSHIP AND CULTURE)

The ability to learn from mistakes is fundamental to creating safe organisations. Grievances, complaints and whistleblowing processes are important feedback mechanisms whereby people who have had, or expected to have, a safeguarding response from the Church can flag up when things have gone awry and errors seem to have been made. They can be used to alert the Church to poor responses to non-recent cases or current issues, and some scenarios will include both. The survey input highlighted how, from the perspective of people who come forward, the Church's response at this stage (Stage Four in our model), provides a litmus test for the integrity and morality of the Church's stance on safeguarding more broadly. People stressed that what they need to see is the Church responding with urgency and thoroughness, with openness and honesty. They need to see humility and readiness from all individuals to acknowledge past failings, regardless of the person's current status within the Church. There is a sense of needing to see a Church-wide responsibility for proactively seeking out and rectifying poor decision-making and practice to keep people safe, and active leadership to that end.

We do not, from the diocesan audits or the survey, have data with which to critique the diocesan or national complaints or whistleblowing processes or clergy disciplinary processes (CDM) for the extent to which it is set up to accomplish what survivors, and those coming forward to share concerns, say they need. With this finding, we raise a different, if linked, systemic issue: do any role models currently exist for how clergy put their hands up and openly acknowledge incidents where they have personally got it wrong in their responses to safeguarding issues? For example, where they may have failed to share information appropriately or follow-up when someone has disclosed abuse to them or where they have not flagged up safeguarding concerns about behaviour of clergy or people in Church-related roles,

that they knew was abusive. No such examples featured in aspects of safeguarding leadership identified in the diocesan audits.

In other sectors, a blame culture often inhibits such openness and honesty about mistakes. The Church has potentially additional inhibitors, not least the question of how acceptable it is deemed to be for a person of God to get things wrong in life. This suggests that strong leadership is required to enable widespread confidence that if clergy do respond with openness and humility about their past personal failures to respond appropriately to knowledge of abuse or risky people or practices, they will themselves be supported, and enabled to work with the survivor to identify and make appropriate amends and not be scapegoated within the Church.

Do senior people in the Church provide leadership in this regard? Are there any examples of Bishops setting the example? This could involve proactively bringing up past failures (rather than waiting for abuse survivors or the media to highlight them), and proactively seeking to find the best ways to rectify them? Where past failures have already been identified and dealt with through formal processes, a positive example could involve talking openly, humbly and constructively about them – what were the mistakes you made and why did they seem sensible at the time or at least the best of a bad set of options? How they were rectified and what have you learnt on a personal level? How would you respond differently in a similar situation today?

Without such a public discourse in the Church, it is more likely that the bringing forward of poor practice and safeguarding mistakes, triggers negative cycles of response and counter-response by the Church and survivor, with no possibility of resolve.

Finding 3 summary:

A lack of role models and leadership about how to hold your hands up to personal mistakes in responding to disclosures of abuse or safeguarding concerns, makes it more likely that people who come forward to flag up mistakes in the past will experience defensive responses when they raise poor past responses by people in the Church.

Questions to consider:

- Has there been adequate discussion within the Church of how to respond in an open and restorative manner to complaints and whistleblowing?
- Might case studies based on real life scenarios be co-produced with abuse survivors to help?
- Is enough known about the perceived and actual barriers to more proactive, open and honest responses, on the part of clergy particularly?

8.5 LONG-TERM SUPPORT (QUALITY OF SERVICE PROVISION)

Through the survey some harrowing accounts were shared of the long-term impact of abuse by clergy and people in Church-related roles. A picture also came through of the kind of good practice survivors would want to see in which the Church genuinely recognise and respond to that reality. This involves willingly providing (where it is wanted) 'after care' in kindness, friendship, support and redress to help tackle the effects including financial, psychological, social and emotional and physical. It needs also to involve the possibility of updates and assurances about improvements made and evidence of ongoing commitment to any necessary risk management related to the abuser.

This view of good practice is not new. Recommendation 3 of the Independent Peter Ball Review: Abuse of Faith (Gibb 2017) included reference to the complex and enduring nature of the harm caused by clerical abuse:

Offers of support cannot be 'one off' as was the case with Neil Todd. Support arrangements made by the Church must be underpinned by a recognition that the harm caused by clerical abuse is enduring and offers of help may need to be sustained and renewed in the face of rejection (2017: 66, para. 7.3.2 bullet point 2).

Yet it is not obvious that any progress has been made in creating the conditions necessary to achieve it.

The framing of safeguarding roles and responsibilities, remains more on preventative work, creating safe environments and culture, enabling disclosures of abuse, on allegations management, appropriate liaison with statutory partners and processes – all, of course, in themselves important. Policy and practice in support services have focused on the provision of authorised listeners to enable disclosures, and on short-term therapeutic support for abuse survivors, with a particular focus on counselling (see section 4.4 above). It does not, as yet, give enough prioritisation to longer-term support, or consideration of the range of kinds and quality of help and care that abuse survivors deem are potentially necessary forms of redress. As such, a high level of unmet need is highly likely to exist and remain. Participants in the survey, highlighted how the lack of a framework for longer-term engagement and responses, can leave them as if they have been 'processed', and then abandoned.

Finding 4 summary:

The impact of abuse by clergy and people in Church-related roles is often profound and lasts a lifetime, emerging and fading at different times over decades. This is not matched by current thinking and provision of support by the Church.

Questions to consider:

- Would developing a framework for long-term support require only a prioritisation in the Church's improvement work of the end stage of Church responses, or a fundamental recalibration of the nature of relationships being extended by the Church to abuse victims of clergy and Church-related abuse?
- How can the flexible provision of long-term options, including financial redress, best be considered?

8.6 PERSON-CENTRED RESPONSES – THE MISSING AUDIENCE (POLICY AND PRACTICE GUIDANCE)

The overview report of the diocesan audits highlights, in section three, that one of the major achievements of the National Safeguarding Team in the last three years has been the total revision of national practice guidance. This has included incorporating reference to responding to victims and survivors of abuse across a range of different practice guidance documents including:

- *Key roles and Responsibilities of Church Office Holders and Bodies*. Practice Guidance (2017)
- *Responding to safeguarding concerns or allegations that relate to children, young people and vulnerable adults* (2018)
- *Responding to, assessing and managing safeguarding concerns or allegations against church officers* (2017)
- *Responding well to domestic abuse. Policy and Practice Guidance* (2017)

Other relevant work is in progress including:

- Guidance on spiritual abuse is nearing completion.
- Guidance on complaints and whistleblowing with 'Safer Environment and Culture Practice Guidance' is due to be finalised, agreed and implemented
- Further development of whistleblowing processes is part of the NST business plan (see 3.2.4).

There are plans to update the guidance *Responding well to those who have been sexually abused* (2011) following, and drawing on the SCIE survey results with the probability of extending its focus so that it is not restricted to one type of abuse.

What is notable about all the revised policy and practice guidance is that as yet, it is written for a single imagined audience: clergy and others within the Church who have a designated safeguarding role. In terms of national policy and practice guidance, the Church does not yet engage directly with survivors of abuse and others the

people who come forward to share safeguarding concerns. This means there is no clear, accessible summary of what the Church is committed to and is seeks to provide.

Finding 5 summary:

Abuse survivors and people who come forward to share safeguarding concerns are currently only addressed indirectly in House of Bishops' policy and practice guidance. What exactly the Church has committed to, in terms of its response, is not therefore clear or accessible either to abuse survivors themselves or those responsible for implementing policy.

Questions to consider:

- Is there shared agreement to the benefits of creating a Charter of what people who come forward to disclose abuse or share concerns can expect of the Church's response to them and the information they share?
- Should there be an accompanying celebration, implementation and evaluation plan?

8.7 KEEPING THE PERSON WHO HAS COME FORWARD AT THE HEART OF EVERYTHING – THE GOLDEN THREAD (POLICY AND PRACTICE GUIDANCE)

The survey results highlighted how important it is for people who come forward to disclose abuse or share concerns, to be appreciated as providing a valuable service and to be involved where possible in determining what happens next and then also to be involved in what follows where possible. Where this is not possible, the survey findings indicate that a key feature of good practice from the perspective of people who come forward, is for them to be kept regularly updated on what is happening or not. It also highlights that they are experts in their own experience, and have much that will be helpful to inform decisions about how to respond well. The data was especially strong in relation to clergy or Church-related abuse. This principle is not new. *Responding well* (2011) states for example: 'Take care if at all possible not to take the matter out of the hands of the person who has made the disclosure. Sexual abuse involves a loss of personal control, so be careful not to add to that' (2011: 25 para (k)).

In Finding 6 below, we point to a specific area in current guidance about responding to allegations about church officers, in which there is little specificity about how the abuse survivor is best kept involved and informed – the current formulation of the allegations management process. In this finding, we focus on the guidance more broadly, asking whether a commitment to keeping abuse survivors at the heart of all Church responses shines through brightly in the practice guidance about requirements in responding to allegations against church officers. Is there a coherent golden thread about treating the person who has come forward as a person providing a valuable service, whose wishes and desired outcomes, including about levels of their involvement, need to be held central to the process? Does this golden thread enable sensitivity to survivor's needs and wishes in every aspect of the

response?

It is a major achievement of the National Safeguarding Team, as noted in Finding 6, that national practice guidance has been totally revised over the last three years. Positively, this does include incorporating reference to responding to victims and survivors of abuse across a range of different practice guidance documents. The systemic strength of these resources can now be bolstered by increasing the specificity of what exactly is required.

For example, *Key roles and Responsibilities of Church Office Holders and Bodies. Practice Guidance (2017)* includes references in relation to survivors in all the key roles, including NST, NSP, Diocesan Bishop, Diocesan Safeguarding Advisory Panel and DSA which is positive. The short-hand phrases used frequently refers to the provision of 'advice and support' to survivors. Survivor's engagement throughout Church response processes, or the principle of person-centredness, is not yet a feature of how roles and responsibilities toward survivors are formulated.

Looking at the practice guidance itself, we can see that, for example, *Responding to, assessing and managing safeguarding concerns or allegations against church officers (2017)* provides more detail on requirements. It provides:

- detail about responding well when hearing disclosures (2.2, 2.3, 2.4)
- in 'additional considerations' about making a referral to statutory agencies
- a brief paragraph on 'what can victims/survivors expect?' in relation to the risk assessment process 5.1)
- a longer concluding section in the same section, titled 'response to victims and survivors'.

Much of the substance of these sections is supported by the survey data. There are however risks to literally containing i.e. limiting or restraining, the reference to survivors into these designated paragraphs and sections. Firstly, and practically, the presentation does not enable the reader to literally see the golden thread of engagement with the abuse survivor, making it harder to hold in mind. Secondly, and linked, it leaves it more to chance whether the potential significance of different issues or stages of the process to an abuse survivor are recognised and explored. It would be helpful, for example, to specify that it is important to talk through any 'conflicts of interest' of people potentially involved in how the Church responds to allegations or concerns, with the person who has come forward. Specifying prompts throughout all sections and stages, would better maximise the reliability with which the practice guidance makes overt expectations about the engagement with survivors.

Finding 6 summary:

Recent revisions to policy and practice guidance include specification of what is required in responding to abuse survivors and people who come forward to share safeguarding concerns. They do not yet constitute a strong golden thread about keeping the person who has come forward at the heart of everything, limiting how specific or helpful they are to people in Church roles who are trying to respond well.

Questions to consider:

- Is there support to strengthen this golden thread across all policy and practice guidance?
- How and when can the embedding into all aspects of policy and practice guidance of the Church's engagement with the abuse survivor, best be achieved?
- Does further work need to be done to think through about whether and how the practice guidance *Responding well to those who have been sexually abused* (2011) needs to be updated, if there is a Charter (Finding 1) and expectations about engagement with survivors is strengthening in core guidance such as *Responding to, assessing and managing safeguarding concerns or allegations against church officers* (2017)?

8.8 ALLEGATIONS MANAGEMENT PROCESSES (POLICY AND PRACTICE GUIDANCE)

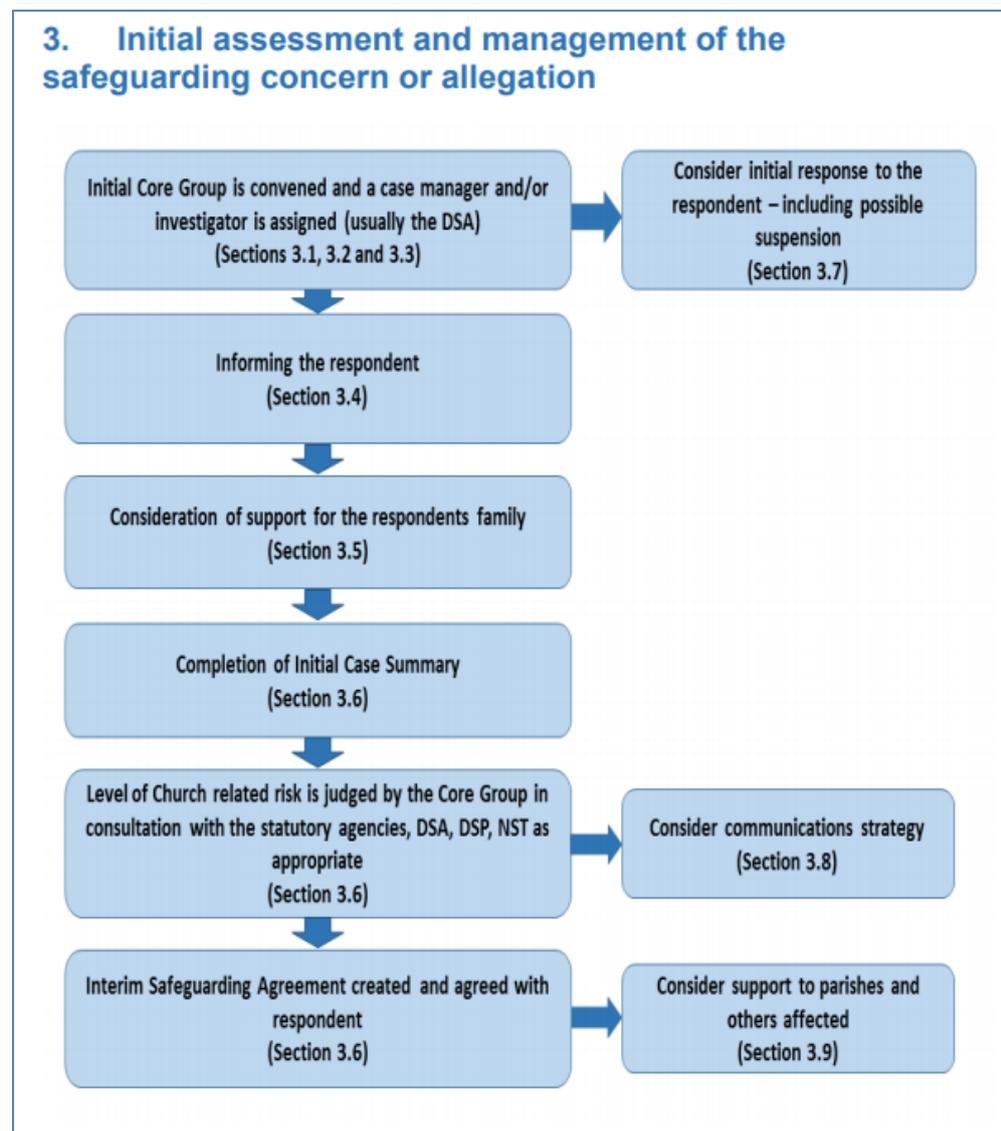
As stated above, the survey results highlighted how important it is for people who come forward to disclose abuse or share concerns, to be appreciated as providing a valuable service and to be involved where possible in determining what happens next and then also to be involved in what follows, where possible. Where this is not possible, the survey findings indicate that a key feature of good practice from the perspective of people who come forward, is for them to be kept regularly updated on what is happening or not. The data was especially strong in relation to clergy or Church-related abuse.

A number of findings in this section highlight underlying, systemic issues that make this harder to accomplish by those involved in responding, rather than making it easier to achieve. This finding focuses on the way in which the allegations management process for allegations against church officers is articulated in policy and practice guidance, key to which is the establishment and running of Core Group processes. The Core Group process is the central mechanism in Church safeguarding policy for initial assessment and management of a safeguarding concern and or allegation against a church officer.

For anyone with a background in statutory child protection services (including some DSAs), the language of Core Groups is potentially misleading. It turns out to be a 'false-friend' of types. Across different languages, a false-friend refers to a word or expression that sounds the same as one in your own native language, but in fact has

a different meaning. In the statutory child protection arena, child and family participation is central to Core Group functioning, where the function of the Core Group is to implement the Child Protection Plan. So logically, you would assume that the participation of abuse survivors in Church Core Groups would be central. In fact, it is not. Integral to the process, and captured in flow charts (see above for example), are issues to do with informing the ‘respondent’ who is subject of the allegation and consideration of support for the respondent’s family. In contrast, there is no articulation of expectations regarding communication or support for the person who has disclosed abuse or shared concerns about safeguarding risks through these stages of Church response to the information.

As an organisational allegations management process for use when allegations or concerns have been raised about someone with a role in the Church, the person who has brought forward the allegation will not have the right to be party to all information. But this needs to sit against considering of the features of good practice highlighted by survey participants about recognising the enormity of disclosing abuse and understanding how hard it is to come forward, and the intense vulnerability sometimes felt after disclosure.



In statutory adult safeguarding, S.42 Enquiries are conducted in response to the raising of safeguarding concerns and the adult and their views, wishes and desired outcomes are central – see for example London ADASS Multi-Agency Safeguarding Policy and Procedures²². Police similarly have moved to put victims at the heart of the Criminal Justice System since the 1990s saw the first Victim’s Charter, now Victim’s Code. This suggests that a more victim-focused allegations management process is likely to be feasible in the Church context too.

Finding 7 summary:

Church processes for allegations management do not currently support a person-centred approach, keeping the survivor of abuse, or person who has come forward to share safeguarding concerns, central to Church responses to disclosures of abuse or hazardous people or practices.

Questions to consider:

- How can learning from other sectors, such as victim-centred processes in policing and criminal justice, person-centred safeguarding processes in adult social care and family involvement in child protection best be drawn on, to inform improvements in the person-centredness of policy and practice guidance for allegations management including Core Group processes?

8.9 SUPPORT VS. ADVOCACY (QUALITY OF SERVICE PROVISION)

A central plank of initial Church provision of support for abuse survivors has been to support people to make disclosures of abuse and be able to tell their stories of abuse as an important part of the healing process. Much of this has focused on enabling people to access someone acting in the role of listener. The *Time for Action* (2002) report made a recommendation for the provision of ‘Authorized Listeners’ and *Responding well* (2011) turned this into a policy.

More recently, attention has been turning to the support needs of people who turn to the Church, during the resultant processes following disclosure of abuse or the sharing of concerns. A key development includes a new role of ‘support person’, to be offered to all victims/survivors. This was introduced in the practice guidance for *Responding to, assessing and managing safeguarding concerns or allegations against church officers* (2017).

The survey results suggest this is a much needed role, one potentially invaluable to attaining specific good practice features of Church responses, identified by participants. As stated above, the survey results highlighted how important it is for people who come forward to disclose abuse or share concerns, to be appreciated as

²² <http://londonadass.org.uk/wp-content/uploads/2015/02/Pan-London-Updated-August-2016.pdf>

providing a valuable service and to be involved where possible in determining what happens next and then also to be involved in what follows where possible. Where this is not possible, the survey findings indicate that a key feature of good practice from the perspective of people who come forward, is for them to be kept regularly updated on what is happening or not.

Linked to the specification of being kept central to subsequent processes, a theme identified in the survey was of needing something like an advocate to enable this to actually happen – ‘someone unequivocally on my side’. Input created a picture of a named person prepared to make a long-term commitment, who takes the burden off the person coming forward of being the one who has to drive things and chase for updates, for example. A person who shoulders responsibility for ensuring that the person is communicated with and involved appropriately and regularly by the Church. The survey highlighted how the person coming forward is likely to be highly vulnerable at being in this situation, and faced with processes about which s/he is unfamiliar. The advocate therefore needs to be someone who brings expertise of how the Church processes work, whilst being outside the parish or church structure so free of conflicts of interest that result.

This raises two important systemic questions. Firstly, to what extent does the role of Support Person in House of Bishops’ guidance, match the role of advocate created in survey responses? Secondly, what is known about the extent to which people are being offered a support person? And how well is the role working for the person who has come forward, where the offer is taken up?

Comparing the specification of the two roles, there is much positive overlap: the Support Person should be independent (not be involved in managing the case), the specifics to be agreed in consultation with the person on a case-by-case basis, and broadly a focus on listening and representing the survivor’s views and needs. Two aspects need to be strengthened to achieve a better match. Firstly, the core function of the role is not presented in a clear accessible way. There is no summary, for example, of the role as being to support and represent the person’s wishes and facilitate their involvement. This could usefully include highlighting the proactive role the support person is expected to take, in keeping the person at the heart of all Church safeguarding processes.

Secondly, at least half of the description available focuses on what the role is NOT (capital letters in the original) and the circumstances in which the Support Person would be required to breach confidentiality with the person they are supporting. When put together with a lack of a clear summary about the core function of the role, this takes away from a sense in which the Church is offering the role as part of its duty of care to the person coming forward, and in reflection of their gratitude for the service the person is generously providing.

If people are to feel genuinely welcomed and appreciated for the service of alerting the Church to abuse and safeguarding risks, the spirit of generosity with which the support role is offered needs to shine through more brightly than it currently does in the presentation of the support role. Someone who is ‘unequivocally on my side’ is not the same as a ‘confidant’ and should of course be expected to share information relevant to safeguarding, with others as and when it was needed. As stands, the guidance seems to conflate and confuse the two, creating a conflicted and contradictory tone and set of expectations about this role.

Finding 8 summary:

The requirement to offer everyone who comes forward a Support Person is a positive development. The specification of role does not yet convey the Church's positive valuing of the person coming forward, or reflect a clear commitment to keeping the abuse survivor at the heart of all Church safeguarding processes.

Questions to consider:

- Are there any issues with revising the Support Person description to reflect the need for proactive advocacy, and to convey more positively the value in which abuse survivors are held, for their contribution to creating a safer Church for all?
- Are there adequate plans to monitor the implementation of this role, including feedback from survivors, in order to feed ongoing improvement?

8.10 ROUTINELY SEEKING & USING SURVIVOR FEEDBACK, INCLUDING COMPLAINTS TO DRIVE LEARNING AND IMPROVEMENT (QUALITY ASSURANCE)

We noted in Part One of the report that the auditors considered that the quality assurance function within diocese and at national level is at a relatively early stage of development. What engaging with abuse survivors through the survey draws our attention are particular gaps in quality assurance activities and frameworks regarding feedback from abuse survivors. This takes a number of forms. Firstly, and straightforwardly, there is no requirement or common framework at diocesan level routinely to seek feedback from recipients of safeguarding responses, as part of standard quality assurance activity. Nor is there a national function to collate and analyse such feedback, in order better understand where issues of dissatisfaction are occurring, and the nature of the quality problems people are identifying.

The only standard mechanism for hearing feedback about the safeguarding service that currently exists is the complaints. But the auditors saw less complaints about the safeguarding service than they expected too – case work showed some examples of complaints being treated as part of the casework and therefore not being identified as a complaints – with all the conflicts of interest that entails. And more widely, there did not generally appear to be processes to extract learning from complaints.

Routinely seeking and using feedback from people receiving a service is a vital part of feedback mechanisms needed to drive a learning organization. In the Church context, such feedback will also cover legal and other processes over which the Church does not necessarily have direct control e.g. criminal justice and civil claims processes. , context of the Church, but over which the Church might wish to exert influence, for the benefit of survivors of clergy and Church related abuse.

Finding 9 summary:

There is not a requirement to routinely seek feedback from people who have received a safeguarding response, nor a common culture of proactively identifying complaints about the safeguarding service. This lessens the chances of understanding where improvements are needed at diocesan or national level and increases risks of leaving people suffering, with little hope of resolution.

Questions to consider:

- What is the best way to embed the routine seeking of feedback from abuse survivors across diocese and enable it to inform strategic, national diagnostics about the nature of problems people are identifying in safeguarding responses?
- How might a diagnostic of areas of dissatisfaction for people with first-hand experience of Church safeguarding responses, be accelerated?

