THE CHURCH OF ENGLAND
Diocese of Chester

Summary Report

Past Cases Review 2

October 2022

Contents

Foreword from the bishops

Conducting a Past Cases Review during a global pandemic was never going to be straightforward and we are hugely grateful to our Independent Reviewers for working in such challenging circumstances and for being so diligent. Our thanks also go out to all our parishes who provided information, our Diocesan and Cathedral staff who facilitated access to files for the reviewers, the members of the Reference Group who steered the review process and to those victims and survivors who contributed to the review. The full PCR2 report provides extensive evidence of safeguarding failings in the Diocese of Chester and of a very poor safeguarding culture over several decades. It is a robust report, and although it focusses on past cases and recognises the positive changes being made in the Diocese, it also sets out some very helpful recommendations for further improvements as we move forward.

The full report is both lengthy and detailed. It contains numerous references to specific cases and individuals. We have chosen not to publish it in full at this time, but to provide this extensive summary instead which sets out the background to the review and then details the key themes and includes the full conclusions and recommendations (with no redaction or editing). We have also prepared a version of the full report carefully redacted to reduce the possibility of identification of any victims or survivors and this will be used by our Diocesan Safeguarding Advisory Panel, our Bishops' Senior Team and our Bishop's Council as we put in place and oversee an Action Plan. We recognise that some individual survivors of abuse in Chester Diocese are rightly entitled to view the full report in its redacted form and we will carefully consider requests for this in a spirit of openness and transparency whilst recognising the need to respect the right of anonymity for other survivors and victims.

We are appalled and angry regarding some of the past safeguarding practice in Chester Diocese. We also recognise that despite our shared commitment to changing the culture and practice in our Diocese, we may still make mistakes or fall short of the expected standards. None of this is good enough and we are committed to learning from survivors and victims, from past cases and from independent reviews. We are intent upon establishing a healthier culture and a safer church and most of all, upon being more Christ-like in how we respond to victims and survivors and to those who are vulnerable.

This report touches upon much that is evil, sinful or inadequate. We rightly feel a deep sense of shame, but above all, we are determined to lead the change that is needed and that has already begun. Safeguarding really is at the heart of what it means to be church and at the heart of our mission.

The Rt Revd Julie Conalty,
Bishop of Birkenhead

The Rt Revd Mark Tanner,
Bishop of Chester

The Rt Revd Sam Corley,
Bishop of Stockport

Background

Over the last two years, the Diocese of Chester has committed itself to the Past Cases Review 2 (PCR2) process, the culmination of which is a 124-page-report submitted to the Church of England's National Safeguarding Team by the two lead Independent Reviewers commissioned by the diocese to complete the task.

The process by which the report has been produced, has been thorough and robust, and has involved contributions in time, energy, and resource from parishes, cathedral and diocesan staff.

As the Independent Reviewers remarked in their report:

> *"The Independent Reviewers are extremely grateful to the Bishop of Chester, Chester Cathedral Chapter, business leads, and team members within HR and Safeguarding in the Diocese who supported them in completion of the PCR2. In particular for the openness and cooperation from the current Diocesan Safeguarding Adviser, Pauline Butterfield, Human Resource Lead, Liz Geddes and the Cathedral Safeguarding Officer, Helen Barber.*
>
> *"The Independent Reviewers would like to place on record that the Diocese of Chester has at every stage been transparent and welcoming towards the PCR2 review and collectively the Diocese is extremely keen to learn the lessons from the findings to ensure that Safeguarding is given the highest priority moving forward. There is clearly much good work ongoing that is proactive in nature in this regard."*

The background to PCR2 begins with the Church of England's original Past Cases Review in 2007. PCR1 sought to look at the Church's handling of safeguarding cases over many years. However, a report in 2018 concluded that it had shortcomings both in the process and the outcome, and as a result, the Church of England announced that all dioceses were to complete a second review.

PCR2 launched in 2019 and background papers and policies were issued to all 42 dioceses in the Church of England. The PCR2 Protocol and Practice Guidance published in July 2019 stated six specific objectives:

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

proportionately to the level of risk identified and with the paramountcy principle evidenced within decision making

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

On 27 January 2020, the former Bishop of Birkenhead, and then Acting Bishop of Chester, Bishop Keith Sinclair, wrote to all Incumbents in the Diocese of Chester. In his letter, he explained why the review was taking place and what parishes were required to do, saying:

> *"As part of the PCR2, I am writing to you to ask you to check all your parish records to ensure that all instances of concern about *church officers, either non-recent or current, have been reported to the Diocesan Safeguarding Adviser (DSA). I recognise that you will have records that will extend for many decades and would ask that, in order to meet PCR2 requirements, all records available are checked, this should include archives and, in many cases, will go back to prior the 1940s.*
>
> *"When reviewing local information in preparation to submit your parish Declaration, I would advise that no burden of proof is required to be satisfied prior to you sharing this information and that information does not have to be complete to meet the threshold for submission. Indeed, sometimes a mere mention or sentence relating to a concern is all that you may be able to locate in your records despite exhaustive searches. This information should still be shared and identified even if it is the only reference to the issue you were able to obtain during your local records examination."*

After an initial false start, over the course of 2021, two lead Independent Reviewers looked at all safeguarding files relating to church officers, both lay and ordained, past and present, and all parishes responded to a request for information. The Reviewers also reviewed the safeguarding files provided by Chester Cathedral in 2020. Two additional Independent Reviewers were appointed in the spring of 2022 in order to complete the process on time.

In April of 2022, the two lead Independent Reviewers submitted their key themes and trends to the National Safeguarding Team, followed a few weeks later by their full 124-page diocesan report.

The conclusion of the PCR2 process is the culmination of hundreds of work hours, and this Summary Report has been produced in order to communicate the Reviewers' findings and conclusions to the public.

Appointing the Independent Reviewers

In January 2020, the Diocese of Chester appointed Suzanne Cottrell as an Independent Reviewer to oversee the PCR2 process. After three months, the Diocesan Safeguarding Adviser (DSA) collated increasing evidence that the Reviewer lacked sufficient independence for the task. As such, the National Safeguarding Team was notified in March 2020 of a conflict of interest. Ms Cottrell's previous role as a Wirral LADO (Local Authority Designated Officer of Child Safeguarding) and prior knowledge of some cases compromised her position. As a result, her services were concluded.

Following this "false-start", two new Independent Reviewers, Claire McEnery and Nicola Bithell, were commissioned to undertake PCR2. The Reviewers are both retired senior police officers from Lancashire Constabulary, and both had conducted the PCR2 process at Blackburn Diocese prior to joining Chester Diocese.

Together with the DSA, the two newly appointed Independent Reviewers decided that it was appropriate to re-start the PCR2 process from the beginning, following the removal of the initial Reviewer. Whilst necessary, this placed additional time scale pressures onto the process.

In late March 2022, as the review reached the latter stages, two further experienced Independent Reviewers were employed to assist in expediting the process in order to meet the agreed deadline. They were Kerry Young and Colin Taylor.

Deadline extensions

As stated above, towards the end of the process additional human resource had to be brought in to meet the deadline. This deadline had been extended for the two lead Reviewers and pressure to meet it was further compounded by the "storage disarray" at Bishop's House, Chester. The Reviewers state in their report:

> *"In December 2021 the Independent Reviewers were approaching the finalisation of the process within agreed timelines, based on limited disclosure of documentation. Such was the storage disarray inherited by the newly appointed Bishop, that whilst the diocese could pinpoint 'Deceased Clergy' files they originally had no knowledge of the whereabouts of any 'Clergy Overseas', 'Clergy Resigned', or 'Clergy Out of Diocese', Lay,*

Reader or volunteer files. Human Resources confirmed that they had no knowledge of the whereabouts or existence of such files (outside the context of brief HR details).

"Due to a lack of capacity within Bishop's House (recently appointed Bishop and then vacant Bishop's Chaplain position), a thorough understanding or search of the Strong room office therein had not commenced.

"In late December 2021 an initial scoping exercise within the Strong room identified the presence of a disarrayed selection of the missing files (circ. of 1,700 additional files). To date there appears to be no separately filed Lay, Reader, or Volunteer files in existence. That said, the Independent Reviewers were faced with the daunting task of commencing reading approximately 840 individual Parish files, many of which had inserted lay, reader or volunteer files within. The subjects of those files were often unique in that they were in the main those to whom speculation or accusation had been levelled. Clearly, these additional findings were a major contributary factor to the delays experienced in completing the Review within the National Team timelines.

"In January/February 2022 the Reviewers were directed to review a large amount of box files and BSM (Bishop's Staff Meeting) minutes within the Strong room, the contents of which were varied and unknown to present staff. Whilst reviewers commenced this time-consuming task, timescales were now becoming critical, and as these files were not strictly in scope of PCR2, a decision was made via consultation with PCR2 Reference group, to defer the review of these non-personnel files until after the submission of the final report. Safeguarding issues identified within a dip sample of these files were sporadic, badly referenced, but reassuringly appeared to be replicated in more detail elsewhere in files within scope. These files will be reviewed expediently post the conclusion of PCR2.

"In March 2022, following internal diocesan negotiation, the Independent Reviewers progressed the review to the documentation within the Cathedral setting. This process concluded, for the purpose of final reporting, in mid-April 2022. The scope consisted of The Cathedral Known Case List / Safeguarding files and a dip sample of 10 'other case files' that the Cathedral did not believe to be within scope of the Known Case List, but for quality assurance purposes the Dean asked that they be reviewed. (As part of the PCR2 protocol shared by the NST the reviewers were informed that the extent of the Review of Cathedral files outside of the known case list was a decision to be made at a local level.)

"On concluding the review of the 'Dip Sample', and on the advice of the independent reviewers, a decision has been made by the Dean in consultation and agreed by DSAP and PCR2 Reference Group, that all remaining Cathedral Personnel files will be reviewed. This review will occur following the submission of this report, by the new CSO who would benefit from the oversight of past issues and has an extensive safeguarding background - for the purpose of completeness. This demonstrates the growing culture within the Diocese to openly embrace safeguarding understanding and learning."

Scope and file review process

The content of the PCR2 report is evidenced-based and reflects the PCR2 review of both the Diocese of Chester, Chester Cathedral, and an associated religious order, The Sisters of Jesus Way.

Content is drawn from documented information, and discussion between the Reviewers and key stakeholders during the file review phase of PCR2.

The original PCR, conducted in 2007/08 looked solely at child safeguarding, whereas the scope of PCR2 includes children and adult safeguarding.

All living clergy and church officers' files, whether in active ministry or not, were within the scope of PCR2. The only files exempt from the review were within the Deceased Clergy category and current live cases.

The Reviewers began the process at Bishop's House, Chester, in April 2021 by reviewing 'Blue' clergy personnel files on site. Thereafter, Safeguarding Files were reviewed remotely due to Covid-19 considerations.

On conclusion of the Safeguarding File review, HR Files and Parish Returns were progressed, both on and off site. Latterly, the Reviewers returned to Bishop's House for a review of, what was at that time, undefined files and parish files. Finally, they worked within the Cathedral grounds to oversee Cathedral Safeguarding Files, and a dip sample of Cathedral case files.

A review of the files with The Sisters of Jesus Way concluded the file review.

Parish returns

In January 2020, the then Acting Bishop of Chester wrote to all parishes and Incumbents, together with other organisations within the scope of PCR2, to request that they review and complete a return of safeguarding files within their parish, saying:

> *"As part of the PCR2, I am writing to you to ask you to check all your parish records to ensure that all instances of concern about *church officers, either non-recent or current, have been reported to the Diocesan Safeguarding Adviser (DSA). I recognise that you will have records that will extend for many decades and would ask that, in order to meet PCR2 requirements, all records available are checked"*

Initially, the subsequent returns were collated by the original Independent Reviewer, and not, as would have been preferable, by the DSA for appropriate attention. The DSA was only therefore in possession of these returns in July 2021, some 19 months after the initial request for information.

Due to time pressures, the parish returns were not translated into managed issues and updated to what is known as a Known Case List but were in fact provided to the Reviewers by the DSA in raw, often badly handwritten format.

As such, the Independent Reviewers state in their report that many parish returns were:

> *"…complex to decipher and contained extremely scant information and sweeping unspecific statements. Many returns had information that was clearly potentially serious, yet there was no corresponding intelligence within the diocese to further inform the reviewers of any investigation or update."*

Known Case List

The Known Case List within a diocese generally derives from the original Past Case Review. Over time this has often been utilised by individual dioceses for additional safeguarding cases arising, and as such would have extended to include other cases managed by the diocesan Safeguarding team.

However, as the Reviewers conclude in their report, the Diocese of Chester did not have an up to date Known Case List in existence. They say:

> *"Reviewers were however presented with a quantity of Safeguarding files that had been referred to the Safeguarding team initially, or through DSA proactive intervention. These files had been personally overseen from receipt of case by the current DSA, and each contained well documented chronologies of investigative progress."*

File quality and missing content

Some of the files reviewed were extremely dense whilst others extremely scant. In their report, the Reviewers state their concerns over the quality of some of the files and the content within them, saying:

> *"It was clear that within 'Clergy' Files, the initial (approximately) 50% of the files had been 'pre-weeded'. There may be several explanations for this, such as appropriate housekeeping of files in line with GDPR compliance, the main file being stored in a previous Diocese, or 'weeding' for a more sinister purpose. Without access to those documents, we cannot offer explanation. We received anecdotal information that the previous Bishop had arranged this process to commence via his now retired staff, but that the process was never concluded. Again, this could not be verified. The current Diocesan Bishop had been installed very recently and was clearly only at the early stages of acquainting himself with the filing system. As such he could offer no explanation."*

Number of files reviewed

The file review stage consisted of 2291 files, from which 253 "issues of concern" were raised.

Some of these concerns were beyond the scope of PCR2 and the way in which they were recorded meant that there was also significant duplication. However, all of the 253 concerns will be managed by the Diocesan Safeguarding Team and work is ongoing to investigate them and take action as required.

Some initial work has been done to review the data in order to identify which concerns were in the scope for PCR2 and to reorganise information where there were duplications. This resulted in a final figure of 136 concerns to be progressed by the Diocese as part of the PCR2 programme, but again, it is important to stress that all 253 concerns will be addressed. The Reviewers stated in their report that the 253 "issues of concern" range from "minor queries easily answered to major omissions and everything in between."

Onward management of "issues of concern"

Any issues of concern highlighted within the review process have been passed on to the Diocesan Safeguarding Adviser (DSA) for ongoing management. The Chair of the Diocesan Safeguarding Advisory Panel (DSAP) has been notified in respect of the on-going work that is required to be undertaken in order to conclude the issues raised within the "Appendix D" forms submitted.

Writing in their report, the Reviewers say:

> *"It should be noted that due to the resourcing issues faced by the Safeguarding team, the ongoing management of these concerns (App D Submissions) has not been witnessed by the Independent Reviewers within the timeframes of the review. Monitoring outcomes is indeed outside the remit of the role of Independent Reviewers. This position however does affect the Reviewers' ability to update the final report outcomes at this stage, in that we are not aware of the case finalisations.*
>
> *"Clearly, this is unfortunate, as many of the cases of concern submitted may latterly be negated or clarified as recorded and managed elsewhere, or within the memories of the relevant staff or DSA who dealt* (sic) *at the time. As such, it must be understood that this report highlights cases in the raw state that they have been reviewed. Unfortunately, without the benefit of knowing the case conclusions, we can only evidence what we have reviewed, at the stage it was reviewed. Any updates that those individuals could in future provide the reader at a later stage, may offer reassurance around case management. Of course, the failure to record those updates anywhere, at the time or since, should be considered an issue in itself."*

Victims and survivors

The Reviewers state in their report that survivors and victims were "central" to the PCR2 process, saying:

> *"Survivors and victims were central to the process. A member of the National Survivors' Consultative Group was invited in to advise the Reference Group and ensure their views and concerns were considered and addressed within the process. This individual has attended three meetings to date and actively contributed.*
>
> *"This included approval of the Survivors' Strategy that has now undergone further development and will be presented to Bishop's Council by summer 22. A Victor Whitsey Survivor gave input at the preparation of the Survivor Care Strategy Document.*
>
> *"The Survivors' Strategy continues to be funded with an initial £20k financial commitment from the diocese.*
>
> *"Meanwhile, the NSPCC hotline number and contact details for the Chester Safeguarding Team are clearly displayed on the website.*
>
> *"The Survivors who are currently engaged with the diocese will be invited to comment/contribute to this report.*
>
> *"Three survivors approached the Independent Reviewers directly during the review. These individuals met with the original Independent Reviewer Susanne Cottrell and a full review of that case has taken place. The family members concerned reported they felt listened to and encouraged by the PCR2 review process."*

Key themes

The Reviewers identified 13 key themes as part of the PCR2 process in the Diocese of Chester. The key themes were submitted to the National Safeguarding Team in April 2022 and will form part of the national PCR2 report.

The key themes from the independent PCR2 report are reproduced in full here:

1. **General Safeguarding**

   There is evidence to demonstrate that Safeguarding referral, investigation, and management in respect of children and vulnerable adults is improved following the original PCR. The investment in an experienced DSA has been invaluable to this process. The positive impact this has made, not just on safeguarding practice, but on the recording of safeguarding intervention, was well evidenced.

This remains directly dependant on the capacity of the Safeguarding Team, and we note recent investment thereof. Failure to address capacity issues within this department will severely affect business continuity. This will directly translate to an adverse effect on Safeguarding in the Diocese.

The Independent Reviewers have evidenced that the more recently concluded safeguarding concerns that have been managed and overseen by the current DSA have been well documented and appropriately risk assessed. The diocese can take comfort in this fact and in the experience of their conscientious DSA.

There has, on occasion been an over emphasis by the DSA to spend an excessive amount of time supporting survivors and their families which could have an adverse effect on business continuity. Whilst these interventions are commendable, there is a necessity to manage survivor expectations, and to outsource where possible (witness care teams, victim support, survivor organisations, counselling support, 3rd sector voluntary support organisations, unconnected pastoral clergy support to name but a few).

2. Safeguarding children

There is evidence to demonstrate that Safeguarding referral, investigation and management in respect of children is improved. Non-recent cases highlighted some concerning professional boundary breaches by Clergy or Lay staff in respect of children. Whilst one case highlighted a current, live, and unaddressed risk, this was the exception to the rule.

The review has highlighted the necessity to ensure that those within the church who are likely to come into contact with children have a clear understanding of professional boundaries that are to be maintained in order that inappropriate behaviour does not develop.

This is particularly important in respect of those who are themselves in the early stages of maturing, and who may be working with children who are not that dissimilar in age, such as some younger youth workers.

The review has also highlighted a potential gap in that some church roles that may not legally require DBS checks can be affected by role blurring, which may bring them into contact with children, for example organists, choir master, vergers, gardeners. Should those individuals, once trusted, help out at church events for example, they may be in a position where children would approach them for assistance. These individuals, and those roles where blurring can occur should be identified, and the necessary safeguarding training and DBS checking should be implemented as a local requirement.

3. Safeguarding adults

Safeguarding adults was not within scope of the original PCR. As part of the PCR2 the Independent Reviewers noted the following themes:

- *Bullying issues*
- *Complaint and CDM issues*
- *Inappropriate relationships / boundary breaches*
- *Issues relating to human sexuality (a number of disclosures made during discernment and Bishop's Advisory Panel (*clergy selection*) process, via appraisals and at times of significant stress)*
- *Stalking and harassment*
- *Mental health*
- *Financial Abuse / Impropriety*

4. Survivors

Historically, there is evidence that the vast majority of survivors were not treated appropriately within the diocese.

- *Historically, support, when offered, was often too late. The senior clergy often had a propensity to deal with safeguarding concerns 'in house' regardless of the seriousness of the complaint. The reputation of the Diocese appeared to be high on the agenda, and a fallback position of 'innocent until proven guilty' could delay support for a victim.*
- *Currently, there is a culture change in this regard with survivors being placed at the front and centre of the safeguarding work in the Diocese.*
- *Consultative Survivors' Strategy in place, following active Survivor Representative input.*

5. Statutory and voluntary agencies

IRs noted the importance of engaging with statutory agencies, good working relationships, sharing information and learning. There was evidence in a number of safeguarding files of the DST contributing to multi agency meetings when invited by the Local Authority Designated Officer (LADO) and examples of the DSA instigating contact with the LADO following a referral.

This was good practice and shows the understanding of safeguarding process and connectivity with statutory agencies. The DSAP process has now achieved a better, more diverse membership profile which will assist in this regard.

Voluntary Sector Agencies were underutilised, which result in some missed opportunities within the Survivor strategy and support systems. Whilst that has also been prevalent in more recent times, it is an improving picture.

Requirement for robustness of links, governance, accountability and sharing of information relating to paid chaplaincy/sector ministry.

6. Risk management in respect of peripatetic nature of staff

Risk Management Issues linked to the movement/peripatetic nature of Clergy members and other church officers (organists, choir etc).

- *Potential fragmentation and missed information between departments across the Diocese where responsibility for files is split and file storage is in different places.*
- *The necessity for robustness and scrutiny around safeguarding training.*
- *Safer recruitment – particularly continuing to ensure DBS checks are recorded and maintained in an up to date living document manner. The need to ensure that DBS self-declarations are both accurately and expediently completed.*
- *DBS considerations for those who may be in roles where 'blurring' occurs bring them in to contact with children and/or vulnerable adults.*
- *Safeguarding record-keeping has been poor historically, and the importance of the same needs to be ingrained in all safeguarding training modules.*
- *The importance of early identification and liaison with the Diocesan Safeguarding Team at an early stage of Safeguarding. Again, this should be incorporated within Safeguarding training modules.*
- *Reader, Lay and Volunteer Files should be created centrally in order to ensure robust management systems are in place.*
- *The DST should adopt a consistent process to ensure that information regarding those who may pose a safeguarding risk is shared with the appropriate Business Lead and cross referenced on the personal file. (Accurate cross referencing needs to ensure that corresponding information is held on the individual's personal file. This in turn will support the ongoing management of risk, welfare and concerning patterns of behaviour, which in turn will facilitate a robust process around providing accurate references and/ or safe to receive assessments.)*

7. Domestic abuse

- *Non-recent cases illustrated a pastoral care approach to DA cases and failure to refer to appropriate agencies for investigation and management.*
- *Signposting of survivors to voluntary sector agencies was poor resulting in missed opportunities to support those affected.*
- *The focus had been on infidelity rather than domestic abuse.*
- *The diocese now has a good understanding of domestic abuse implications and management processes.*

8. Culture

- *The review can evidence a reluctance historically for the previous Senior management to engage appropriately with and refer safeguarding concerns to the DSA. This was particularly evident with Clergy staff issues as opposed to lay issues, and where additional disciplinary or pastoral support was offered, or when safeguarding was not the central issue. Historic strategic BSM (Bishop's Staff Meeting) minutes provide good evidence for such failings. Despite proactive action made by the DSA on occasion in respect of case intervention, the exclusion had remained.*
- *Historically, there has been a reluctance to intervene regarding safeguarding disclosures made by those early in their ministerial career or disclosed via the discernment and assessment process, or within appraisals of those staff. Understanding how to manage disclosures, and understanding when confidentiality does, or does not apply is key to the handling of these sensitive situations.*
- *Culturally there has been a strong desire to manage safeguarding by moving the offending individual to a new role and keeping the matter 'in house'. We have evidenced less recent cases where the Diocese has encouraged victims not to approach outside agencies. On occasion this has been inappropriately backed up by suggestions around 'forgiveness' and what God would want. This reluctance to share the information more widely with outside statutory or voluntary organisations had been detrimental to victims and is reflective of a desire to preserve the reputation of the Church. This also leads to wider vulnerability within public protection beyond the church doors.*
- *Safeguarding issues relating to parish clergy, and those residing in vicarages, was often seen as 'coming with the territory'. In particular, issues of stalking and those encounters surrounding parishioner mental health behaviour often went unaddressed. Additionally, the diocese was less inclined in the past to recognise the high stress levels parish-based clergy may encounter.*
- *Historically, Domestic disputes in particular between clergy relationships have resulted in some limited or on occasion good pastoral or counselling support, but the aim appears to have been to ensure that the couple remain together. Often this is the wrong decision and victims may face further harm. Religious perspectives on divorce, and reputational concerns appeared to be the driver in these cases.*

9. Clergy Infidelity

Historically, the investment of time into the investigation of Clergy infidelity or Clergy marriage breakdowns seemed to outweigh investment made into the investigation of domestic abuse, or child or adult safeguarding issues. Reputational damage seemed to be a high cause for concern in most cases. The safeguarding aspect within such cases was often overshadowed by the desire to reunite the couple and save the marriage.

10. Diocesan Safeguarding Team capacity

Safeguarding Team Capacity *– The Safeguarding team capacity and resourcing at the commencement of the review was woefully inadequate. The IRs recognised at an early stage of the process that Chester Diocese Safeguarding team in post at the time of commencement of the review, was minimal in terms of resourcing, consisting of an experienced DSA (Diocesan Safeguarding Advisor) with only sporadic administrative support.*

Despite the lack of capacity, the Reviewer's noted that the recently concluded safeguarding concerns managed by the DSA had been well handled in an effective and timely manner. Nevertheless, the ability to maintain effective business continuity of ongoing safeguarding concerns and issues is capacity dependant. The DSA has recognised herself and has rightly highlighted to the Independent Reviewers that the workload exceeded her capacity levels. Indeed, we have witnessed in documentary form these concerns having been raised to little effect by the DSA for several years.

It is to the credit of this individual that she has managed to remain so effective and proactive under this level of demand over such a protracted period. Throughout the review this was highly apparent as we witnessed first-hand the excessive demands placed on one individual. This in itself was becoming a major safeguarding risk for Chester Diocese, and its ability to handle safeguarding effectively. An example of this increasing risk was the lack of capacity by the DSA, alongside daily business, to review the original Appendix D (Cases of Concern) forms submitted by Suzanne Cotterill the previous Independent Reviewer, and latterly the appendix D forms submitted by ourselves.

This necessitated very high-risk cases needing urgently highlighting to mitigate current and still (then)outstanding risk. The DSA was often embroiled in the management of these high-risk interventions and risk management plans, which further reduced her capacity to deal with daily business concerns. This situation was clearly averse to the individual concerned and to Diocesan safeguarding strategy.

We report below on some welcome improvements in this situation but remain mindful that Appendix D intervention work and safeguarding interventions remain reliant on appropriate resourcing to function well and reduce risk exposure.

Update *- During the latter stages of the review, we have been pleased to report that some much overdue investment into the Safeguarding Team has been made, with the recent recruitment of an experienced Assistant DSA from a policing background, an ongoing recruitment process for a Safeguarding Trainer, further administrative assistants, and an ongoing recruitment process for a paralegal to service safeguarding meetings.*

These changes will clearly enhance safeguarding capacity and will negate what must have been an extremely detrimental effect on the wellbeing of the current DSA. ***The***

decision by Chester Diocese to invest in and increase the Safeguarding Team is the single most important strategic decision made that will translate into Chester Diocese being a safer place for Children and Vulnerable adults.

11. Complex case management

Whilst there may be no easy answers, the Independent Reviews have noted that DSA involvement in particularity complex and protracted safeguarding case (often those with disciplinary matters running parallel) can have a crippling effect on capacity of a Safeguarding Team. Much time in these cases is invested in Core Group attendance, subject access requests, employment Law Considerations, and extensive survivor support and management.

The diocese may wish to consider contracting particularly complex cases out to maintain the capacity of the team.

12. DSA Exclusion

The current DSA had been in post since 2014. The reviewers have seen documentary evidence, in particularly historically, to demonstrate that the Diocesan Leadership has had a propensity to exclude the DSA from some matters that related either centrally, or peripherally to safeguarding.

This is predominantly when the subject of the issue is a Clergy member, when there seems to be a leaning towards managing the collective issues, including the safeguarding in a more central framework, be it pastorally, disciplinary or both. Much of the collated material evidencing these failings are located within the BSM (Bishop's Staff Meeting) minutes, where we have noted that some information has been deliberately withheld from the DSA.

Whilst this legacy may have been precipitated by the previous Bishop (evidence of which has been clearly identified in email correspondence between the DSA and the previous Bishop), we are informed that Senior Management did not appear to appropriately challenge these exclusions. We note that BSM members would also be at that time the direct line managers of the DSA, therefore this position must have felt at times extremely difficult to challenge. It is vital that there is no misunderstanding remaining within Chester Diocese and that all matters relating to safeguarding must be passed to the Safeguarding team for triage.

All senior management must have a full understanding of how safeguarding presents, in order that there can be no rational for misunderstanding in respect of the duty to refer to the DSA, nor any collusion to act outside protocols as we have evidenced under the directorship of a previous Bishop. This message must be enforced by the current diocesan Bishop, who we have found to be extremely proactive in his desire to increase safeguarding understanding and collaboration throughout the Diocese.

13. Disconnect between the Diocese and Cathedral Chapter

The Independent reviewers have also noted both personally through our interactions, and through documentary evidence, a disconnect between the Cathedral Chapter and the wider Diocese with regard to safeguarding. We noted for example that whilst Cathedral Clergy DBS was managed via central HR, the Volunteers and employed staff are managed inhouse by the Cathedral staff. Worshippers, offenders, staff and volunteers may clearly transcend across both establishments and a more collaborative approach to safeguarding would be mutually beneficial.

An interrelated digitalised recording of safeguarding concerns would ensure a clearer overview. During the review we noted safeguarding cases within the cathedral that were not in the knowledge of the DSA, and some safeguarding cases related to the Cathedral not maintained or provided us by the Cathedral Chapter. A centralised system would prevent slippage.

We note and welcome that the Cathedral Lead is now able to attend the DSAP, and this should improve joint working protocols. However, Independent Reviewers have been made aware of a degree of inter Cathedral / Diocese politics that have previously hindered the response to safeguarding concerns being shared and managed collaboratively. This has left the Dean feeling vulnerable. Any role of lead Safe guarder requires access to peer expertise and specialists.

When these are not in place vulnerability is inevitable. Whilst the issue possibly rests at a strategic level, the practicalities of joint working have perhaps been also frustrated or adversely affected by the DSA's lack of capacity to incorporate Cathedral Safeguarding onto her already extensive workload, despite her desire to do so since the appointment of the Cathedral Safeguarding Officer in 2019.

The journey to improve this connectivity appears to be in its infancy, supported by the Dean's enthusiasm to make the Cathedral a Safer Place, and a proactive and new Diocesan senior management. This pathway to improving communication, inclusivity, and shared protocol - despite the implementation of a Terms of reference in 2020 to facilitate joint management of safeguarding issues when required - has a way to go, to establish trust and to build a genuine team ethos.

At present, the Reviewers' perception is that in respect of Safeguarding Practice, the Cathedral Chapter is somewhat alienated from the Diocese in respect of support and inclusive practice. This silo working is never beneficial in a safeguarding environment.

Conclusions

Writing in their report, the Independent Reviewers stated their conclusions, the entirety of which can be found below. All emphasis, including bold type, grammar and punctuation is reproduced as written by the Reviewers in their report:

SECTION	CONCLUSION / THEME
Conducting PCR2	PCR2 was conducted in line with the requirements of the Protocol and Practice Guidance of July 2019. This included establishing a Reference Group. Two Independent Reviewers were secured (equivalent of one full time post) and undertook the review commencing in in April 2021 concluding in April 2022. • **Geographic Storage of Files** – The Reviewers noted issues arising from the separation of files, stored in different places, and administered differently. Of concern was the fact there is no written process for sharing information between Bishop's House Clergy Blue files and the Safeguarding Team, or the Cathedral Safeguard files and the Safeguarding Team. Should the DSA need to access Blue Clergy files, or Cathedral Safeguarding files urgently this is severely hindered by geography, and by arranging an individual to secure the access. Within Bishop's house, locating the file may also be a time-consuming process. We estimate, not including reading the file, the turnaround process in each case exceeds 90 minutes. This is impractical. Whilst interim measures may be considered, digitalisation of filing systems is clearly the way forward. • **Reader, Lay and Volunteer** - Files should be created centrally in order to ensure robust management systems are in place. • **Appendix D statistics** - It is important to review Appendix D statistics from this review with caution. The Independent Reviewers have submitted a large amount of these documents in order to ensure the DSA is well placed to accurately result each concern. In so doing, Independent Reviewers have often separated issues out generating more Appendix D's than required, for example on occasion 2 or 3 small issues each within separate forms. Some files are duplicated, and this can result in several App D submissions regarding the same

	issue. Also, a safeguarding issue may be raised within for example the parish return, the clergy file, and within a safeguarding file. This may generate 3 Appendix D forms being submitted for the same issue. Additionally, many Appendix D forms relate to issues that have occurred outside this diocese, or even outside this country. The parish returns were received by the Independent Reviewers in such a poor state, that nearly each return was transferred to an Appendix D form for clarification purposes, regardless of whether they were merely a repeat of a safeguarding matter managed appropriately elsewhere. Finally, many Appendix D forms may not subsequently relate to safeguarding at all. The Reviewers have been faced with illegible writing, incomplete documents, and difficult to decipher comments that may or may not relate to a safeguarding matter. For the purpose of completeness, these have been submitted using the Appendix D as the vehicle to seek the clarification. • **Timescales** - The Review commenced in April 2021 concluding April 2022. It was indeed the last diocese in the process within the country to be completed. This resulted from a late commencement date, proceeded by a 'false start' with an Independent Reviewer who was subsequently found to have a conflict of interest, and was stood down (Previous role as LADO in area). The newly appointed Independent Reviewers (2 reviewers incorporating a 'job share' amounting to 1 full time post) continued working despite national lockdowns and 2 bouts of COVID, from either their homes or the Diocesan offices. In 2022 newly appointed proactive management staff from Bishop's House identified a large quantity of documentation that was undeciphered and may relate to safeguarding. This sifting review added to the review timescales. The Parish Returns were in a poor state, resulting in submission of multiple Appendix D Forms. This transferred to vast amounts of time being utilised against what was already a tight deadline. • **KCL** - The Independent Reviewers found that the Diocese had no KCL (Known Case List), and no formal Reader or Lay files. The gap in the latter is concerning as safeguarding concerns are not therefore maintained within a subject file.

	• **Parish Returns** - Returns were not translated into managed issues updated to a Known Case List but were concerningly presented to the Independent Reviewers by the DSA in the raw, often badly handwritten format. As such, many were complex to decipher, contained extremely scant information and unspecific statements. Many returns had information that was clearly potentially serious, yet there was no corresponding intelligence within the diocese to further inform the reviewers of any investigation or updates. This increased time parameters and resulted in the production of excessive clarification Appendix D Forms being submitted. Many of these have yet to be finalised by the Safeguarding Team, rendering the Independent Reviewers in a position where they cannot provide update within this report. • **Missing content in Files** - It was clear that within 'Clergy' Files, the initial (approximately) 50% of the files had been 'pre- weeded'. There may be several explanations for this, such as appropriate housekeeping of files in line with GDPR compliance, the main file being stored in a previous Diocese, or 'weeding' for a more sinister purpose. Without access to those documents, we cannot offer explanation. • **Onward management of Actions raised via Appendix D Forms** - Until recent months the Diocesan Safeguard Team Capacity was severely depleted, and the DSA was under severe pressure, and over capacity. This was a serious concern not just for the onward progression of the review findings, but for daily business continuity. The reviewers were concerned and constrained by the lack of progress to address safeguarding concerns raised during the review that required intervention. As the review has progressed the safeguard team had benefitted from an increase in resourcing, and we are more satisfied that the safeguard issues raised are being addressed. This will require onward monitoring as the situation remains capacity dependant.
Findings Safeguarding Children	• **Safeguarding of Children has improved within the Diocese** - The Independent Reviewers were reassured that modern day safeguarding concerns raised within Chester Diocese in respect of children would be recognised sooner, referred to the safeguard team more expediently, and managed more effectively than they

	would have been prior to PCR1. The implementation of an experienced DSA, Safeguard Training roll out, and Parish Safeguard Officer implementation has been key to these improvements. The Independent Reviewers were able to see a clear improvement over time in the process when a complaint was made relating to safeguarding issues in respect of children. • **Voice of the child currently more likely to be sought -** Historically the IRs noted that the child's voice was not always heard but they were able to report that there was recent evidence to provide assurance that this was more likely to happen in currently reported safeguarding cases. The impact of the original PCR and the review of past cases of safeguarding children appeared to have had a beneficial impact since the 2007 – 2009 initial review period. • **No evidence of Systemic Offending against Children** - The reviewers saw a concerning history within Chester Diocese of past case sexual and physical abuse against children, or disclosures or intelligence suggesting such abuse. Several cases were known in the public domain and had national oversight. It is acknowledged that such cases have placed a spotlight within this diocese (Pearl report). It is not the reviewer's opinion that this level of abuse and offending against children is ongoing. The Independent Reviewers are content that there is appropriate oversight and ongoing action in this Diocese or elsewhere in relation to the past cases highlighted surrounding abuse in Chester Diocese – Particularly around the Previous Bishop's, and that the current position within this diocese is appropriate to manage future complaints appropriately. The caveat on this is that those complaints are brought to the attention of the Diocesan Safeguard Team, and not managed in silo within parishes, or within Senior Management Teams without the expertise of DSA oversight. • **Several outstanding cases of risk of harm to children was identified**. **These were swiftly addressed -** There were several more recent cases where the risk posed by an individual working within the Church could be deemed of concern, and action in those cases was taken expediently.

	• **Referrals to statutory agencies improving, and DSA Social Care background** - Referrals to Statutory agencies and collaborative partnerships with the local authority, the Police and Social Care has dramatically improved the Diocesan Capacity to Safeguard Children. The DSA's background in Children's social care and her commitment to Continued Professional development especially around the management and assessment of risk brings specialist expert knowledge into the forefront of the Diocesan commitment to safeguard children within the church setting. Chester Diocese is currently working well within the House of Bishops Guidance in relation to safeguarding policy and protocol when the concerns are escalated to the DSA for management and oversight. • **Safeguarding Children in Diocese totally reliant on Safeguard Team Capacity** - Successful safeguarding in this Diocese will always be codependant on the capacity and resourcing capability of the Diocesan Safeguard Team, and early recognition and referral into that team by those identifying safeguarding concerns. It is also dependant on a topdown strategic culture that recognises and embraces the priority of safeguarding. All issues relating to Safeguarding Children must be overseen by Diocesan Safeguard Team. Safeguarding Children is less effective within Chester Diocese when safeguarding concerns in relation to Children are not escalated to the DSA. • **Safeguard Training** - Safeguarding Children is improving across the diocese due to the continued roll out and uptake of Safeguarding training within the parishes and across the church establishments. • **Managing Sex Offenders** - The IRs felt that the management of such offenders in the past was unreliable. Where Sexual Offenders within their own ranks are charged and convicted as a result of the British Justice system Chester Diocese perform well in line with support from statutory agencies and benefitting from their decision making. Chester Diocese can be too reliant on Statutory Agencies being central in their decision making in the early stages of their Clergy or Lay Staff being investigated for sexual offending. Reticence to manage perceived risk by suspension and restriction of role on the basis of "Innocent until proven guilty" has in

	the past failed to protect against further offending and provoked a lack of resilience in safeguarding matters. This may be to some extent because of the reliance on difficult to navigate National Policies that fail to empower senior managers within the capacity to make appropriate and robust decisions in the management of those considered a risk. This in turn exacerbates risk and reduces the ability of the Church to manage risk appropriately to strategic constraints. As Independent Reviewers we are not conversant with CDM procedure, but comment that if this system is not fit for purpose then the Church of England must review it to ensure that children and vulnerable people can be protected from harm during the investigative stages of an enquiry. Previously risk management of Sexual offenders either convicted or those subject of current or previous investigation has been inadequate due to the management of this risk remaining within the Parish environment. This increased the propensity for further offending as a result of greater access to children and vulnerable adults within the church setting. Due to a previous lack of appropriate training within the parishes managing these cases, this resulted in an over reliance on an individual's personal knowledge and experience of the case. The systems in place remain Parish based with oversight of the DSA and as stated, are reliant on the appropriate resourcing of the Parish Staff and adequate handover during staff transitional periods. Worshipping Agreements can place risk appropriate constraints on a sexual offender who wishes to continue to worship in a parish, and managed appropriately, these can work well in keeping parishioners safe in the Church environment. The ongoing management of Clergy or Church officers convicted of sexual offending was historically poor due to a desire to protect the church reputation over victim focus and management of potential risk. This is an improving picture and the Independent Reviewers have seen some more recent well managed and risk assessed cases of offender management via Worshipping Agreements which are robustly managed. This expertise is still DSA-centric and reliant.

	Close multi-agency working with Police and Probation Offender Managers via DSAP, or inter-agency linkage is vital, and the diocese should consider negotiating information sharing agreements with these organisations to remove the bureaucracy that can lead to delays, and poor safeguarding practice in respect of information transfer. The often-transient nature of sexual offenders also needs managing. The Diocese is committed to attempts to establish move on plans and in turn notify the relevant statutory agencies/other faith denominations/local area neighbouring parishes as appropriate. This is seen as good practice. The Diocese should be informed of prison release dates and ensure clear links with offender managers to ensure there is a plan to mitigate the risk of an undetected return, especially where those connected to the church formally are concerned. This level of diligence is vital to ensure that children and vulnerable adults remain protected. A proactive approach to offenders moving on must be adopted and maintained at Parish and diocesan levels. In addition to annual review, consideration could be given to a safeguarding exit interview or proforma in respect of those leaving a post, to capture the live safeguarding issues. This of course, may require additional resource investment. Historically, there was a lack of understanding of the deviance that can be associated with such offenders, and a propensity to work in silos, with information relying only on local staff knowledge. Internal bespoke training has addressed some of these knowledge gaps. Managing such offenders for any organisation carries complexities and the risks associated with poor management can be high. The transience of some offenders can add to this burden. Bespoke Sexual Offender Training packages come at a cost to the Diocese, and training cannot always be resourced internally from an overstretched Safeguarding Team. The Diocese may need to consider outsourcing this work to sex offender specialists.

	• **Professional Boundary issues, especially in less mature leaders** - The review has highlighted the necessity to ensure that those within the church who are likely to come into contact with children have a clear understanding of professional boundaries that are to be maintained in order that inappropriate behaviour does not develop. This is particularly important in respect of those who are themselves in the early stages of maturing, and who may be working with children who are not that dissimilar in age, such as some younger youth workers.
Findings Safeguarding Adults	• **Safeguarding of Adults has improved within the Diocese** - The Independent Reviewers were again reassured that modern day safeguarding concerns raised within Chester Diocese in respect of vulnerable adults would be recognised sooner and managed more effectively than they would have been prior to PCR1. The implementation of an experienced DSA, Safeguard training roll out, and Parish Safeguard Officer implementation has again been key to these improvements. This reassurance comes on the basis only of those cases that are referred into the Diocesan Safeguard Team expediently, and again, this is key to the successful management of the case. • **Context of Cases Reviewed** - Often extremely Historical - whilst the Independent Reviewers fully recognise that a case never becomes 'historical' to a survivor, it should be highlighted that many of the particularly concerning cases highlighted within the findings occurred in a very different era, in some cases as far back as the 1940's. This does not of course diminish their seriousness, but it should be acknowledged by the reader that these types of instances are not occurrences that we are seeing frequently in current case papers. Like all organisations, there will be serious safeguarding that still occurs. Our experience has been that the prevalence of historic abuse is not evidenced within the documentation we have read that would suggest any pattern of abuse is ongoing in this Diocese. That is, of course, not to say that incidents of serious abuse could not be identified in the future. Whilst reviewing the learning from the cases presented it should be noted that improved practice and a better understanding of safeguarding within the Diocese has rendered a repeat of past failures less likely.

	• **Previous Adult Safeguarding Cases dealt with Inadequately** - Historically, the IRs identified that the initial response to safeguarding adults' concerns, including those involving the clergy (either as a risk to others or to themselves) was generally poor and dealt with pastorally. • **The DSA - Wellbeing** – The Independent Reviewers have highlighted that the DSA has been under extreme pressure, and was certainly over capacity as the sole member, until recent times of the Diocesan Safeguard Team in a large Diocese. This pressure to some extent seems to be continuing. This needs careful monitoring as it is no doubt a standalone safeguarding concern. The Independent Reviewers remain somewhat concerned as this pressure was originally highlighted as far back as the Pearl Report 2019. They have seen regular reference to this issue but little reference to any support being offered. The previous culture adopted by the past bishop and potentially not challenged by his then staff team (some of whom were likely to be the DSA managers) was exclusionary to the DSA which must have caused considerable distress to the individual. The DSA safeguarding workload has been conducted to a high standard. The Diocese needs now to recognise this extraordinary effort, whilst at the same time recognising, as the IR's have, that this individual is now in much need of some wellbeing support and recuperation. • **3rd Sector referrals** - We have identified a gap in service and victim provision in that the Diocese has often not referred victims into the support networks provided by 3rd sector voluntary organisations e.g., Wish Centre for Domestic Abuse Victims. There is a necessity to manage survivor expectations, and to outsource support where possible (witness care teams, victim support, survivor organisations, counselling support, 3rd sector voluntary support organisations, unconnected pastoral clergy support to name but a few). These organisations/ individuals are often far better equipped and specialised to assist a survivor, but we fail those survivors when we as experts do not ourselves recognise the benefits available, and therefore do not fully explain them to the victim, resulting in a refusal from the victim to allow the referral.

	• **Domestic Abuse** there has been a leaning towards a more pastoral approach to Domestic abuse cases historically, rather than towards the making of external referrals to appropriate agencies. Failures to refer domestic abuse to voluntary or statutory services often resulted in the victims failing to gain access to invaluable resource and support. The emphasis for this approach historically seemed to be to keep the couple (in marital abuse situation) committed to one another. Finances were often made available for professional counselling. This approach could leave a victim vulnerable to further attack and unsupported to leave the relationship, and the offender unmanaged. Whilst this is not the case currently, and referrals are made into statutory agencies as appropriate i.e., police, adult safeguarding teams etc the Safeguard Team must avail itself of the constantly changing 3rd sector opportunities to assist the victim to move on with the benefit of a professional support network. The diocese must recognise that when a clergy marriage ends, not only does the clergy member or wife lose a partner and their self-esteem, but often (especially in the case of Clergy wives) they lose their entire church community, their home and their access to ongoing financial support, which can be extremely isolating in respect of move on plans. Domestic Abuse Charities can often serve to re-build new networks, and confidence in the individual. Whilst the Christian Faith is keen to assist married couples to remain together, this should never be at the expense of the victim's emotional or physical wellbeing. In the past, a greater prevalence was placed upon clergy infidelity or marital breakdown than to addressing safeguarding issues associated with domestic abuse. There were a significant number of CDM's relating to Clergy adultery and there appeared to be more focus on infidelity than domestic abuse within the files. • **Domestic Abuse** - **Children** - Historically, there was a lack of emphasis or even safeguarding reference to children that may be caught up in domestic abuse issues between their parents. Reports of domestic abuse where children were involved were not referred and statutory agencies were not informed on the child's behalf. It is clear that in current cases when safeguarding issues relate to a child that they would be heard more readily,

	dealt with more sensitively, positive intervention would be considered, and referrals would be made to the appropriate statutory agencies. • **Spiritual Abuse / Deliverance Ministry** – The Reviewers identified that Deliverance type ministry has been unregulated historically. The diocese should ensure robust, specialist policies are in place to prevent this type of abuse, and that within this type of ministry the subject and minister's mental health vulnerability is administered to and managed appropriately throughout, via professional intervention where appropriate. **Key themes:** • **Bullying** - The Reviewers noted that the term 'bullying' is over-used and often inaccurately used. Many of the concerns identified as 'bullying' throughout this review were swiftly negated following clarification or have been shown to be internal disputes between parties. The review did indeed highlight further cases whereby the diocese failed to investigate serious allegations of bullying. The Reviewers did see some limited evidence of a previous culture of acceptance and excusing behaviour in respect of bullying cases being raised, often moving on one or the other party from their roles rather than dealing with the issue presented, and often excusing the offender as it was 'just how they were'. • **CDM** – The Reviewers witnessed difficulties expressed by those managing working within the confines of the CDM process who felt constrained to be able to safeguard others via suspension of the individual facing investigation. This would seem to suggest that the CDM process may not be fit for purpose, in that it failed to allow them in many cases to safeguard others. Should this be the case, the National Team should review the process and legislation. • **Stalking and harassment** - When Clergy members suffer the effects of stalking or harassment they can be profoundly and adversely affected. The distress often affects the minister's entire family. Historically there has been a propensity to try to deal with these cases in a pastoral manner, and the victims have often felt unsupported by the Diocese. There appeared to be a

	culture historically by the victim of reluctance to raise the issue to the diocese in a timely manner, or for the Diocese to intervene, or for either party to formalise the concerns. There was a tendency to try to deal pastorally, especially when the offender was considered to have some form of vulnerability themselves. Stalking offences were minimised, and the seriousness of the issue was not given due regard by either the Diocese or in some cases, the Police. The importance of documenting and recording incidents from an early stage of the offending is also vital, as is the removal of the clergy from any 1:1 support of the individual and the implementing exit strategies where necessary. Stalking offences are relatively new, because of this we noticed in the past that the Police could also fail to recognise the serious nature of stalking offences. We think that both the Police and the Diocese have improved in their understanding of this offence. Clearly the effects on the victim can be life changing and should be recognised early and never underestimated. • **Mental health** – Many of the safeguarding concerns reported had elements of mental health. There were concerns in relation to the impact of dealing with people with mental health issues, not least the impact on clergy dealing with parishioners. The IRs also indicated the lack of awareness in recognising mental health problems in correspondence and other interactions, although conversely, we saw some good practice in this regard. • **Clergy Stress Levels** - The Reviewers did recognise a pattern in respect of evidence to suggest those in ministry, particularly parishbased ministry, suffered from stress and work-based anxiety. Once the issue has been highlighted there is in the main an excellent response, but this is often too late in the process. Long hours, a lack of work / life balance, over exposure to stressful situations and high emotional reliance by the Parishioners is a key factor in Clergy Stress. • **Financial Abuse/ Financial Exploitation of the Vulnerable** The diocese needs urgently to adopt a policy around the receiving of monetary gifts/benefacting of wills to clergy members. Transparency needs to be adopted when parishioners are minded to bequest large sums to vicars to ensure said vicars are not of a mind to exploit such individuals in their final months of life. In the

	cases we have reviewed, often the individual, rather than the parish personally benefits from the gifts provided or left in wills. Any such money should be fully disclosed to the Diocese, and a professionally inquisitive process of investigation should be progressed. This should be built into safeguard training as, essentially, unacceptable. Clergy, acting in a capacity of servant leaders, should not financially gain from their parishioners.
Recommendations Victims/Survivors	• **The Survivors Care Strategy** is in place and is being used appropriately, funded by a budget to enable survivors to access support services There was evidence to suggest that the additional vulnerabilities of victims in past cases were often overlooked. Historically, support, when offered, was offered too late. The senior clergy often had a propensity to deal with safeguarding concerns 'in house' regardless of the seriousness of the complaint. The reputation of the Diocese appeared to be high on the agenda, and a fallback position of 'innocent until proven guilty' could delay support for a victim. Currently, there is a culture change in this regard with survivors being placed at the front and centre of the safeguarding work in the Diocese. The Reviewers have seen some really positive survivor interventions and support more recently. Indeed, we have commented that the DSA has gone too far in this support on occasion. We have suggested some of this support is outsourced or delegated. The Reviewers are pleased to report a much-improved recent picture in Chester Diocese in regard to Survivor Care.
Findings Links with Statutory Agencies	• There was clear evidence of engagement with statutory agencies in the case records, including in line with Working Together to Safeguard Children and the Care Act, 2014. Information sharing was highlighted as a specific barrier to effective multiagency working by the DSA/ADSA. The DSA has built up good working relationship with some statutory agencies and regular consultation and information sharing is ongoing where opinions are freely exchanged. The Police and Probation services as well as the prisons lacked consistency in response and on occasion hindered the Churches ability to adequately manage risk.

	Sector Chaplaincy - The review highlighted the risks associated with having poor diocesan communication between the Diocese and the supervisors/ governing bodies of those agencies supporting sector chaplaincy such as hospitals, prisons etc. It should be noted that this refers to paid chaplaincy or sector ministry. This could result in serious risk being unchallenged. The Diocese needs to be confident that a safeguarding risk or investigation (or other disciplinary issue) allegedly committed by a church officer working offsite would be effectively communicated between organisations. Diocesan Supervisor and Chaplaincy Placement supervisory links have been poor, and we have no evidence that this situation has changed. This has enabled Clergy who have acted inappropriately to return to Diocesan ministry unchecked, which on occasion has placed others at risk of victimisation.
Findings Risk Management	• **PCR2 Recommendations and Implementation Process** - It has been unclear to the Reviewers on occasion as to line management and ownership of oversight and responsibility / accountability. As such it has been complex to break down the relevant actions raised into departmental areas of responsibility. As the lead for safeguarding the Bishop will be responsible for ensuring the recommendations are embedded within practice in the Diocese. • **Information Sharing Agreements -** It is clear that there is a National Information Sharing project in train, but information sharing is a major concern across all elements of Ministry in relation to both Clergy and those working within the church community. Information sharing agreements should be a clear matter of policy and should relate to Information sharing not only between Statutory Agencies, but between Parishes / Diocese and the Cathedral. • **Split File Storage** - Potential fragmentation and missed information between departments across the Diocese where responsibility for files is split and file storage is in different places.

	• **The management of filing** - Security in general around file storage was good. We recommend clear booking in and out processes (excluding blue files which remain on site unless removed around the building) and the creation of Reader and Lay, and Volunteer files. • **GDPR Compliance** - There was a concern with relation to GDPR compliance within many of the files whereby confidential information referring to an unrelated clergy member was contained within the body of an unredacted document stored within a personnel file belonging to a third party. • **DBS Process** - The need to ensure that DBS self-declarations are both accurately and expediently completed. We have raised queries in respect of the system being an administrative process, and the potential likelihood of those wishing to minimise blemishes on self-declarations being able to circumnavigate the system. Collaboration with the Diocesan Safeguard Team will be important to close this potential gap. We have also raised our concerns regarding volunteer or paid roles which legally may not require DBS, yet in a Church setting may incur some role-blurring and have given examples in this regard. Transparent understanding of the nature of the role and the potential blurring should dictate what checks are required by local agreement. The individual roles themselves should be reviewed annually to identify any roleblurring that may have increased the individual's access to children or vulnerable adults, and a DBS request made if this is the case. Personnel files need to clearly evidence DBS level, renewal date and a record of past disclosures. • **Sharing of Information in respect of staff moves** - The Reviewers identified on occasion a failure to share information when people move between parishes, diocese and beyond. This is vital to safeguarding. • **Parish Safeguarding Officers** - There is further work to do to strengthen the role and recognise the importance of the parish safeguarding officers by providing appropriate training and support. Continuous professional development is also a factor, and the diocese should encourage PSO's to take responsibility for

	their own development as well as undertaking training provided by the diocese. • **Safeguard Team Resilience** - Due to depleted strength within the department the DSA at Chester has been working without an assistant or dedicated administrative support. The recruitment of an assistant DSA has been a long awaited and much welcomed addition. It is clear that this lack of support has significantly affected the DSA's personal wellbeing and her resilience to manage demand. Such was the concern of the Reviewers that they raised concerns about her welfare to senior management. This is not acceptable, and we are pleased to note further investment into the team. Onward monitoring required. • **DSA Exclusion** - The review can evidence a reluctance historically for the previous Senior management to engage appropriately with and refer safeguarding concerns to the DSA. This was particularly evident with Clergy staff issues as opposed to lay issues, and where additional disciplinary or pastoral support was offered, or when safeguarding was not the central issue. Historic strategic BSM (Bishop's Staff Meeting) minutes provide good evidence for such failings. Despite proactive action made by the DSA on occasion in respect of case intervention, the exclusion had remained. The current DSA had been in post since 2014. The DSA must be the central figure in safeguarding issues managed in the Diocese. • **Safeguarding training** – The necessity for robustness and scrutiny around safeguard training. We are pleased to see the focus upon training all relevant staff. The Independent Reviewers noted that a small percentage of clergy coming from other dioceses who were granted PTO did not always have record of up-to-date training displayed on their files. • **Safer Recruitment** – Overall, the Diocese has demonstrated a strong commitment to Safer Recruiting protocols, and much work was done to ensure new recruits were subject of the relevant checks dictated by the role profile. There were however some issues that were apparent. All DBS checks need to be in date and submitted with complete and accurate information to

	ensure the appropriate level of risk identified. The Review highlighted cases where those with blemishes could minimise these on the DBS, despite the issues being well known, and even investigated within the Diocese. • The Reviewers also have concerns around Volunteers, Lay and Readers as there does not appear to be any central managing system or oversight, and many are not DBS checked despite their roles often having spontaneous interaction with children and vulnerable people. • **Inappropriate relationships** – There was evidence that in the past such matters were not managed appropriately by the Diocese and allowed to continue for too long before intervention. We are confident that this is not the case now. This subject should be high on the agenda for safeguard training. We identified that younger leaders (Youth workers etc) would particularly benefit from this aspect of training. Inappropriate relationships by Clergy members are particularity concerning in respect of the power imbalance, and because parishioners approach them for support and moral guidance. Whether the abuse is through sexual relationships or financial grooming, the parishioner in many cases would have had vulnerabilities by the nature of the original approach made to the clergy member. Such cases must be robustly managed and a topdown culture of the unacceptance of these offences must be emphasised. • **Cathedral/Diocese Disconnect** - We have evidenced a disconnect between the Diocese and Cathedral Chapter in respect of Safeguarding. This disjoin is averse to diocesan safeguarding, and leaves the Dean alienated from necessary expertise, top cover and support. Safeguarding issues can be lost between the Cathedral and the Safeguarding Team with an unclear information sharing strategy. This should be rectified. • **DSAP membership** has been sporadic. It is incumbent on statutory agencies to provide membership to the group in order that effective expedient information sharing can occur. This directly links to good safeguarding practice • **Choir Leaders or Organists / Musical / Other volunteer roles** - We have evidenced that child and adult

	abuse can be perpetrated against children and adults by this sector in sufficient numbers to state that the roles can become blurred creating access to the vulnerable. We advocate voluntary locally requested DBS where there is any likelihood that the role profile could become blurred. Parish reps need to be alive to the changing role profiles and the need for DBS checks to be progressed. • **Poor Diocesan and Chaplaincy Links** - The Review highlighted the risks associated with having poor lines of communication between HR and Bishop's House and the supervisors/governing bodies of those agencies which employ Sector Chaplains such as hospitals, prisons etc. This could result in serious risk going unnoticed or being unchallenged. • **Poor Record Keeping - Overarching theme** – This finding was predominant across all sectors of the review and was the most prevalent issue. The reviewers were hampered in conducting the review because of poor record keeping. It is likely that far greater Safeguarding Implementation has taken place, but without a documented record, this cannot be stipulated or evidenced. The Independent Reviewers cannot stress enough the critical need to ensure that safeguarding issues are documented well with investigative chronologies and appropriate recording. Without this, safeguarding practice is incomplete, and the organisation is placed in a position of extreme vulnerability.
Findings Culture	• In the past, the investment of time into the investigation of Clergy infidelity, or Clergy marriage breakdowns seemed to outweigh investment made into the investigation of child or adult safeguarding issues. Reputational damage seemed to be a high cause for concern in most cases. In house management of safeguarding issues - culturally there seems to have been a desire to increase pastoral support and or professional counselling to safeguarding concerns which relate to individuals from within the church but a reluctance to share the information more widely with outside statutory or voluntary organisations. There appeared to be a culture in the past that safeguarding issues relating to parish clergy, such as

	stalking and issues surrounding mental health behaviour, especially towards those residing in vicarages, 'came with the territory'. Additionally, the Diocese was less inclined to recognise the high stress levels parish-based clergy may encounter.

Recommendations

Writing in their report, the Independent Reviewers made a number of recommendations. They have been reproduced in full below:

1.	**CONDUCTING PCR2:**
1.1	**Safeguarding Audit** 1.1.1 A safeguarding audit with the Safeguarding Team should be conducted within the parish's settings. It was clear from lack of detail and documentary evidence on the parish returns that appropriate record keeping and management of confidential information was poor.
1.2	**File storage / GDPR** 1.2.1 The Diocesan Safeguarding Team, Chester Cathedral, and Bishop's House should review their policy on storage of safeguarding files in line with its Partnership Agreement with the Diocese of Chester. 1.2.2 Duplicate safeguarding files held by Diocese of Chester, Chester Cathedral and Bishop's House should be weeded, consolidated and a single storage point identified. 1.2.3 The digitalisation of Files would ensure accessibility and centralised storage. This should be considered. 1.2.4 Reader, Lay and Volunteer Files should be created centrally in order to ensure robust management systems are in place. 1.2.5 A KCL (Known Case List) should be created.

	1.2.6 Onward Management of Actions raised. The Diocese should follow the agreed sign off process via PCR Reference Group for all App D's, including those still under investigation after completion of the file review phase. 1.2.7 PCR2 Recommendations and Implementation Process. It has been unclear to the Independent Reviewers on occasion as to line management and ownership of oversight and responsibility / accountability for these recommendations. As the lead for safeguarding the Bishop will be responsible for ensuring the recommendations are embedded within practice in the Diocese, or a said individual nominated by him.
2.	**SAFEGUARDING CHILDREN:**
2.1	**Sexual Offenders** 2.1.1 The Safeguarding Team is key to implementing risk management plans in respect of sexual offenders who wish to worship in a parish. The diocese must ensure that worshipping agreements in place for this purpose remain as living documents and are implemented under the governance of the Safeguarding Team. To ensure diarised timely reviews of safeguarding agreements are made in order to facilitate current risk management and to update changing circumstances and factors relevant to the ongoing risk. 2.1.2 Development of a national list should be considered of unlicenced staff or parishioners where there is evidence that they may pose a safeguarding risk as they seek to work, volunteer or worship within the wider Church of England. 2.1.3 The Diocese needs to formalise practices within Prison Chaplaincy roles, and with Statutory Agencies to establish accurate move on plans in respect of the release of Imprisoned clergy members. This will ensure that appropriate risk management can be resumed on release. Should intelligence suggest that the subject is moving out of area, the relevant area should be informed, in view of the high likelihood the individual will wish to resume worshipping on release. 2.1.4 The Safeguarding Team must maintain established links with offender managers to ensure a proactive approach to offenders and their management is maintained, to identify any indications they may wish to worship, and to enable them to do so while keeping the congregation at large safe. 2.1.5 Bespoke Sexual Offender Training packages come at a cost to the Diocese, and training cannot always be resourced internally from an overstretched Safeguarding Team. The Diocese may need to consider outsourcing this work to sex offender specialists. 2.1.6 Recommendation for DSA oversight and management of ALL Safeguarding agreements held by the diocese and the Cathedral.

2.2	**Youth Workers** 2.2.1 Continued vigilance required in the safer recruitment and monitoring of youth workers, paid or volunteers. Continued and improved mechanisms to ensure safeguarding training and other relevant training in their role, so they understand boundaries and how to maintain these. 2.2.2 The implement of appraisals and oversight to enable closer scrutiny and monitoring of their work and behaviour, and to ensure any necessary support and training gaps are addressed.
2.3	**Choir Leaders or Organists / Musical / Other volunteer roles** 2.3.1 We have evidenced that child and adult abuse can be perpetrated against children and adults by this sector in sufficient numbers to state that the roles can become blurred creating access to the vulnerable. We advocate voluntary locally requested DBS where there is any likelihood that the role profile could become blurred. Parish reps need to be alive to the changing role profiles and the need for DBS checks to be progressed.
3.	**SAFEGUARDING ADULTS:**
3.1	**Inappropriate Relationships** 3.1.1 Those within the church who are likely to come into contact with children need to have a clear understanding of professional boundaries that are to be maintained in order that inappropriate behaviour does not develop. This is particularly important in respect of those who are themselves in the early stages of maturing, and who may be working with children who are not that dissimilar in age, such as some younger youth workers. We recommend awareness raising in respect of guidance as to 'what is an inappropriate relationship'. Training inputs must ensure that these breaches are recognised, and that interventions can occur which take into consideration the safeguarding issues arising. There should be clear understanding around supporting survivors. This should include using other professional agencies and organisations and continuing with the signposting to the voluntary sector resources. 3.1.2 The Diocese should continue to provide up to date information on the Diocesan website for people and places survivors and parish safeguarding leads can contact for help and information or to report safeguarding concerns.
3.2	**Domestic Abuse** 3.2.1 Increased recognition of the vulnerability of Clergy spouses involved in domestic abuse and the requirement for appropriate and targeted support, including practical support such as housing and signposting to financial support.

	Ensuring early referral to appropriate agencies such as LADO, Police and voluntary sector support. 3.2.2 Signposting and referral to other voluntary agencies such as an Independent Domestic Abuse Adviser or courses such as the Freedom course. 3.2.3 Where appropriate to continue to work in partnership with Victim Support and witness support agencies in relation to court attendance or hearings. 3.2.4 Improved recognition of domestic abuse as abuse and how cases should be managed.
3.3	**Bullying** 3.3.1 Ensuring this term is understood, used, recorded, and managed appropriately. Due consideration should be given to each case bespokely to identify if the safeguarding threshold has been breached. To ensure that allegations of bullying are recognised and reported through the appropriate HR channels and dealt with quickly and according to best practice. 3.3.2 The Diocese should ensure it is making best use of restorative justice or mediation between the parties where appropriate, and that the issues are not merely resolved by moving one or the other party, if clear inappropriate behaviour in one of those parties had been evidenced. This can perpetuate the behaviour within future roles.
3.4	**Foreign Nationals who are given PTO in the Diocese** 3.4.1 Continue to implement the mentorship support and ensure appropriate induction and training to reduce the impact of different cultural approaches.
3.5	**Stalking and Harassment** 3.5.1 When Clergy members suffer the effects of stalking or harassment they can be profoundly and adversely affected. Stalking and Harassment should be taken seriously within the Diocese with appropriate recording and referral to statutory agencies. Where there is potential for an over reliance on a clergy member by a parishioner, or a concern re any Harassment issue, relevant intervention should be facilitated, and an exit strategy implemented to withdraw the relevant aggrieved party from the individual concerned. 3.5.2 Early identification and robust intervention and management is critical. 3.5.3 Ensuring there is a plan/strategy in place to support either the member of the Clergy and their family or the parishioner to remove them from the area/direct contact.

	3.5.4 Involving the Police when appropriate and necessary. An early visit or harassment warning etc can aid prevention or de-escalation at an early stage. 3.5.5 Training to recognise stalking and harassment and management strategies. Provision of support or signposting to appropriate support for victims/survivors whether members of the Clergy or not. This also applies to offenders who may present with adverse behaviours due to their own vulnerabilities or their inability to understand and recognise personal boundaries. 3.5.6 Clergy wellbeing should be brought to the forefront of the Senior Managements priorities.
3.6	**Clergy Stress Levels** 3.6.1 There was evidence that individuals within parish-based ministry often suffered from stress and work-based anxiety. Long hours, a lack of work / life balance, over exposure to stressful situations and high emotional reliance by the Parishioners is a key factor in Clergy Stress. Clergy wellbeing should be brought to the forefront of the Senior Managements priorities.
3.7	**Financial Abuse / Financial Exploitation of the Vulnerable** 3.7.1 The diocese needs to adopt a policy around the receiving of monetary gifts/ benefacting of wills to clergy members. Transparency needs to be adopted when parishioners are minded to bequest large sums to vicars to ensure said vicars are not of a mind to exploit such individuals in their final months of life. This practice should be built into safeguarding training as, essentially, unacceptable. Clergy, acting in a capacity of servant leaders, should not financially gain from their parishioners.
3.8	**Spiritual Abuse/ Deliverance Ministry** 3.8.1 The diocese should ensure robust, specialist policies are in place in respect of Deliverance Ministry to ensure the Mental Health Vulnerabilities of the subject, and the exposure of the minister are appropriately (and professionally in the case of the subject) catered for. There should be robust monitoring at strategic level in all Deliverance Ministry to prevent Spiritual Abuse occurring, in particular as the 'subjects' are by very nature extremely vulnerable.

4.	**VICTIMS/SURVIVORS:**
4.1	**Victims/survivors** 4.1.1 Refresh the Survivor Care Strategy and maintain the budget for therapeutic support for survivors. 4.1.2 Diocese to ensure that whilst maintaining recently achieved good standards of care for survivors this is not at the expense of the wellbeing of the DSA or other nominated staff, alongside extremely busy roles. We recommend that some of this support is outsourced to relevant support agencies or delegated to those with more capacity to conduct the role.
5.	**LINKS WITH STATUTORY AGENCIES:**
5.1	**Sector Ministry Chaplaincy** 5.1.1 Improved links and Joint supervisory oversight is required in respect of Licensed Chaplaincy Positions. There is currently a clear gap between the governance of those clergy members employed external to the diocese in other sectors e.g., NHS / universities etc, and the Diocesan governance. In relation to the management of, and response to safeguarding and discipline concerns that arise outside of performance issues, the Diocese has on occasion remained in the dark. During, but in particular on return to ministry within the diocese, there should be a formal handover and information sharing between relevant agencies, as the review has identified that those clearly posing a risk have been re-admitted to the diocese roles due to the lack of knowledge of the Diocese of the safeguarding incidents that have arisen in the previous role.
5.2	**Information Sharing** 5.2.1 Information sharing was highlighted as a specific barrier to effective multiagency working by the DSA/DSAP. The DSA has built up good working relationship with some statutory agencies and regular consultation and information sharing is ongoing where opinions are freely exchanged. The Police and Probation services as well as the prisons lacked consistency in response and on occasion hindered the Churches ability to adequately manage risk. DSAP membership has been sporadic. It is incumbent on statutory agencies to provide membership to the group in order that effective expedient information sharing can occur. This directly links to good safeguarding practice.

6	**RISK MANAGEMENT:**
6.1	**Parish Safeguarding Officers** 6.1.1 There is further work to do to strengthen the role and recognise the importance of the parish safeguarding officers by providing appropriate training and support. Continuous professional development is also a factor, and the diocese should encourage PSO's to take responsibility for their own development as well as undertaking training provided by the diocese.
6.2	**Training** 6.2.1 Mandatory Safeguarding Training is vital to Safeguarding provision. The Diocese needs to consider the imposition of appropriate consequences of mandatory training not being undertaken within required timescales. 6.2.2 Inclusion of available training packages on dealing with sex offenders to be available. Continuing the delivery of Sex Offender Workshops.
6.3	**Record Keeping** 6.3.1 This finding was predominant finding of the Independent Reviewers cannot stress enough the critical need to ensure that safeguarding issues are documented well with investigative chronologies and appropriate recording. Without this, safeguarding practice is incomplete, and the organisation is placed in a position of extreme vulnerability. 6.3.2 The recording of information and updates on safeguarding files (or a link to where the information is held) is vital when safeguarding issues are highlighted on paper or digitally. This is regardless of the setting. 'If it isn't documented, it didn't happen' summarises the position well. This ethos must run through all training in respect of safeguarding training. 6.3.3 We recommend the implementation and training on best practice in relation to appropriate recording. It is vital to ensure basic formats are adhered to in recording of specific details and ensure correct terminology. Entries should be signed, and date stamped across church business. 6.3.4 We recommend that personal files are consolidated, and all duplicates removed, and a single (recommended electronic) filing system, with all information stored securely and in one place should be considered. This would enable themes to be more evident, reduce the risk of duplication or missing information, and would make accessibility easier regardless of geographic location.

6.4	**GDPR Compliance** 6.4.1 There was a concern with relation to GDPR compliance within many of the files whereby confidential information referring to an unrelated clergy member was contained within the body of an unredacted document stored within a personnel file belonging to a third party. This process must cease.
6.5	**The management of filing** 6.5.1 Security in general around file storage was good. We recommend clear booking in and out processes.
6.6	**Safer Recruitment**. 6.6.1 Overall, the Diocese has demonstrated a strong commitment to Safer Recruiting protocols. 6.6.2 All DBS checks need to be in date and submitted with complete and accurate information to ensure the appropriate level of risk identified. The Review identified where the subjects had minimised blemishes. 6.6.3 The Independent Reviewers also have concerns around Volunteers, Lay and Readers as there does not appear to be any central managing system or oversight, many not DBS checked despite their roles often having spontaneous interaction with children and vulnerable people. DBS should be considered for those who have any form of public facing role if there is any possibility of role-blurring that would incorporate contact with children or vulnerable adults within their role. More scrutiny should be placed on this issue, and annual reviews to identify any changes to the remit and nature of the role. 6.6.4 The Diocese should ensure that the recruitment process in respect of incoming individuals who have blemishes or who carry a degree of risk are managed appropriately, and these risks are without fail brought to the attention of the DSA for onward risk assessment and management. 6.6.5 Ensure all implementation from the Independent Safer Recruitment Review are in place. Safer recruitment protocols should be adhered to prior to any licence being permitted. Should a concern be raised, a full rationale should be recorded with regards to decision making 6.6.6 Ensure any Safe to receive reference is given fully informed – continue with established good practice of the safeguarding team reviewing the Clergy Blue file ahead of the CCSL being written.

6.7	**DBS** 6.7.1 DBS should be managed robustly and recorded on personal files. Recording of DBS and safeguarding training relevant dates should be entered clearly on a person's personal file, as should reference to any disciplinary issues and an indication to the location of the relevant papers.
6.8	**CDM** 6.8.1 The Independent Reviewers witnessed difficulties expressed by those managing working within the confines of the CDM process who felt constrained to be able to safeguard others via suspension of the individual facing investigation. This would seem to suggest that the CDM process may not be fit for purpose, in that it failed to allow them in many cases to safeguard others. Should this be the case, the National Team should review the process and legislation.
6.9	**Complaints Procedures** 6.9.1 When dealing with complaint investigation, the requirement is for the Diocese to be alive to reviewing everything not just in the original complaint material, but all subsequent or prior correspondence or items of information to identify trends, common issues, concerns, and to ensure that safeguarding concerns are not masked or ignored. 6.9.2 This can relate for example to the situation whereby lots of emails are exchanged, but then the final official complaint only contains a summary of the main aspects or events. It is vital not to lose sight of periphery details and safeguarding concerns that may be embedded within the complaint material as there is a tendency to miss these additional safeguarding concerns. 6.9.3 Complaint submission in written form - Ensuring complaints or safeguarding concerns which may come in the form of an informal call, or a letter rather than as part of the formal process are nevertheless given the same rigour of review, investigation, and management by sharing them with the safeguarding team. 6.9.4 Simplifying the complaints procedure (CDM) and creating a safe environment in which people feel comfortable and confident in making a complaint. Lack of educational standard or literacy should not be a barrier to complaint making, and safeguarding issues cannot be 'unseen' or 'unheard' because of the lack of a formal complaint being received. Support should be offered to complete documentation where appropriate to ensure the complaint is raised.

	6.9.5 The DSA should be an integral part of all relevant safeguarding matters within the Diocese and in her absence or under delegation the Assistant DSA. 6.9.6 The Cathedral will commission a full review of Case files that have not been reviewed by the Independent Reviewers on the commencement of the new CSO as part of her induction to role and in order for her to establish the Current Status of Cathedral Safeguarding. We recommend that this process should again be undertaken with independence.
6.10	**DSA Exclusion** 6.10.1 Historically the DSA was excluded from some safeguarding case management. This is inappropriate. The current DSA had been in post since 2014. The DSA must be the central figure in safeguarding issues managed in the Diocese.
6.11	**DSA wellbeing** 6.11.1 The IRs have been concerned regarding the workload this individual has maintained sole charge of over a protracted period of time in a large diocese. It has been recognised throughout this report that the work was conducted to a high standard. The Diocese may need to recognise this extraordinary effort, whilst at the same time identifying, as the IR's have, that this individual is now in much need of some wellbeing support and a period of recuperation.
6.12	**Safeguarding Team Resilience and Capacity vital to safeguarding children and vulnerable adults** 6.12.1 Successful safeguarding in this Diocese is dependent on the capacity and resourcing capability of the Diocesan Safeguarding Team, and early recognition and referral into that team by those identifying safeguarding concerns. It is also dependant on a top-down strategic culture that recognises and embraces the priority of safeguarding. All issues relating to Safeguarding Children must be overseen by Diocesan Safeguarding Team.
6.13	**Mental Health** 6.13.1 Continued development of a psychologically safe environment that enables and empowers members of the clergy and staff and church officers to speak out about their mental health, but also to know that support is available. 6.13.2 Early recognition of stress, or the signs of stress, and other mental health concerns in members of the clergy and staff and church officers; understanding and recognition of the circumstances in which mental health can be affected (dealing with death, a trauma etc.).

	6.13.3 Continue to ensure the Diocese act as a caring employer and look to best practice approaches to employee wellbeing and access to support services such as counselling. 6.13.4 Strategies and training for effective and supportive line management techniques.
7	**CULTURE:**
	7.1 Disclosures 7.1.1 Ensure the individual making the disclosure (the victim/survivor) has access to specialist support in relation to the impact of the abuse they disclose. 7.1.2 Ensure the environment in which a disclosure may be made is psychologically safe, this may be during the discernment process, at BAP or during their ministry. 7.1.3 Through training and advice continue to develop understanding about the handling and managing of disclosures, and particularly an understanding of confidentiality issues. 7.1.4 Continued top-down support of the importance of safeguarding by the Diocesan Bishop and their senior leadership team. 7.1.5 Continue to provide support for those who are victims/survivors, including pastoral care and support, to ensure they are safe, and the impact of disclosures is managed.
	7.2 Cathedral 7.2.1 Improve collaboration between the Cathedral and the Diocese in order to engage an inclusive working relationship with safeguarding at the heart of its practices.

Glossary of terms

We recognise that there may be a number of terms within this report that are unfamiliar to readers unaccustomed to Church processes and practices. Below is a list of the common terms referenced in this Summary Report and an explanation for each.

For consistency and to aid communication of the Independent Reviewers' findings, some of the terms used by the Reviewers in their final report may have been altered in this Summary Report. For example, the Independent Reviews mostly refer to themselves as "Independent Reviewers" or "IRs". We have tried to apply consistency throughout and have chosen to refer only to the "Independent Reviewers" and "Reviewers" thereafter. Other similar amendments have been made but the overall meaning has not been altered in anyway.

Appendix D/App Ds	A section in the Parish Return in which any known cause for concern was to be listed for the attention of the DSA
BAP	Bishop's Advisory Panel
Cathedral Chapter	Cathedral Chapter is the traditional name for the governing body of the Cathedral.
CDM	Clergy Disciplinary Measure
CCSL	Clergy Current Status Letter
CSO	Cathedral Safeguarding Officer
DA	Domestic abuse
DBS checks	Governmental Disclosure and Barring Service check
DSA	Diocesan Safeguarding Adviser
DSAP	Diocesan Safeguarding Advisory Panel, the group that holds strategic responsibility for the governance of safeguarding in a diocese
DST	Diocesan Safeguarding Team
IRs	Independent Reviewers
KCL	Known Case List
LADO	Local Authority Designated Officer, the person responsible for responding to allegations made about people who work with children
NST	National Safeguarding Team based in Westminster
PCR1	This refers to the original Past Cases Review from 2007

PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
PTO	Permission to Officiate is a licence granted to clergy from the bishop

Notes

The two lead Independent Reviewers were Claire McEnery and Nicola Bithell. The two additional Independent Reviewers that were brought in towards the end of the process to ensure the work was completed on time were Kerry Young and Colin Taylor.

Independent Reviewer, Claire McEnery

Independent Reviewer, Nicola Bithell

Independent Reviewer, Kerry Young

Independent Reviewer, Colin Taylor

Further information about each of the Reviewers can be made available on request.

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