PAST CASES REVIEW 2 FINAL REPORT FOR THE DIOCESE OF CHICHESTER – EXECUTIVE SUMMARY

INTRODUCTION

This summary reproduces the introductory sections of the PCR2 Final Report for the Diocese of Chichester, covering overview and governance of the PCR2 project itself and the purpose of the project, and reproduces the complete list of all Recommendations, which were grouped under thematic headings.

1.0 OVERVIEW AND GOVERNANCE

1.1 GOVERNANCE AND OWNERSHIP OF THE REVIEW

1.1.1 As per national protocol, the final PCR2 report for the Diocese of Chichester is ultimately owned by the Bishop of Chichester. It has been presented to the PCR2 Project Manager for the National Safeguarding Team, the PCR2 Reference Group for the Diocese of Chichester, and the Diocesan Safeguarding Advisory Group, before being sent to the Bishop of Chichester for final receipt and response.

1.2 PROJECT MANAGER

1.2.1 A project manager was recruited in summer 2020 to manage the overall process of PCR2, including the recruitment and selection of Independent Reviewers, liaising between Diocesan staff and IRs regarding access to files and other information, coordinating communication strategies for PCR2, and coordinating survivor support strategies. The Project Manager remained in post until the end of the project and was managed by the Diocesan Safeguarding Adviser.

1.3 RECRUITMENT OF INDEPENDENT REVIEWERS

1.3.1 The Independent Reviewer (referred to as IR in the report) roles were openly advertised. Successful applicants were selected based on written material provided at the application stage, and competitive interview. IRs were line-managed by the Project Manager throughout PCR2, although with a 'light-touch' management approach that reflected their independence.

1.3.2 The IRs selected were Paul Barton, a former Detective Superintendent with experience in child and adult safeguarding and an accredited Senior Investigating Officer and reviewer with the College of Policing, Katrina Ugur, a qualified social work manager with over 15 years' experience dealing with vulnerable children and adults and Julie Gross, a recently retired Detective Sergeant from Sussex Police who has spent over half her career specialising in Child Safeguarding and Adult Protection. A fourth reviewer was also selected however left the project half way through.

1.4 REFERENCE GROUP

1.4.1 The Reference Group (RG) was set up at the beginning of PCR2 as per the national PCR2 Guidance. The RG was chaired by the Chair of the Diocesan Safeguarding Advisory Panel

(DSAP) to ensure consistency of oversight between the two groups, and in particularly to ensure a clear handover from PCR2 to DSAP at the end of the PCR2 project.

1.4.2 The RG consisted primarily of representatives of various statutory safeguarding agencies in Sussex, including Sussex Police, Brighton and Hove Council (the B&HC LADO was a member of the group) and Survivor's Network to ensure a consistent voice for survivor advocacy on the group. Each of those individuals had extensive experience of working with the Diocese on a number of cases or in a strategic capacity and was therefore familiar with the context. In addition, a person with experience of having been abused within the Diocese of Chichester (and with significant relevant professional experience) was also on the Panel. This person, in particular, was able to provide a consistent advocacy for survivors and to ensure robust challenge throughout the PCR2 process, ensuring that it met its objectives throughout. Diocesan officers formed the remainder of RG membership.

1.4.3 The RG met quarterly throughout PCR2 and received updates directly from the Independent Reviewers prior to each meeting. This allowed the RG to maintain clear oversight of the work and to receive direct reports from the IRs, not just mediated through the Diocesan officers.

2.0. PURPOSE OF THE REVIEW

2.1. PURPOSE AND OBJECTIVES FOR PCR2

2.1.1 The objective of PCR2, as set out in the national protocol, is to ensure that any file that could contain information regarding a concern, allegation, or conviction in relation to abusive behaviour by a living member of the clergy or church officer, whether still in that position or not, will have been identified, read and analysed by independent safeguarding professionals.
2.1.2 At the completion of the review process it will be possible to state that:

- all known safeguarding cases involving clergy and other church officers have been appropriately managed and reported to statutory agencies or the police where appropriate
- that the needs of any known victims have been considered and that sources of support have been identified and offered where this is appropriate
- that all identified risks have been assessed and mitigated as far as is "reasonably possible"

2.2 PARAMETERS OF THE REVIEW

2.2.1 The review included all clergy files ('blue files') held within the Diocese of Chichester and at Bishop's Palace, Chichester, all safeguarding case records held by the Diocese involving clergy and other church officers, and all personnel (HR) files held by the Diocese of Chichester and Chichester Cathedral for staff in positions which give them contact with children or vulnerable adults.

2.2.2 The national PCR2 protocol limits PCR2 to files for people who are alive. Along with all other Dioceses the Diocese of Chichester conducted a 'deceased clergy file review' in 2016. At the mid-point of PCR2 the Diocese calculated that it possessed approximately seventy files of clergy who had died between the end of the deceased clergy review in 2016, and the beginning of PCR2 in 2020. As these files were not in scope for either review there was a risk that they could remain un-reviewed. The Diocese therefore agreed that these files would be reviewed by the IRs at the end of the PCR2 project.

2.2.3 The review commenced in September 2020 and concluded in December 2021.

12.0 RECOMMENDATIONS

12.1 FILE MANAGEMENT AND RECORD KEEPING

12.1.1 Recommendation (local) [3.2.39]

The national policy for Clergy File management should be adopted by the Diocese

This policy has been in since 2018 and provides clear direction on the management of Blue Files and information contained within which will address many issues identified with Chichester.

12.1.2 Recommendation (local and national) [3.2.39]

Consideration should be given to moving to a digital solution for Clergy Files

Accepting there is a huge cost to this, the use of paper files in 2021 is archaic and leaves the Diocese open to risks of loss or destruction of data with no clear audit trail. Safeguarding and CDM records could easily be linked to the Blue File ensuring a holistic view of the individual.

12.1.3 Recommendation (local) [3.2.39]

A retention and weeding policy should be adopted and all files should be subject to a review for GDPR compliance on a regular basis

The national policy provides a useful appendix with advice and guidance on what should be retained and for how long. Bulky files are less likely to be thoroughly reviewed when providing a CCSL which is a risk.

12.1.4 Recommendation (local) [3.2.39]

A Blue File checklist detailing minimum requirements should be considered to assist in the administration of the file and compliance with the national policy

This would ensure consistency and compliance and assist in CCSL and other personnel management queries.

12.1.5 Recommendation (local) [3.2.39]

CPOMS and Sharepoint should be subject to a similar review in accordance with GDPR compliance particularly concerning personal details of survivors

Evidence has been found of duplicated emails being retained, duplicated copies of minutes, correspondence relating to other individuals not relevant to the case and on some occasions medical information and information relating to survivors which could be a breach of GDPR.

12.1.6 Recommendation (local and national) [3.2.39]

The movement of Blue Files needs to be more timely and deadlines should be set and followed up when Blue Files are expected

Blue Files hold far more information than a CCSL and so it is important that when a priest moves Diocese, the Blue File follows as soon as practicable. The Diocese needs to have a process to ensure any requests for Blue Files are followed up quickly.

12.1.7 Recommendation (local) [3.2.39]

An internal examination of the notification of deceased process needs to take place in order to identify the issue

The national policy indicates that the Pension Board are responsible for notifying the Diocese of the death of a member of clergy, yet a number of files have been reviewed whereby the Diocese had no knowledge of the death. The Pension's Board are therefore either not notifying the Diocese of the death or if they are, this information is not being actioned by the Palace Admin team.

12.1.8 Recommendation (local) [3.2.56]

Formal safeguarding meetings led by the Diocese must be supported with professional administration

12.1.9 Recommendation (local) [3.2.59]

Data accuracy needs to be improved on CPOMS including the spelling of names and dates of birth of subjects.

12.1.10 Recommendation: (local and national) [3.2.65]

A central register for volunteers is kept which can be checked each time a volunteer is appointed.

12.2 PERMISSION TO OFFICIATE

12.2.1 Recommendation: (local) [3.2.64]

PTO should be removed when safeguard training has lapsed.

12.3 VICTIM / SURVIVOR CARE AND PASTORAL SUPPORT

12.3.1 Recommendation (local) [6.1.6]

IRs believe it is not too late to publish the Survivor Care Strategy and should do so in order to reach potential victims and survivors who have not yet come forward.

12.3.2 Recommendation (local) [6.3.5]

Consideration should be given to having a victim / survivor contract between the safeguarding team and the victim / survivor clearly setting out method and frequency of communication.

12.3.3 Recommendation (local) [6.3.8]

A pastoral service for both Clergy and victims / survivors should be implemented to ensure equity in pastoral care during a safeguarding investigation.

12.4 RESOURCING

12.4.1 Recommendation (local) [11.2.14]

The Diocese should review the current resourcing levels of the Safeguarding Team and assess whether further resources are required to deal with the high caseload.

12.4.2 Recommendation (local) [11.2.16]

The role of the DSA should be reviewed against the Job Description to ensure the role is focussed primarily on safeguarding and not used for other time consuming, non-safeguarding administrative functions.

12.5 NATIONAL POLICY

12.5.1 Recommendation (national) [6.3.12]

A review of the legislation to give the Archbishop the power to remove Holy Orders from a member of the Clergy is needed.

12.5.2 Recommendation (national) [6.3.15]

The church needs to take greater care during the C4 process and justify why, in such circumstances as in the case C125022, it is proportionate and necessary to make victims / survivors relive such trauma and at the very least, offer some professional support to those affected.

12.6 PCR 2 SPECIFIC RECOMMENDATIONS

12.6.1 Recommendation (local) [4.3.7]

The PCR 2 Reference group or DSAP acknowledge and review all recommendations made on the Appendix D's and monitor their progress.

12.6.2 Recommendation (local) [11.1.8]

For completeness, the Diocese consider reviewing the outstanding deceased clergy files and files not fully completed by the 4th IR.

12.6.3 Recommendation (local) [11.1.8]

The Diocese make every effort to try and locate blue files that should be in their possession but are currently unaccounted for.

12.7 SAFEGUARDING

12.7.1 Recommendation (local and national) [5.1.6]

As seen in other Dioceses, good practice would be for clergy to encourage congregations to undertake the C0 safeguarding course.

12.7.2 Recommendation (local and national) [5.1.6]

To highlight good leadership regarding safeguarding, all PCC members should take the safeguarding courses (C0-C2) which in turn may encourage others.

12.7.3 Recommendation (local and national) [5.1.23]

Where an allegation has been made, the individual being accused needs to be informed as soon as is practicable unless clear rationale is provided as to why not.

12.7.4 Recommendations (local) [5.2.3]

IRs were initially confused to learn that the Diocese are using the term 'core group' when this term is used in Children's Services. In order to gain clarity, it is recommended that the Diocese refers to this as a Diocesan led professionals meeting.

12.7.5 Recommendation (local and national) [5.3.3]

For the NST to ensure that all DSA's receive specific safeguarding supervision on a regular basis.

12.7.6 Recommendation (local and national) [5.3.3]

For management oversight to be present and clearly recorded on files when a case is discussed.

12.7.7 Recommendation (local) [5.3.4]

For the Diocese to set regular reviews of 4-8 weeks when managing a case in order to prevent drift.

12.7.8 Recommendations (local) [5.3.7]

For the Diocese to ensure that all record keeping is up to date.

12.7.9 Recommendations (local) [7.2.4]

For the DST to comply with the National Policy regarding core groups being held within 48 hrs.

12.7.10 Recommendation (local) [7.3.8]

For the DST to ensure that all relevant records are uploaded to the electronic systems in a timely manner.

12.7.11 Recommendation (local) [Parish visit appendix]

The Diocese to consider more support for PSOs including CPD and potential area co-ordinators to ensure consistency, mentoring and support.

12.7.12 Recommendation (local) [Minority Groups appendix]

For the Diocese to have a specific equality and diversity or inclusivity strategy, which also covers recruitment from other underrepresented groups.

Recommendation (local) [Minority Groups appendix]

For the 'Unconscious Bias' training to be extended to PCC and lay members with a three year refresher course (or for new clergy arriving in the Diocese).

12.8 RISK MANAGEMENT

12.8.1 Recommendation (local) [5.4.3]

For risk assessments to be undertaken in a more timely manner before suspension is lifted and/ or the CDM concluded.

12.8.2 Recommendation (local and national) [5.4.3]

DST to consider using a risk assessment template for every occasion when risk is being assessed.

12.9 DOMESTIC ABUSE

12.9.1 Recommendation (local) [9.1.3]

For the Diocesan Safeguarding Team to review their processes and procedures concerning domestic abuse.

12.9.2 Recommendation (local) [9.1.10]

For the Diocesan Safeguarding Team and the Bishop of Chichester to explore appropriate timescales when commissioning risk assessments.

12.9.3 Recommendation (local and national) [9.1.12]

Specialised domestic abuse training is provided for members of the PCC's and all Clergy.

12.10 WELFARE

12.10.1 Recommendation (Local and National) [Welfare appendix]

Within the Diocese, at all levels, supervisors hold regular 'one to one' welfare meetings with those for whom they are responsible.

12.10.2 Recommendations (local) [Welfare appendix]

For the Diocese to ensure that HR issues are not undertaken by the DST but by specialist HR professionals.

12.11 GOOD PRACTICE

12.11.1 Fixed date for the renewal of licenses and DBS for lay ministry

By setting a fixed date, all parties know when a renewal is due and the process can be easily managed and monitored.

12.11.2 Simple Quality Protects

An excellent online tool allowing Parishes to self-assess their safeguarding processes and provision and improve where needed.

12.11.3 Designated ISVA provision

This shows the commitment to victims / survivors and provides independent, funded support to those that require it.