Diocese of Guildford
THE CHURCH OF ENGLAND

Past Cases Review 2 in the Diocese of Guildford

Executive Summary

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Contents

Response to the Past Cases Review 2 (PCR2) from the Diocese of Guildford

Any abuse against anyone is one abuse too many. Having met many victims and survivors over the years, I've been reminded time and again of the immense damage such abuse can do to people's lives, even decades after it was first perpetrated. And there is something peculiarly disturbing about abuse taking place in the context of the Christian Church – the polar opposite of Christ's offer of life in all its fullness. I therefore fully endorse the findings of the second independent Past Cases Review (PCR2) in the Diocese of Guildford, and hugely welcome the reviewers' challenge to us to learn from the past and improve our safeguarding practice for the future.

In doing so, I would particularly like to thank victims and survivors who courageously shared their story and reflections, and whose voices added greatly to the content and impact of the review. I would also like to acknowledge safeguarding failures in the diocese in the past, and am profoundly sorry for the additional pain that they have caused.

PCR2 in this diocese, has been robust, independent and thorough, and I'm deeply grateful to the reviewers for their perseverance, integrity and honesty throughout the process. The report shows up a number of failings in our past safeguarding practices, most commonly around clear record management, and – whilst recognising too that there have been substantial improvements in recent years – we need to ensure that we are not complacent, and continue to review and improve the way things are done. We accept all the report's findings and are already acting on all its recommendations within a carefully drawn-up PCR2 action plan.

Safeguarding must be a priority and focus for everyone at all levels, as together we work towards making the Church a safe and welcoming place for all.

The Right Revd Andrew Watson, Bishop of Guildford

"The rigorous report from the independent reviewers who looked at all identified past cases makes for sad and sombre reading. We take very seriously and must learn from the poor practices and responses to cases that have been identified. While the reviewers have confirmed significant improvements in current safeguarding practice there is no room for complacency. We must all take responsibility for ensuring that our churches and the cathedral are the safest possible places they can be."

Chris Cloke
Independent Chair, Guildford Diocesan Safeguarding Advisory Panel
Chair, Guildford Past Cases Review Reference Group

Executive Summary

The PCR2 Reference Group would like to acknowledge and thank all those who have contributed to the Review in a transparent, open and constructive way. In particular, we would like to thank the victims and survivors of church-related abuse who bravely came forward to share painful experiences.

Background and context

In 2007, the House of Bishops authorised an extensive review of all past cases of child abuse within the Church of England.

In 2015, concerns were raised with the National Safeguarding Adviser (NSA) about inconsistencies in how the PCR had been conducted. At the same time, the Independent Inquiry into Child Sexual Abuse (IICSA) announced an investigation into the Anglican Church, including the adequacy of the 2007-2009 Past Cases Review (PCR).

In 2016, a preliminary process was conducted by the National Safeguarding Team (NST) to ascertain how PCR had been conducted and its outcomes. An Independent Scrutiny Team (IST) was then formed to examine the adequacy of the PCR in more detail. The IST made nine recommendations for further work by dioceses and the NST. Seven dioceses were required the repeat the PCR review in its entirety because of shortcoming in the 2008-2009 process. The Diocese of Guildford was not one of these dioceses.

Introduction to PCR2

The Past Cases Review 2 (PCR2) project commenced nationally in 2019 with all 42 dioceses being required to undertake the review.

The objectives were as follows:

- 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 all safeguarding allegations have been referred to the Diocesan Safeguarding Advisors 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.

PCR2 governance

A PCR2 Reference Group was established in the Diocese of Guildford in line with the House of Bishops guidance and was chaired by Christopher Cloke, the Independent Chair of the Diocesan Safeguarding Advisory Panel (DSAP).

The Reference Group included internal and external representation, including a victim and survivor organisation, the police, and social services. The role of this group was to steer and support the Review, to ensure transparent and robust risk management and to ensure that appropriate care and support was in place for anyone impacted by the Review, including victims and survivors of abuse.

The Reference Group convened in March 2020, met on 13 occasions and received the final report from the Independent Reviewers on 12th March 2022. The final report was submitted to the national church PCR2 Project Management Board who confirmed that they had unanimously accepted the report and acknowledged the rigour with which the review had been undertaken.

The Reference Group also made the decision to review the files of deceased clergy, although this is outside the scope of the PCR2 Review. It was agreed that this review would take place following the submission of the diocesan Report due to the volume of work required to complete the substantive Review.

PCR2 Review process

The Review process involved the 162 parishes in the diocese and institutions employing licensed clergy (educational institutions, hospitals and prisons).

The Diocese of Guildford commenced their review of files, case management records and parish returns in May 2021. There had been several delays to this start date, primarily due to the Covid 19 pandemic.

Two Independent Reviewers were appointed, both highly experienced safeguarding professionals, independent of the Diocese. Two further reviewers assisted in the short term, due to the delays and the high volume of work.

A total of 1007 files, plus corresponding safeguarding files and Clergy Discipline Measure (CDM) files were reviewed over a period of 10 months. The files and records reviewed included clergy personnel files, safeguarding case work, completed summaries from parishes, and institutions employing licensed clergy.

Engagement with Victims and Survivors of Abuse

A recognised omission from the original Past Case Review was engagement with victims and survivors of abuse. Victims and survivors were invited to come forward. Four survivors wanted to engage with the Review and meet with the Independent Reviewers. They shared their painful, lived experience of church-related abuse and about how they had been treated by the Church following the abuse. They all had a compelling story to tell and important suggestions for lessons that the Church can learn about survivor support and engagement. They added great value to this review and the Independent Reviewers and PCR2 Reference Group are very grateful to them for coming forward.

The Report and Review also highlighted the slowness in some cases of the response to victims and survivors and the need to listen to them more.

Key findings of the Independent Reviewers

Having reviewed the 1007 files, the Review identified 47 cases of concern where poor safeguarding practice, including a lack of robust case recording, poor investigation and case management, lack of adequate risk management and a lack of clear outcomes from cases contributed to further action being required. Six of these cases of concern identified by the Reviewers were not previously known to the Diocesan Safeguarding Team (DST).

The 47 cases of concerns were then prioritised by the Independent Reviewers principally based on potential current risk; other factors, such as inadequate support for survivors, were also considered. Of these, five cases were considered to require urgent review by the Diocesan Safeguarding Adviser to identify any potential current risk.

All 47 identified cases of concern have been fully documented by the reviewers with recommendations for further action by the DST. This follow up work by the DST is currently ongoing and has been prioritised according to the level of risk identified by the Reviewers.

The Independent Reviewers highlighted that there were also examples of professional competence and safe past safeguarding practice, some of which were referenced in more detail in the Report.

By definition, a Past Case Review looks predominantly at past practice, which this Review has highlighted as often being inadequate. This needs to be considered in the context of safeguarding practices at the time and the resources available. As a contrast, the Independent Reviewers undertook ‘dip checks’ of 9 current, live cases to assess current practice. In addition, they obtained information about current practice and protocols from members of the DST.

The Independent Reviewers’ Report stated that it was clear that current practice has improved significantly, particularly in relation to clear case recording, timely management of risk, following practice guidance in relation to convening core groups and the introduction of a Victim and Survivor Strategy. The resourcing of safeguarding in the diocese has increased

considerably over recent years, which has assisted in the improvement of current safeguarding practice.

In addition, the Diocese has robust external scrutiny and multi-agency engagement with DSAP and its Case Work Sub Group, which will hold the Diocese to account against delivery of the recommendations in this report.

Conclusion of the Independent Reviewers

The Independent Reviewers stated that, in their view, the prime objectives of PCR2 in the Diocese of Guildford have been achieved, however, it was important to note that there is further work to be undertaken by the DST in completing the recommendations. The Independent Reviewers made 34 recommendations arising from their Review and expressed their confidence that their recommendation would be given full consideration.

The Reviewers wished to thank and acknowledged and the contribution of all those who had participated in the review, and particularly to victims and survivors of abuse who had come forward. The Reviewers confirmed that the review had been undertaken in the spirit of transparency and openness, with the full co-operation and support from diocesan staff including the Bishop of Guildford, the Chair of the PCR2 Reference Group and the Diocesan Safeguarding Team. The Reviewers expressed their confidence that their recommendations would be given full consideration.

In conclusion, the Independent Reviewers stated that they 'acknowledge the positive response this report has received from all those involved, despite some of the findings that make painful reading. The identified past poor practice has been accepted with humility and an obvious desire to continue to move forward. The Reviewers are confident that this will happen'.

Signed by Kate Wood, Independent Reviewer

Additional Links

- Link to National Past Cases Review 2 report and press release
- If anyone reading this has been impacted by the subject or would like more support please visit https://www.cofeguildford.org.uk/about/safeguarding/support-for-survivors-victims