MANCHESTER DIOCESE PAST CASES REVIEW 2

Executive Summary



Foreword

I am hugely grateful to all who have played their part in producing the second independent review of past safeguarding cases (PCR2) in the Diocese of Manchester. Alongside our Safeguarding Team, we have benefitted greatly from the contribution of external panel members, statutory partners, survivors of abuse, and in particular our Independent Reviewer who reviewed over 1400 files.

PCR2 has served as far more than a review of all known safeguarding cases. It has proved to be a robust health check for the living body that is our present-day safeguarding work. Like all health checks, it has both identified what is good and provided recommendations where we can improve. Significantly, it found nothing that might represent a major health failure or risk. The report shows that we are doing many things well; we can take that as encouragement to spur us on to continue to improve as we set about implementing the recommendations.

Whilst this Executive Summary is specific to Manchester, it should be read in conjunction with the national PCR2 Report, which incorporates findings from all 42 dioceses as well as other major Church of England bodies.

The Rt Revd Dr David Walker Bishop of Manchester

As the person who oversaw the work of the Diocesan Safeguarding Advisory Panel and the PCR2 Reference Group, I can vouch for the hard work and commitment of diocesan officers to ensure the integrity of the review, thereby establishing that that any risk, historic or current, was known and being managed properly. As Bishop David has said, the review could not have been achieved without the cooperation of statutory colleagues and the contribution of survivor representatives.

The PCR2 review process is complete but, in many ways, it is part of an overarching aim to improve safeguarding practice within the diocese. The recommendations and learning from the review will inform the safeguarding development plan, which itself will provide a framework for improving practice for the next two years. No one who works in safeguarding, in whatever setting, should ever be complacent that all the systems, processes and responses are as they should be. Creating a culture of awareness, accountability, empathy, and trust takes time. However, I believe that in Manchester Diocese there is a strong base on which to build, and that with the commitment shown by the Bishop, the leadership team, and the Safeguarding Team there is good reason to look forward to us being able to achieve a safe Church for all.

Kathy Batt
Independent Chair of the Safeguarding Panel

Introduction

Along with all the other dioceses in the Church of England, Manchester Diocese undertook a comprehensive safeguarding review during 2020 and 2021 - PCR2.

A previous past cases review, carried out from 2007 to 2009, looked at safeguarding complaints made against clergy in relation to children. PCR2 has been much broader in scope, having looked at all complaints made against clergy and church officials relating to children and adults, including domestic abuse. Listening to survivor voices helped shape how Manchester Diocese's PCR2 was conducted and the diocese is committed to continuing to ensure the voices of survivors are heard.

The Review

Manchester Diocese's PCR2 was carried out by an Independent Reviewer - an experienced safeguarding professional - between September 2020 and June 2021. The PCR2 included Manchester Cathedral. The principal tasks of the Independent Reviewer were to:

- Read the files of all clergy and employees of the diocese within the scope of the review and record all cases of concern.
- Consider the Known Cases List drawn up by the Diocesan Safeguarding Advisor and assess the arrangements for managing cases.
- Prepare summaries of cases requiring further action.
- Engage with those victims and survivors who wished to make contact five victims and survivors gave feedback to the independent reviewer.

The diocese agreed its approach to involving survivors at the start of the review. This involved working with the diocese's Communications Team to publicise the review internally and externally. The diocese also paid for an independent counselling service to support survivors during the review.

As part of PCR2, the Bishop of Manchester wrote a letter to all 252 parishes in the diocese in February 2020 asking them to identify all current or historic safeguarding concerns. Only two parishes did not respond and these were contacted directly. From the parish returns, 70 disclosed information for PCR2. New cases identified through the returns were added to the Known Cases List.

The Chair of the Safeguarding Panel also wrote to the ten local authorities covered by the diocese and to all relevant local Children and Adult Safeguarding Boards to advise them of the review.

A total of 1,407 files were reviewed. As a result of the review as a whole, three new safeguarding cases relating to children and vulnerable adults, not previously known to the Safeguarding Team, were identified. During the review the Independent Reviewer was responsible for sending all concerns where follow-up action was required to the Diocesan Safeguarding Advisor.

Role of the Diocesan Safeguarding Panel

Manchester Diocese has a strong Safeguarding Advisory Panel with good representation from the statutory agencies. The diocese also benefits from strong leadership by the Independent Chair of the Safeguarding Advisory Panel.

A PCR2 Reference Group met frequently to oversee progress and consider the Independent Reviewer's findings, reporting back regularly to the Safeguarding Advisory Panel. The Reference Group included representatives from the diocese, a survivor advocate, and senior representatives from the police and social services. The Independent Chair of the Safeguarding Advisory Panel also chaired the PCR2 Reference Group. The final PCR2 report was endorsed by the Diocesan Safeguarding Panel and submitted to the Bishop of Manchester, prior to being reviewed by the National Safeguarding Team.

Overall Conclusion from PCR2

Following PCR2, the Independent Reviewer was able to confirm that in Manchester Diocese:

- all known safeguarding cases, relating to children and adults, have been appropriately managed and reported to statutory agencies where required.
- the needs of any known victims/survivors have been considered, and sources of support identified and offered where this is appropriate.
- all identified risks have been assessed and mitigated as far as reasonably possible.

Local Themes

Safeguarding Children and Vulnerable Adults

- While there is a strong commitment to safeguarding from the Diocesan Bishop and other senior clergy in the diocese, this is not always shared at parish level, sometimes resulting in delays in referring to the Safeguarding Team.
- There is a particular concern that clergy and church officers may not be aware of the threshold for referring concerns regarding vulnerable adults or are not applying this in a consistent way.
- The Safeguarding Team was found to respond promptly to referrals.
- There were good standards of case management. Where there were shortfalls, this was mainly with historic cases.
- In general, there was a lack of concluding information to support risk assessments, although systems have now been put in place to address this concern.
- Manchester Diocese has had very few cases of domestic abuse suggesting that this could be a knowledge gap for clergy and church officers.

Recommendations

- Write to clergy and church officers with the learning from PCR2, including the need for timely referrals to the Diocesan Safeguarding Adviser with a variety of examples, such as offender worship, domestic abuse and the process for supervising those about whom concerns have been raised; also emphasise the need for appropriate records to be kept at parish level.
- Fully document clear reasons as to why a person who is suggested as being vulnerable is deemed not to be so - the Diocesan Safeguarding Adviser should make the final decision on vulnerability.
- Provide clear communication to parishes on domestic abuse and reporting requirements in relation to it. Provide dedicated training on all areas of domestic abuse in the diocese.
- Communicate the diocese's safeguarding strategy to all clergy and publish it on the website.

Survivor Strategy

- Offering support to victims/survivors is embedded practice in the diocese.
 Victims/survivors were clearly signposted to external sources of support and often received high levels of support from the Safeguarding Team.
- While the diocese had a clear approach to supporting survivors during the review, the
 diocese has not yet developed a more general survivor strategy to communicate what
 parishes and the diocese should offer by way of the support to victims.
- There is a lack of consistency in placing the victim/survivor at the centre of safeguarding plans.

Recommendations

- Develop the diocese's survivor strategy to ensure that appropriate support is offered to survivors/victims, communicate it to clergy and parishes, and publish it on the diocese's website.
- Set up a system of allocating a 'supportive friend' external to the diocese who can provide ongoing support, including when the clergy discipline process is underway.
- o Put the survivor/victim at the heart of safeguarding agreements.

Partnership working

- The Diocesan Safeguarding Adviser has good working relations with a variety of statutory and non-statutory agencies and contributes fully to multi-agency working.
- Manchester Diocese provides a safeguarding service to Manchester Cathedral, which is good practice.
- There is a lack of connection between the diocese and other organisations with volunteer chaplains.

Recommendation

 Put in place a point of contact for chaplain roles, to enable good communication and liaison on safeguarding matters.

Risk Management

- There have been delays to completing formal risk assessments. This matter has
 recently been addressed through the appointment of a suitably qualified person to
 undertake all risk assessments.
- Risk assessments were found to be of varying quality and in some cases, there were no
 written details of how the risk assessment had been implemented, monitored or how
 effective it was.
- There are concerns about a lack of formal process for when an individual is asked to 'step back from role' while a safeguarding issue is being investigated. It has been agreed that when a person is asked to step back, this will be followed up by a written communication setting out clearly what this means and when it will be reviewed.
- Safe recruitment across large parts of the diocese is limited to the requirement for a DBS check and Current Clergy Status Letters (CCSL).

Recommendations

- Put in place formal processes to support parish staff when they choose or are advised to ask an individual to step back from role.
- o Ensure that all safeguarding agreements are up-to-date.
- Confirm the requirements for safer recruitment processes with parishes and support them with implementing this.
- Ask all parishes to confirm the names of their Readers to the diocese, to ensure this information is complete and up-to-date.
- Update cases of concern records arising from PCR2 to ensure that any actions taken following the review are documented and that this is also included in clergy files.

Central Support for Safeguarding

- The Diocesan Safeguarding Advisor has a good reputation amongst the large majority of clergy and parish officers who actively seek out her and her team, welcoming their support, and trusting and implementing their professional advice and recommendations.
- The diocese has used an electronic case management system since 2015. Generally, the standard of documentation is excellent, although historically there is evidence of poor practice.
- The clergy files were found to be of mixed presentation, with some being well ordered and others less so. Reader files were found to be well organised.
- File security is taken seriously with regard to both paper and electronic records.
- The administration of DBS requests has improved over recent years.
- The diocese's Safeguarding Team is considered by the Independent Reviewer to be under-resourced.

Recommendations

- Hold information in a front-sheet of all clergy files, documenting all safeguarding information including DBSs, safeguarding training, recruitment information and details of any concerns raised with dates and outcomes, along with information about PCR1 and PCR2.
- Apply national Church of England guidance on personal files relating to clergy, in particular the requirement to include all safeguarding information in full, and to include a full audit trail of all documentation from the initial disclosure through the investigation process to the conclusion - also apply these policies to employee files.
- Consider the safeguarding resources available and whether more safeguarding case management time is required.

Implementation of local recommendations

Manchester Diocese has drawn up an action plan in the light of the Independent Reviewer's recommendations which has been agreed by the Diocesan Safeguarding Advisory Panel. The PCR2 action plan will be monitored regularly by the Panel, to ensure that improvements continue to be made to the diocese's safeguarding arrangements.

5 October 2022