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Independent Lessons Learnt Case Review
Diocese of Bath and Wells

Undertaken by Independent Reviewer – Kate Wood

Executive Summary

On legal advice the Summary and Recommendations have been redacted and amended, with the agreement of the Reviewer, to minimise disclosure of personal data.

1. The Diocesan Bishop of Bath and Wells, Bishop Peter Hancock, commissioned this Lessons Learnt Review in May 2019, with the objective of ascertaining the key actions and decisions of the Diocese; whether these were in line with national policy and what lessons can be learned for the future.

2. The Review has considered the Diocesan response to a serious safeguarding situation within the Diocese involving a member of clergy.

3. A Clergy Discipline Measure was instigated.

4. An Independent Safeguarding Risk Assessment was commissioned. The Risk Assessor's conclusion was that the member of clergy was low risk and safe to return to ministry. The Bishop considered the Risk Assessment and was minded to impose a conditional deferment if the Risk Assessment recommendations could all be implemented.

5. The risk assessment indicated that processes needed to be in place to manage the residual low risk, but ultimately this was not possible, despite significant effort by the Diocese and a group of Parish Officers.

6. The reviewer has seen a well intentioned response from the Diocese in managing a complex case. The Diocese correctly identified the need to work to a draft national Practice Guidance for responding to the safeguarding situation and for the management of the Risk Assessment. This was new working practice for the Diocese with the introduction of Core Groups, the proposed inclusion of Parish Officers in these meetings and the requirement for Independent Risk Assessments. During this process, the draft guidance was then amended and given full approval, resulting in the Diocese having to adapt again to changes in practice.

7. Throughout most of this time there were two separate but intertwined processes trying to work together: the Clergy Discipline Measure and the Safeguarding Practice Guidance. The review highlights how these processes clash at the turn of every corner and how the victim is, in contrast to safeguarding processes, not central and thus often forgotten in the discipline process. From the outset of the first CDM complaint, the process was legally, not safeguarding led.

8. The review shows a Diocesan team learning the new processes as they went, making some excellent decisions, working well as a team, despite there being several changes to the procedures and making every effort to adhere to the new guidance. However, omissions and mistakes were made and issues were sometimes not grasped as forcefully as they should have been. Many of these were correctly highlighted by parish representatives. Their concerns were listened to and had a positive influence on the management of the case at the start of the communication. However, the relationship became more difficult as time went on.

9. The parishes were predominantly held at arms length, until their help was needed to draft and manage an ongoing Safeguarding Agreement. Parish officers and other parishioners became frustrated at the lack of information from the Diocese although had unrealistic expectations of what could be shared.

10. The significant question highlighted in this review is how can a member of clergy return to a pastoral role when there are concerns that it may not be safe for them to do so?

11. There are many lessons to be learnt from this case, hence the significant number of observations and recommendations made by the reviewer. This demonstrates the complexities of the case and a misunderstanding of some of the new working practices rather than a lack of motivation to get it right. Many of the recommendations are for the consideration of the National Safeguarding Team.

12. The review would highlight the following three areas:
• The time this situation took to resolve was unacceptable;
• The CDM process as it stands, does not fit within a safeguarding process and loses sight of victims.
• It is important for the Diocese to engage with the affected parishes at an early stage and to work together to achieve a safe outcome.

Conclusions

The aim of this review as stipulated in the Terms of Reference was:
To provide an independent assessment of events surrounding the case and to identify the key lessons for the Diocese going forward.

The reviewer has detailed in this review the many twists and turns of this case, which became a complex and complicated situation to deal with. The management of the safeguarding situation ran alongside CDM complaints. It demonstrated how having two separate processes with different objectives caused frustration, confusion and delay. This was often at the expense of the victims and the subject of the complaint and also the parishioners.

The Diocesan team managing this situation worked hard to adhere to new safeguarding practice guidance and new working practices. In many of the situations, this was achieved, particularly in the early stages; this was largely an excellent example of an immediate Diocesan response to a serious safeguarding situation.

The Diocese struggled with the concept of parish involvement with Core Groups, which caused some frustration, with distrust by some parishioners of how the Diocese was managing the situation and a lack of information given. In relation to the Core Groups, it was unfortunate that the template agenda from the draft guidance wasn't adopted in its entirety and used throughout, as this would have triggered actions, which were not always recognised as necessary. Examples were the requirement for confidentiality to be agreed and referral to the Charity Commission.

The process highlighted the difficulties, if not impossibilities of a member of clergy returning to a pastoral role following partially substantiated safeguarding concerns.

The CDM proceedings are a reminder that the people involved appear to be a minor consideration in a bureaucratic legal process. The treatment of the complainant by the CDM system was nothing short of appalling and lessons must be learnt.

The reviewer hopes that all contributors feel that she has reflected their views and concerns in this review. She received support from the Diocese with many open and honest conversations and a welcome number of written submissions and conversations with parish officers and others affected by this situation.

The reviewer has made 46 recommendations from the review, which reflects the complexity of the case and working with new guidance rather than the inadequacy of the Diocesan response.

Many of the recommendations are wider than just for the Diocese of Bath and Wells, and the reviewer anticipates that these will be passed to the National Safeguarding Team for consideration. She hopes they will value feedback in relation to the Practice Guidance. Often new guidance needs to be tried and tested before it is fully fit for purpose. She would suggest that it was fully tried and tested in this case.

Recommendations

1. In safeguarding situations relating to church officers, a reminder should be given to the Core Group members that all relevant documentation and records of actions, including emails, should be shared with the DSA unless they are bound by CDM or statutory agency confidentiality. The safeguarding file should be the complete safeguarding record. A suggestion should be made to the NST that this is considered as an addition to the Practice Guidance when amended.

2. If a Core Group cannot be organised within 48 hours of the DSA receiving a safeguarding concern due to non – availability, then consideration should be given to an earlier Core Group conference call, to be followed up with a further meeting shortly afterwards.

3. Statements made to the congregation regarding their incumbent having been suspended should only be made after full consultation and preferably only after it has been discussed at a Core Group and where relevant, with the statutory agencies.

4. The complexities of engaging with a benefice in managing a safeguarding concern are not acknowledged in the current Practice Guidance. The number of parishes which need to be involved in the process makes several aspects of managing the case more difficult. The NST should consider acknowledging this in the Practice Guidance particularly in relation to Core Groups, communication and managing risk.

5. When managing safeguarding cases which impact upon parishes, Section 3.1 of the Practice Guidance should be considered good practice in relation to parish membership of Core Groups and unless there are valid reasons not to invite them, they should be invited from the beginning of the process. Consideration should be given to inviting the most appropriate parish officers with relevant skills and capacity for the role.

6. The first role of the Core Group is to establish the boundaries of confidentiality and to obtain agreement. This must be fully minuted.

7. To reinforce and remind the Core Group of its role as stated at Section 1.6 of the Practice Guidance:

   Every safeguarding concern or allegation involving a church officer should be managed by a defined core group, convened for the specific situation. The purpose of the core group is to oversee and manage the response to a safeguarding concern or allegation in line with the House of Bishop's policy and practice guidance, ensuring that the rights of the victim/survivor and the respondent to a fair and thorough investigation can be preserved.

8. The minutes of a Core Group should be taken by an administrator whenever possible who is skilled and experienced at taking minutes. The minutes should include clear actions, follow the agenda items and be sufficiently detailed to properly reflect the discussions. They should be circulated to all those present to check for accuracy.

9. Enquiries to be made with the NST regarding the removal of the Core Group Agenda from the Practice Guidance.

10. Support for victims should be a separate agenda item for all Core Group meetings.

11. When the offer of support has to be made via a third party then there should be a follow up from the DSA in writing to ensure that the offer has been made and for this to be recorded on the file.

12. In safeguarding cases, the role of the AD needs to be clarified. In the majority of clergy cases the AD role will be disciplinary rather than pastoral, and independent pastoral support needs to be put in place. This needs to be clearly explained to the subject.

13. It is good practice for a member of the Diocesan Safeguarding Team or a Communications Officer to attend court trials of members of the clergy and take comprehensive notes.

14. Clarity to be sought with the NST as to whose responsibility it is to discuss with a victim the process of making a claim, what advice should be given to the victim and at what stage this discussion should take place. Clarification is needed in the Practice Guidance.

15. A suggestion is made to those who are currently reviewing the CDM process that an information leaflet regarding the CDM process from the perspective of the complainant and victim is produced.

16. When the complainant is also the victim in a CDM case, then there needs to be a sensible and sensitive approach regarding what papers are sent to them. The victim may legally be regarded as 'the prosecutor' but importantly, they are also a victim and should be treated with this in mind. If it is felt that Rule 17 (6) of the Clergy Discipline Rules 2005 does not allow for such reasonable discretion and sensitivity, then there needs to be an urgent change to the legislation in this regard.

17. When a victim is approached to ask if they wish to make a CDM complaint, if a senior clergy person such as an Archdeacon is also making a complaint, then the victim must be informed and the consequences explained i.e. does this negate the need for the victim to make a complaint or will it be regarded as a weakening of the prosecution case if the victim declines to make a complaint on that basis.

18. Training should be offered for DSAs on the CDM process and how it relates to safeguarding situations.

19. The reason for the risk assessment as stated in the Terms of Reference must fully reflect the allegations made rather than just what has been admitted by the subject.

20. Clarification to be sought from the NST regarding the expectations for communication between the DSA and the subject before the commencement of the risk assessment and for the clarification to be included in the Practice Guidance.

21. Consideration should be given to the Practice Guidance being amended at section 5.6a to include as best practice that when the Bishop receives the draft risk assessment report from the assessor that he shares it with his DSA and Registrar before determining whether there is a need for clarification to be sought from the assessor. This should happen before sharing the draft with the subject.

22. Consideration to be given to rewording and expanding sections 5.7a and 5.8a of the Practice Guidance for clarity.

23. When a CDM and a safeguarding case are running parallel to each other, there should be a clear distinction when the Bishop is meeting with the subject between a CDM meeting and a safeguarding meeting and appropriate advisers should attend each.

24. Consideration to be given by the NST for guidance to be included in the Practice Guidance for:

    I. How a Core Group can challenge the conclusions of a risk assessment if the Group decides this is necessary and;
    II. If there are problems in implementing the recommendations of a risk assessment, how to refer back to the Risk Assessor for further consideration and clarification.

25. When there is only one representative from each parish, the Core Group should encourage the parish representatives to set themselves up for mutual support with an external supporter if necessary. This is all the more necessary in a benefice.

26. The issue of confidentiality requirements for Core Group members needs to be expanded upon in the Practice Guidance to include advice on what actions can be taken if confidentiality is breached and for the NST to consider drafting a form of Non-Disclosure Agreement template for Core Groups.

27. When drafting a safeguarding agreement, the DSA and the drafting group should always have in mind whether the agreement will;

    a) Contain sufficient restrictions on the subject to appropriately minimise the risk posed and;
    b) Whether the adherence to the agreement can be managed.
    If it is recognised that either requirements cannot be met, then this needs to be taken back to the Core Group for further discussion.

28. The issue of the impracticality and even impossibility of a Safeguarding Agreement to be effective and manageable for a member of clergy when they are active in their role needs to be discussed with the NST and guidance sought.

29. Advice needs to be sought as to whether a Bishop can see the minutes of the Core Group meetings. Regardless, the Practice Guidance needs to be clear on this point.

30. Consideration is given to formalising a process of peer support for Diocesan Bishops in complex safeguarding cases with 'professional case supervision' being provided by the lead or deputy safeguarding Bishop to create a safe space for the issues to be discussed. This must not be used to influence any CDM decision making.

31. When an incumbent is subject to a safeguarding concern, particularly if he is suspended from his role, there needs to be an understanding by the parish that there is a limited amount of information that can be shared by the Diocese to those not on the Core Group. However there also needs to be a recognition from the Core Group as to the frustration and misperceptions which will develop in the parishes when no information is forthcoming. Updates from the Archdeacons and the DSA will always be helpful, even if the update can only be limited, but consideration should be given to providing more general information about processes.

32. Clarification is needed in the Practice Guidance about named support for parishes; information sharing; advice on communications and response to specific issues they raise should be offered to parishes when their incumbent has been suspended due to safeguarding concerns.

33. When an incumbent is suspended for safeguarding concerns for a prolonged period of time, consideration should be given to a Suffragan Bishop taking on a pastoral role in the parish or benefice.

34. The issue of confidentiality requirements for Core Group members and Parish Officers outside of the Core Group but involved in the management of a Safeguarding case needs to be expanded upon in the Practice Guidance. Guidance is particularly needed regarding what action to take if confidentiality is breached. Exclusion from the Core Group should be considered. If the breach has been by a Church Officer, then disciplinary action should be an additional consideration.

35. The attendance and participation of the Communications officer at Core Groups is vital. Their role is not just to advise on media issues but also to advise on the wider communications issues in parishes.

36. That reassurance is sought that the Registrar is in agreement with the new guidance issued for referrals to the Charity Commission on the issue of reportable incidents.

37. Registrars should be offered Diocesan safeguarding training, particularly when new safeguarding guidance is produced.

38. Advice to parishes on how to deal with the issue of parish equipment, such as computers and phones, at an early stage of suspension to be included in the Practice Guidance.

39. Any revision of the Practice Guidance should include step by step advice regarding the support of victims and survivors. This should include the issue of counselling and discussing with the victim/survivor on whether they wish to make a claim.

40. There is a need for a readily accessible, informative and sensitive information document for all victims of safeguarding cases where the person of concern is a Church Officer. This should include information about processes; terminology; support; and single points of contact. This could form the basis of a Victims Charter.

41. The offer of making an apology to a victim/survivor should be considered in all cases. The Practice Guidance at Section 5.10.1 should be followed regarding the timing of the apology, how this should be made and by whom. If there is a justifiable reason for why the DSA and the Core Group feel that an offer of an apology is not appropriate, then this must be documented on the safeguarding file.

42. A process of DSA peer review or independent case review for DSAs needs to be considered for complex cases, at regular intervals as the case progresses. This is not the same as professional supervision and should be kept separate. This could be provided by an Independent Safeguarding Consultant. The need of peer review should be included in the Practice Guidance.

43. A benefice that has been through a difficult safeguarding situation should be provided with some healing support arranged by the Diocese. This should be arranged in consultation with the PCCs.

44. This Review Report should be shared with the Chair of the Diocesan Safeguarding Advisory Panel for discussion with the Diocese about the involvement of the DSAP and its Sub Group in this case.

45. An independent safeguarding risk assessment will be required in the event of the member of clergy requesting a return to ministry at the end of the CDM measures. An Internal Investigation will be needed to inform the risk assessment. This should be linked to the CDM assessment.

46. That the reviewer's observations on the process of a lessons learnt review should be passed to the NST for consideration.