Overview of the independent review of files held by the Archbishop of York for the Northern Province under the PCR2 project.

In June 2018 an independent scrutiny team reported on the Past Case Review of 2007, recommending a fresh review of files held by the 42 dioceses and 2 provinces of the Church of England. (PCR Report of IST - final version June 2018.pdf (churchofengland.org)

Subsequently, the 'Past Case Review 2' (PCR2) project was commissioned with a more wide reaching remit than the 2007 review. The intention of PCR2 was that *"any file that could contain information regarding a concern, allegation or conviction in relation to abuse 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 an independent safeguarding professional."*

The PCR2's objectives included:

- *identifying all cases of concern relating to clergy or church officers causing harm to children or adults (including where domestic abuse is alleged) and ensuring they have been independently reviewed;*
- *ensuring that all identifiable safeguarding concerns relating to living clergy or church officers have been referred to the DSAs;*
- *ensuring any allegation made since the original PCR took place have been handled appropriately and proportionately to the level of risk identified and that the support needs of survivors have been considered; and*
- *ensuring that cases meeting the relevant thresholds have been referred to statutory agencies and that all cases have been managed in line with current safeguarding practice guidance.*

As part of PCR2 (2020/21), three experienced independent reviewers (IRs) were engaged to examine all relevant files held by the Northern Province/Archbishop

of York to identify any evidence of individual and/or institutional failings in relation to how allegations of abuse had been handled.

The nature of the files reviewed in the Northern Province was different to those held in each diocese, reflecting the distinct roles of an archbishop and a bishop. The material in the northern provincial review consisted of personnel files, complaints, and miscellaneous correspondence dating back over half a century, which related to members of clergy and other individuals. Current live cases and files of deceased members of the clergy did not form part of this review. The file distribution was as follows:

File type	Number reviewed
Provincial Bishop's Blue (Personnel) Files	24
Provincial HR Personnel Files	43
Selected Sample files of Correspondence re Known Areas of Concern	3
Disciplinary (Lambeth & Bishopthorpe and the Archbishop's List) and Potential Pending Files	486
Miscellaneous Files A-Z (No Q, X or Z) (Contained multiple documents)	23
Safeguarding Files	41
Total	**620**

The majority of files and documents reviewed at Bishopthorpe Palace were paper-based and spread across a timespan of at least 65 years. In addition, with the historical autonomy given to the 42 diocese and 2 provinces, the file management 'system' led to a separation of information and an inconsistent approach to both the control and distribution of material contained within the records. At a provincial level, the majority of files examined dealt with complaints. The detail behind safeguarding decisions and actions documented were largely recorded on files held by the local diocese.

The Clergy Discipline Complaints process itself was not found to be 'user-friendly' for a person unfamiliar with ecclesiastical legislation, with responsibility firmly placed on the complainant to prove the case. There were instances where, regardless of the type of complaint, the same expectations were placed on victims of abuse who were questioned in their motive and delay in bringing the complaint forward, with disregard for the psychological impact the abuse was likely to have had and the years it may have taken before they had stepped forward. It is recognised that victims and survivors often find it difficult to report abuse until sometime after the event. As a result, safeguarding failures are equally likely to become known outside of the 12-month limit. The IRs did note that the legislation now recognises these issues and the 12-month limit has allowances for where there are safeguarding concerns. Prior to establishing the role of archbishop's visitor in the mid 2000's, the IRs saw little evidence of any independent service made available to complainants, nor an indication that the process was described in layman terms.

Between the 1980's to the 2000's, the IRs observed a pattern of decision making that demonstrated a culture that sought to protect the reputation of the Church, its members and to rehabilitate offenders, whatever the nature of their offence. This was often at the expense of the victim. There are several examples where media attention is cited as the factor which instigated action rather than a response to the allegation of abuse. The review also found examples of several high-profile cases of serious sex offenders where disclosures made were not shared with statutory agencies resulting in lengthy delays in offenders being brought to justice.

The IRs were fully cognisant of the needs of survivors/victims and how integral these were to the PCR2 process. However, they found that information relating to the interaction with the victim and the support/service provided, was primarily captured in aspects of the complaint or safeguarding file held by the diocese and in many cases was not seen by the provincial IRs. Due to the nature of the files held by the archbishop, a lot of the focus observed was often solely on the

rehabilitation of the perpetrator and the care of the victim, if seen, was ancillary. The notable exception to this was the care provided to wives of male members of the clergy after the husband had been involved in infidelity and or the breakdown of marital relationships.

There was little evidence within files, dating from before the appointment of safeguarding experts, of consultation or involvement of statutory agencies, with examples of clergy moved between diocese rather than being disciplined and/or brought to justice. It was not until 2015 that the Church of England began to significantly invest in safeguarding resources. Even then, the review found later examples where the advice of safeguarding staff had been apparently ignored by senior clergy. In recent years, however, files generally show the benefits of working more closely with statutory agencies, the use of core groups and seeking the advice of those with professional expertise in the protection of children and adults.

The practice of formal risk assessment and mitigation towards safeguarding was mostly absent in the earlier years. Decision making was, in the main, an internal discussion between senior clergy and their legal advisors. This was also characteristic of earlier complaint files that dealt with those ordained overseas and were disciplined in this country, with little detail on file of previous offending history in their home country. However, in recent years, with the introduction of formal risk assessments and associated training for staff, such changes have helped further the understanding and management of risk, in particular when considering the reintegration of clergy who have offended in the past and improved information sharing with overseas bishops. Decision making is further supported with detailed guidance and safeguarding advisors to help navigate the process. The review observed a noticeable change in the church's approach towards the management of sex offenders, which is now proactive, driven by the respective safeguarding advisers and the National Safeguarding Team.

The IRs saw consistent, but not comprehensive, evidence of those facing allegations involving safeguarding issues being withdrawn from their

responsibilities. In the earlier files, this was generally on a voluntary basis after arrest but before being charged or convicted. Isolated examples were, however, found of members of the clergy being allowed to remain in post, even after being cautioned for sexual offences, as recently as in the last 20 years.

The IRs found little evidence regarding how much information was requested or shared with external agencies employing ex clergy staff. Similarly, there was little information within the files regarding how much information was sought from external secular agencies when individuals were being reconsidered for 'Permission To Officiate' (PTO) or other positions within the church beyond initial employment references.

The IR's noted a marked improvement in the quality of reports from those appointed by the archbishop to an advisory pastoral role. The substance of the reports was generally well structured and informative with a clear thread of risk assessment. Several of the 'advisers' refer in their correspondence either to the training they have had or having requested guidance from the archbishop's chaplain before taking on the role.

It is evident that major social changes have impacted the Church of England's more traditional interpretation of scriptures. Among these changes have been transformation in the role and status of women and in sexual practices and attitudes. Changes of attitude, concerns, and practice within the wider society over the past 60 years have been reflected in the files reviewed, both in the content of the complaint and how the complaints have been handled and resolved. As such, there has been an evolution rather than a revolution in relation to the wider safeguarding agenda reflected in today's standards of practice.

The Church of England has faced significant challenges in respect of its progress in the safeguarding of children and vulnerable adults. There has been a recognition and acceptance that it has historically failed in its duty of care towards the victims of predatory clergy. In recent times, the Church of England has

embarked on a journey to embed safeguarding into every aspect of church life through its' employment of professional safeguarding staff, revised policy and practice, involving external agencies and training for members of the clergy and laity with responsibility; in this respect, the review of the Northern Province's files demonstrate that there has been visible progress.

The IRs would like to place on record their sincere thanks to all the Bishopthorpe Palace staff who assisted with the review.

Whilst a review of files can only go so far in identifying the extent of a cultural change within an organisation, the IRs considered the objectives of the PCR2 project were met for the review of the files held by the Northern Province and that current practice was effectively managing the risk associated with potential or actual abusers with an appropriate focus on victims and the care of vulnerable children and adults.

The IRs would also wish to emphasise that no new cases were identified within the material reviewed.

The Northern Provincial IRs made the following recommendations to the Archbishop of York and the PCR2 project board:

1. The Church of England should introduce an electronic record management system that ensures consistency, accessibility and would mitigate against the risk of information being missed.

2. The Church of England should ensure that a complainant/victim management strategy, a living document, with an allied assessment of the individuals needs is an integral part of the discipline process.

3. The Church of England should ensure its proactive involvement in addressing domestic abuse within church families. Recognising that the

church may employ victims or perpetrators, the church needs to ensure that when addressing the issue of domestic violence, this is separate to workplace violence prevention plans or harassment policies.

4. Staff that have a managerial responsibility should, as part of their general training, be sufficiently equipped to distinguish between cases of complaint they should escalate to a higher authority immediately and those that require further investigation. Furthermore, those with a specific responsibility to investigate an internal complaint should be trained to a sufficient standard of knowledge and competence to undertake such an investigation to an acceptable level that could withstand external scrutiny.

5. The recording of the rationale for decision making pertaining to discipline files should become required practice.

6. The Church of England should ensure that where a penalty by consent has been imposed, the definition of the misconduct reflects the nature of the allegation.

7. The independent reviewers observed an improvement in the archbishop's advisors reports and the management of alleged offenders where the DSA/PSA and NST were involved. However, the Church of England should ensure consistency in sanctions for like offences especially when considering granting PTO.

8. The Church of England should ensure a holistic approach to the care of complainants/victims where allegations span different diocesan and provincial boundaries.

9. The Church of England should avoid disparity when using standard form of words in correspondence to complainants/victims and alleged offenders.

10. The Church of England should review its information management systems and ensure material is not stored in multiple locations.

11. The Church of England should ensure its' information sharing procedures in respect of overseas clergy and clergy that work abroad are robust.

For further reading the national report published by the PCR2 Project Board can be found at the following link: (https://www.churchofengland.org/safeguarding/past-cases-review-2)