Past Cases Review 2: National Safeguarding Report

On 5 October 2022, the Church of England published the report of the National Safeguarding Steering Group.[1] Forty-five independent reviewers spent more than a year examining 75,253 files on clergy and church officers going back to the 1940s. They identified 383 cases where safeguarding was inadequate and more action was needed. Each diocese has received a report and recommendations specific to the diocese. For example, the executive summary of the findings on the Guildford Diocese is published on the diocesan website.[2] This has been an important and valuable process. However, I am less impressed by the recommendations in the overarching 129 page national report[3]:

1.) Some recommendations are too general to be useful.

For example:

> "children must always have the opportunity to speak out and to be listened to when raising their concerns. While the independent reviewers did not determine how this should be done, they were keen to exhort the Church to consider how this can be achieved effectively and incorporated into policies and professional practice." Page 43.

The 45 independent reviewers are experts in safeguarding who have been studying the Church of England's policies and procedures for a year. They had the ability to say what specific procedures should be changed and how. Instead, they gave a general exhortation for the Church to think about.

2.) Some recommendations just state the obvious.

For example:

> "Recommendation 3: Through the Safeguarding Learning and Development Framework, church bodies are to ensure that all clergy, church officers and volunteers are equipped with sufficient knowledge and skills, proportionate to their role, to recognise safeguarding risks and make effective referrals to safeguarding professionals in all dioceses and settings." Page 51.

Church policies are already committed to this. So how can we action this recommendation?

3.) Some recommendations don't go the extra mile to be helpful.

For example:

> "Recommendation 8: Dioceses to review their current Information Sharing Agreements (ISAs) within their local partnership arrangements and update them where required. The ISAs should be robust, withstand legal scrutiny and cover all key and statutory partners." Page 59.

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[1] https://www.churchofengland.org/safeguarding/past-cases-review-2
[2] https://www.cofeguildford.org.uk/about/safeguarding/past-cases-review-2-(pcr2)
[3] https://www.churchofengland.org/media/28281

Amongst the 45 experts would have been the legal expertise to produce a template that could be used. They didn't go the extra mile to be helpful by producing one.

4.) Some recommendations are to do something that is already being done.

For example:

> "The independent reviewers' comments provide support for the Church's procurement and implementation of a consistent electronic case management system for all dioceses. This system has been developed and will support safeguarding teams in capturing and holding information on safeguarding cases in an accurate and consistent manner. One of the aims of delivering the system is the standardisation of safeguarding cases and recording. This will also improve outcomes and the all-round service for survivors and victims." Page 61.
>
> Recommendation 9: Dioceses, cathedrals and the National Safeguarding Team to support the implementation of a national safeguarding case management system to enable standardised recording and effective case management." Page 63.

The recommendation is to bring in a case management system, that is being brought in.

5.) One recommendation does what they criticise others for.

For example:

> "The security arrangements in one diocese were described as robust without explaining what 'robust' meant or what measures were thought to be robust." Page 64.
>
> "Recommendation 11: Diocesan bishops to be satisfied that there are appropriate and robust arrangements in place for the management and control of all blue clergy files [...]" Page 67.

They criticise a diocese for using the word "robust" without being specific about what that means. Three pages later their own recommendation is for something to be "appropriate and robust" without being specific about what they mean by that.

Conclusion

My above criticisms of these recommendations aren't unique to this report. It is generally the case when a group conducts a review, they are good at identifying the problems and issuing general recommendations. They then leave it to the receiver of the report to try and work out how to implement these general statements. The reviewers assume that this is the best way to do it because it forces the receiving body to 'own' the process by working out how to implement. But really what is happening is that the reviewers are avoiding the really hard work of identifying the specific steps that need to be taken. The receiving body are then left trying to mind-read what the reviewers had in mind, when trying to work out how to implement the general exhortations.

In the Press Release[4] that accompanied the publication of the Report, the Lead Bishop for Safeguarding, Jonathan Gibbs said that the national recommendations "have all been accepted by the National Safeguarding Steering Group."

I am sure they will do their best to implement them.

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[4] https://www.churchofengland.org/safeguarding/safeguarding-news-releases/national-report-church-englands-second-past-cases-review