Diocese of Sheffield

PCR2 report Executive summary

The Diocese of Sheffield, created in 1914, is made up of Church of England organisations located throughout South Yorkshire and the southern parts of the East Riding of Yorkshire. It comprises parishes, schools, chaplaincies, missional communities and other organisations. Some churches are part of Local Ecumenical Partnerships. It is located within the ecclesiastical Province of York, serving a population of 1.2 million people. There are 207 churches in 159 parishes. In addition to the Diocesan Bishop there is one suffragan bishop and two archdeacons. The Cathedral is in the centre of Sheffield, with the administrative centre of the Diocesan Board of Finance located at Church House in Rotherham.

This report presents the findings of the Past Cases Review 2 (PCR2) in Sheffield conducted by a lead independent reviewer, with the brief support of a second reviewer, between November 2019 and November 2021. Both reviewers were commissioned by the Diocese, were fully independent and approved by the National Safeguarding Team (NST).

The July 2019 Background and Overview document, setting out the objectives of the national review, and associated practice guidance underpinned the diocesan review process. In total 890 files and other records were reviewed. Of these, 5 were considered to be Appendix D cases requiring further attention and investigation by the Diocesan Safeguarding Team (DST). In addition, 364 'blue' clergy files were reviewed by a further team of independent reviewers in 2017/18 prior to the formal launch of the PCR2 process in 2019. Because of the thoroughness of that exercise, the Diocese successfully obtained exemption from undertaking further review of these cases.

Arrangements for completing PCR2

A PCR2 Reference Group was established in 2019, chaired independently and drawing its membership from the DST, senior clergy and statutory agency partners. This group subsequently received the substantive report in November 2021 and considered its recommendations. The lead reviewer was appointed in October 2019, starting work in November the same year. The reviewer was provided with office space at Church House, the Cathedral and Bishopscroft (the home of the Diocesan Bishop) in order to review paper files and given access to the computerised recording system in use by the DST.

The DST and other colleagues supplied spreadsheets relating to clergy and church officers in scope and constructed a known case list (KCL). These records were invaluable in enabling the reviewer to access and navigate record systems in three locations. The KCL brought together information from safeguarding files, parish returns, the product of the 2017/8 clergy review and cases from the 2009 PCR1 process. In summary, the reviewer conducted

a thorough review of Clergy 'blue' files, reader and lay employee files, PTO files and current and historic safeguarding records.

There was regular and ongoing close co-operation between the DSA, an identified lead administrator and the reviewer to monitor progress and address emerging issues and queries. This contact was replicated with the Cathedral Safeguarding Adviser and the Bishop's PA. The reviewer is extremely grateful for the resources supplied and support offered by the Bishop, Diocesan Secretary and the Cathedral Chief Operating Officer, and their respective teams, which made completion possible.

The Covid pandemic resulted in a substantial but not complete pause in the process from March 2020 until June 2021, as it was possible to conduct some review activity remotely. It is also important to note that the review was carried out during a period when the DST was impacted by significant staff sickness with the current DSA under significant operational pressure as a result.

Key findings from review of information obtained from files

The reviewer was able to sustain direct contact with the DSA to resolve immediate case queries. However, as indicated, 5 Appendix D cases were referred for immediate attention. Of these, 1 case is now closed and 2 others referred to other dioceses. 2 remain open with one under core group scrutiny.

364 active clergy files were reviewed in the pre-PCR2 2017/18 project. The reviewers noted concerns in 34 of these cases. The PCR2 reviewer was asked to identify whether the recommendations relating to these had been fully implemented and was able to confirm that in 32 cases they had been. The other 2 cases concerned matters still under investigation at the time. The PCR2 review considered 85 files relating to clergy not included in the above project (i.e. those recently ordained or having moved to the Diocese since the start of 2019). A concern was raised in one of these cases.

Files were maintained in line with House of Bishops' Guidance 2018, but there was variation in content, and limited cross referencing with safeguarding files where appropriate. One recommendation relates to the need to address this last point. Since 2019, there has been significant improvement in the recording of safe recruitment information, including Current Clergy Status Letters, and completion of mandatory training on clergy files.

The second reviewer carried out a sub-project to review 104 retired clergy files. He raised concerns with the DST in six cases, four of which primarily related to poor recruitment practice. A further case from this project was referred to another Diocese and another related to domestic abuse. All matters were appropriately investigated by the DST. The findings from this particular aspect of the review process highlighted historic poor record keeping, indecipherable handwriting, two cases where the PCR1 process had not highlighted

concerns appropriately and very little evidence of discussions about safeguarding in ministerial development reviews.

114 active reader paper files were reviewed, and there was a concern that at the time of the review (December 2019) only 72 were recorded as having up to date DBS checks and 64 completing requisite training. This was brought to the attention of the Reference Group and the former Warden of Readers.

The Diocesan KCL supplied to the reviewer comprised 147 cases, but only 95 were deemed to be in scope. From these, 31 quality and practice queries were raised with the DST. Some of these queries related to concerns about the current whereabouts of the subjects and the potential for their being involved in church life elsewhere. More recent cases, since the introduction of computerised records in 2017, were recorded well and showed appropriate consideration of both adult and children's needs. However older paper files were often in poor condition, some records consisting of no more than sheets of paper, sometimes with attached post-it notes. Post 2017 records are generally far more robust and comprehensive.

Cathedral records, both paper and computerised, are of generally good quality. Of the 30 KCL files reviewed, the reviewer raised issues in 8 cases. 7 of these were explained and resolved to the satisfaction of the reviewer and in the other case there was dialogue with another diocese to enable them to address some relevant issues locally.

Survivor engagement

The file review identified some good practice examples of effective work undertaken to support survivors at each stage of their personal journey. Whilst this was most evident in more recent cases, one case which dated back to the late 1990s was included as a good practice example as it demonstrated a clear commitment to supporting a survivor against the background of a church that challenged good safeguarding practice at the time.

Three survivors agreed to meet with or speak to the reviewer and their positive experiences are recorded in the main report as good practice examples. The reviewer thanks them for their contribution to the review.

The Diocesan Survivor Engagement Strategy was agreed in January 2021 and the reviewer noted the contribution of a small group of survivors to it. Given the pandemic and

associated operational difficulties it was not possible for the reviewer to assess the impact of this to date. This is now an important priority area of work for the Diocese.

The review process did however identify an earlier, less supportive approach to addressing the concerns and needs of survivors who made representations to the Diocese and the reviewer prepared a separate detailed report for the PCR2 Reference Group to consider.

Obtaining the views of children who are victims of abuse

The review identified how the needs of children are prioritised, and there was good evidence of prompt safeguarding referrals made to statutory partners. The DSMG colleagues interviewed (see below) agreed that to their knowledge referrals were timely and appropriate. Subsequent plans generally included church participation. However, one case seen by the reviewer highlighted the need for improved clarity about information sharing between a local agency and the Diocese. It was not possible for the reviewer to gather direct testimony from children about their experience of the DST's work to support them.

Engagement with partner and statutory agencies

The review highlighted some good practice examples of effective joint work with statutory agencies, in respect of both children's and adult work. The Diocesan Safeguarding Management Group (DSMG) has multi-agency representation, and the reviewer interviewed two group members representing statutory agencies who identified both the quality of working relationships and their ability to help problem solve 'stuck' situations. However, the reviewer did note a small number of cases where the Diocese's role in safeguarding was less well understood.

Safer recruitment

The reviewer was able to be reassured about the systems in place for safely recruiting clergy and paid staff. As indicated above there is scope to improve how the safe recruitment of readers is evidenced.

Safeguarding agreements

The case files reviewed which contained safeguarding agreements, generally demonstrated a growing quality, and consistency of practice. One good practice example demonstrated how an agreement had worked well, had been modified appropriately and reviewed

regularly. Some, however, were unsigned, and the evidence of regular review was not always recorded on file.

Domestic Abuse

The review demonstrated that although the growing incidence of domestic abuse was well recognised and being appropriately responded to by the DST, there were no detailed statistics of cases known to the Diocese. The reviewer recognised the scope for more preventive and promotional activity and recommended taking note of emerging best practice from other denominations.

Key themes emerging from PCR2

Six themes stand out from the review:

Information sharing: the review noted case and personnel records held in 3 separate locations, with 3 data controllers as required by GDPR, that in some cases related to the same person. There was no protocol in place to achieve effective cross referencing nor govern formal information sharing. One recommendation proposes the development of more appropriate arrangements, including single file systems where appropriate, to prevent safeguarding information gaps.

Clergy Blue files: the reviewer was able to note significant improvement in the quality of record keeping in these files over the extended two-year review project timetable reflecting practice improvements recommended at the start. However, the quality of older files remains a concern. The reviewer also made a recommendation relating to ensuring that Ministerial Development Reviews (MDRs) better evidenced active consideration of safeguarding issues.

Case file recording: the review noted far better and more consistent recording practice since 2017, but it was agreed locally that the computerised system currently in use merits review and its full potential to supply management information reports has not been tapped. It is anticipated that the introduction of the National Case Management System will improve practice in this area. It is pleasing to note that the Diocese has volunteered to be part of the national development group and an early adopter of the new system. However, the review noted few casework supervision decisions were recorded, local risk assessments were of variable quality and there were particular information gaps that failed to identify the current whereabouts of individuals of concern.

Reader files: the review noted the relative thinness and inconsistency of reader records in respect of safeguarding along with a lack of formalised links between the Warden of

Readers role and the DST. The review included a recommendation to the Diocese to identify resources that could help to deliver the necessary improvements.

Safer recruitment to particular posts: after consultation with the relevant Archdeacon, the review noted the need for better scrutiny of appointments of retired clergy to local parish roles to ensure a similar level of due diligence to that applied to active clergy. In addition, the review identified the need for improved partnership working between the Church Army, based in Sheffield, and the Diocese in matters relating to safe recruitment and information sharing. The reviewer has recommended that this be referred to the NST as a wider policy and practice issue. One case example also exemplified a requirement to achieve better and more timely coordination of granting PTO to chaplains appointed by other bodies such as health services.

Quality of direct work with children and vulnerable adults: the review included 8 case studies, 4 of which highlighted good practice in respect of children and 1 in respect of a vulnerable adult. This reviewer was therefore reassured that the response to initial referrals, early investigation processes and core group practice was generally good. The other 3 case studies identified where there was some scope for improvement although all these began several years ago. Two other case studies demonstrated good practice in supporting survivors.

Conclusion and recommendations.

The review report has drawn attention to the fact that the Diocese of Sheffield was one of several dioceses required to repeat every aspect of the 2009 Review of Past Cases. The report also describes 2 SCIE practice audits that took place in 2016 and 2019 in the Diocese and at the Cathedral respectively. The bishop's commitment to improving safeguarding has been amply demonstrated by commissioning a review of Clergy Blue files in 2017 before PCR2 was launched, and more recently following a visitation, initiating a review of safeguarding practice in the Music Department at the Cathedral. This level of scrutiny and the positive responses made to the SCIE recommendations has meant that this reviewer has not identified any major concerns nor significant practice deficits. Although queries were raised in almost a third of KCL cases, there were only 5 cases reviewed that required immediate attention.

There were 20 recommendations made by the reviewer arising from the PCR2 process and all these have been accepted by the Diocese. An action plan to implement them has been developed which the DSMG will oversee.