Past Cases Review 2 (PCR2)

The Diocese of Derby

and

Derby Cathedral

Executive Summary

October 2022

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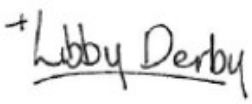
Introduction from the Bishop of Derby

I, along with diocesan colleagues and Derby Cathedral, welcomed the opportunity offered by PCR2 to reflect on our practice. We also welcome the advice and challenges arising from the report. We are grateful for the level of detail in the 40 recommendations made by the Independent Reviewers for consideration by the diocese, cathedral or Church of England. Many of these recommendations reiterate a process change that had been recognised by senior officers, and are underway or have already been completed.

We are committed to attending to the recommendations made and have been glad of the opportunity this process has provided to learn and improve.



The Rt Revd Libby Lane

Executive Summary of the Diocese of Derby Report

The PCR2 was jointly commissioned by the Diocese of Derby and Derby Cathedral. It was completed between 26th April and 29th October 2021 by two independent safeguarding professionals. The review process was overseen by a PCR Reference Group with an appointed independent chair. The process achieved the PCR2 specific objectives and complied with the PCR2 Practice and Policy Guidance (PCR2 PPG) issued by the Church of England PCR2 Management Board.

In compliance with PCR2 PPG, the diocese was in Category B - those dioceses who did not need to carry out a repeat of the original PCR but who have not conducted further review work since January 2007. The diocese did not seek any exemptions in the file review phase.

The Diocese of Derby and Derby Cathedral actively engaged with the PCR2 process, meeting all the requirements specified in the PCR2 PPG. The review was welcomed as a learning opportunity by the bishop and all those supporting the review, many of whom were new in post and seeking to benchmark their ongoing work.

The content of the PCR2 report was drawn from documented information, and discussion between the independent reviewers and key stakeholders in the diocese and Derby Cathedral.

The file review phase consisted of 1,164 files and, as a result, one new case was identified. Of the files reviewed, 70 were cathedral files.

Local Themes

File Storage and Data Accuracy

The pre-preparation phase was comprehensive with those supporting the review knowing where files were physically located. In the majority of cases, files were located as expected, however, the review did highlight some gaps to be resolved. The PCR2 has provided the diocese with an accurate record of files held. The file storage arrangements were robust in the majority of locations, with the need for some improvements already identified. Additional attention was required to improve the storage of archived former clergy files.

In the absence of a central CofE case management system, the diocese invested in its own electronic database in 2017, which was a positive decision. A database entry has been created to reflect the existence of a paper file for pre 2017 cases.

A number of individual databases were used to record details of personal files held by different business areas, however, there was no single record of which personal files were held by the diocese. Some inaccuracies were identified within databases and between databases and the physical location of files. The PCR2 provided opportunities for the diocese to consider gaps in process mapping and develop a business continuity plan for all areas of business, including where knowledge was exclusively held by one individual.

A recommendation was made reflecting the need for paper files to be weeded and file content to be GDPR compliant. It was acknowledged that Covid restrictions may be a contributary factor in the database accuracy and file storage issues.

The chief operating officer at Derby Cathedral has responsibility for personal files relating to staff, volunteers and cathedral safeguarding files, with access being limited. Paper files are securely stored and an electronic database, supported by the cathedral IT platform, is used to record safeguarding referrals.

Recording of DBS Checks, Safeguarding Training and Licences

The House of Bishops' Policy Relating to Personal Files 2018 states that personal files should contain accurate details of Disclosure and Barring Service (DBS) status and safeguarding training dates. Compliance varied across business areas with very high compliance in Permission to Officiate (PTO) files but information gaps evident in clergy files and readers files.

The review data provided the diocese with a baseline to prioritise DBS renewals and safeguarding training and to improve the underlying administration processes.

The current administration process for reader licencing was robust, with plans already identified to improve supervision for readers. The omission of clergy licences from personal files was identified and an immediate plan implemented by the diocese to resolve this issue.

Administration processes in Derby Cathedral were found to be robust with DBS renewal reminders and safeguarding training renewal prompts sent out to all cathedral clergy and relevant staff / volunteers.

Safeguarding and the Diocese Safeguarding Team (DST)

There has been significant investment in the DST resources and a clear culture of safeguarding is being driven across the diocese by the Diocese Safeguarding Adviser (DSA) and DST and by the bishop and senior leaders. There is positive reinforcement of diversity and inclusion within the diocese, notwithstanding the challenges identified in some cases of concern.

There is a solid relationship between the DST and cathedral safeguarding lead underpinned by a partnership agreement.

The overall quality of safeguarding investigation in the Known Case List files was generally of a good standard. It was evident from the file review phase that DST members understood and implemented the Promoting a Safer Church policy and drew on their professional safeguarding experience to ensure everyone in the church community was kept safe. The review found there was a lot of evidence of very good safeguarding by the DST and very comprehensive risk management.

25 of the 120 Known Case List files reviewed (21%) resulted in a case of concern being identified. The key themes identified by reviewers in the cases of concern were:

- Failure to record full case notes detailing investigation and outcomes
- Management of risk not evident in case notes
- Failure to follow process or complete agreed actions or record as completed
- Timeliness of investigation process.

Completion of the cases of concern will equip the DSA with details of the action required to improve case management records with implementation driven through regular supervision with DST members.

Working with Statutory Agencies and other Dioceses

There were numerous examples of where the DST has engaged appropriately and effectively with statutory agencies, i.e., police and social care. The diocese is signed up to the local multi-agency information sharing protocols.

The reviewers identified that sharing of information between dioceses is inconsistent, with both good examples and gaps in information sharing evident. The diocese should continue with its plans to review the Clergy Current Status Letter (CCSL) process and ensure that responsibility for completion of Part A referrals has great clarity.

Survivor Strategy

The Diocese of Derby had a bespoke PCR2 survivor strategy approved by the PCR Reference Group. A recommendation of the review was to enhance this for publication as the diocesan survivor strategy. The strategy detailed the Survivor Lead role, engagement (including use of advocates) and pastoral care and specific cases process and policy.

The diocesan website contained PCR2 information, including details of the dedicated national helpline operated by the NSPCC and the telephone numbers of both the NSPCC hotline and the Derby DST telephone number. It details Safe Spaces, a CofE project which provides an online and telephone service to help victims of abuse carried out by clergy or church officers irrespective of timescales. The information was accessible via the safeguarding page or a search of the website using the word 'survivor'.

Despite the challenges of being a third-sector agency, it was extremely positive that the diocese had a survivor representative, from Derbyshire Victim Support Services, on DSAP and on the PCR2 Reference Group. This ensured that the survivor voice was heard and responded to.

There were numerous examples within the files reviewed, where it was clear that appropriate support had been provided to survivors.

Diocese Safeguarding Advisory Panel (DSAP)

In line with the national practice guidance, DSAP convened a PCR2 reference group with an independent chair. The reference group met regularly and was responsible for ensuring progress and robust risk management during the process.

Following the completion of the review, DSAP will continue to offer advice to the bishop regarding implementation of PCR2 recommendations. DSAP will be updated on progress in addressing the cases of concern.

Local Implementation of PCR2 Recommendations

A system has been put in place to address the cases of concern and for independent sign off – this work is well underway and is continuing.

A quality improvement plan has been drafted to address each of the local recommendations and will be delivered, with review on a regular basis. Work has commenced in many of the areas identified, with significant progress already made in the recording of DBS and training, ensuring these are updated in line with national guidance. Work is also underway in relation to all aspects of file maintenance and storage.

We would like to thank our reviewers for their commitment and diligence. The review process and the report have been well received and have provided a valuable opportunity for learning. We remain committed to implementing the recommendations and to improving our practice in all areas identified.