COURAGE, COST & HOPE

The Report on the PAST CASES REVIEW

2013 - 2015

The Methodist Church

CONTENTS

DEDICATION

This review is dedicated to survivors/victims of abuse that has occurred within the Methodist Church with the hope that its findings and subsequent actions will contribute to making the church a safer place for all in the future.

ACKNOWLEDGEMENTS

Completing review responses was for many a difficult and painful task, particularly for survivors/victims but also for those in pastoral roles who made decisions in the past that they now regret. Heartfelt gratitude is owed to them for their courage. All ministers and laypeople who have thoughtfully contributed responses to the review deserve acknowledgement and thanks.

There has been a core team of 3 independent safeguarding consultants who have reviewed, between them, over 2000 responses, which has often been a difficult and troubling task. A supernumerary minister has also worked as an investigator to follow up certain responses. Their work has been key to the successful completion of the review and enormous thanks are due to them.

This small team has been joined by three additional reviewers who have stepped in to deal with the significant surges in volume of responses. Another reviewer has undertaken a learning review of some difficult Complaints and Discipline cases. Thanks are due to all of them.

The Connexional Safeguarding Team has been under great pressure over the review period and, even with the additional staff appointed to respond to past cases and follow-up work, their workloads have soared. Their professionalism has always been of the highest standard and their support for the Past Cases Review (PCR) has been critically important in delivering a successful review. The follow-up work for the Safeguarding Team is still a very significant commitment. They have specifically asked that the active cooperation of so many ministers across the Connexion who have been involved in this follow-up work is acknowledged with thanks.

DSOs have also been key to the successful completion of the PCR review stage, submitting responses, supporting those in their districts who have found the process particularly difficult and assisting with follow-up work.

PART 1

A. BACKGROUND

The Methodist Conference in 2010 adopted replies to Memorials 35 and 36 that accepted the need for a review of past child protection cases, something to which the Methodist Council was already committed, and asked for a strategy for such a review process to be presented to the Methodist Council and for progress to be reported to the Conference in 2011.

The 2011 Conference approved the outline plan for the Past Safeguarding Cases Review (2011 Conference Agenda, pp. 119-129), which included proposals for a pilot to be based in the Wales Synod and Leeds District.

The following remit was agreed:

> ***Remit – what is a case?***
> *It is suggested that 'case' is defined as a 'safeguarding concern'.*
>
> *The Church of England focused its work, which started in 2007, on child protection cases. Since that date, the work with adults who may be vulnerable has developed in importance. The Methodist Church has just published a new policy 'Safeguarding Adults'. It is therefore proposed that this review incorporate harm to adults.*
>
> *The Church broadly responds to two types of abuse issue: matters which have occurred within a church context and matters which are reported to the church as a matter of pastoral concern, but which have occurred away from the church. The boundaries can become very blurred – for example, when the familial abuse was perpetrated by someone holding office in the church. The data collection process will seek to capture these distinctions, but broadly all types of abuse should be covered in the review. The issues to be covered in the review should be:*
>
> *a)* ***sexual or physical abuse against a child or adult***
> *b)* ***emotional abuse/neglect if at the level of significant harm – against a child or adult***
> *c)* ***domestic abuse of any kind (child v. parent; wider family; woman v. man as well as the more usual male v. female violence)***
> *d)* ***any other abuse of a vulnerable adult - financial institutional***
> *e)* ***accessing abusive images on screen.***
>
> *There is a difficulty about non-criminal boundaries with inappropriate adult sexual behaviour. For example, the vast majority of clergy discipline cases in the Church of England relate to clergy adultery. Such cases need reviewing as part of the initial screening, to check that 'adultery' or 'inappropriate sexual behaviour' is not a sanitised reference to domestic violence or sex with a child or vulnerable adult, but adultery per se should not be deemed a 'case'.*

Remit – who and what is under review?

There are four categories of people to be reviewed:

a) ministers (presbyters and deacons)

b) lay volunteers with designated roles but who are not paid employees, eg local preacher; circuit steward

c) lay employees

d) members of Methodist churches, including as part of Local Ecumenical Partnerships (LEPs).

The last three categories often overlap – a person can be employed as a lay pastoral worker, who is also a local preacher within the same Circuit, and a Methodist member.

The review will seek to identify all cases of safeguarding concern; to ensure that safe arrangements are now in place and to enable lessons to be learned. These lessons will relate not only to how the Church responded to concerns that have been raised. In addition, lessons will need to be learned about how well the Church enables such concerns to be recognised, voiced and responded to – the review will provide a picture of how open is the culture to noticing and reporting concerns.

Remit – how wide across the Connexion?

The Church of England review did not cover church schools or religious orders, although such establishments were encouraged to adopt a similar process. Within the Methodist context, it is suggested that the following must be included:-

- *all Local Churches, Circuits, Districts and regional training forums*
- *all employing bodies that are consolidated into the annual accounts of the Methodist Church in Great Britain as a registered charity, including mission partners (who are contractually employees of the Methodist Council).*

Decisions will be needed about other bodies that are either perceived to be part of the Methodist family or report to the Conference. It is proposed that the Church of England model of writing to all such bodies, telling them what is happening and encouraging them to adopt a similar process, would be suitable for the following:

- *church maintained and independent schools*
- *Action for Children*
- *MHA*
- *Trustees for Methodist Church Purposes*
- *Central Finance Board*
- *and any other bodies identified through the governance scrutiny process.*

The 2012 Conference received a report on the pilot (2012 Conference Agenda, pp. 465-485) and agreed that the Past Cases Review (PCR) should be rolled out across the Connexion, taking account of the learning identified through the pilot.

B. OBJECTIVES AND REQUIREMENTS OF THE REVIEW

The 2011 Conference set out the purpose of a PCR within the Methodist Church as follows:

Objective 1

Identify all safeguarding cases.

In order to provide reasonable future assurance every effort will be made to identify all safeguarding cases documented or known about since 1950.

Objective 2

To review the Church's historical response in each identified safeguarding case in order to ensure that responses across the Connexion have been:

- safe
- compliant with legislation and policy (both state and church)
- pastorally appropriate.

Objective 3

To implement remedial action wherever this is identified as necessary.

Objective 4

To learn lessons about any necessary changes or developments in order to ensure that safeguarding work within the Methodist Church is of the highest possible standard.

Requirements

Require each district chair, superintendent and minister to research and identify what may be held in church, circuit, district offices or personal records as written information relating to any concern at all to assess whether there are safeguarding implications.

Require each district chair, superintendent and minister to supply details of any names/events in their memory relating to any safeguarding concern and to confirm if they are aware of any evidence or other people to contact to secure any additional information/material.

Require each minister to ensure that their congregations are aware of the Past Cases Review and how they can make a response.

Require each superintendent to ensure that there is a face to face conversation with every supernumerary minister in the circuit who is in good enough health explaining the requirements of the review.

C. INTRODUCTION AND REVIEW PROCESS

C.1 Introduction

One of the learning points from the pilot PCR was that dedicated management/coordinator time would be needed to ensure that the project was properly managed. In the event the Connexional Safeguarding Advisor met with Jane Stacey who had recently retired as the Deputy Chief Executive of Barnardo's and had a long career in senior management of organisations in the child welfare field. It was agreed between them that Jane would assume the role of PCR project manager on a volunteer basis which would provide an important element of independence. In the light of this appointment the learning points from the pilot were revisited and the process, outlined below, for the full PCR was agreed by the Chair of Methodist Council.

The project manager role included: being the public face of the PCR, supporting the team of safeguarding consultants who have acted as independent case reviewers and providing a further layer of scrutiny by reading all reviewer forms and agreeing initial outcomes. The role has involved working very closely with the Connexional Safeguarding Team. The project manager is the author of this report but the views expressed in it are shared by the team of independent reviewers. The timescales involved in the production of the report were extremely short but members of the Safeguarding Team and DSOs were able to feed in learning points, and given some opportunity to comment on emerging learning themes as identified in a presentation to the annual Safeguarding Conference on 5 February 2015 and a subsequent half day session on 25 March 2015. The consultation has not been full enough to ensure that there is endorsement by all these groups of all the recommendations.

C.2 Review process

C.2.1 Engaging ministers

A high priority from the outset was engaging as many ministers as possible in face to face discussions leading up to their participation in the review. This is reflected in the process undertaken as outlined below.

- A roll-out plan for launch meetings was agreed with district chairs in January 2013. This involved clustering districts together whenever possible. Subsequent additional meetings were agreed when district chairs requested them to enable wider participation. The programme is attached as Appendix 1.

- A letter was sent to all active ministers in the district cluster where the PCR was about to be launched outlining the process and requirements. The response form that all ministers were required to complete was attached. The letter also invited them to the launch meeting. Sixteen launch meetings were held across the Connexion which in total were attended by approximately 1,000 ministers, plus other people with a specific safeguarding brief.

- Reminder emails were sent to all active ministers one week after the initial deadline and a second reminder with a copy to the district chair after a further four to six weeks.

- In September 2014 the General Secretary used his electronic communication with all ministers to remind them of the Conference requirement that they should respond to the PCR.

C.2.2 Engaging laypeople

Inviting laypeople to respond to the review was a more difficult task. Information has been on the Methodist Church website, including forms, a frequently asked questions document and advice about support. There was a front page article in the Methodist Recorder in the 15 March 2013 edition.

Halfway through the review period the number of lay responses was not high and so it was agreed that further action would be taken to encourage more participation. In September 2014 the General Secretary wrote to all superintendents with an open letter to the Methodist people, asking them to ensure it was disseminated in an appropriate way to all congregations. The open letter is attached as Appendix 3.

C.2.3 Process following submission of response forms

- All responses received were acknowledged by email.
- All response forms with something to report were sent to an independent safeguarding consultant who read them and completed a reviewer form, including recommendations (Appendix 4).
- There were periods during the review when there was a lengthy gap between submission of response forms and review, due mainly to the volume and pattern of responses. When this became clear people were informed of the delay in advance.
- Every review form was read by the project manager who made the final decision on whether to refer the concern for allocation to the Connexional Safeguarding Team. With the exception of a very small number of cases, the independent consultant's recommendations with regard to further actions on the particular case were followed. In the small number of cases where this did not happen the project manager discussed the level of risk with a senior member of the Safeguarding Team before making a final decision. One important advantage of one person reading all the review forms was to capture learning as effectively as possible.
- Once a case was passed to the Safeguarding Team for further action the responsibility for the activity and decisions made was through this team's normal accountability processes.
- An email was sent to all respondents informing them of the result of the review in relation to all their submissions. Resource issues have meant that there was often a delay in sending these, but people had been forewarned of this.

C.2.4 Complex cases

There have been a number of highly complex cases where there were significant learning issues. In these cases there has been close liaison between the PCR project manager and the Safeguarding Team, always ensuring clarity of boundaries around accountability.

The report on the pilot PCR identified the priority of examining Complaints, Discipline (C&D) and Resignation files. Two independent safeguarding consultants started to review all the C&D files, after the pilot ended but before the main roll-out started. Once responses started to come in it was clear that many of these cases would be the subject of response forms. It was therefore decided that they would be considered in detail as and when related submissions to the PCR were made. There are a small number of cases on the original consultants' lists that have not been raised through PCR submissions and these are being re-examined.

In a small number of cases serious concerns were raised about C&D processes in relation to safeguarding. All of these individual situations were followed up in relation to objectives 2 and 3 of the review and specifically identifying any possible current risk. However there appeared to be significant learning that needed to be captured. The PCR project manager therefore commissioned a learning review of C&D processes relating to safeguarding. The scope and terms of this review were agreed with the Assistant Secretary of the Conference. This review informs the recommendations included in this report in section H.2.

D. RESOURCES EXPENDED TO 28 FEBRUARY 2015 – END OF REVIEW PHASE

In 2012/13 the expenditure on the PCR was £38,000.

In 2013/14 the expenditure on the PCR was £133,000.

In 2014/15 expenditure, until the end of February, was £91,000.

Total expenditure to the end of the review phase £262,000.

E. EVALUATION OF OBJECTIVE 1

Identify all safeguarding cases. In order to provide reasonable future assurance every effort will be made to identify all safeguarding cases documented or known about since 1950.

The process for the PCR as described above in section C was ambitious and far reaching. The Methodist Church does not currently keep personal files on ministers that would hold the kind of information relevant to this review. The source of information therefore needed to be the memories and records that ministers and others had acquired over the years. The standard of record keeping in the past was very poor (this is not unique to the Church context) which made the process of identification of cases very challenging. It needs also to be acknowledged that for many the recalling of some of these events has been very painful. It is therefore important to commend the level of participation in the review which has resulted in 2,566 responses reporting a safeguarding concern.

These responses relate to 1,885 individuals as perpetrators/alleged perpetrators of the safeguarding concerns, as multiple response forms were submitted relating to some individuals. For the purposes of this report the terminology used is that each of these individual perpetrators/alleged perpetrators is referred to as a 'case'.

Assessing the level of assurance that these figures provide requires examination of the breakdown of who submitted these responses. As stated in the requirements of the review agreed by the Conference (see section B above) all ministers were required to complete a response form whether they had something to report or not. For the purposes of the PCR, active and supernumerary ministers were treated differently, on the basis of learning from the pilot. Active ministers received a direct personal communication and follow-up reminders as described above. The final response rate for this group was 81%. For supernumeraries communication was through superintendent ministers and an overall response rate of 33% was achieved. Neither of these figures reflect an even geographical spread and response percentages varied considerably (see Tables A.1 and A.2 in Part 2 of the report), which should raise questions for the Church leadership.

The response rate from laypeople increased in the later stages of the review and 477 responses with something to report came from this group. This figure includes 357 responses from DSOs. For the submissions from this group it was clarified that the remit of the PCR would be incidents or concerns that occurred before the end of December 2012.

Of the submissions very few people directly identified themselves as victims/survivors of abuse. However there were others who had disclosed to a third party who then completed the form. There are no exact figures available.

Although the overwhelming majority of ministers clearly gave a great deal of thought and attention to their responses, it became clear through a number of different routes that a not insignificant number declared nothing to report when they had in fact been involved in safeguarding concerns. In some cases this might have been because they knew others were reporting the situation but this did not apply in all cases. It is hard to estimate the impact of this.

Another factor that needs to be acknowledged is how difficult it is for survivors/victims to come forward. The process of the PCR itself has further raised awareness of safeguarding and it may well be that this leads to further survivors/victims disclosing abuse from the past.

Even taking account of the previous points, the level of assurance that past safeguarding cases have been identified is reasonably high.

F. EVALUATION OF OBJECTIVE 2

To review the Church's historical response in each identified safeguarding case in order to ensure that responses across the Connexion have been:

- **safe**
- **compliant with legislation and policy (both state and Church)**
- **pastorally appropriate.**

F.1 Respondents' assessments

Every respondent was given the opportunity on their response form to record their assessment of whether a safeguarding concern had been well managed. The results of these assessments are presented in chart C.1 in Part 2 of this report. The most significant finding was that 241 response forms identified that the respondent felt anxious that matters were not left safely and that there may still be risk to children or vulnerable adults.

F.2 Reviewers' assessments

Every response form was read by a reviewer who completed a review form, which included an assessment of whether the concern had been responded to in a safe and compliant way. A further assessment was made on the level of current concern. The findings are presented in charts in Part 2 of this report. In summary, the reviewers' assessments were that 48% of the cases submitted were satisfactorily dealt with both in terms of internal Methodist processes and external liaison with statutory authorities. In 22% of cases there was insufficient information to make a finding.

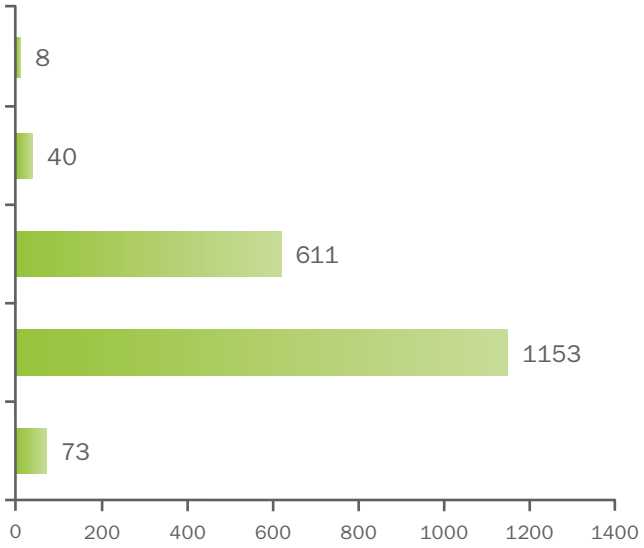
In terms of current risk 61% were identified as there being no apparent current concern, irrespective of the seriousness of the case and/or past risk. Responses that were given scores of 1 and 2 (ie high levels of risk) by the reviewers in relation to possible current risk were allocated to a safeguarding worker immediately following review. If further responses were submitted to the PCR at a later date relating to the same perpetrator/alleged perpetrator these were allocated to the same worker.

F.3 Cases requiring follow-up

The volume of cases and the number (611) that were given a '3' grading namely "there is concern but further information is required to establish the level of concern" raised significant resource issues and a need for further prioritisation. Just three months into the PCR it was clear that there were far more cases that needed follow-up to assess current levels of risk than could be addressed by the existing resource in the Connexional team. An additional safeguarding worker was recruited in June 2013.

The PCR project manager, who was reading through all the reviewer forms, also started to identify the cases that scored '3' that should be allocated without undue delay. The volume of work continued to grow and agreement was obtained to recruit a further safeguarding worker in June 2014. The supernumerary minister who was part of the PCR team followed up cases where contact with a particular minister(s) might identify missing names of perpetrators/alleged perpetrators or other key pieces of information. At the end of the review phase the allocation of scores relating to current risk by cases is shown on the chart below:

1. There is immediate and significant concern and an urgent response is required.
2. There is immediate and significant concern and a planned response is required.
3. There is concern but further information is required to establish the level of concern.
4. There is no apparent current concern, irrelevant to the seriousness of the case and/or past risk.
5. Not specified or n/a.



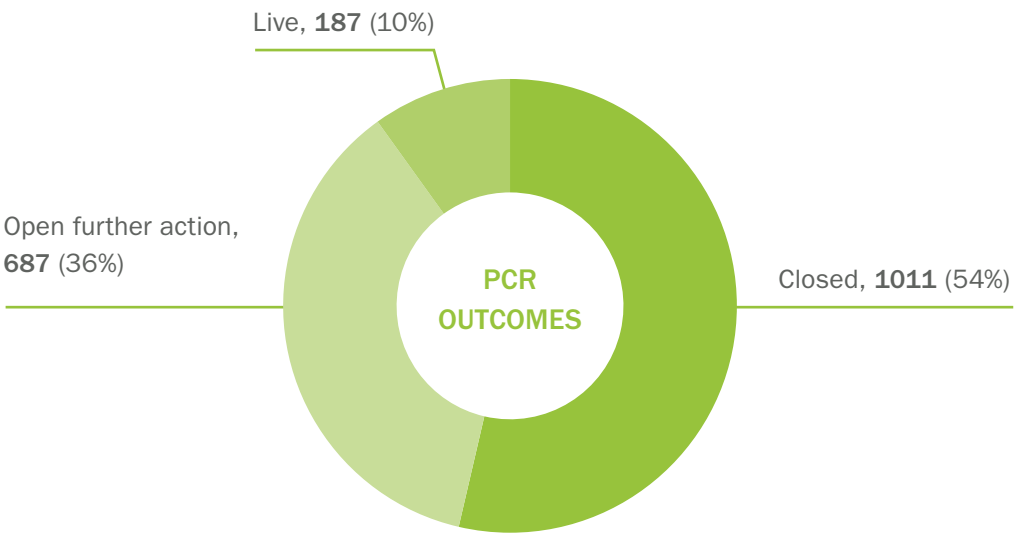
It is important to note that the main reason response forms could not be completed in full and allow an assessment of risk to be made at the initial review stage was that recording practice has been so poor. This is not unique to the Methodist Church but the itinerancy of ministry amplifies the problem. The handover of key information when ministers change appointments has often been non-existent. This is addressed in section H.1.5 of this report. On the positive side the information from different sources sometimes provided the missing 'pieces of the jigsaw' which enabled risk to be more accurately assessed.

F.4 'Live' cases

The PCR used the term 'live' case to refer to a case that was already known to the Connexional Safeguarding Team prior to the start of the full PCR roll-out. Some of these cases had been allocated to a safeguarding worker as a result of the pilot PCR. Of the 2566 responses with something to report 345 related to cases that were already live (the corresponding number for cases is 187 out of the total of 1885). The response forms relating to live cases were read by the reviewers and review forms completed in order for the statistical information to be included in the final data analysis. The reviewers did not have access to the full safeguarding file and were therefore making assessments based only on the information in the response forms.

F.5 PCR outcomes at end of review phase

Of the 1885 cases referred to the PCR, the outcomes at the end of the review process were as follows:



It is important to note that responses may have been closed, not because the right thing was done at the time, but because there is no longer an identifiable risk. This was often because the perpetrator/alleged perpetrator has died or become very elderly and infirm. There were also a number of cases where the person had moved on and could not be traced.

In summary, there has been a robust review process that initially filtered out 54% of cases as being currently safe, compliant and pastorally appropriate as far as it was possible to ascertain. The Safeguarding Team has closed 222 cases having completed assessments and carried out any required follow-up. They are currently working on 393 cases, with 259 cases waiting for allocation. When all of these cases have been assessed there will be a high level of assurance that this objective has been met. The best estimate of the resource required to achieve this is included in section I. of this report.

G. EVALUATION OF OBJECTIVE 3

To implement remedial action wherever this is identified as necessary.

In order to provide information on the nature of the remedial action required two sources of evidence are presented in this report, hard data and case studies. It is difficult to capture hard data in this area of work but to provide as much as possible a short questionnaire, focused on key indicators, was devised in consultation with the Safeguarding Team. The sample was 503 PCR cases that have already been allocated to a current safeguarding worker.

G.1 Remedial action to ensure safety and compliance with policy (both state and Church)

The cases allocated to the Connexional Safeguarding Team have required a very wide range of intensity of intervention to ensure safety and compliance with policy. At the low end of the scale it has involved gathering information to complete the initial assessment of risk and either closing the case or passing it on to the DSO. As an indicator of the scale of work involved, one of the safeguarding workers who has been in post for 20 months working exclusively on PCR cases has worked on 205 cases and has been able to close 107 during this period.

G.1.1

At the high end of the scale of risk the Safeguarding Team contacted statutory agencies in connection with 125 of the 503 cases analysed. In 61 of these cases the contact was with the police and there are 6 ongoing police investigations. The three case studies below are examples of where victims have come forward as a result of the PCR and there are ongoing investigations.

Case study 1

Awareness of the PCR led to a man in his thirties disclosing abuse that occurred in the early 1990s when the alleged perpetrator was a youth worker within the Methodist Church. The alleged perpetrator is currently a lay pastor and a youth worker in four different churches including a Methodist church. He has been suspended from his church roles and there is a current police investigation in process.

Case study 2

An adult now in her 50s disclosed abuse that happened to her in the 1970s when she was 12-14 years old. The incidents reported are: inappropriate touching, groping and exposure by a Methodist minister's husband. The incidents were reported to the local minister at the time but it is unclear what action if any was taken. The victim has no knowledge of any action taken and says she is aware of at least one other victim. The safeguarding worker is currently following this up with the local DSO and others. The minister is now a supernumerary.

Case study 3

A Methodist minister was convicted on charges of sexual assault on children and received a prison sentence. He was allowed to retire on compassionate grounds and this has caused great offence to his victims and those who have supported them. Through the PCR a further four victims have been identified, with two having made complaints that are currently being investigated by the police.

G.1.2

In relation to internal Church processes at the higher end of risk, the team have commissioned 20 new formal risk assessments of which 9 have been completed, resulting in 5 Covenants of Care and 1 other safeguarding measure. The next three case studies are examples of this work which has often required extensive enquiries to pull together all the relevant information required to enable a robust risk assessment to be carried out.

Case study 4

Eight responses were submitted to the PCR concerning a Methodist minister, now a supernumerary. The responses related to alleged sexual advances to children and an alleged abuse of power in relation to an adult in a vulnerable situation. Although one matter had been considered by a Connexional Disciplinary Committee, all the issues involved had not been considered together until the PCR responses and follow-up 'completed the jigsaw'. A risk assessment was commissioned, which involved considerable work, and as a result there is now a formal Covenant of Care in place.

Case study 5

A Methodist minister was convicted of indecent assault, gross indecency and assault on children in the late 1990s. He received a suspended prison sentence and was subject to a supervision order. A later risk assessment identified him as unwilling to acknowledge any need to change and as at very high risk of further offending. He was allowed to resign from the ministry following suspension. Although now in his early 80s the PCR follow-up work highlighted that risk does not disappear with age necessarily and in accordance with policy ensured that informal arrangements to enable him to worship are replaced by a more robust formal Covenant of Care.

Case study 6

Three responses were made to the PCR concerning the grooming of teenage girls through Facebook and approaching girls in an inappropriate manner. The two incidents reported occurred 12 years apart, the last in 2013. The alleged perpetrator is an organist in the Methodist Church. The safeguarding worker commissioned a risk assessment which has resulted in a Covenant of Care.

G.1.3

Of the 503 cases analysed, 94 had a Covenant of Care in place pre-PCR. Of these, follow-up work by the Safeguarding Team found that 62 were active, and of the active cases 9 were identified as not being well managed and required remedial action to rectify this.

Of the inactive cases, it was difficult to establish what had happened to the subject of the Covenant of Care but in 14 cases the safeguarding worker managed to track them to a new location and therefore ensure that safeguarding measures could be put in place. The following case studies illustrate this work.

Case study 7

A former teacher who became a Methodist youth officer and was a local preacher was found to have indecent images of young boys on his computer. He was convicted and was the subject of a three year Probation Order. While on this order he continued as a local preacher, communion steward and as a member of a church sports club. With his Probation Order still in place he was further charged with molestation of two boys and received a 12 month custodial sentence. A senior minister involved with this case was highly resistant to cooperating with statutory agencies and put pressure on the minister not to report behaviour she had witnessed. All involved were deeply affected. The perpetrator left the country for five years and was imprisoned on his return. He was released and approached a community centre in his home circuit even though he was not living there. The PCR follow-up work involved extensive contact with statutory agencies which has resulted in locating him. All the relevant churches concerned have been informed so that safeguarding measures can be put in place should he decide to worship or participate in the life of a Methodist church.

Case study 8

Three submissions were submitted to the PCR about someone who had held office in the past in the Methodist Church and was involved in youth work. A Methodist minister found out about a conviction for abuse of boys by this individual while reading a newspaper report. The abuse took place in a youth group run by another denomination. The perpetrator was removed from his roles within the Methodist Church and he moved away. Records were very incomplete and no new location for him was established until the PCR worker conducted extensive follow-up enquiries with the statutory agencies. He was eventually located in another part of the country and the safeguarding worker was able to inform the independent church he now attends who were not aware of his background. The local DSO is now in possession of relevant information and records.

Case study 9

In the early 2000s a volunteer youth worker within the Methodist Church, who was also a teacher, was found to have indecent images of children on his computer. He was suspended from his youth worker role and a small group was formed to monitor and support him before conviction. He was given a prison sentence and on release changed his name and did not return to his home church. The referrer to the PCR had no knowledge of his whereabouts. Extensive enquiries by the safeguarding worker led to locating the perpetrator. He is currently attending worship in a Methodist church and has a tight Covenant of Care in place as further offences have subsequently come to light and he has been described as a highly manipulative offender. The DSO is actively involved. The perpetrator is described as being very charismatic and members of the church find it hard to believe he is potentially harmful.

G.2 Remedial action to ensure pastoral support is appropriate

Supporting survivors/victims has been and will continue to be a vital part of the Connexional Safeguarding Team's work. Some survivors/victims contacted the team directly and did not complete a PCR form but have still been supported. This work has involved a range of activity from some direct support, followed by a referral to a more specialist resource, to very intensive support over a limited period. This intensive support has often been to help a survivor/victim in the period following a disclosure or in situations where the original harm has been compounded by the actions of the Church. The data from the team's open cases show that support was provided in 34 of the 503 cases and this was intensive support in 15 cases.

Case study 10

A referral to the PCR concerns allegations of rape in the early 1990s which were subsequently reported to several ministers. The alleged perpetrator was an office holder within the Methodist Church until his death. Several ministers responded to these allegations in an inappropriate way and the victim is now highly distressed. The PCR process has listened to her tragic experience and has enabled her to write and present her meditations which have restored her self-worth and enabled her to help others.

Case study 11

This response concerned a victim of childhood abuse at the hand of her youth worker. The PCR process assisted the victim with guidance and reassurance which enabled her to make her intended formal complaint with the statutory agencies. She continues to be supported extensively by her local church, support which includes professional counselling.

Case study 12

This response concerned a victim of adult abuse by a prominent Methodist greatly abusing his position of authority and power. The PCR process and the support from the safeguarding worker assisted the victim in feeling that her story was being heard and acknowledged and she finally found a sense of closure.

For many survivors/victims the PCR has been a helpful process and they have valued the support they have been given. For a few it has been an unsatisfying experience. It has not been possible to investigate events of many years ago as though they were occurring now and the focus, as defined by the PCR objectives, has been identifying possible current risk and learning for the Church. The PCR process has as a result not met the expectations of some survivors/victims.

The level of specialist support some survivors/victims need has resource implications for the Church which will be picked up as a recommendation in section I. of this report.

G.3 Remedial action still required

The Safeguarding Team has 383 cases open that still require remedial action. In addition there are 259 cases awaiting allocation which require further assessment and possibly remedial action. When this work has been completed there will be a high level of assurance relating to Objective 3. The best estimate of the resource required to achieve this is included in section I. of this report.

H. EVALUATION OF OBJECTIVE 4

To learn lessons about any necessary changes or developments in order to ensure that safeguarding work within the Methodist Church is of the highest possible standard.

Evaluating this objective and identifying lessons learnt will be considered under three main headings:

- Culture
- Complaints and Discipline processes
- Specific areas of practice

H.1 Culture

H.1.1 The importance of culture

Few would argue with the statement that the culture of an organisation is a critical factor in ensuring it is a safe organisation. The Methodist Church has a record of producing some excellent reports and documents that highlight what underpins safe practice. The Methodist Conference welcomed the *Time for Action* report (produced by Churches Together in Britain and Ireland in 2002) that explores the Church's response to those who have suffered sexual abuse and includes the following:

> *Fundamentally, sexual harassment and abuse is a serious misuse of power and authority, committed by the dominant partner in an unequal relationship. Power is a fact of life. It is present in every relationship and situation. Clergy and others with leadership roles have been granted power as a resource and responsibility to support, lead and serve other people. The institution of the Church, and individual members, have a right to expect that such authority will be trustworthy and used in the best interests of those who are served. Ministry carries with it spiritual authority, and privileged, if not unique, access to people's homes. Clergy are expected to demonstrate high standards of moral and sexual integrity: those to whom they minister hope and expect, not that those whose vocation comes from God will be 'perfect' or beyond the reach of ordinary human complexity in relationship but that they should embody a mature and careful Christian understanding of the responsibility to respect and honour all members of their community.*

The Methodist Church produced its own response to *Time for Action* – the report *Tracing Rainbows through the Rain* (2006) which was agreed by the Methodist Conference.

The themes of *Time for Action* chime with the evidence in the National Crime Agency's CEOP Thematic Assessment *The Foundations of Abuse: a thematic assessment of the risk of child sexual abuse by adults in institutions:* "The sexual exploitation and abuse of children is most likely when vulnerability meets power." Professionals in the field would say that this not only applies to children but also to adults and the same issues apply to other all other areas of abuse, eg emotional abuse, domestic abuse/violence, physical abuse, etc.

H.1.2 Evidence from the PCR relating to culture

One key question is: how far does the practice of the Methodist Church, as demonstrated by the cases reported to the PCR, match its intentions and public statements? There is learning from the process as well as the content of the review responses.

The PCR covers a much wider brief than the role of the minister, but what has emerged in relation to ministers, both in terms of being perpetrators, but also how they respond to recognising abuse committed by others must be highly significant in making an assessment of whether the Church has a culture that is safe.

The number of ministers who have been perpetrators of abuse of power is a strong indicator that the culture does not match in practice what it claims in words. Two hundred Methodist ministers were identified as perpetrators/alleged perpetrators. Of these 200 it was identified that the concern related to a direct abuse of their church role in 142 cases and in a further 10 cases there was a church context. The table in section B.1.2.a in Part 2 of this shows that the numbers have been consistent over the last 12 years and have shown no sign of decline. The concerns/abuse were of a sexual nature in relation to 102 of the 200.

Responses were submitted for 43 of the 200 ministers in relation to abuse/concerns where the victims were under 18. In relation to 106 of the 200, the victims were over 18. There can be debate over where the line is to be drawn between abuse that constitutes a safeguarding case in relation to adults and other abuse of power such as bullying/harassment or inappropriate sexual relationships. The threshold for a referral to safeguarding professionals will lie at one point on the spectrum but the other cases will still be highly relevant to whether or not there is a safe culture and so absolutely relevant to safeguarding in its widest sense.

What is evident from many of the cases reported to the PCR is that the culture is made unsafe, not only by the actions of the perpetrators, but also by the subsequent actions of those in authority or in colleague relationships who have failed to respond in a way that recognises the reality of the abuse that has taken place. Examples of this can be seen in numerous personal accounts in response forms and also from the outcome decisions in some Complaints and Discipline cases.

The review responses show that ministers not only have difficulty recognising and accepting that abuse has taken place when the perpetrator is a colleague but also struggle to recognise it when it is a lay person abusing. In some cases individual ministers have recognised the abuse but felt not listened to and/or believed when they have raised it with those in authority.

Although it is not explicit in responses a key theme appears to be that many within the church have difficulty reconciling the theology of forgiveness and redemption with safeguarding. This is critical to the issue of culture.

H.1.3 Components of culture

In order to understand the weaknesses in the Church's current culture in relation to safeguarding it is necessary to examine the relevant components of the culture. Those identified from the PCR material are:

i) understanding the nature of safeguarding
ii) policies and procedures
iii) training
iv) accountability
v) support
vi) listening to the voices of children/young people and vulnerable adults
vii) leadership.

H.1.4 Understanding the nature of safeguarding

The core of safeguarding relies on an understanding and awareness of the dynamics between power and vulnerability in relationships. This is not a specialist activity that is only undertaken by those with qualifications or experience in the safeguarding field. Pastoral relationships which are core to the mission of the church will always include these dynamics. To practise safely ministers and others engaged in pastoral work, community work or counselling need to reflect on these issues and their boundaries in these relationships. There is a spectrum of risk and unless this is understood, patterns and early signs of unsafe practice will not be picked up in the person themselves or in others. It is evident from many responses that this perspective has not been the dominant one. There are far more signs that indicate that many ministers view safeguarding as an activity that should be passed on to specialist workers and/or is about ticking the boxes to make sure processes such as employment checks have been completed.

Some key power dynamics are illustrated by the PCR statistics. Children are vulnerable whether male or female and the figures in table B.2.3 in Part 2 of the report show this, although there are more female than male victims (48%:28%). In relation to adult victims the gender percentage changes significantly, with far more females than males (72%:15%). This reflects wider societal power imbalances.

The evidence from secular organisations working in the social welfare field is that good safeguarding practice, when it is mainstreamed, is an indicator of good practice in other areas. It is hard to think of reasons why this would be different in the Church, which may overuse the phrase 'watching over one another in love' without thinking through what this means in practice. Some of the recommendations at the end of this section on learning are concerned with this key aspect of embedding a wider safeguarding understanding in all areas of Church life.

H.1.5 Policies and procedures

Considerable progress has been made over the last few years in terms of producing policies and guidelines in the safeguarding arena. There will need to be a detailed review of all these policies in the light of the findings of the PCR. This review needs to ensure that all documents are clear about what the requirements are and what is guidance relating to best practice. However the major issues do not relate to the policies that are currently in place but to the lack of policies in a few key areas.

Given the evidence that all pastoral relationships and professional caring relationships need to be underpinned by clarity of understanding of power and vulnerability, what is recorded by ministers and others in relation to their pastoral work is extremely important. Safeguarding concerns often develop over a period of time and are about patterns of behaviour, not just a single incident. There is an urgent need for policy and guidance on what should be recorded in relation to all pastoral work. This policy and guidance needs to be clear on what is required - the 'must dos' - and what is guidance to promote good practice. Policy needs to be role-specific, covering all those engaged in pastoral work or professional work with vulnerable children/adults/families in the name of the Church. This new policy and guidance will need to match with any specialist safeguarding requirements.

Linked to this is the urgent need to have clear policy and guidance on how the above records are stored, how they are retained, accessed and, in particular, the arrangements for ministerial handover. Only 57% of the responses to the PCR indicated that records had been kept and it was clear from the reviewers' assessments that even where records were kept they were often not sufficient to inform an initial assessment of risk. This is a very significant problem as there was little evidence from the PCR that the standard of record keeping improved though the period under review.

H.1.6 Training

The Foundation and Leadership Modules of safeguarding training are excellent. They will need to be reviewed in the light of the PCR findings and additional sections will need to be added to the Leadership Module. There will also need to be a review of who attends both modules. In relation to achieving the outcome of mainstreaming safeguarding into all Church life it is important that all trainers fully understand this perspective and its significance. It is therefore recommended that all who deliver these courses are required to undertake training on the results of the PCR.

H.1.7 Accountability

This is one of the two most worrying overarching themes to emerge from the PCR. Secular organisations whose work involves contact with vulnerable children/families or adults would be regarded as unsafe and potentially dangerous if they did not have in place robust measures to ensure that policies are followed in practice, and that any training undertaken is reflected in subsequent practice.

The reviewers' assessments (chart C.2 in Part 2 of the report) identify 209 cases where the internal or external processes were not satisfactory. This does not include the 289 cases where it was identified that safeguarding processes were not in place at the time. This is an unacceptably high figure given the vulnerability of the victims involved and the level of risk.

These statistics only cover part of the picture. The PCR project manager and all the safeguarding consultants who acted as reviewers and therefore had the qualitative knowledge of the cases referred, in addition to the statistical findings, have expressed extreme concern at the weakness of accountability structures evidenced in so many of the responses. Later sections of the report dealing with specific areas of practice provide further evidence of weak accountability.

Addressing this deficit needs to be a major priority for the church if it is to become a safe and resilient organisation.

H.1.8 Support

This is the second worrying overarching theme to emerge from the PCR.

There is no doubt that the appointment of the DSOs and the strengthening of the Connexional Safeguarding Team have been appreciated and have made a difference to the management of the situations and cases that are referred to them. This is reflected in response forms. However it is only the tip of the iceberg.

Having a safeguarding perspective and 'safeguarding antennae' is critical to safe practice in all pastoral activity. Understanding the relevance of developing patterns of behaviour is key and this places heavy demand on all ministerial staff and others involved in overseeing pastoral activity. In addition there are very difficult considerations that arise when ministers start to feel concerned about colleagues' or other church leaders' boundaries and behaviour. Effective early interventions can often make a difference to outcomes but this is a stressful and difficult area and people involved need support. It is important to stress that this is separate from the professional safeguarding input that is vital when a particular situation reaches the point where it has crossed a formal safeguarding threshold. These are identified in the Safeguarding policy.

When this threshold has been reached and a situation has been accepted as a formal safeguarding case it is often very difficult to manage. It frequently involves managing the tension between pastoral care and safeguarding measures. The whole church community can become involved and managing significant community conflict is not an uncommon experience for ministers. Specific recommendations will follow in later sections of this report that relate to the detail of these issues. The stress generated by these situations requires that ministers involved should have a structured support system in place in addition to professional safeguarding input or extra pastoral care that may be needed.

The response forms indicate that only 27% felt that the local church had been well supported in relation to the incident concerned. There is no information to indicate what support people felt was lacking but in the text of their responses many ministers identified their need for support and how difficult the situation they reported was to deal with. This has also been a theme which has been raised repeatedly at the launch meetings held

across the Connexion. It would not be considered safe practice in a secular organisation for people with the same level of contact with vulnerable people as ministers experience not to have a structured system of support in place. The same would apply to first line supervisors, who would normally be superintendents in the Church context.

Support is still an issue for the senior leaders within the Church as they may be making very difficult decisions re ministers or others, or they may carry overall responsibility for implementing difficult decisions that others have made. The nature of the support that senior leaders require will be different, but needs to be addressed.

H.1.9 Accountability and support - the case for supervision

"Studies have demonstrated that one of the most effective safeguards within organisations or professional settings is to provide frequent, open and supportive supervision of staff."

Extract from the National Crime Agency paper CEOP Thematic Assessment *The Foundations of Abuse: a thematic assessment of the risk of child sexual abuse by adults in institutions.*

The Church is not the same as secular organisations in many respects, particularly as ministers are not employees, but it is difficult to see reasons why the evidence from studies such as the one referred to above do not apply. In fact the CEOP study specifically included religious organisations.

The term supervision can be used to describe a range of activities and it is important to identify relevant features that are necessary in order to meet the baseline deficit in accountability and support identified so clearly through the PCR. First it may be helpful to describe what is not being referred to. Counsellors or other professionals undertaking in-depth work with a vulnerable individual/family would expect to receive supervision that is variously described as 'clinical supervision', 'casework supervision' or 'professional consultation'. This needs to be provided by someone with the recognised skills and expertise, normally with a recognised qualification. There may be situations where some ministers require this but it would be in addition to the core supervision that is being recommended in this review report.

It is recognised that the issues of accountability are wider than the safeguarding remit and any recommendations will need to take account of this. There also needs to be a clear and explicit theological basis for a supervisory structure. This is beyond the scope of this report but needs to be taken account of in the recommendations.

The features of supervision that are being recommended to address the key areas of accountability and support in relation to safeguarding that have been identified above are:

Supervision to take place within the remit of a clear supervision policy that details the requirements and expectations placed both on the supervisor and the supervisee. This would include requirements relating to:

- training essential to be a supervisor
- frequency, both baseline requirement and best practice guidance
- content of sessions
- record keeping.

In order to fulfil the accountability role the supervisor needs to be the person within the church structures who carries a supervisory responsibility for the work of the role. In relation to ministers this would be the superintendent or deputy superintendent. In relation to superintendents it would be the district chairs. It is recognised that these relationships are not line management ones within the Methodist Church but this does not mean that supervision cannot be a feature of the relationships. In secular organisations increasingly all volunteers carrying roles in relation to children and or vulnerable families would expect and receive supervision.

As guidance to assist in the initial identification of the capacity/skills and resource issues that are raised, which it is recognised are not inconsiderable, secular organisations would normally expect monthly supervision for someone whose role involved contact with vulnerable children/families or adults with six-weekly being considered a minimum requirement. It is true to say that some statutory organisations are currently failing to meet this standard, but it is often key to a local authority department being placed in 'special measures' The church should not expect to be alongside those in 'special measures' in this regard but a beacon of good practice, recognising the different context.

H.1.10 Listening to the voices of children/young people and vulnerable adults

The Methodist Church already has some good mechanisms in place for listening to the voice of young people at a policy level. Some vulnerable adults who are survivors of abuse have been involved in the development of safeguarding policies and training materials. It is important that at this level listening is developed and consistently practised in furtherance of a culture that is experienced as open and welcoming of these groups.

However the main recommendations of this review relate to learning from particular situations where the voices of children and the voices of survivors have not been paid sufficient attention. The sections of this report on family conflict and domestic abuse, provision for children/young people within the Church and complaints and discipline consider the issues in detail.

H.1.11 Leadership

The process of the PCR indicated that there are variations in the level of commitment and endorsement of the process from the most senior leaders. The examples of best practice were seen when district chairs not only communicated a message to their ministers on the importance of attending the launch events, but also took an active role on the day of the event and then ensured that ministers took seriously the requirement to complete a response. This was not uniform. This variation in response may or may not indicate a variation in commitment to safeguarding but it does raise questions about the issue of visible leadership.

There is no clear relevant statistical data but the view formed by the PCR project manager and reviewers was that in far too many cases superintendents, and to a lesser extent district chairs, did not take seriously enough people who were raising concerns, or listened but did not take robust enough action. Some of these situations regrettably led to vulnerable adults or children being abused. This must be seen in the context of leadership training being relatively new and to the fact that accountability frameworks are weak for leaders as well as front line ministers.

H.1 Recommendations relating to overarching themes and cultural change:

1. That an Implementation Group be established to oversee the implementation of all the PCR's recommendations that are agreed by the Conference and that membership of this group be agreed by the Conference.

2. That selection criteria for district chairs, the Warden of the Methodist Diaconal Order and members of the Senior Leadership Group of the Connexional Team include awareness of and ability to deal effectively with safeguarding issues.

3. That policy and guidance be provided to define what should be recorded by ministers or others undertaking pastoral work and that this be clear about requirements for each specific role as well as providing guidance for best practice.

4. That policy and guidance be provided about storage and access to pastoral records, specifying particularly requirements on ministerial handover.

5. That all people who deliver safeguarding training at Foundation or Leadership Module level be required to attend training on the findings of the PCR.

6. That the findings from the PCR be incorporated into the training of ministers irrespective of the pathway they are following.

7. That a system of structured supervision for ministers be instituted to address the identified weakness in relation to accountability and support in terms of safe practice.

   The urgency of this requirement is recognised but also the capacity/skills/resource issues that are raised. Ideally the timescales would be as follows:

   - A draft supervision policy is produced by a working party that has the skills/knowledge to reflect the relevant dimensions of accountability and important theological underpinning. The draft policy to be considered by the Methodist Council in October 2015.
   - A training course for supervisors to be developed by end of December 2015.
   - A pilot roll-out of supervision across 2 districts is undertaken for 12 months (January – December 2016) starting with the training of supervisors in January/February and supervision sessions starting in March 2016.
   - A report on the pilot to be presented to the Methodist Council in October 2016 with recommendations for a roll-out across the Connexion to start in January 2017.

   It is however recognised that as such timescales have resource implications, the Implementation Group should meet as soon as possible following the Conference, to agree a timetable and secure the required resources.

8. That serious consideration be given to producing a Code of Conduct for ministers along the lines of that produced by the Church of England.

9. That, until the Methodist Church has robust accountability processes in place and fully operational, an annual independent audit of progress on these culture change recommendations and in particular on the mainstreaming of safeguarding awareness be carried out; and that a framework for the audits and proposals on who should carry them out be agreed by the Methodist Council in October 2015.*

* As an indication of how this could be implemented, a team of three or four volunteers with safeguarding expertise would conduct structured interviews with: a small sample of district chairs, superintendent ministers and DSOs; the Connexional Safeguarding Adviser and the Assistant Secretary of Conference.

H.2 Complaints and Discipline processes

Reading all the case reviews as an independent person who has not been involved in the Church's processes, the overwhelming impression formed by the PCR project manager was that a significant number of situations appeared not to have been picked up and dealt with at an early stage but were allowed to progress to formal complaints and discipline processes. This was further evidence of weak accountability. In an organisation where there is a supervision structure many, but not of course all, of the early signs of over involvement, lack of boundaries, potential bullying behaviour, non compliance with policies, etc would be expected to be dealt with through the normal supervisory process.

The tables in section D.4 of Part 2 of this report show the numbers of cases from the sample which Safeguarding Team members are involved in that link with complaints/discipline processes. They have been involved in a significant number of cases where further action is required to ensure that any current safeguarding risk is identified and well managed. There is clear evidence from this work that many outcomes from past complaints/discipline processes would be different if the cases were being dealt with currently, but there were also issues raised that relate to current processes. In addition to this casework it was clear from a number of review responses that there were more general learning points emerging from the relationship between safeguarding and complaints/discipline processes. Complaints and discipline processes were an area that a number of survivors/victims described as leaving them feeling very angry and hurt. The PCR manager therefore commissioned a learning review by a former DSO with a legal background of some of the most complex cases in this area that were referred to the PCR. This review was set up in consultation with the Assistant Secretary of the Conference.

This review has informed the following recommendations relating to Safeguarding, Complaints and Discipline processes and resignations.

10. **Training: that the pattern of training for members of the Connexional Complaints Panel continue to be developed so as to ensure: an annual training event; that all members of the Panel undertake both the Foundation Module and the Leadership Module; that additional sections of the Leadership Module be prepared to cover the impact of abuse on victims, patterns/models of abuse and risk management in the Church; and that, when developed, these sections be required training for those hearing complaints relating to a safeguarding concern.**

11. **That the Past Cases Review definition of a 'Safeguarding concern' be used by Local Complaints Officers, Complaints Teams and Discipline Committees.**

12. **That work be undertaken to ensure a rigorous system of liaison and consultation between all parts of the complaints process, the resignation (of ministers) process, suspensions, and the Connexional Safeguarding Officer to ensure that appropriate advice is obtained on cases that contain a safeguarding concern or sexual harassment.**

13. **That work be undertaken to develop further best practice guidance including, but not limited to, guidance on appropriate communication with complainants and respondents; guidance on the choice of venues for meetings and hearings; and guidance on questioning of complainants and respondents.**

14. **Recording and monitoring: that a system be established to monitor the implementation of decisions of Discipline Committees (and where appropriate Complaints Teams) and that their implementation be recorded.**

H.3 Specific areas of practice

This section of the report will cover learning that relates to specific areas of practice or particular church processes. The following will be covered:

- impact on victims/survivors of abuse
- situations of family conflict and domestic abuse
- recognising and responding to neglect
- working with those who have abused
- working with those where there is suspicion and/or where a criminal case has resulted in a not guilty verdict
- the church community as a safe space, bullying and harassment
- the impact of abuse within church communities
- working with statutory agencies
- safer recruiting
- working with youth organisations linked to the church
- working with Methodist schools
- working ecumenically
- overseas work
- communication.

H.3.1 Impact on victims/survivors of abuse

A small number of response forms were received from victims/survivors. Other victims/survivors asked another person, usually their minister, to submit a response on their behalf. Some of the victims/survivors had disclosed before, but for some the PCR was the trigger to speak out for the first time. Many of the responses highlight the vulnerability of victims. There are accounts from a number who were not believed and who experienced community or family stigma. Research shows that the impact of abuse is most often profound and long term and the victim/survivor accounts submitted to the PCR reflect this.

> One respondent said: *"I have learnt that it is impossible to recover from sexual abuse when no-one recognises the seriousness of it. My church did not want a scandal, my parents did not want a scandal. I was left to feel worthless and devalued, while the man was left to get on with his life and for all I know repeat the crime with someone else."*
>
> *"I was emotionally and physically devastated."*

The importance of this opportunity to tell their story has been recognised by several victims/survivors. The following quotes illustrate this.

> *"A candle is lit and it is no longer completely dark."*
>
> *"I want to prevent the church and other people from handling things wrong in the future. I don't want other girls to suffer like I have."*

"I am incredibly relieved that finally the Methodist Church is taking seriously its responsibility to try to make the church a safe place."

Section B.2 in Part 2 of this report shows the information captured by review responses on the gender and age profile of victims and, where known, the identification of adult vulnerability.

Learning point: the ongoing pain and distress of victims/survivors is deep and lasting. It is amplified when they feel they have not been listened to.

The invisibility of children through many Methodist processes that purport to relate to their well-being was noted by the President's Inquiry into a different safeguarding situation, which was reported to the Methodist Conference in 2011. The PCR provides further evidence of this.

Learning point: the voices of children/young people who may be vulnerable are not always listened to and their need for separate support responded to.

Once a disclosure has been made careful thought should be given to who provides support to the survivor/victim. This should be a dedicated resource, ie not shared with others involved, and someone who can carry the role in the long term. A number of responses identified major difficulties that had arisen because the minister tried to support both the victim and the perpetrator. Any preference for a particular supporter expressed by a survivor/victim should be met whenever possible.

Learning point: the same supporter cannot meet the needs of the victim/survivor and the perpetrator.

H.3.2 Situations of family conflict and domestic abuse

Family conflict, family breakdown and domestic abuse were the subject of a significant number of cases (85 situations of domestic abuse were identified). Many of these situations were not handled well within the church. One of the underlying reasons for this that was demonstrated repeatedly was the failure of the key church officials to understand the power dynamics that operate in families, and particularly within families where there is domestic abuse and violence. Abusers typically exercise very tight control over family members and often effectively keep the abuse hidden for years. It was clear from a number of responses that the impact on children in the family was not understood and in none of the reported cases was there a record of children having a voice in their own right. Domestic abuse cases should always be considered as safeguarding cases and be discussed with the DSO. There may well need to be a referral to statutory agencies.

One of the first priorities in any situation of family conflict or family breakdown, and in cases of domestic abuse, is that each of the parties, including the children should be given their own source of support. All pastoral care offered in these situations should be with 'safeguarding antennae' firmly in place. Where one or more family members are in a formal leadership role within the church, the breakdown and its impact upon the local church will need a core group akin to other safeguarding situations. There is a significant body of learning about how the dynamics of family conflict can work through those people who are alongside or working

with family members. Care needs to be taken to equip pastoral supporters to remain just that, rather than becoming partisan or embattled in turn. This is far easier recommended than accomplished in the emotional turmoil of some breakdowns and so in these very difficult situations, structured oversight and consultation should be provided for the nominated supporters.

Family breakdown within church communities can lead to communal breakdown. The focus of oversight and support needs to encompass the limitation of 'knock-on' damage within the church community, and avoiding entrenched conflict wherever possible. In particular, it is hard to envisage any situation where it would be appropriate for a minister, local preacher or leader of worship to share an individual conflict and distress from the pulpit – and it is never appropriate within intercessory prayer to identify particular situations without the consent of all involved.

When one or more family members are in a formal leadership role within the Church, and especially when the family has lived in a manse, the impact of the family breakdown can become magnified into matters of church discipline as well as legal concerns around accommodation, access to stipend, etc. Within the family of a minister, this difficulty is exacerbated by the normal pattern of close overlap between the church community and the family living in the manse. This means that additional, explicit attention is required to the maintenance of appropriate boundaries and high standards of professional behaviour within situations of family breakdown. Pastoral support should be distinct, and offered by a separate person, from those responsible for the oversight of work and the maintenance of standards. The application of this careful boundary can, of itself, assist individuals to limit the degree to which their own boundaries become blurred. Quality structured supervision of ministers involved in many of the situations submitted to the PCR would, very likely, have improved the practice in almost all cases.

Learning point: the Church struggles to respond effectively to domestic abuse in its leadership and congregations.

H.3.3 Recognising and responding to neglect

There were 135 cases relating to neglect referred to the PCR. Situations such as these are clear cases where patterns of behaviour and observation over time are critical to an assessment of whether a situation is one of neglect, unless there is an obvious serious incident which comes to light. These cases illustrate the need for a clear explicit policy on pastoral record keeping and should inform the writing of such a policy. Similarly they are also cases where supervision is so important, as one individual who is closely involved will find it difficult to exercise the required level of objectivity. Once a pattern of behaviour that gives signs of neglect, or a single serious incident, occurs a referral to the DSO should be made. A few responses to the PCR demonstrated very effective support for families where there had been neglect.

Learning point: responding to neglect within a family in the church community requires very careful attention to both pastoral support and safeguarding awareness.

H.3.4 Working with those who have abused or where there is suspicion of abuse

H.3.4.1 Working with convicted sexual offenders

There were 31 responses to the PCR which concerned how the Church enables convicted sexual offenders to worship and participate in the life of the Church. Some responses showed excellent practice, a Covenant of Care was in place, regularly reviewed and the subject was keeping to the contract. It was often not possible to assess from the information in the response forms whether the Covenants of Care referred to were active and were being well managed. As a result many cases were referred to the Safeguarding Team to make an assessment.

The Safeguarding Policy of the Methodist Church (section 9) states: *The purpose of providing good practice for ministering to, and providing pastoral care for, those who pose a risk is to enable them to worship and be part of a church community more safely.*

Many submissions demonstrated good practice and effective use of Covenants of Care and also good follow-up when an offender left the particular church. However many demonstrated failings in carrying out the requirements of the Safeguarding Policy and in some cases, which occurred after the Multi-Agency Public Protection Arrangements (MAPPA) were introduced, these arrangements were breached. The following were not uncommon:

- Covenants of Care had been set up without consultation with someone with safeguarding expertise and knowledge, which often led to poor practice.
- Monitoring/support groups stopped meeting and reviews were not held, even though the offender still attended the church.
- Breaches of the 'contract' were not reported to the offender/case manager.
- Insufficient attempts were made to follow up the whereabouts of offenders who stopped attending a particular church.

The PCR reviewers and the project manager regarded these situations as very serious and if there was no evidence provided of a Covenant of Care being managed according to the policy the case was allocated for follow-up by the Connexional Safeguarding Team. This is another area where it would be expected that formal supervision would have an impact on practice. Where Covenants of Care are in place they would need to be a standing item on the supervision agenda of the responsible minister.

The information collected to date from this follow-up work has shown that, in a significant number of cases, offenders who had gone missing have been tracked and information passed onto another church/ denomination or to the relevant statutory authority. This level of diligence is vital to securing protection for children and a more proactive approach to offenders moving on must be addressed at district and local level. The number of offenders who move on once an effective Covenant of Care is in place is high. A connexional tracking system needs to be set up so that there is a record of all sex offenders who are referred to Methodist churches through the MAPPA arrangements, a record of all Covenants of Care and a system to alert people when the subject of the Covenant of Care moves on. The current arrangements rely too heavily on individuals' knowledge and are too specific to localities. As one reviewer put it *"it is unclear how the Methodist Church would keep current any continuing concerns about an individual who might attend services long after the original*

notification was received and the original recipients have either moved on or forgotten the details." This should be reflected in the review of Covenants of Care that the Conference of 2014 initiated.

Although there is mention of training for members of monitoring/support groups in the Safeguarding Policy, the learning from the PCR is that more attention needs to be given to this and the possibility of making training a requirement seriously considered. Each Covenant of Care group needs to include people who can provide a high degree of robustness and challenge to the way the group operates. The demands on this group of people should also not be forgotten and support should be offered.

"Though the offender was co-operative throughout, the emotional cost to the small group was high."

Learning point: there are still areas where the Church is not safe when working with convicted sex offenders.

H.3.4.2 Working with those where there is suspicion and/or where a criminal case has resulted in a not guilty verdict

Suspicion can be triggered by a one-off serious incident or by a pattern of behaviour that is identified over time, even though some individual incidents may not be clear evidence of abuse. In the first circumstance it is clear in the Safeguarding Policy that there must be a referral to the DSO. The responses relating to more recent incidents indicate that there is a higher level of compliance with this policy requirement although it cannot safely be assumed that this is 100%.

There is not the same evidence of positive change where concern is indicated by a pattern of behaviour. Two major weaknesses identified in the responses are, firstly, the lack of good recording and sharing of information and, secondly, lack of understanding of the significance of patterns of behaviour. There was evident pain in the accounts of several ministers who had observed incidents and either done nothing because they thought there was insufficient factual information to go on or had had a pastoral conversation with a person and it later transpired the individual had gone on to seriously abuse a child/children. Supervision would be a check that proper recording was being undertaken and also provide two heads to make critical decisions as to when to approach a safeguarding professional. The assurance from a supervision structure in this respect will increase as the skills of the supervisors increase. It would be considered unsafe in a secular environment for decisions on levels of risk, even at the early stage, to be taken by one individual.

A specific area which gives rise to concern from a number of responses (and this was also apparent at discussion at the PCR launch meetings) is the appropriate response if an individual has been found not guilty of an offence in a criminal court. It must be stressed and needs emphasising in training that the standard of proof to secure a criminal conviction is 'beyond reasonable doubt'. This does not mean that abuse did not take place. It is helpful to recognise that the standard of proof in civil and childcare proceedings is 'on the balance of probability'. It is acknowledged that this raises difficult dilemmas for ministers and others in relation to their responsibilities but in these situations the 'safeguarding antennae' should remain very active. Again in these situations supervision and good recording will be key to identifying concerns that need formal safeguarding responses.

A few responses raised questions about how the Church best responds to people with mental health problems, or with learning difficulties, who display difficult behaviour that is hard to manage.

There appears from some responses submitted to be a need for clearer understanding about risk assessments and when safeguarding measures and particularly Covenants of Care are appropriate.

Learning point: it is hard for many in the Church to acknowledge risk when there is no conviction and a difficult assessment of risk is required.

H.3.5 The church community as a safe space, bullying and harassment

Local churches will not become really safe place places until the understanding of safeguarding, and abuse of power in relationships is understood by the whole congregation. Unfortunately too many church people see safeguarding as synonymous with DBS checks which can lead to dangerous complacency. It is extremely hard for people to comprehend that people who are ministers, stalwarts of the church, including church leaders can be offenders. The following section relates to church communities who have experienced the impact of abuse but here the focus is on prevention and greater awareness. Events in wider society may have opened the eyes of some but this will not be sufficient to raise awareness to the level needed. Developing house group material and healthy church audits are two routes that have been identified by safeguarding professionals consulted on this report, but there may well be others. This should be a learning and development priority as it will not only, and most importantly, make the church a safer space, but also limit the widespread pain that can come from the aftermath of abuse within a community.

Relevant to this is how the Church responds to bullying and harassment. It has already been mentioned in the section on culture in this report that a circuit/church where there is bullying and harassment will not be a safe place. The bullying may be of ministers towards colleagues or towards church officials or the other way round. Submissions made to the PCR show the depth of pain and distress that bullying and harassment can lead to. These situations may not need to be dealt with by the formal safeguarding route but the principles of safeguarding practice should be adhered to. Namely individuals who experience bullying/harassment should not be expected to take a lead. Once the issue has been brought to the attention of the minister (where they are not the subject), they should lead on investigating and seeking ways to resolve matters, ensuring the victim is not pressured into a particular response but has their feelings treated with the utmost concern. A good understanding and analysis of the power dynamics in the particular situation will be vital. Supervision should support better practice than is evident from a number of PCR submissions. If the minister is the subject of bullying/harassment then the initiative to ensure resolution, taking account of power dynamics lies with the superintendent or relevant senior person.

Learning point: the Church needs to be proactive to increase understanding among congregations about how it can become a safer space.

H.3.6 The impact of abuse within church communities

> *"It felt hard knowing that there was a risk to the church which kept its doors open to many children and vulnerable adults. There is a need to keep reiterating to parents to exercise oversight of their children but it was hard to see the church as other than a large loving family."*

The reality of many of the situations of dealing with abuse reported to the PCR was that very limited information could be given to the wider church community and therefore people often reacted with anger when a longstanding member of the community and office holder was suspended and/or removed from office.

In other situations congregations had seen media reports of the offender's actions and therefore had knowledge of one part of the picture.

In both cases this is often extremely hard to manage. The PCR submissions included situations where very destructive splits had occurred within the community. People took sides, grievances built up and the impact was deep-seated and long-term. Regular supervision is necessary to support the minister through the full range of these situations but in the most serious is likely to be insufficient. In these circumstances access to skilled outside help may well be required. The Connexional Safeguarding Team can signpost people to resources, both written material and skilled mediators.

Learning point: the impact of abuse within a church community is often deep and lasting and sometimes cannot be resolved by those enmeshed within it.

H.3.7 Working with statutory agencies

This section starts with learning identified by two ministers who made responses to the PCR.

> *"I came to this situation in the middle of concerns that had been growing over many years. In retrospect it could have been better to involve other agencies much earlier on. Help in the way of counselling was found, but the church was trying to keep it in house as long as possible. I wonder how to break down the fear of involving outside agencies and how to reassure church carers that doing so is not a sign of poor pastoral care."*

> *"The concern raised in 2010 was noted, and therefore we could make a valued contribution when contacted by LADO regarding the external events at X College. This co-operation led to further disclosures being made that directly affected the Methodist Church. This sharing of information would not have been possible a few years ago."*

Both these quotes demonstrate positive experiences of working with statutory agencies and highlight important learning. In the first case, the church held out too long before contacting the statutory agencies based on fears that were not well grounded. This was a theme in quite a number of responses. In the second case there is evidence that because the key people in the church had made good records when concerns around a youth worker were first raised they were able to have very constructive dialogue with the Local Authority Designated Officer (LADO) which led to important safeguarding action.

Some responses show that relationships with statutory agencies are not always positive and LADOs vary considerably in how they relate to churches. Examples show that cultivating good working relationships between the DSO and LADO before there is a crisis can be helpful. Several respondents asked for Connexional Team guidance on how to proceed if there is conflict with the LADO/local authority.

Learning point: the tensions and complexities in working with statutory agencies cannot be a reason for not referring.

H.3.8 Working with youth organisations linked to the church

A considerable number of responses (137) related to abuse that took place within youth organisations linked to the church. The uniformed organisations featured in many of the situations reported. The experience of those responding to such situations has been very variable.

At a local level many of the learning points above in the section on working with people where there is suspicion are relevant. Dialogue around safeguarding policies is to be encouraged at local level and offering support where there is expertise and experience within the church.

At national level the dialogue has already started but it is strongly recommended that the results of the PCR relating to each organisation are discussed with them to identify ways to improve practice.

Learning point: cooperative working around risk at national and local level can help promote good safeguarding practice.

H.3.9 Recruiting safely

It appears from the responses submitted to the PCR that practice in this area has improved. Some specific issues emerged from individual cases. One is the importance of checking gaps on an application form. Another is the need for guidance on the recruitment and support of people with learning difficulties, or other vulnerabilities, to work or volunteer with children/young people.

A small number of responses highlighted the particular attention that needs to be paid to supporting young youth leaders in relation to appropriate boundaries.

Learning point: although overall practice has improved there is a need for some further work.

H.3.10 Working with Methodist schools

A number of situations relating to Methodist schools were submitted to the PCR. Although there are systems and processes within the Methodist education structures to meet safeguarding requirements it is recommended that there are discussions between the key people from the Education field and the Connexional Safeguarding Adviser to see whether there are areas of joint working that would enhance practice in either or both school and church setting.

Learning point: more joint working between safeguarding professionals within the schools and DSOs may be helpful.

H.3.11 Working ecumenically

There are guidelines around safeguarding in Local Ecumenical Partnerships in the existing Safeguarding Policy but some of the responses indicate that this should be expanded and strengthened.

Learning point: the revision of guidelines on safeguarding in an ecumenical context needs to further clarify lines of responsibility.

H.3.12 Overseas work

There were a small number of responses that referred to concerns/incidents that took place outside the UK. In particular, there were suspicions about the behaviour of ministers in other countries and how information channels can be improved. Individual responses related to a range of different scenarios which make generalised learning difficult.

Learning point: consideration needs to be given to how to address situations where there are suspicions of poor practice that has occurred overseas.

H.3.13 Communication

Although this is the last learning point to be considered, communication is a theme that runs through most of the topics covered above. Good communication is essential internally, with external agencies, with congregations, and with the wider public in certain circumstances.

Several responses expressed how helpful the Connexional media staff had been both in advising about communication within congregations as well as to external media.

In situations where stress levels are high ensuring communication happens with all the relevant people can often be a casualty. The learning from the PCR cases is that in all situations where there is a safeguarding incident or concern and there are a number of people involved there should be a communication plan agreed

right at the start of the process. This must explicitly say who should be responsible for communicating with whom and who should agree the content of any communication.

One particular issue around communication was raised in several responses from DSOs. They had been instrumental in raising concerns that had resulted in other processes such as a President's Inquiry but were excluded from contributing to the process and then were not informed of the outcome.

Learning point: when there is a safeguarding concern ensuring communication is good both internally within the church and externally needs to be a priority which can be overlooked because of pressures in dealing with immediate issues.

Recommendations arising from section H.3

15. That, in the light of the learning points raised in section H.3 of the full report, all current safeguarding training materials be reviewed and that, specifically, further sections be added to the Leadership level, using anonymised case material from the PCR.
16. That the roles that are required to attend training at which level be reviewed.
17. That the appropriate bodies consider developing materials to promote wider awareness of safe relationships within church communities.
18. That, in the light of the learning from section H.3 and H.1 of the full report, the Safeguarding Policy and other relevant policies be reviewed and amended.
19. That a connexional register of Covenants of Care be established and held by the Connexional Safeguarding Team in order to promote effective and consistent monitoring of those who might pose a risk; and that this register include those who have requested to worship under such arrangements but not followed the request through; and that policies be developed to ensure that all sharing of information is justified and safe.
20. That all reviews and amendments to policies and training material involve consultation with victims/survivors.
21. That the Connexional Safeguarding Team identify any further learning points emerging from their follow-up work and report them initially to the Implementation Group when the PCR-related activity is completed, or by March 2016, whichever is the sooner.

I. RESOURCES

I.1 Safeguarding Team

In order to complete the follow-up work on cases allocated as a result of the PCR the two additional safeguarding worker posts need to be retained. The best current estimate is that these posts will be needed for a 12-18 month period.

The dedicated admin post working on the PCR will not be required as a full-time post after June 2015 but a half time post will be required to support the additional workload of the team, a need that will continue until the PCR follow-up is completed.

There is a significant amount of work that is required to review and develop training materials and to review and rewrite policies. Expert advice will also be required to implement many of the other recommendations of the PCR. In addition there will be demands from districts to support the training of their trainers (recommendation 4). The work involved in the above requires the equivalent of a half time safeguarding officer post until the implementation of the recommendations are completed.

I.2 Counselling for victims

In the first instance it is the responsibility of districts to provide resources to support counselling or other specialist help for survivors/victims. However there are circumstances where this is not possible or appropriate and therefore a connexional resource is required to meet this need.

Resources recommendations

22. **That the resources required for the Safeguarding Team to complete the PCR work as outlined in section I of the full report be agreed.**

23. **That a connexional resource be identified to support survivors/victims if district support is not appropriate/possible; and that resources be identified to support working with established survivor/victim groups.**

I.3 Other

There are significant resource implications in implementing the recommendation relating to supervision, mainly capacity and training for superintendent ministers and others.

There is a resource requirement to produce the policy on pastoral recording and record keeping.

J. CONCLUSION AND RECOMMENDATIONS

J.1 Courage

The Past Cases Review has been an act of courage. First and foremost it has been an act of courage on the part of survivors/victims to tell their stories and relive very difficult experiences. Experiences that were often made worse by not being listened to or believed by people within the Church.

There has also been courage on the part of ministers who have faced their past actions/inactions which they now understand might have contributed to a perpetrator continuing their abuse.

The Methodist Church showed courage in commissioning this wide ranging and comprehensive review and in the efforts taken to enable participation.

J.2 Cost

There has been a cost to this review.

The cost for survivors/victims of having to relive very painful experiences. The cost of reliving the hurt and anger of not being believed. The cost of having expectations that have not always been met.

The cost for ministers and laypeople of having to take time in their busy lives to think back and record details that were hard and sometimes painful to remember. For some ministers there has been anger and hurt when they tried to raise doubts and concerns but were not listened to or not believed.

The cost for the case reviewers who have read so many first or second hand accounts of abuse or wrongdoing. “Is this my Church?” several of them have said when it has seemed overwhelming.

The cost for the Safeguarding Team and the district safeguarding officers as they have supported people and responded to the cases that have needed follow-up.

J.3 Hope

Through the cost there is now greater hope. The Church had already taken major steps to make itself a Safer Space but the review reveals new learning points. Above all it highlights that deep cultural change is needed to fully understand what safeguarding means in every part of the life of the Church.

This is a challenge for everyone within the Church and a challenge that will require courageous leadership as the recommendations are considered and implemented.

Jane Stacey, Past Cases Review Project Manager
April 2015

J.4 Recommendations

1. That an Implementation Group be established to oversee the implementation of all the PCR's recommendations that are agreed by the Conference and that membership of this group be agreed by the Conference.

2. That selection criteria for district chairs, the Warden of the Methodist Diaconal Order and Members of the Senior Leadership Group of the Connexional Team include awareness of and ability to deal effectively with safeguarding issues.

3. That policy and guidance be provided to define what should be recorded by ministers or others undertaking pastoral work and that this be clear about requirements for each specific role as well as providing guidance for best practice.

4. That policy and guidance be provided about storage and access to pastoral records, specifying particularly requirements on ministerial handover.

5. That all people who deliver safeguarding training at Foundation or Leadership Module level be required to attend training on the findings of the PCR.

6. That the findings from the PCR be incorporated into the training of ministers irrespective of the pathway they are following.

7. That a system of structured supervision for ministers be instituted to address the identified weakness in relation to accountability and support in terms of safe practice.

   The urgency of this requirement is recognised but also the capacity/skills/resource issues that are raised. Ideally the timescales would be as follows:

   - A draft supervision policy is produced by a working party that has the skills/knowledge to reflect the relevant dimensions of accountability and important theological underpinning. The draft policy to be considered by the Methodist Council in October 2015.
   - A training course for supervisors to be developed by end of December 2015.
   - A pilot roll-out of supervision across 2 districts is undertaken for 12 months (January – December 2016) starting with the training of supervisors in January/February and supervision sessions starting in March 2016.
   - A report on the pilot to be presented to the Methodist Council in October 2016 with recommendations for a roll-out across the Connexion to start in January 2017.

   It is however recognised that as such timescales have resource implications, the Implementation Group should meet as soon as possible following the Conference, to agree a timetable and secure the required resources.

8. That serious consideration be given to producing a Code of Conduct for ministers along the lines of that produced by the Church of England.

9. That, until the Methodist Church has robust accountability processes in place and fully operational, an annual independent audit of progress on these culture change recommendations and in particular on the mainstreaming of safeguarding awareness be carried out; and that a framework for the audits and proposals on who should carry them out be agreed by the Methodist Council in October 2015.

10. Training: that the pattern of training for members of the Connexional Complaints Panel continue to be developed so as to ensure: an annual training event; that all members of the Panel undertake both the Foundation Module and the Leadership Module; that additional sections of the Leadership

Module be prepared to cover the impact of abuse on victims, patterns/models of abuse and risk management in the church; and that, when developed, these sections be required training for those hearing complaints relating to a safeguarding concern.

11. That the Past Cases Review definition of a 'Safeguarding concern' be used by Local Complaints Officers, Complaints Teams and Discipline Committees.

12. That work be undertaken to ensure a rigorous system of liaison and consultation between all parts of the complaints process, the resignation (of ministers) process, suspensions, and the Connexional Safeguarding Officer to ensure that appropriate advice is obtained on cases that contain a safeguarding concern or sexual harassment.

13. That work be undertaken to develop further best practice guidance including, but not limited to, guidance on appropriate communication with complainants and respondents; guidance on the choice of venues for meetings and hearings; and guidance on questioning of complainants and respondents.

14. Recording and monitoring: that a system be established to monitor the implementation of decisions of Discipline Committees (and where appropriate Complaints Teams) and that their implementation be recorded.

15. That, in the light of the learning points raised in section H.3 of the full report, all current safeguarding training materials be reviewed and that, specifically, further sections be added to the Leadership level, using anonymised case material from the PCR.

16. That the roles that are required to attend training at which level be reviewed.

17. That the appropriate bodies consider developing materials to promote wider awareness of safe relationships within church communities.

18. That, in the light of the learning from section H.3 and H.1 of the full report, the Safeguarding Policy and other relevant policies be reviewed and amended.

19. That a connexional register of Covenants of Care be established and held by the Connexional Safeguarding Team in order to promote effective and consistent monitoring of those who might pose a risk; and that this register include those who have requested to worship under such arrangements but not followed the request through; and that policies be developed to ensure that all sharing of information is justified and safe.

20. That all reviews and amendments to policies and training material involve consultation with victims/survivors.

21. That the Connexional Safeguarding Team identify any further learning points emerging from their follow-up work and report them initially to the Implementation Group when the PCR-related activity is completed, or by March 2016, whichever is the sooner.

22. That the resources required for the Safeguarding Team to complete the PCR work as outlined in section I of the full report be agreed.

23. That a connexional resource be identified to support survivors/victims if district support is not appropriate/possible; and that resources be identified to support working with established survivor/victim groups.

PART 2

STATISTICAL FINDINGS

SECTION A: RESPONDENT INFORMATION

A.1 ACTIVE MINISTERS

Districts	No of ministers sent letters	No of ministers who responded	% of ministers who responded	No of ministers who submitted nothing to report	No of ministers who submitted positive responses	No of positive responses submitted by ministers
1 - Cymru	12	7	58%	5	2	3
2 - Wales (pilot)	**31**	**15**	**48%**	**8**	**7**	**18**
5 - Birmingham	79	72	91%	50	22	54
6 - Bolton & Rochdale	37	25	68%	12	13	47
7 - Bristol	78	66	85%	36	30	70
9 - Cumbria	31	27	87%	19	8	17
10 - Channel Islands	13	13	100%	7	6	12
11 - Chester & Stoke-on-Trent	53	37	70%	17	20	43
12 - Cornwall	44	36	82%	20	16	35
13 - Darlington	58	44	76%	25	19	44
14 - East Anglia	74	52	70%	23	30	78
15 - Isle of Man	7	4	57%	1	3	6
16 - Leeds (pilot)	**28**	**7**	**25%**	**4**	**3**	**4**
17 - Lincolnshire	43	36	84%	15	21	48
18 - Liverpool	48	41	85%	26	15	69
19 - Manchester & Stockport	67	59	88%	23	36	94
20 - Newcastle upon Tyne	68	61	90%	35	26	63
21 - Lancashire	57	42	74%	22	20	49
22 - Nottingham & Derby	70	68	97%	22	46	153
23 - Northampton	102	95	93%	57	38	91
24 - Plymouth & Exeter	63	48	76%	19	29	58
25 - Sheffield	65	62	95%	26	36	103
26 - Southampton	90	74	82%	41	33	79
27 - West Yorkshire	51	46	90%	24	22	64
28 - Wolverhampton & Shrewsbury	66	56	85%	35	21	41
29 - York & Hull	70	55	79%	22	31	83
31 - Scotland	27	22	81%	12	10	17
32 - Shetland	4	4	100%	3	1	4
34 - Bedfordshire, Essex & Herts	65	58	89%	21	37	132
35 - London	197	162	82%	108	54	108
36 - South East	98	86	88%	49	37	82
40 - Connexion	36	12	33%	8	4	13
55 - Pacific	1	1	100%	–	1	1
Totals	**1833**	**1493**	**81%**	**795**	**697**	**1783**

● Leeds & Wales Districts were covered as part of the pilot phase; the numbers above and below relating to these districts are for ministers who have moved into these districts after the pilot phase.

A.2 SUPERNUMERARIES

Districts	No of ministers in the district	No of ministers who responded	% of ministers who responded	No of ministers who submitted nothing to report	No of ministers who submitted positive responses	No of positive responses submitted
1 - Cymru	13	6	46%	6	–	–
2 - Wales (pilot)	**84**	**10**	**12%**	**7**	**3**	**4**
5 - Birmingham	85	36	42%	28	8	11
6 - Bolton & Rochdale	33	4	12%	1	3	3
7 - Bristol	100	24	24%	15	9	15
9 - Cumbria	50	8	16%	7	1	1
10 - Channel Islands	9	7	78%	6	1	2
11 - Chester & Stoke-on-Trent	71	23	32%	18	5	7
12 - Cornwall	47	10	21%	6	4	10
13 - Darlington	35	13	37%	10	3	9
14 - East Anglia	101	34	34%	28	6	7
15 - Isle of Man	5	–	0%	–	–	–
16 - Leeds (pilot)	**57**	**9**	**16%**	**8**	**1**	**1**
17 - Lincolnshire	58	40	69%	36	4	4
18 - Liverpool	38	17	45%	16	1	3
19 - Manchester & Stockport	47	15	32%	14	1	1
20 - Newcastle upon Tyne	58	18	31%	15	3	5
21 - Lancashire	61	27	44%	22	5	10
22 - Nottingham & Derby	90	17	19%	10	7	16
23 - Northampton	110	20	18%	14	6	6
24 - Plymouth & Exeter	88	14	16%	12	2	2
25 - Sheffield	59	24	41%	14	10	12
26 - Southampton	109	60	55%	37	23	37
27 - West Yorkshire	50	18	36%	11	7	9
28 - Wolverhampton & Shrewsbury	67	15	22%	10	5	5
29 - York & Hull	105	48	46%	40	8	17
31 - Scotland	52	36	69%	33	3	3
32 - Shetland	2	–	0%	–	–	–
34 - Bedfordshire, Essex & Herts	53	25	47%	17	8	12
35 - London	59	25	42%	18	7	17
36 - South East	104	37	36%	28	9	17
40 - Connexion	21	1	5%	–	1	10
Totals	**1921**	**641**	**33%**	**487**	**154**	**256**

A.3 AUTHORISED / ASSOCIATE MINISTERS

Districts	No of authorised / associate ministers who responded	No of authorised / associate ministers who submitted nothing to report	No of authorised / associate ministers who submitted positive responses	No of positive responses submitted
1 - Cymru	1	–	1	1
5 - Birmingham	2	2	–	–
6 - Bolton & Rochdale	3	1	2	2
7 - Bristol	4	4	–	–
9 - Cumbria	4	4	–	–
11 - Chester & Stoke-on-Trent	2	2	–	–
12 - Cornwall	3	3	–	–
13 - Darlington	17	17	–	–
14 - East Anglia	13	13	–	–
16 - Leeds (pilot)	1	1	–	–
17 - Lincolnshire	6	5	1	1
18 - Liverpool	2	2	–	–
19 - Manchester & Stockport	4	4	–	–
20 - Newcastle upon Tyne	6	6	–	–
21 - Lancashire	5	5	–	–
22 - Nottingham & Derby	4	4	–	–
23 - Northampton	14	13	1	1
24 - Plymouth & Exeter	2	2	–	–
25 - Sheffield	9	8	1	1
26 - Southampton	4	4	–	–
27 - West Yorkshire	9	8	1	1
28 - Wolverhampton & Shrewsbury	3	3	–	–
29 - York & Hull	4	4	–	–
31 - Scotland	3	3	–	–
34 - Bedfordshire, Essex & Herts	17	13	4	4
35 - London	2	2	2	2
36 - South East	9	7	–	–
Totals	**153**	**140**	**13**	**13**

A.4 LAYPEOPLE

Districts	No of lay people who submitted positive responses	No of positive responses submitted
5 - Birmingham	4	4
7 - Bristol	7	11
9 - Cumbria	1	10
10 - Channel Islands	1	1
11 - Chester & Stoke-on-Trent	9	24
12 - Cornwall	1	1
14 - East Anglia	4	4
16 - Leeds (pilot)	1	3
17 - Lincolnshire	1	1
18 - Liverpool	5	29
19 - Manchester & Stockport	3	21
20 - Newcastle upon Tyne	4	4
21 - Lancashire	6	18
22 - Nottingham & Derby	5	153
23 - Northampton	6	6
24 - Plymouth & Exeter	3	3
25 - Sheffield	6	21
26 - Southampton	4	30
27 - West Yorkshire	2	5
28 - Wolverhampton & Shrewsbury	1	61
29 - York & Hull	10	14
31 - Scotland	1	1
34 - Bedfordshire, Essex & Hertfordshire	7	13
35 - London	11	20
36 - South East	7	18
40 - Connexion	1	1
Totals	**111**	**477**

A.5 OVERALL TOTALS

Districts	No of respondents	No of responses received	No of positive responses submitted
1 - Cymru	14	15	4
2 - Wales (pilot)	**25**	**37**	**22**
5 - Birmingham	116	151	69
6 - Bolton & Rochdale	33	67	52
7 - Bristol	103	153	96
9 - Cumbria	41	59	28
10 - Channel Islands	21	28	15
11 - Chester & Stoke-on-Trent	76	116	74
12 - Cornwall	50	75	46
13 - Darlington	76	107	53
14 - East Anglia	104	153	89
15 - Isle of Man	4	7	6
16 - Leeds (pilot)	**20**	**23**	**8**
17 - Lincolnshire	83	110	54
18 - Liverpool	66	146	101
19 - Manchester & Stockport	83	159	116
20 - Newcastle upon Tyne	91	130	72
21 - Lancashire	81	127	77
22 - Nottingham & Derby	94	358	322
23 - Northampton	138	191	104
24 - Plymouth & Exeter	99	128	63
25 - Sheffield	102	186	137
26 - Southampton	142	228	146
27 - West Yorkshire	75	122	79
28 - Wolverhampton & Shrewsbury	75	155	107
29 - York & Hull	117	181	114
31 - Scotland	62	69	21
32 - Shetland	4	7	4
34 - Bedfordshire, Essex & Hertfordshire	107	212	161
35 - London	201	274	145
36 - South East	140	204	119
40 - Connexion	14	32	24
55 - Pacific	1	1	1
Totals	**2458**	**4011**	**2529****

- Leeds and Wales Districts were covered as part of the pilot phase; the numbers above relating to these districts include active ministers who have moved into these districts after the pilot phase.

** The number of response forms received in the table above may differ from actual positive responses as some respondents used one form to inform us of multiple concerns.

SECTION B: INFORMATION SUBMITTED TO PAST CASES REVIEW

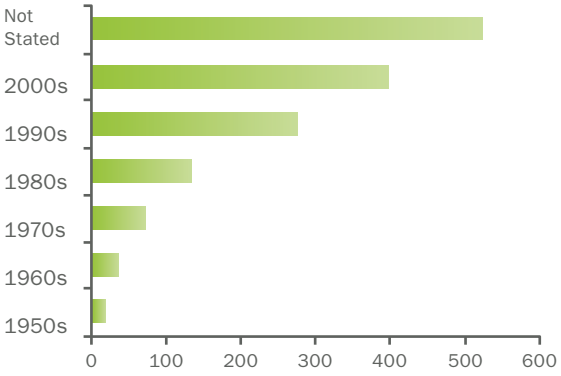
The information in this section was extracted from the response forms relating to individuals of concern. In the tables and graphs which follow, data for ministers and lay employees has been analysed separately because of their particular significance in the life of the Church.

B.1 DATE / LOCATION / TYPE OF CONCERN / ABUSE / INCIDENT

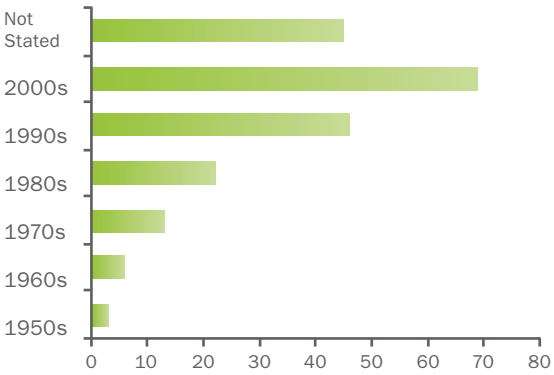
B.1.1.a Date of safeguarding concern by decade - including different groups of perpetrators/alleged perpetrators

	All	Ministers	Lay employees
1950s	18	3	2
1960s	36	6	6
1970s	73	13	18
1980s	134	22	30
1990s	275	46	46
2000s *(2000-2009 inclusive)*	398	69	124
Not stated	522	45	85

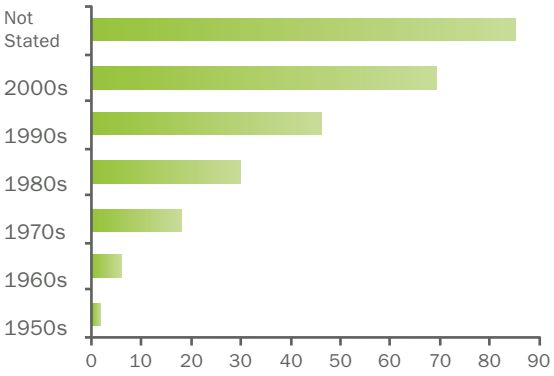
ALL



MINISTERS



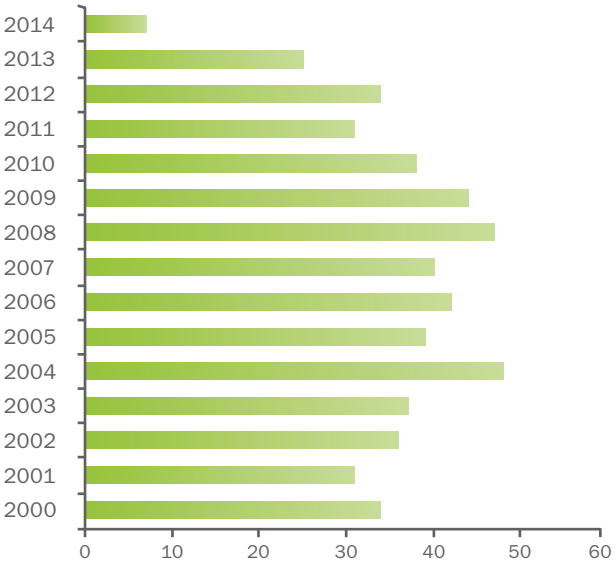
LAY EMPLOYEES



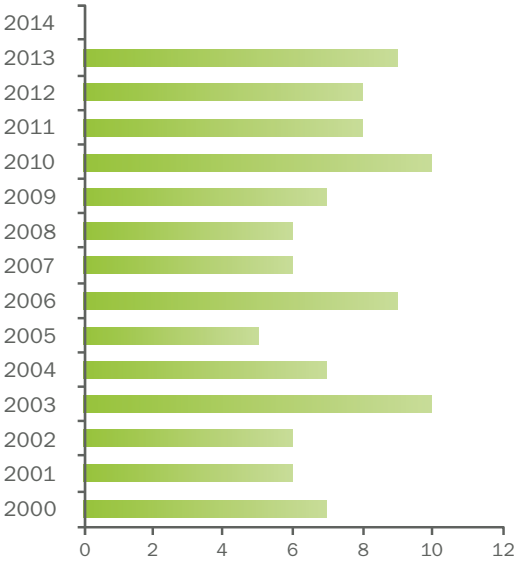
B.1.2.a Date of safeguarding concern by year for post 2000 (inclusive)

	All	Ministers	Lay employees
2000	34	7	11
2001	31	6	11
2002	36	6	12
2003	37	10	8
2004	48	7	14
2005	39	5	11
2006	42	9	14
2007	40	6	13
2008	47	6	15
2009	44	7	15
2010	38	10	8
2011	31	8	16
2012	34	8	16
2013	25	9	7
2014	7	0	1

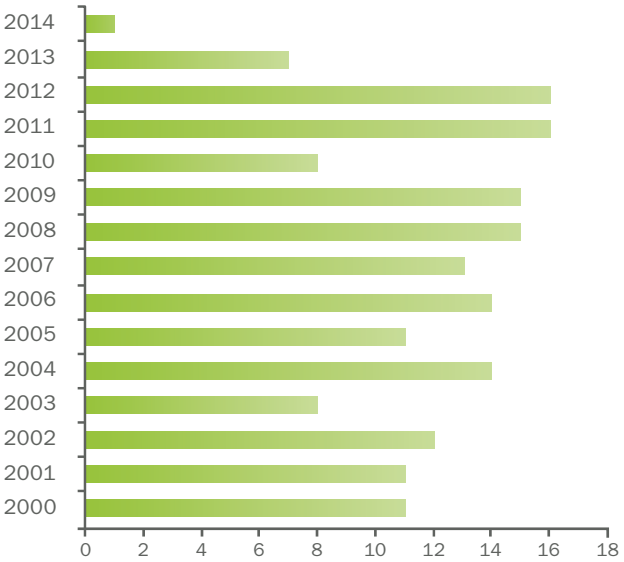
ALL



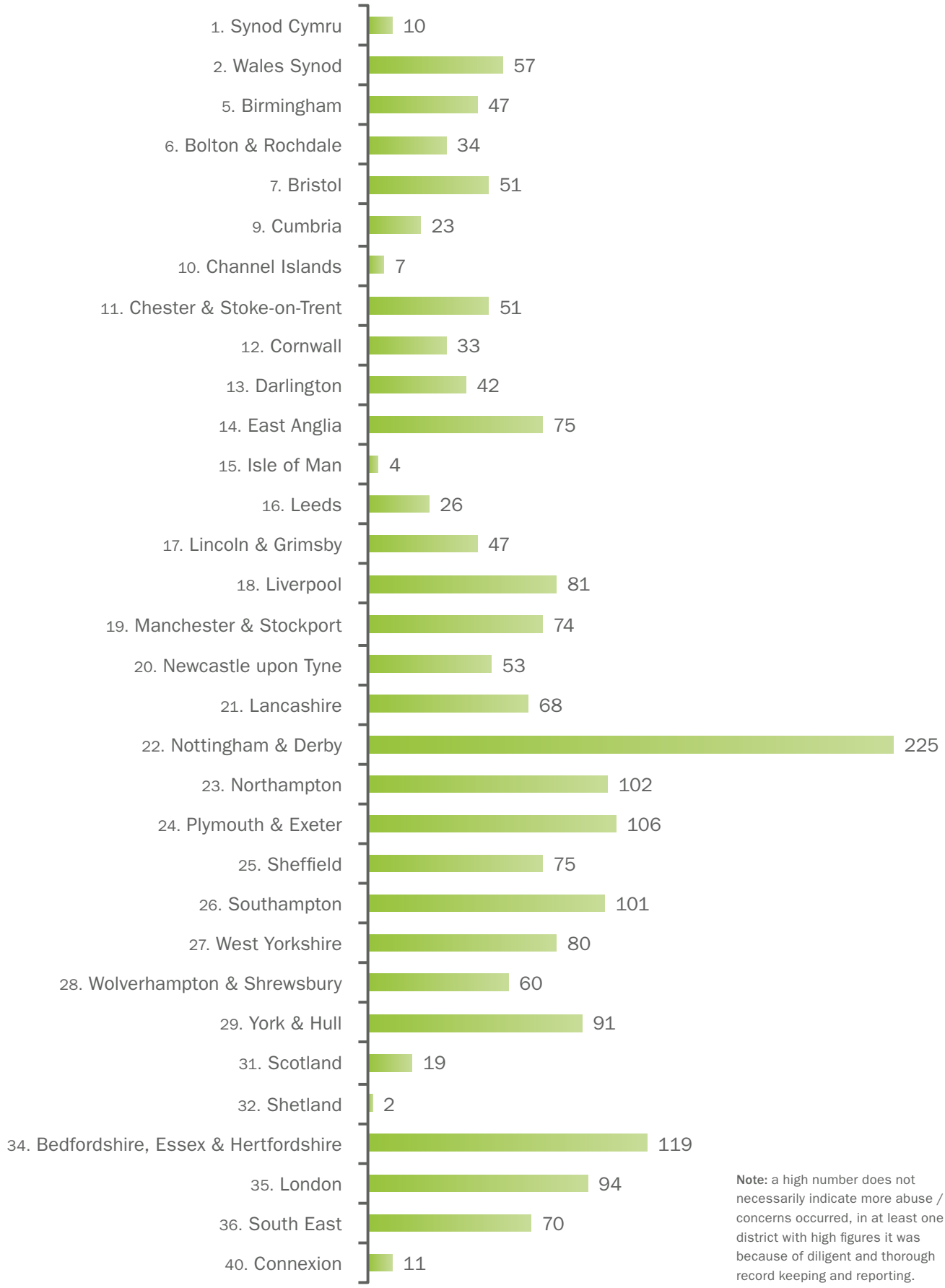
MINISTERS



LAY EMPLOYEES



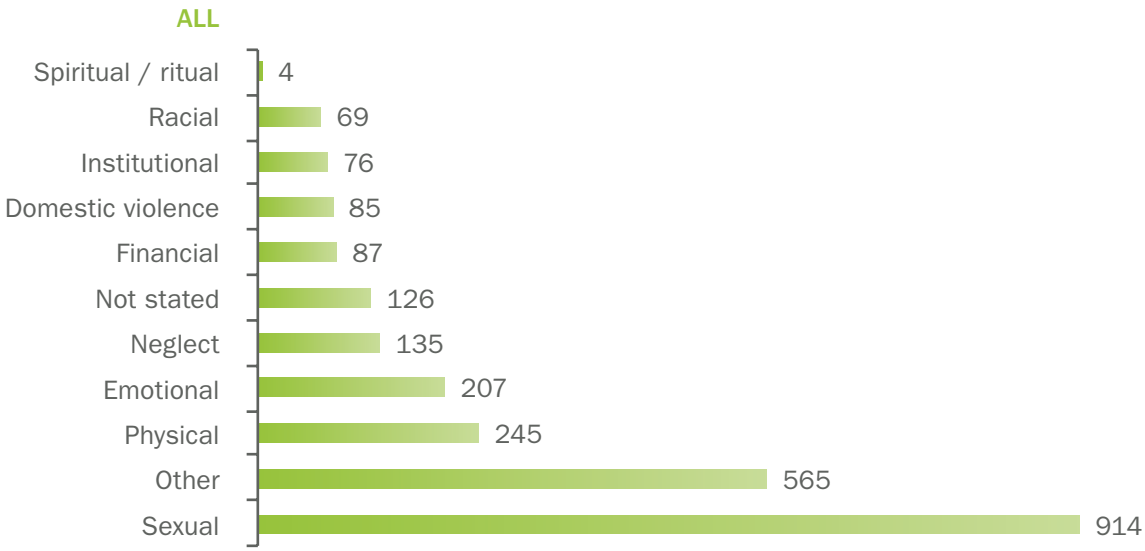
B.1.3 Safeguarding concerns by District

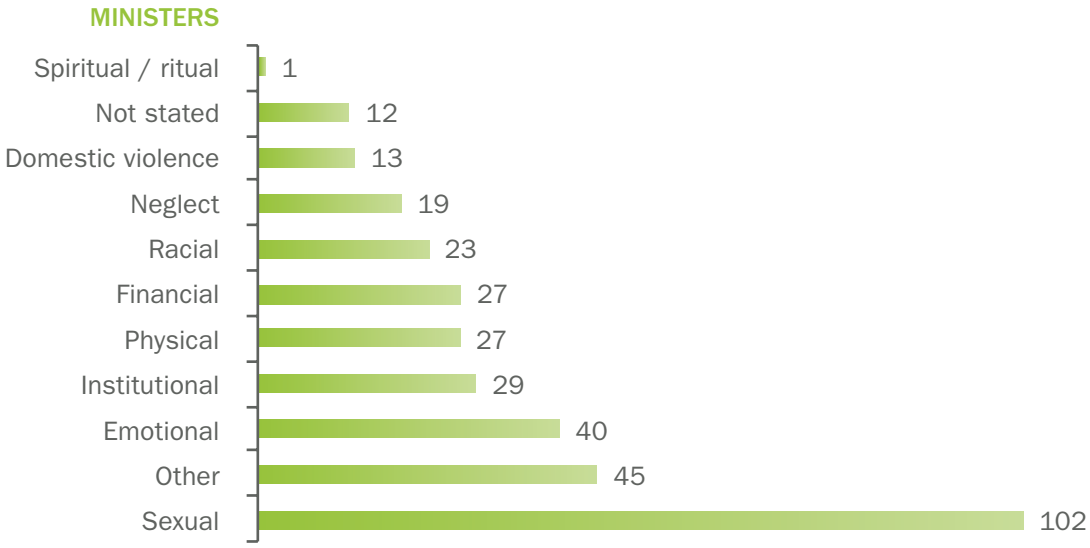


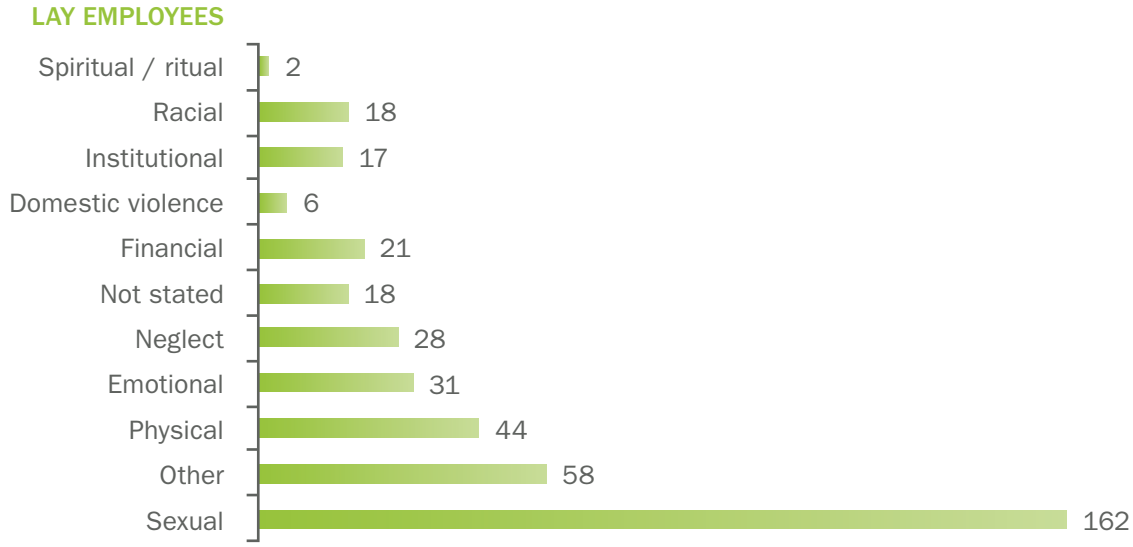
Note: a high number does not necessarily indicate more abuse / concerns occurred, in at least one district with high figures it was because of diligent and thorough record keeping and reporting.

B.1.4 Type of concern by category of abuse

A case may have multiple categories of abuse.

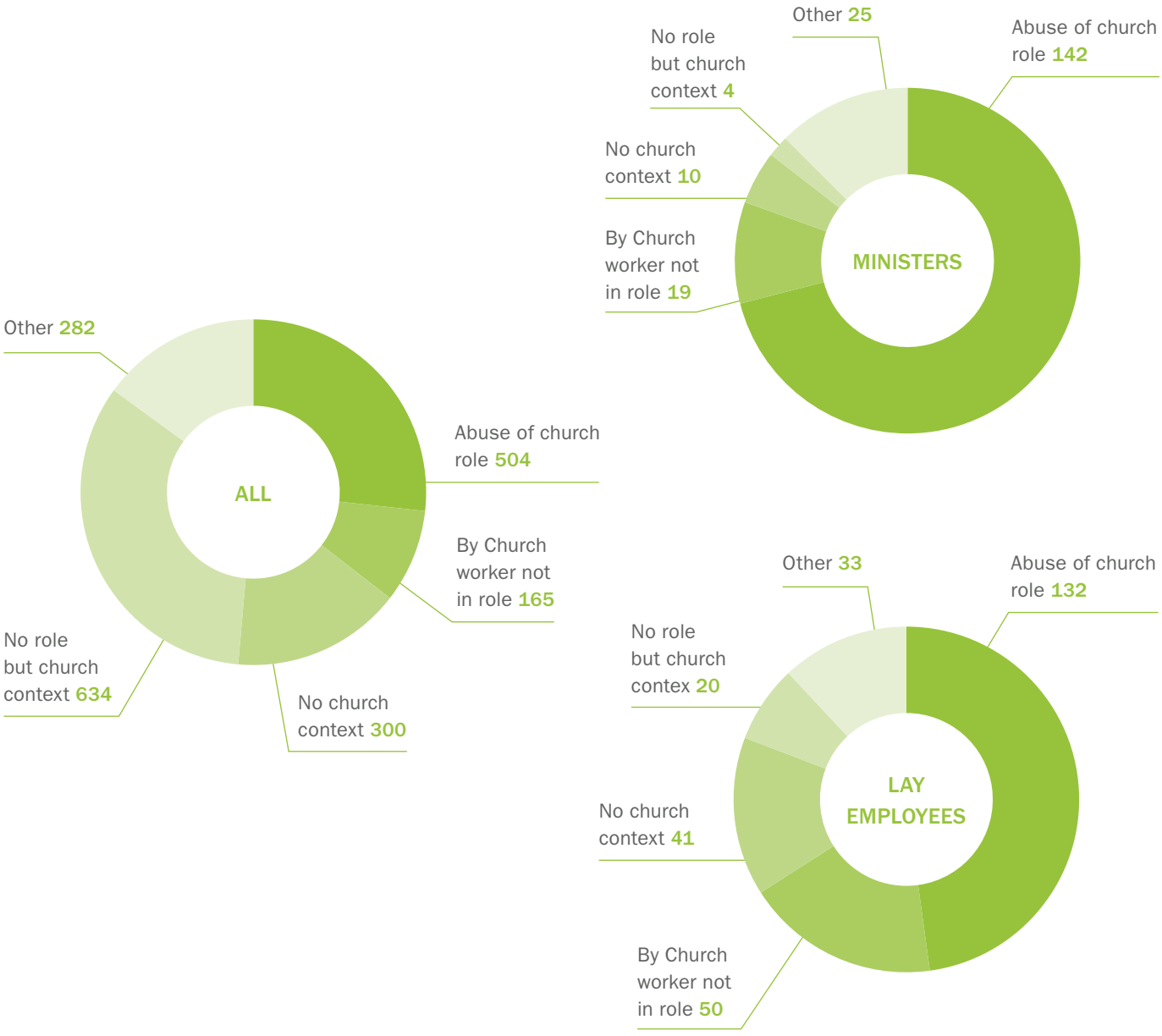






B.1.5 Context of abuse

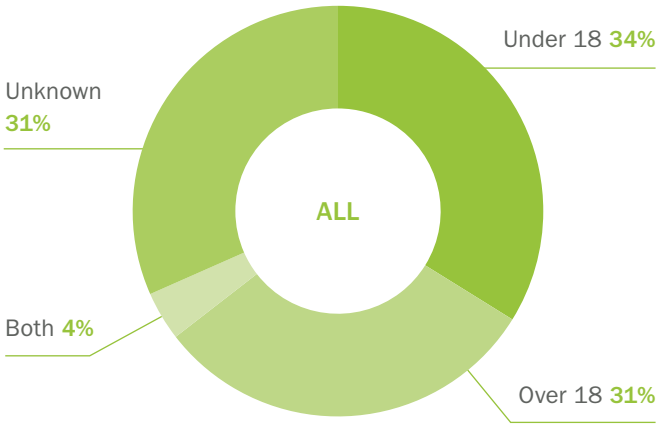
	All	Ministers	Lay Employees
Abuse of church role	504	142	132
By Church worker not in role	165	19	50
No church context	300	10	41
No role but church context	634	4	20
Other	282	25	33
Totals	**1885**	**200**	**276**



B.2 VICTIM INFORMATION

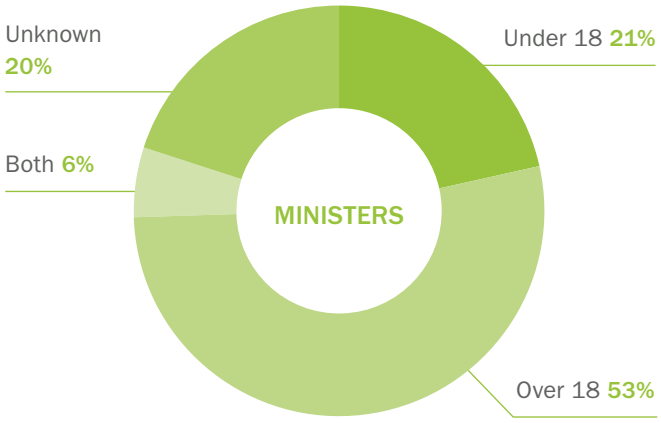
B.2.1.a Victims by age – ALL

Under 18	638	34%
Over 18	578	31%
Both	73	4%
Unknown	596	31%



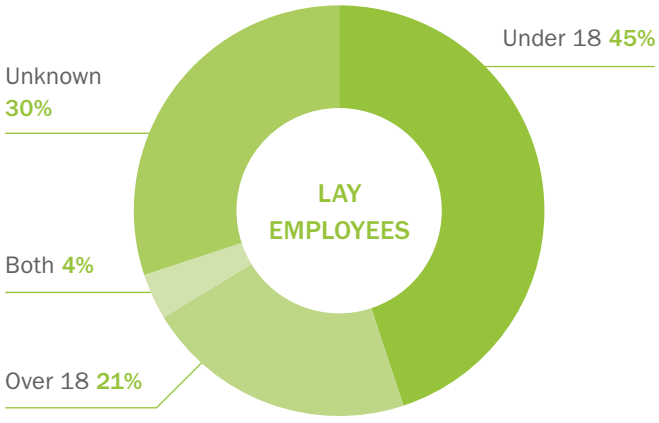
B.2.1.b Victims by age – MINISTERS

Under 18	43	21%
Over 18	106	53%
Both	11	6%
Unknown	40	20%



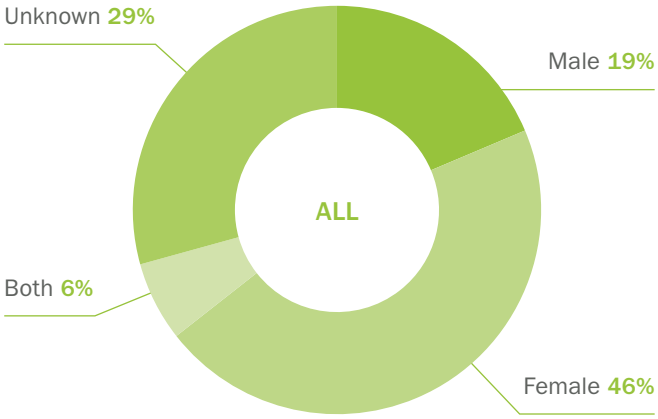
B.2.1.c Victims by age – LAY EMPLOYEES

Under 18	124	45%
Over 18	59	21%
Both	10	4%
Unknown	83	30%



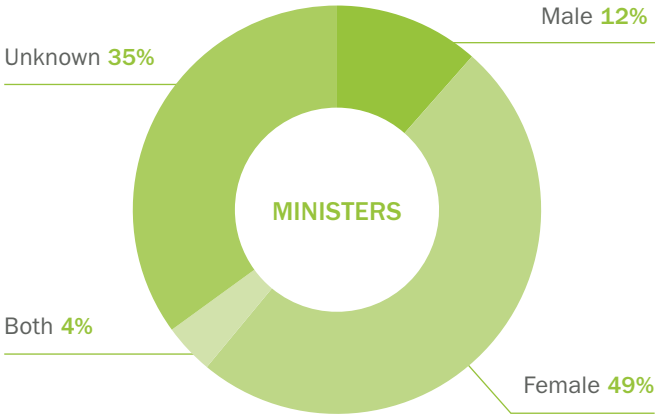
B.2.2.a Victims by gender – ALL

Male	355	19%
Female	872	46%
Both	120	6%
Unknown	558	29%



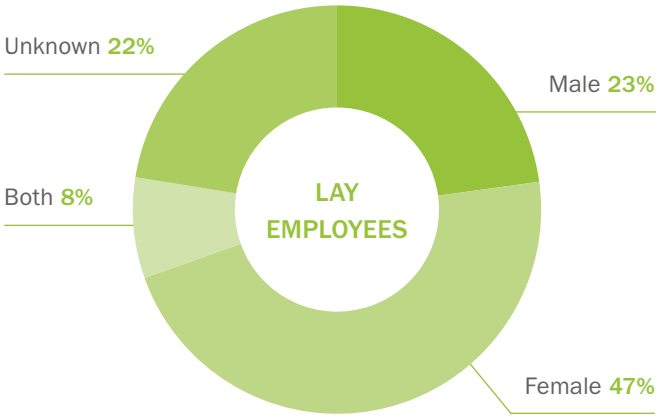
B.2.2.b Victims by gender – MINISTERS

Male	23	12%
Female	99	49%
Both	8	4%
Unknown	70	35%



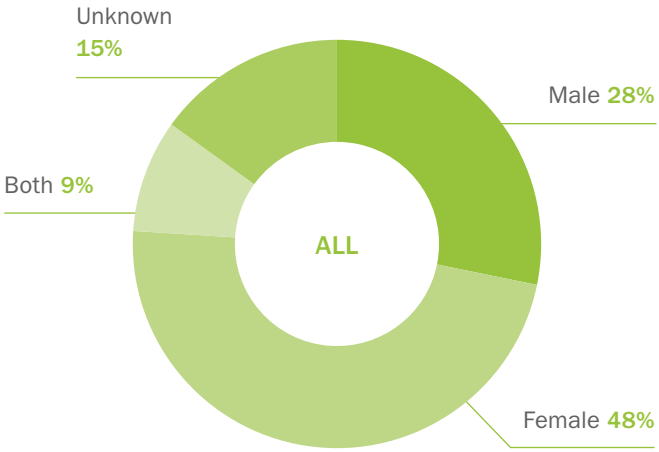
B.2.2.c Victims by gender – LAY EMPLOYEES

Male	63	23%
Female	129	47%
Both	22	8%
Unknown	62	22%



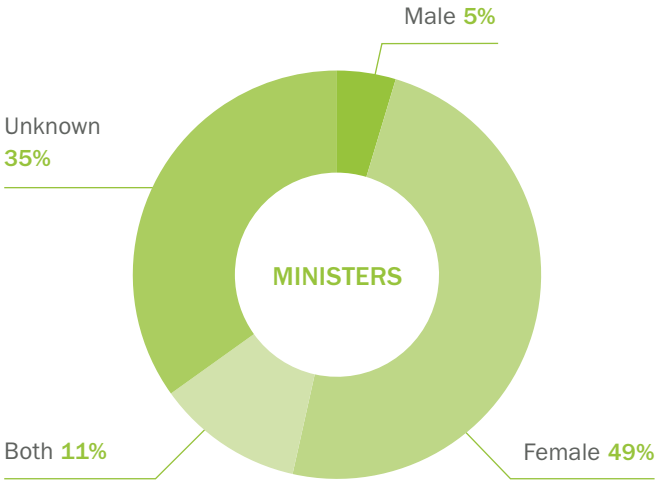
B.2.3.a Victim gender - under 18 – ALL

Male	180	28%
Female	305	48%
Both	57	9%
Unknown	96	15%



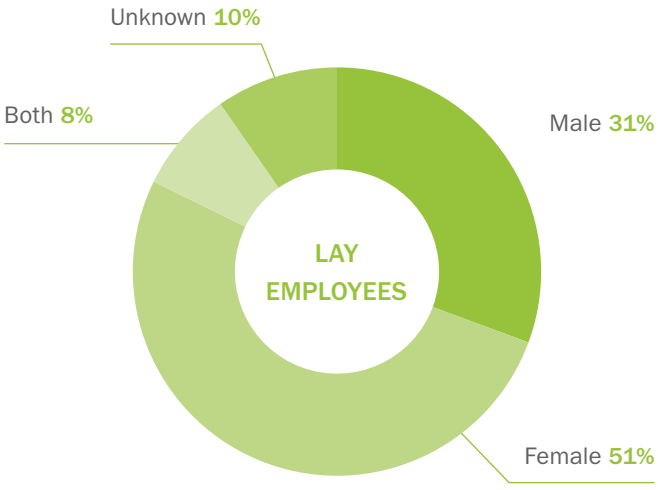
B.2.3.b Victim gender - under 18 – MINISTERS

Male	2	5%
Female	21	49%
Both	5	11%
Unknown	15	35%



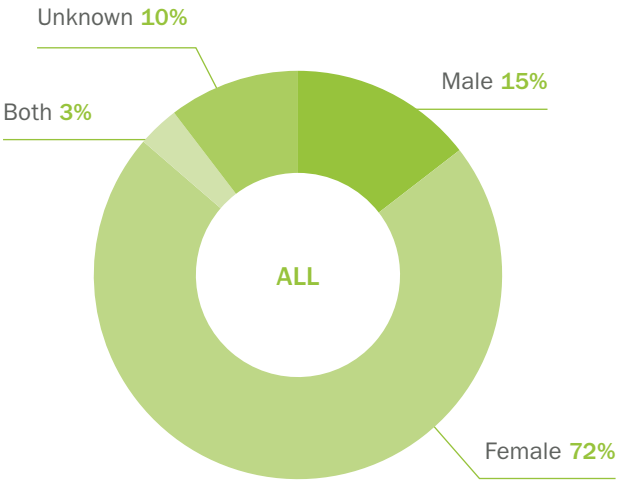
B.2.3.c Victim gender - under 18 – LAY EMPLOYEES

Male	38	31%
Female	64	51%
Both	10	8%
Unknown	12	10%



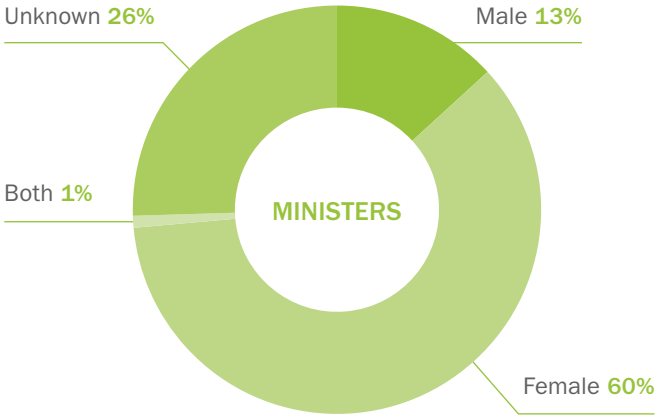
B.2.4.a Victim gender - over 18 – ALL

Male	84	15%
Female	415	72%
Both	19	3%
Unknown	60	10%



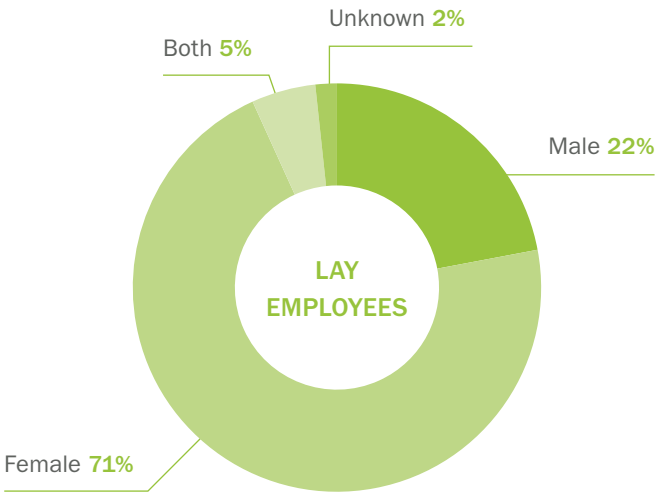
B.2.4.b Victim gender - over 18 – MINISTERS

Male	14	13%
Female	64	60%
Both	1	1%
Unknown	27	26%



B.2.4.c Victim gender - over 18 – LAY EMPLOYEES

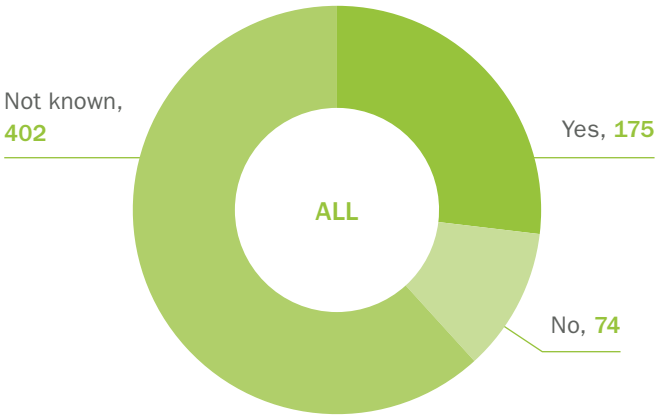
Male	13	22%
Female	42	71%
Both	3	5%
Unknown	1	2%



B.2.5.a Adult victims by vulnerability – ALL

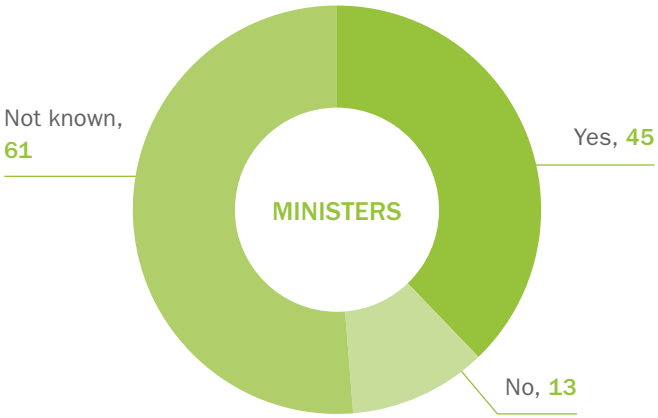
These figures are based on responses where victims have been identified to be either over 18 or both (651)

Yes	175	27%
No	74	11%
Not known	402	62%



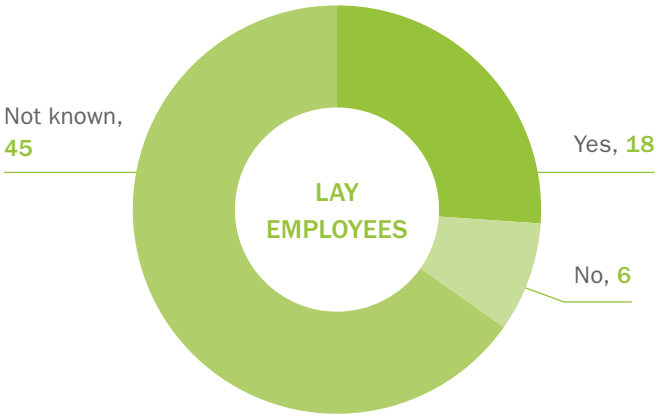
B.2.5.b Adult victims by vulnerability – MINISTERS

Yes	45	38%
No	13	11%
Not known	61	51%



B.2.5.c Adult victims by vulnerability – LAY EMPLOYEES

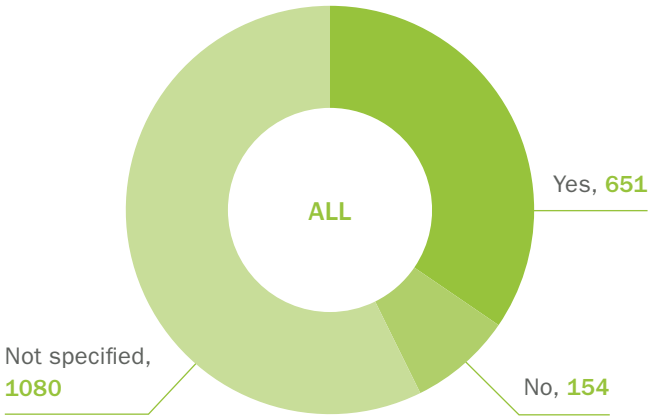
Yes	18	26%
No	6	9%
Not known	45	65%



Unknown 26% Male 13%

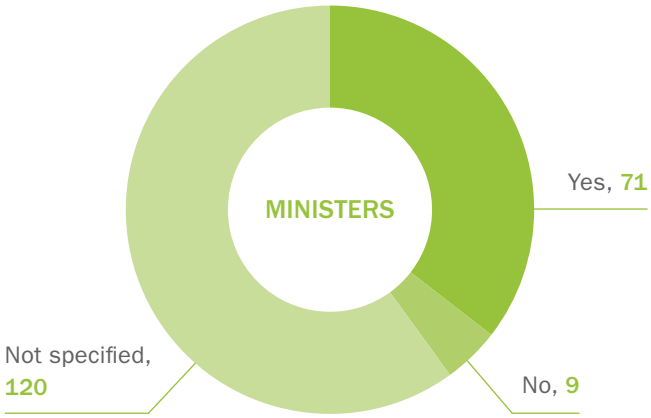
B.2.6.a Was support provided to the victim? – ALL

Yes	651	35%
No	154	8%
Not specified	1080	57%



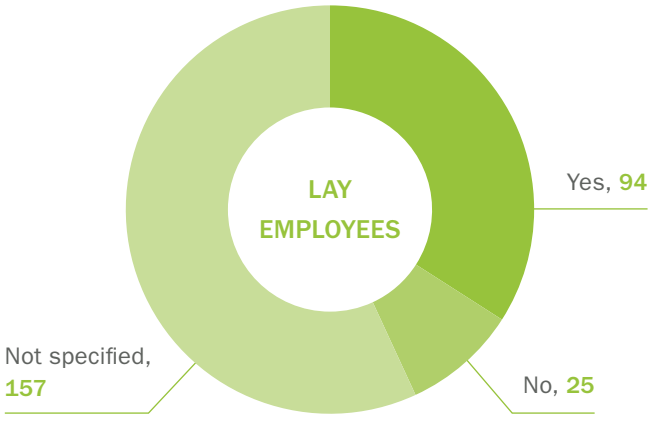
B.2.6.b Was support provided to the victim? – MINISTERS

Yes	71	35%
No	9	5%
Not specified	120	60%



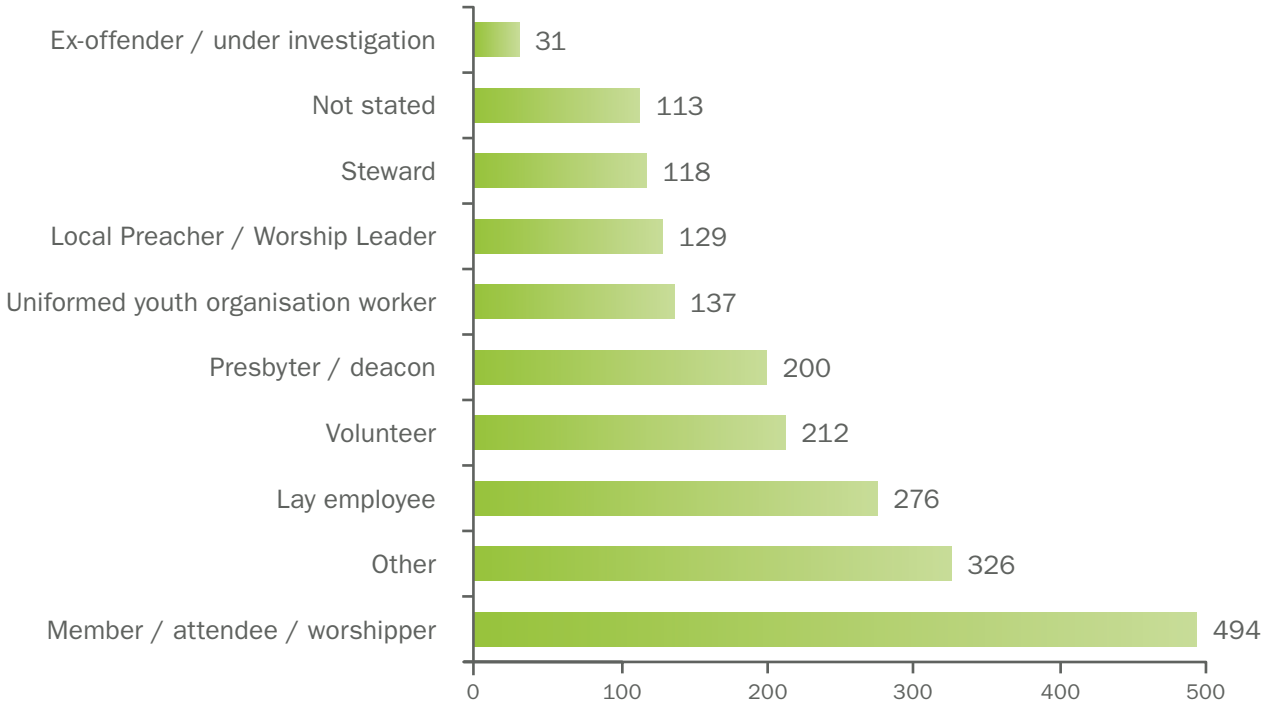
B.2.6.c Was support provided to the victim? – LAY EMPLOYEES

Yes	94	34%
No	25	9%
Not specified	157	57%



B.3 PERPETRATOR/ALLEGED PERPETRATOR INFORMATION

B.3.1 Perpetrator/alleged perpetrator by ROLE

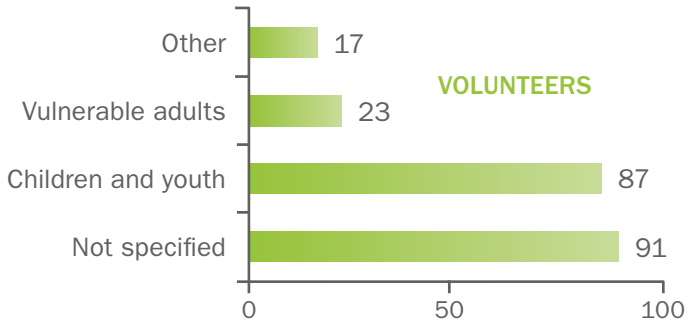


Member / attendee / worshipper	494	24%
Other	326	17%
Lay employee	276	15%
Volunteer	212	11%
Presbyter / deacon	200	11%
Uniformed youth organisation worker	137	7%
Local Preacher / Worship Leader	129	7%
Steward	118	6%
Not stated	113	6%
Ex-offender / under investigation	31	1%

B.3.2 ROLE SPECIFIC

B.3.2.1 Volunteers:

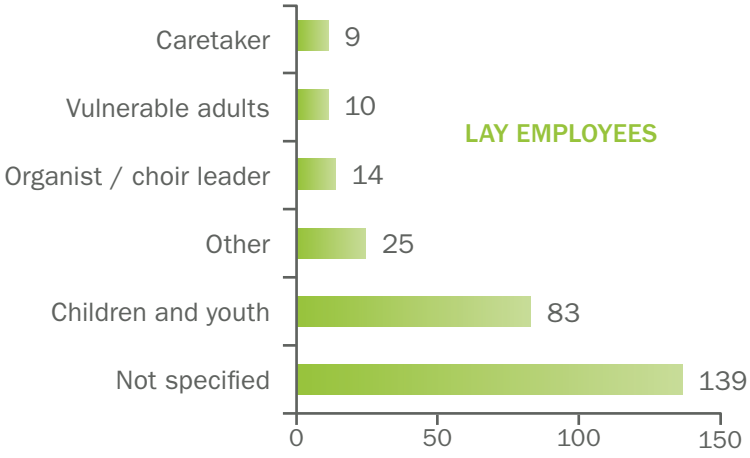
Not specified	91	42%
Children and youth	87	41%
Vulnerable adults	23	10%
Other	17	8%



B.3.2.2 Lay employees:

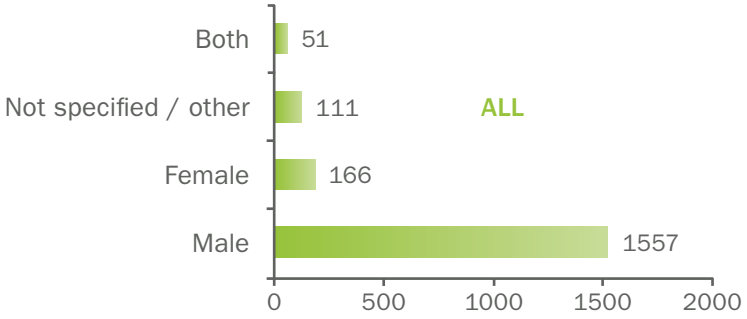
Individuals 275
Note: some individuals had more than one of the above roles

Not specified	139	50%
Children and youth	83	30%
Other	25	9%
Organist / choir leader	14	5%
Vulnerable adults	10	3%
Caretaker	9	3%



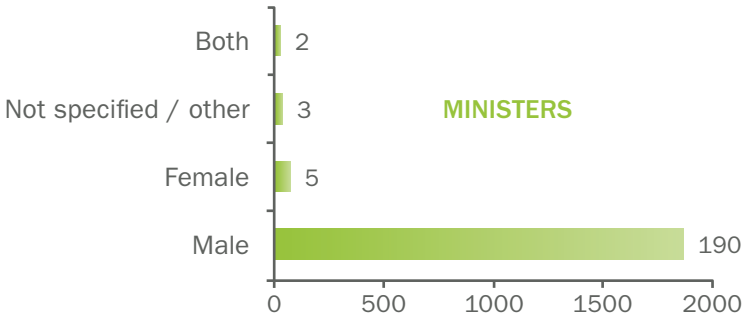
B.3.3.a Perpetrator/alleged perpetrator by gender: – ALL

Male	1557	82%
Female	166	9%
Not specified / other	111	6%
Both	51	3%



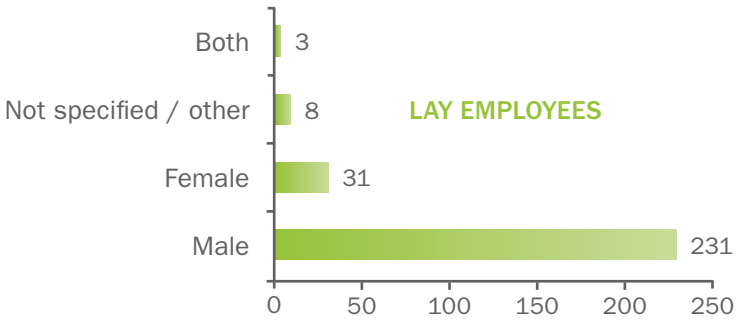
B.3.3.b Perpetrator/alleged perpetrator by gender: – MINISTERS

Male	190	95%
Female	5	2%
Not specified / Other	3	2%
Both	2	1%



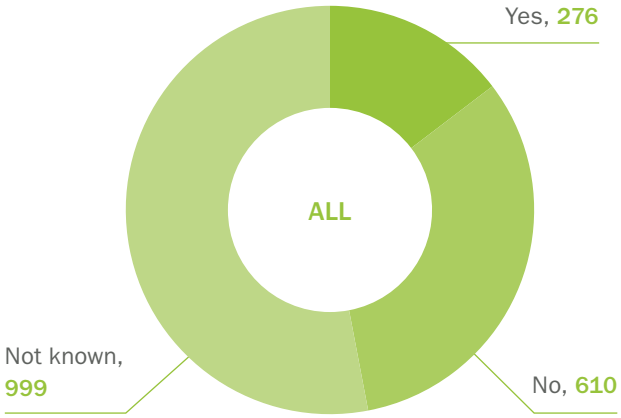
B.3.3.c Perpetrator/alleged perpetrator by gender: – LAY EMPLOYEES

Male	231	84%
Female	34	12%
Not specified / other	8	3%
Both	3	1%



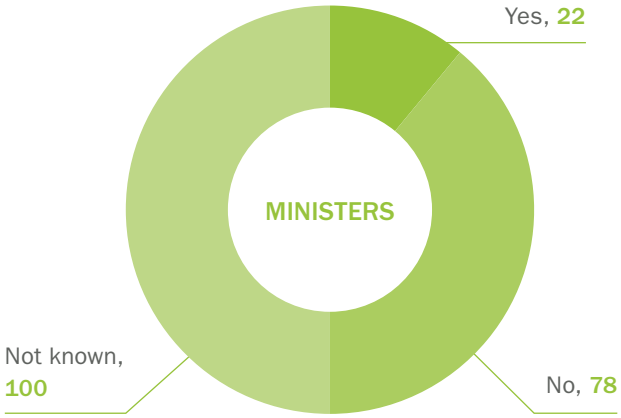
B.3.4.a Perpetrator/alleged perpetrator by vulnerability: – ALL

Yes	276	15%
No	610	32%
Not known	999	53%



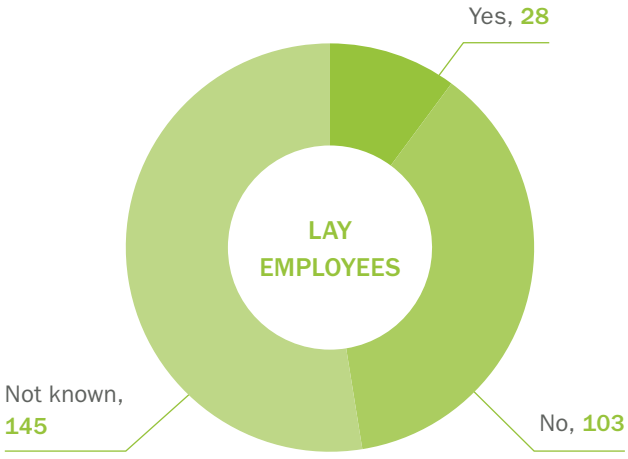
B.3.4.b Perpetrator/alleged perpetrator by vulnerability: – MINISTERS

Yes	22	11%
No	78	39%
Not known	100	50%



B.3.4.c. Perpetrator/alleged perpetrator by Vulnerability: – LAY EMPLOYEES

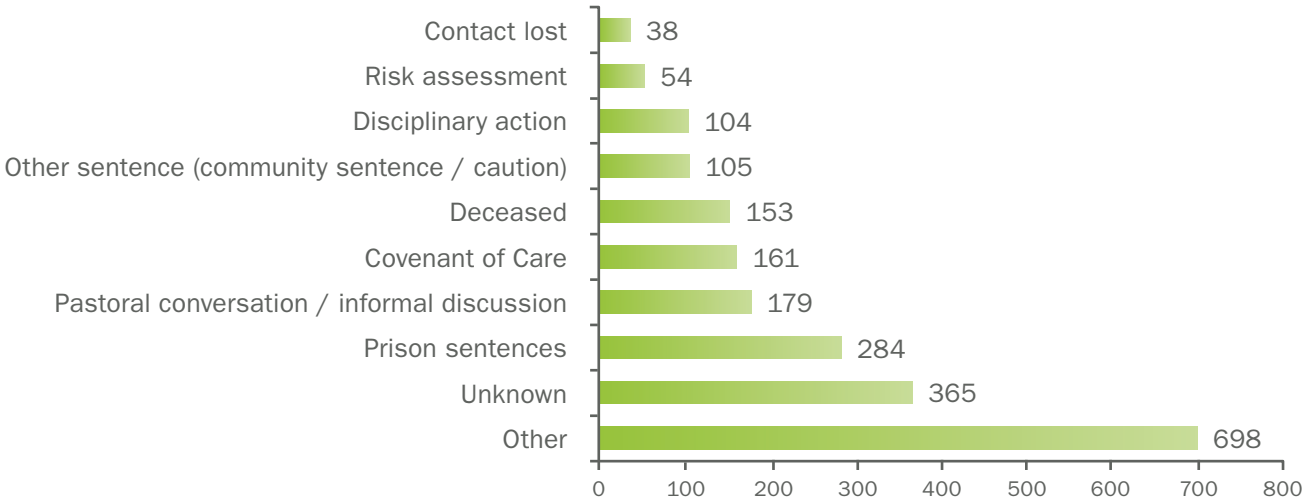
Yes	28	10%
No	103	37%
Not known	145	53%



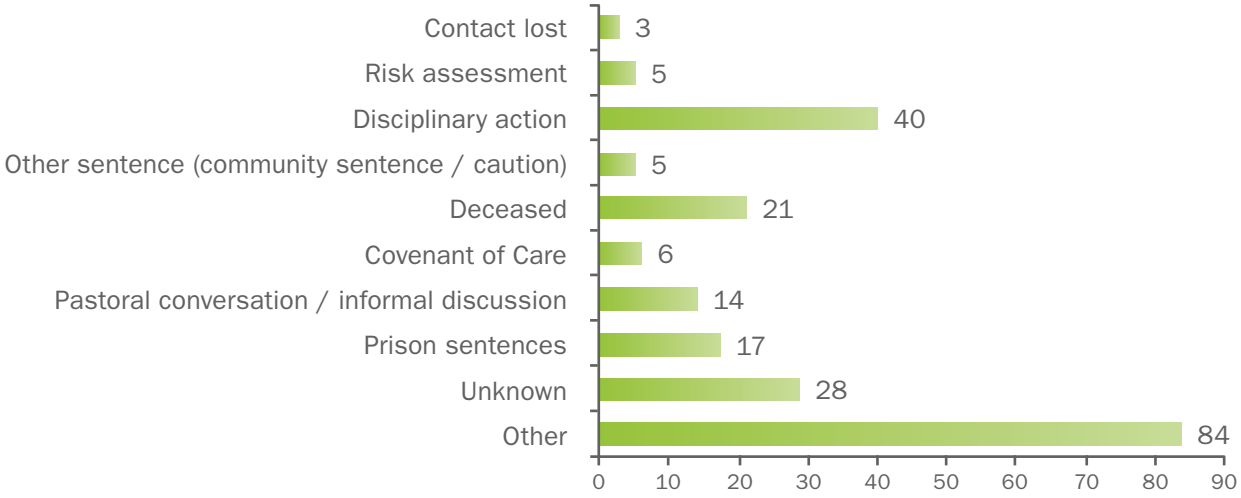
B.3.5 Reported outcomes for perpetrator/alleged perpetrator:

Note: Individuals may have had more than one of the above outcomes

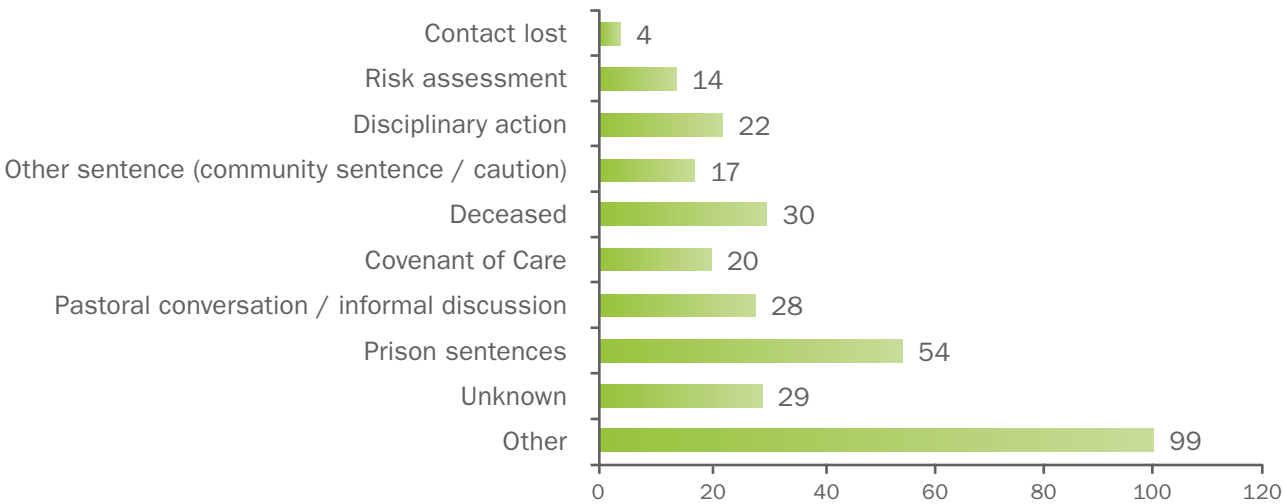
ALL



MINISTERS



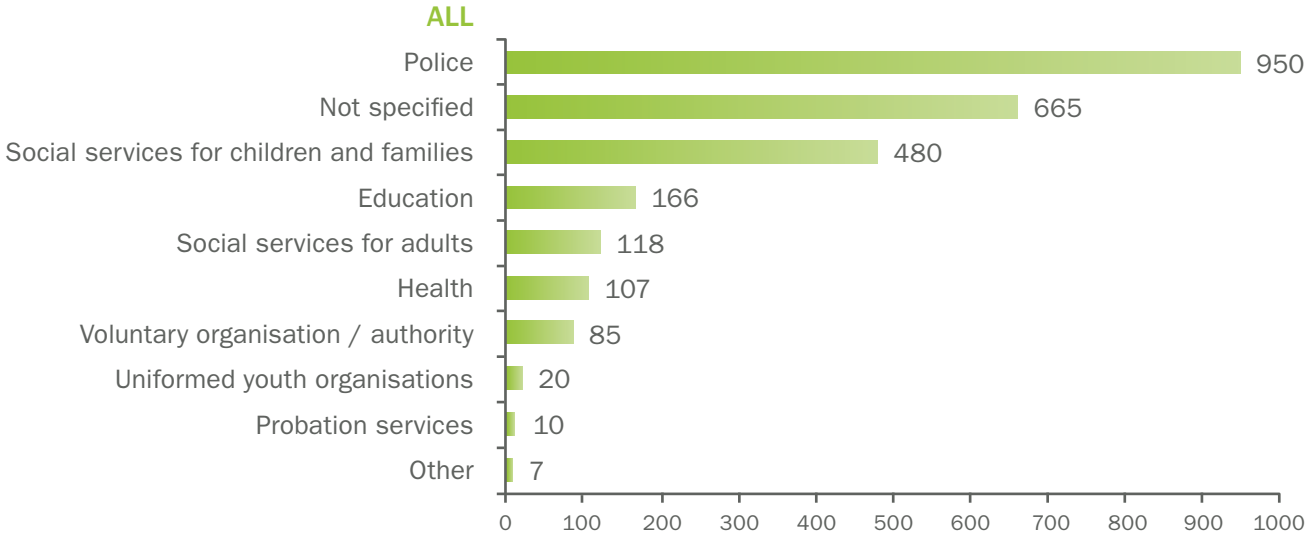
LAY EMPLOYEES

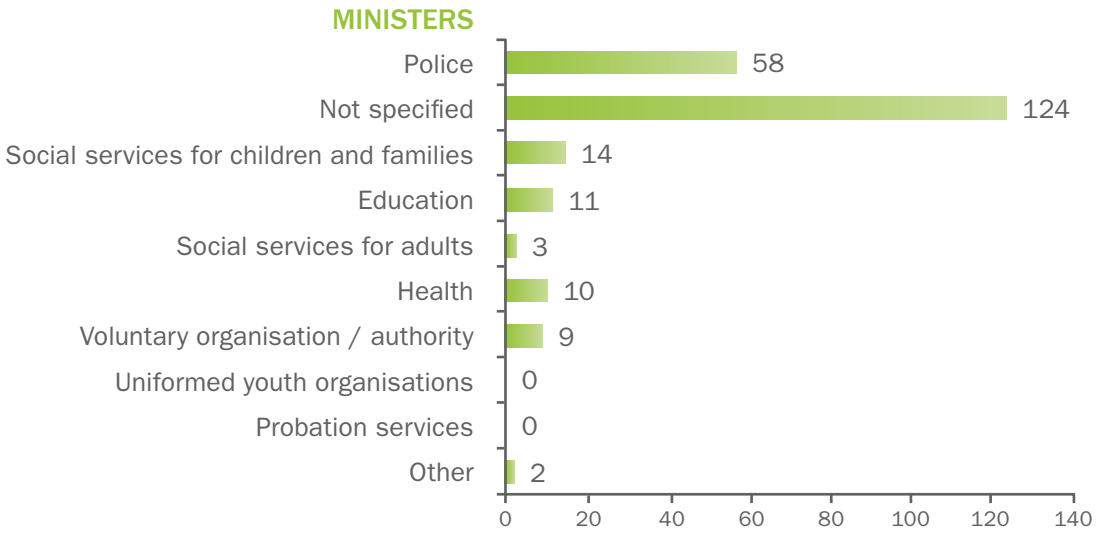


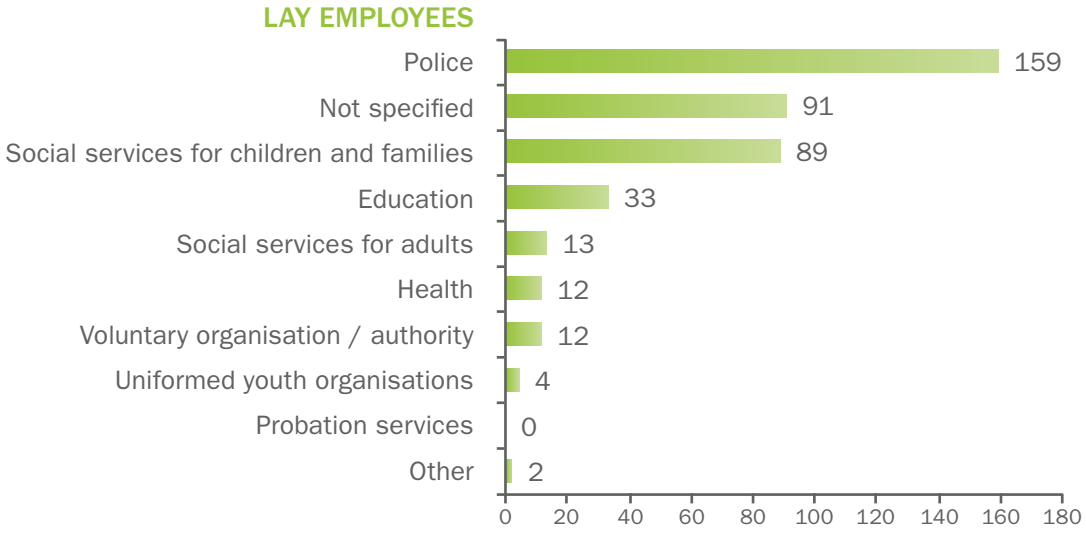
B.4 INVOLVEMENT OF STATUTORY AGENCIES / RECORDS

B.4.1 Involvement with statutory or voluntary authorities:

Note: each individual may have had involvement with more than one of the agencies below

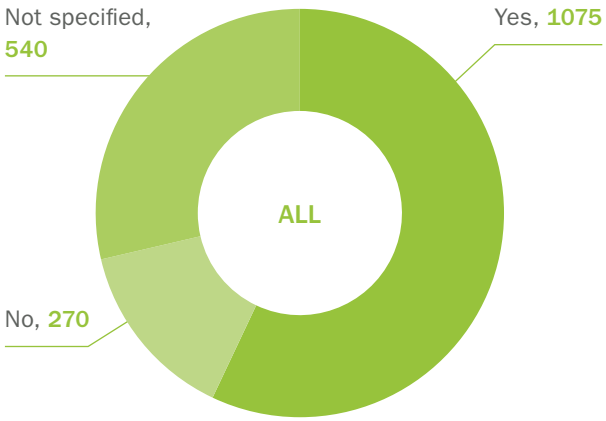






B.4.2 Were records kept?

Yes	1075	57%
No	270	14%
Not specified	540	29%



SECTION C. REVIEW/ASSESSMENT OF INFORMATION SUBMITTED

C.1 RESPONDENT'S ASSESSMENT

C.1.a Assessment from response form – relating to all perpetrators

a. I am left anxious that we did not leave matters arranged safely – there may still be risk to children or vulnerable adults.

b. The Church did a good job in dealing with the risk.

c. The Church locally received good support in dealing with this.

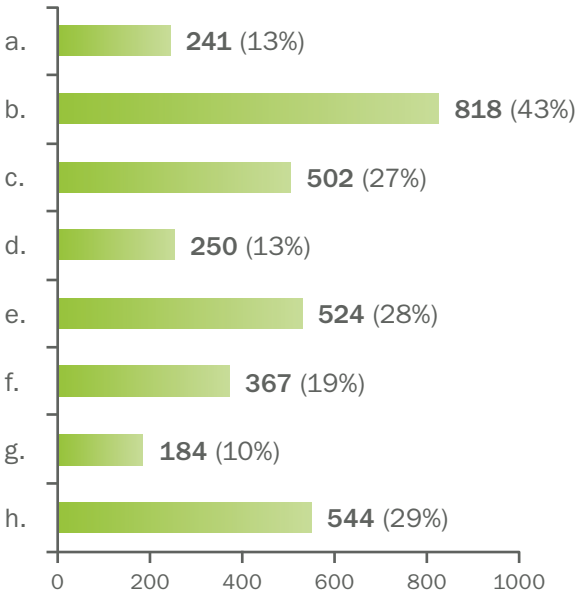
d. The Church recognised the risk but tried to deal with it all internally without making referrals to other agencies.

e. The Church worked well in partnership with the external authorities.

f. It was a very difficult time and the people involved and / or the church community were badly affected by the process.

g. Other.

h. Feel unable to comment.



C.1.b Assessment from response form – relating to MINISTERS

a. I am left anxious that we did not leave matters arranged safely – there may still be risk to children or vulnerable adults.

b. The Church did a good job in dealing with the risk.

c. The Church locally received good support in dealing with this.

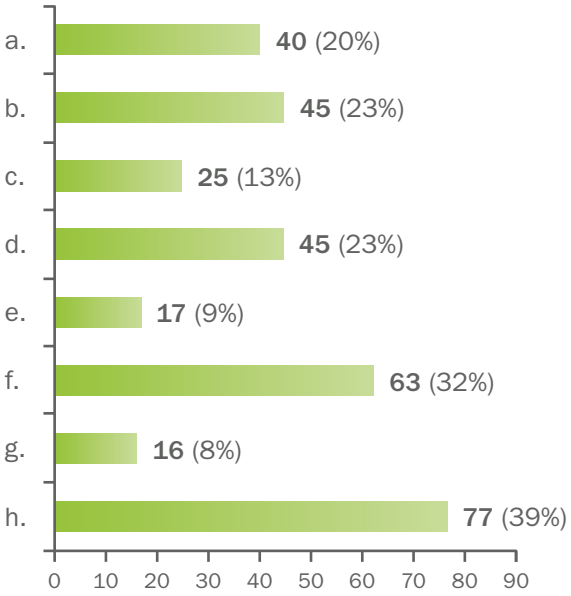
d. The Church recognised the risk but tried to deal with it all internally without making referrals to other agencies.

e. The Church worked well in partnership with the external authorities.

f. It was a very difficult time and the people involved and / or the church community were badly affected by the process.

g. Other.

h. Feel unable to comment.



C.1.c. Assessment from response form – relating to LAY EMPLOYEES

a. I am left anxious that we did not leave matters arranged safely – there may still be risk to children or vulnerable adults.

b. The Church did a good job in dealing with the risk.

c. The Church locally received good support in dealing with this.

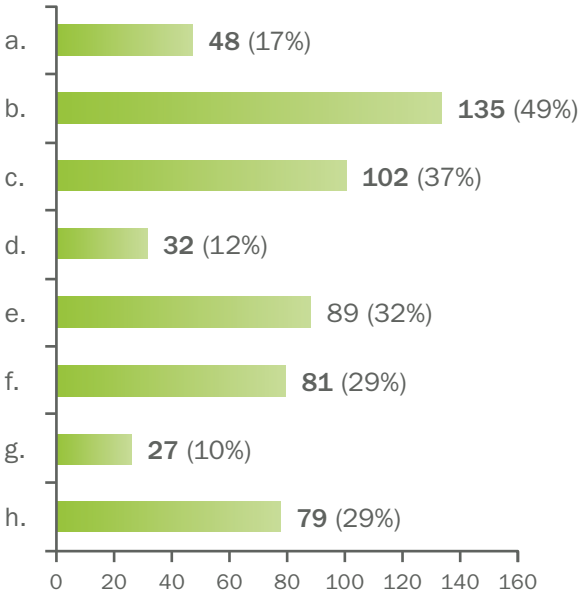
d. The Church recognised the risk but tried to deal with it all internally without making referrals to other agencies.

e. The Church worked well in partnership with the external authorities.

f. It was a very difficult time and the people involved and / or the church community were badly affected by the process.

g. Other.

h. Feel unable to comment.



C.2 REVIEWER'S ASSESSMENT

C.2.1.a Findings from reviewer form – relating to all perpetrators

a. Internal Methodist processes satisfactory and external liaison with statutory authorities satisfactory.

b. Internal Methodist processes satisfactory but external liaison with statutory authorities needs more work.

c. Internal Methodist processes need more work but external liaison with statutory authorities satisfactory.

d. Internal Methodist processes need more work and external liaison with statutory authorities need more work.

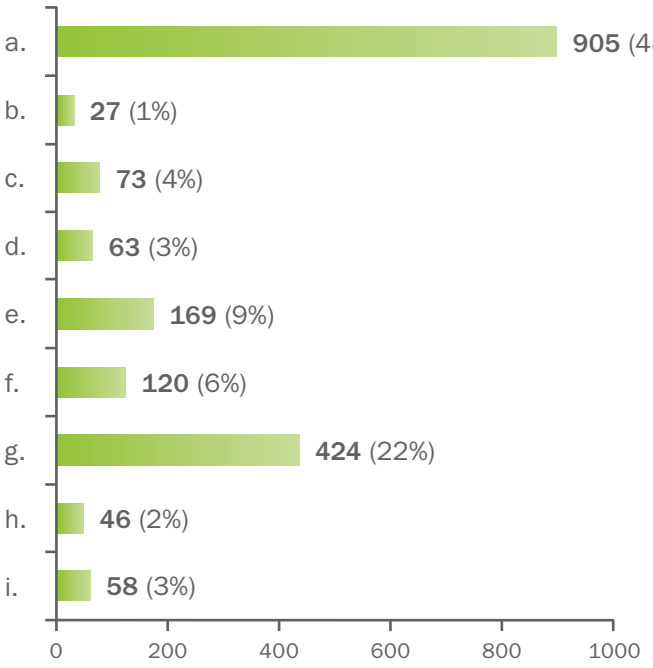
e. Safeguarding processes not in place at time – needs more work.

f. Safeguarding processes not in place at time – no further work needed.

g. Insufficient information available to the reviewer to categorise findings.

h. Internal Methodist processes and external liaison with statutory authorities not satisfactory - but despite this, no further work is currently necessary.

i. Not specified or n/a.



C.2.1.b Findings from reviewer form – relating to MINISTERS

a. Internal Methodist processes satisfactory and external liaison with statutory authorities satisfactory.

b. Internal Methodist processes satisfactory but external liaison with statutory authorities needs more work.

c. Internal Methodist processes need more work but external liaison with statutory authorities satisfactory.

d. Internal Methodist processes need more work and external liaison with statutory authorities need more work.

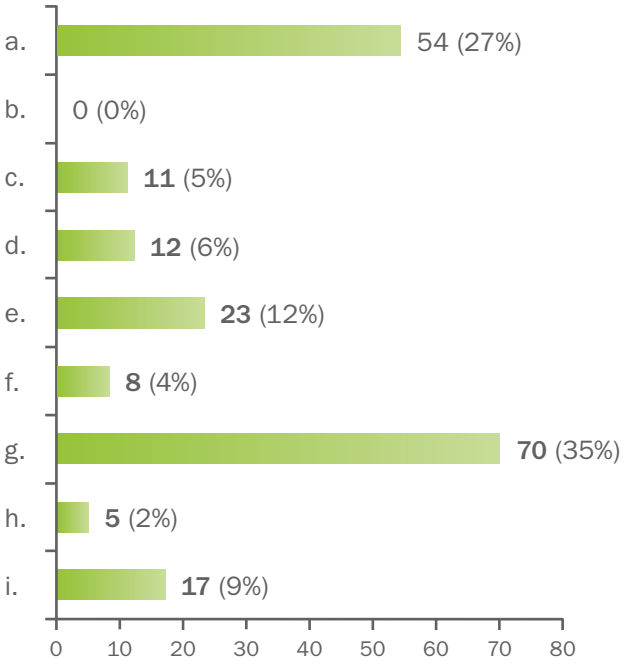
e. Safeguarding processes not in place at time – needs more work.

f. Safeguarding processes not in place at time – no further work needed.

g. Insufficient information available to the reviewer to categorise findings.

h. Internal Methodist processes and external liaison with statutory authorities not satisfactory - but despite this, no further work is currently necessary.

i. Not specified or n/a.



C.2.1.c Findings from reviewer form – relating to LAY EMPLOYEES

a. Internal Methodist processes satisfactory and external liaison with statutory authorities satisfactory.

b. Internal Methodist processes satisfactory but external liaison with statutory authorities needs more work.

c. Internal Methodist processes need more work but external liaison with statutory authorities satisfactory.

d. Internal Methodist processes need more work and external liaison with statutory authorities need more work.

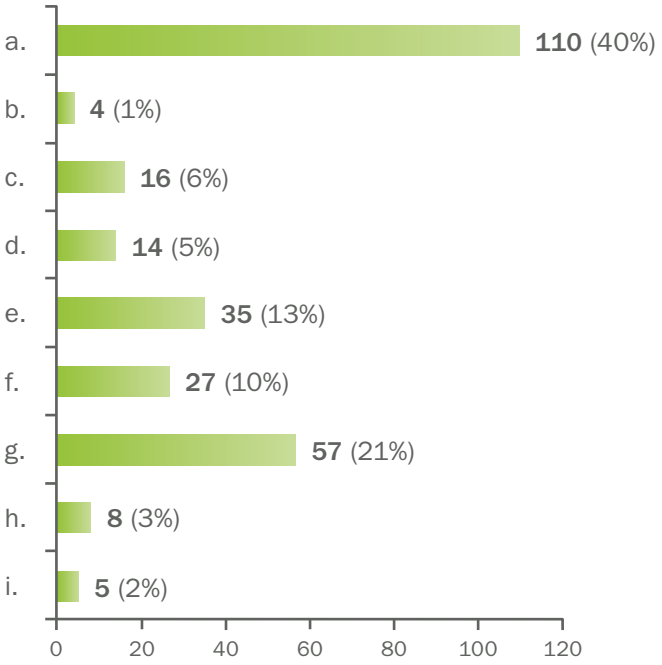
e. Safeguarding processes not in place at time – needs more work.

f. Safeguarding processes not in place at time – no further work needed.

g. Insufficient information available to the reviewer to categorise findings.

h. Internal Methodist processes and external liaison with statutory authorities not satisfactory - but despite this, no further work is currently necessary.

i. Not specified or n/a.



C.2.2.a Priority Grading from reviewer form – relating to all perpetrators

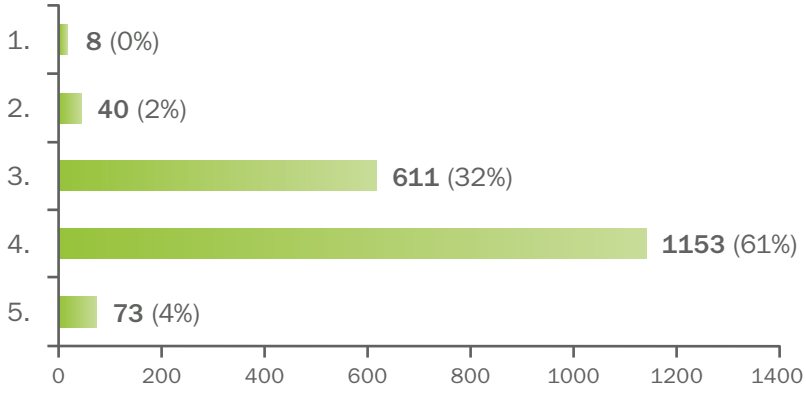
1 – There is immediate and significant concern and an urgent response is required.

2 – There is immediate and significant concern and a planned response is required.

3 – There is concern but further information is required to establish the level of concern.

4 – There is no apparent current concern, irrelevant to the seriousness of the case and/or past risk.

5 – Not specified or n/a.



C.2.2.b Priority Grading from reviewer form – relating to MINISTERS

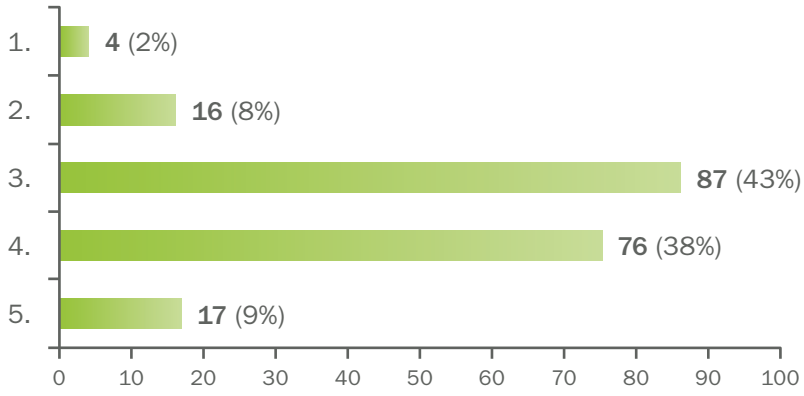
1 – There is immediate and significant concern and an urgent response is required.

2 – There is immediate and significant concern and a planned response is required.

3 – There is concern but further information is required to establish the level of concern.

4 – There is no apparent current concern, irrelevant to the seriousness of the case and/or past risk.

5 – Not specified or n/a.



C.2.2.c Priority Grading from reviewer form – relating to LAY EMPLOYEES

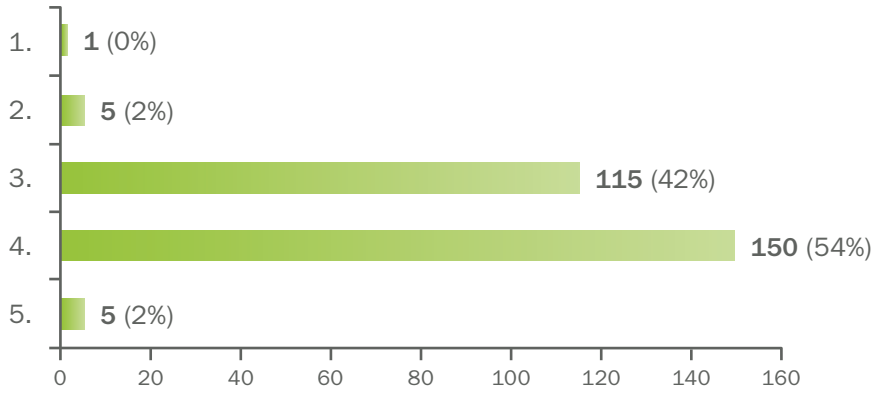
1 – There is immediate and significant concern and an urgent response is required.

2 – There is immediate and significant concern and a planned response is required.

3 – There is concern but further information is required to establish the level of concern.

4 – There is no apparent current concern, irrelevant to the seriousness of the case and/or past risk.

5 – Not specified or n/a.



SECTION D: PAST CASES REVIEW FOLLOW-UP

This section looks at a sample of 503 cases that caseworkers have been allocated and have worked on. Of the cases allocated to caseworkers 83 were relating to ministers and 111 were relating to lay employees.

D.1 RISK ASSESSMENTS

D.1.1 Risk assessment commissioned as result of PCR information

	All	Ministers	Lay employees
Yes	20	3	6
No	335	51	67
To be decided	148	29	38
Totals	**503**	**83**	**111**

D.1.2 Risk assessment already completed on PCR case

	All	Ministers	Lay employees
Yes	9	1	3
No	11	2	3
Totals	**20**	**3**	**6**

D.1.3 Outcome of risk assessment

	All	Ministers	Lay employees
Covenant Of Care	5	1	2
Other safeguarding measure	1	0	0
Other	2	0	1
To be recorded	1	0	0
Totals	**9**	**1**	**3**

D.2 COVENANTS OF CARE

D.2.1 Covenant of Care in place

	All	Ministers	Lay employees
Yes	116	10	35
No	259	45	46
To be determined	136	28	30
Totals	**503**	**83**	**111**

D.2.2 If Yes, was Covenant of Care in place pre/post PCR?

	All	Ministers	Lay employees
Pre PCR	94	6	26
Post PCR	20	4	7
To be determined	2	0	2
Totals	**116**	**10**	**35**

D.2.3 Is Covenant Of Care active/inactive?

	All	Ministers	Lay employees
Active	62	7	19
Inactive	43	3	13
To be determined	11	0	3
Totals	**116**	**10**	**35**

D.2.4 If active was it effectively managed pre PCR follow-up?

	All	Ministers	Lay employees
No	9	2	2
Yes	40	3	14
To be determined	13	2	3
Totals	**62**	**7**	**19**

D.2.5 If inactive had subject died/moved away/other?

	All	Ministers	Lay employees
Died	4	1	1
Moved Away	19	1	7
Other	20	1	5
Totals	**43**	**3**	**13**

D.2.6 If moved away had new location been established and referral on been made pre PCR follow-up/post PCR follow-up?

	All	Ministers	Lay employees
Post PCR	14	1	7
Pre PCR	4	0	0
To be determined	1	0	0
Totals	**19**	**1**	**7**

D.3 STATUTORY AND OTHER AGENCIES

D.3.1 Have statutory agencies been contacted as part of PCR follow-up?

	All	Ministers	Lay employees
Yes	125	19	35
No	221	36	38
To be determined	157	28	38
Totals	**503**	**83**	**111**

D.3.2 Did agencies take further action?

	All	Ministers	Lay employees
Yes	28	9	11
No	91	10	24
To be determined	6	0	0
Totals	**125**	**19**	**35**

D.3.3 Specify outcome: conviction, other

	All	Ministers	Lay employees
Conviction	1	1	0
Other	20	5	10
To be determined	7	3	1
Totals	**28**	**9**	**11**

D.3.4 If conviction please specify

	All	Ministers	Lay employees
Prison only	1	1	0
Totals	**1**	**1**	**0**

D.3.5 Have other agencies been contacted as part of PCR follow-up?

	All	Ministers	Lay employees
Yes	97	7	31
No	216	39	36
To be determined	190	37	44
Totals	**503**	**83**	**111**

D.4 COMPLAINTS AND DISCIPLINE

D.4.1 Complaints process related to safeguarding concern applied

	All	Ministers	Lay employees
Yes	37	18	4
No	251	30	57
To be determined	215	35	50
Totals	**503**	**83**	**111**

D.4.2 If Yes, was it pre/post PCR follow-up?

	All	Ministers	Lay employees
Pre PCR	32	17	3
Post PCR	3	1	1
To be determined	2	0	0
Totals	**37**	**18**	**4**

D.4.3 Outcome of complaint process

	All	Ministers	Lay employees
Upheld	16	11	2
Not upheld	4	2	0
Other	9	3	0
To be determined	3	2	2
Totals	32	18	4

D.4.4 Discipline process applied related to safeguarding concern

	All	Ministers	Lay employees
Yes	60	18	16
No	147	12	29
To be determined	296	53	66
Totals	**503**	**83**	**111**

D.4.5 If Yes, pre/post PCR follow-up

	All	Ministers	Lay employees
Post PCR	4	0	3
Pre PCR	50	17	11
To be determined	6	1	2
Totals	**60**	**18**	**16**

D.4.6 Outcome of disciplinary process

	All	Ministers	Lay employees
Dismissed	16	3	7
Dismissed as Local Preacher then subsequently resigned Church membership	1	0	0
Dismissed as Minister and LP Membership retained	1	1	0
Other	18	7	4
Resignation	18	4	4
Supernumerary inactive	1	1	0
Warning	3	2	0
To be determined	2	0	1
Totals	**60**	**18**	**16**

D.5 SUPPORT FOR THE VICTIM/S

D.5.1 Has the safeguarding worker provided support for the victim/s?

	All	Ministers	Lay employees
Yes	34	13	8
No	412	60	89
To be determined	57	10	14
Totals	**503**	**83**	**111**

D.5.2 If Yes, has it been substantial?

	All	Ministers	Lay employees
Yes	15	3	4
No	16	9	4
To be determined	3	1	0
Totals	**34**	**13**	**8**

APPENDIX 1. PAST CASES REVIEW ROLL-OUT PROGRAMME

Districts in Cluster	Letters sent out	Launch event dates	Deadline for initial returns (4 weeks after launch)
Cluster 1 – Southampton (26), South East (36) 5 past Presidents, 5 past Vice-Presidents (most recent not already covered)	11 February 2013	14 March 2013	12 April 2013
Cluster 2 – London (35)	5 April 2013	7 May 2013	7 June 2013
Cluster 3 – 15 Presidents and 15 Vice-Presidents.	To be contacted with their current district	No launch just correspondence	–
Cluster 4a – Birmingham (5), Wolverhampton & Shrewsbury (28)	2 September 2013	3 October 2013	8 November 2013
Cluster 4bi – Cornwall (12), Plymouth & Exeter (24)	2 September 2013	7 October 2013	8 November 2013
Cluster 4bii – Bristol (7)	2 September 2013	8 October 2013	8 November 2013
Cluster 5 – Nottingham & Derby (22), Sheffield (25), Northampton (23)	w/c 7 October 2013	11 November 2013	13 January 2014
Cluster 6 – Chester & Stoke on Trent (11), Manchester & Stockport (19), Liverpool (18)	w/c 2 December 2013	7 January 2014	7 February 2014
Cluster 7 – Lancashire (21), Cumbria (9), Bolton & Rochdale (6)	w/c 3 February 2014	4 March 2014	4 April 2014
Cluster 7 – Isle of Man (15)	w/c 3 February 2014	29 April 2014	29 May 2014
Cluster 8 – West Yorkshire (27), Darlington (13), York & Hull (29), Newcastle upon Tyne (20)	w/c 31 March 2014	6 May 2014	6 June 2014
Cluster 9 – Scotland (31), Shetland (32)	9 July 2014	9 September 2014	9 October 2014
Cluster 9 – Channel Islands (10)	30 July 2014	30 September 2014	31 October 2014
Cluster 10 – East Anglia (14), Beds, Essex, Herts (34)	8 September 2014	7 October 2014	7 November 2014
Cluster 10 – Lincolnshire (17)	24 July 2014	24 September 2014	27 October 2014
Cluster 11 – Cymru Synod Current and former Secretaries of Conference, Assistant Secretaries of Conference plus other relevant current or past connexional officials.	17 August 2014	16 September 2014	16 October 2014
Initial reviews completed	–	January 2015	–

APPENDIX 2.1 LETTER TO MINISTERS

The **Methodist** Church

Methodist Church House, 25 Marylebone Road, London NW1 5JR

General Enquiries: 020 7486 5502

Email: helpdesk@methodistchurch.org.uk

5th April 2013

Dear Colleague

Methodist Church Review of Past Safeguarding Cases

This letter asks you to complete the attached pro-forma in relation to any safeguarding concern that you have been aware of since 1950 onwards.

The pro-forma needs to be completed even if you have no concerns to submit. Please return your form by 7th June 2013.

In 2011 the Conference supported the plan for the Past Cases Review. You can read the Conference report on-line on the Methodist Church website, follow this link www.methodist.org.uk/pastcasesreview or by asking us for a paper copy by post. More information is available in the attached leaflet, which can also be downloaded from the website along with the Frequently Asked Questions.

A pilot review with all leaders, churches, ministers and safeguarding workers in two Districts (Leeds and Wales) was conducted during 2011/2012. Following this pilot a report went to the Methodist Conference in 2012 and it was agreed that there would be a roll-out of the review, ensuring that lessons learnt were incorporated into the revised design of the review process. Your District is in the second cluster for this process.

This letter comes to you now as the first stage of the national roll-out. You are part of a cluster which includes the London District only. Please note: we ask you for information about *all relevant matters* of which you have had knowledge, and not just matters relating to your current district. This is important as otherwise we would be having to seek repetitive disclosures of information from you.

The Methodist Church historically has not held files for presbyters and deacons. There are Complaints and Discipline files held either at Connexion or at District level. There are files relating to lay employment. There may well be files stored at local church, circuit or district level about particular incidents. We hope to gather in all relevant matters from these resources. Notwithstanding this written documentation, by far the most significant amount of information about the people called Methodists is stored within the memory banks of people like you. That is why we are contacting you to ask for this information to be shared with us.

In addition, we ask that you share news of this progress with your local churches, and encourage anyone who wants to respond to get a copy of the referral form either from you, or from the website.

We ask one more step from superintendent ministers: we have no way of knowing centrally how well any individual supernumerary minister may be. The Conference therefore agreed that rather than us contacting supernumerary ministers directly, you should be asked to have a pastoral conversation with each of them, to share these resources and ask them to participate. Their memories can be important. You should use your discretion about those whom you deem too frail to be asked. Of course, in circuits with large numbers of supernumerary ministers, you may well plan to share out the responsibility for these direct conversations with colleagues.

Do's and Don'ts

There are some important rules here:

- Do take care of yourself in this process. If you have any queries, or would appreciate a pastoral conversation or support because of difficult memories that have been stirred up, then do not hesitate to contact the Safeguarding Team on 020 7467 5189 and arrangements will be put in place.
- Do not withhold anything because you assume someone else is better placed to tell us about it. We would rather be told many times than none.
- Do share all material which is *possibly* relevant even if you are unsure. That way we can sift through centrally and achieve some consistency, rather than each recipient of this letter making individual judgements.
- Do not be deterred because of anxieties about confidentiality. Great care has been taken to ensure that this process respects confidentiality and complies with all Data Protection requirements about the safe storage and proper use of information.
- Do not fear any 'witch hunt' about past decisions made according to different processes and widely different standards. We recognise that the past was often a very different country. The process will not identify any individual, church, circuit or district.
- Do tackle this very difficult subject quickly rather than hoping your memory will become clearer at a later date! We do recognise just how hard it is to be asked to recall such hard matters en bloc – but you will appreciate the importance of the task.
- Do ensure you tell us all you can but do not be deterred because of missing details. All safeguarding work is a jigsaw of information collected from a variety of places. Please just contribute your part of the jigsaw.

So what are we asking?

First, please use the accompanying template to tell us about any safeguarding cases of which you have been aware, dating back as far as 1950 if possible. Please sign and return the attached form whether or not you have information to share. The form advises how to do this securely.

Second, an independent consultant working on the review or a minister working with the PCR team may need to speak with you by telephone.

Third, if yours is one of the cases where further work is needed, then we ask that you cooperate with whatever arrangements need to be put in place – just as you would if a new concern had arisen.

We repeat – this is not an easy or a light request. It is being made because we need to ensure that past concerns have been resolved safely, and that we have learned the good and the bad lessons from the past to make our response now as good as it can be. The Catholic Church leads the way in the courage of some church leaders in responding to these difficulties and we end this letter with a quotation:

A Church which becomes a restorative community will be one where the care of each one of the most vulnerable and most wounded will truly become the dominant concern of the ninety-nine others, who will learn to abandon their own security and try to represent Christ who still seeks out the abandoned and heals the troubled."
Archbishop Diarmuid Martin (April 2011) Archbishop of Dublin and Primate of Ireland

In order to support you with the task of completing the response template there will be an informal meeting on **7th May 2013** at 1:30pm at the Aldersgate Room at the Central Hall in Westminster London. At the meeting there will be background information given, further guidance on completing the template and an opportunity for any questions. You are warmly invited and should receive booking details from your superintendant minister or district safeguarding officer.

Should you have any questions or comment, please contact Mya Rahisi, the Past Cases Review officer, via the Helpdesk at Methodist Church House
Tel: 020 7486 5502 or email Mya via pastcasesreview@methodistchurch.org.uk. Mya will pass your query on to the appropriate person.

Alternatively if you want to contact someone within the District, the relevant safeguarding officer is:

LONDON DISTRICT
Sandra Oborski
E: sfmoborski@gmail.com

With many thanks for your help

Jane Stacey
Past Cases Review Project Manager

Elizabeth Hall
Safeguarding Adviser (Child & Adult Protection) for the Church of England & Methodist Church

Enclosed: Prayer card, Leaflet, Template

APPENDIX 2.2 RESPONSE FORM

CONFIDENTIAL
British Methodist Church
Past Safeguarding Cases Review

PCR Admin use
Ref No:

RESPONSE FORM

Please use a separate form for each situation. It is not possible to stipulate whether or not you as a referrer should seek out adults who have previously disclosed to you, to seek consent. You will need to make this decision based on the individual circumstances. Do seek advice if you need to from the PCR team on pastcasesreview@methodistchurch.org.uk

1. CONTACT DETAILS	
i. Your name	
ii. Address:	
iii. Tel No:	
iv. Email:	
If you do not have any concerns to report please tick (√) this box. Please sign and date at the end of this form and ignore the following questions.	

2. YOUR ROLE WITHIN THE METHODIST CHURCH	
i. When safeguarding concern arose.	
ii. Your current role within the Methodist Church.	

3. IN WHICH BRITISH METHODIST CHURCH, CIRCUIT AND DISTRICT WAS THIS CONCERN LOCATED.

i. if spread across more than one location please give all.
ii. give full details if not in local church but in a different context (as examples only: Methodist Missionary Society, Easter People).
iii. if a Local Ecumenical Partnership, please provide details of the other denominations in the LEP and if possible under the policies of which denomination the matter was dealt with.

4. TYPE OF CONCERN - DELETE *any which* **DO NOT** *apply in this case*
i. Sexual abuse of a child ii. Sexual abuse of an adult iii. Physical abuse of a child iv. Physical abuse of an adult v. Significant emotional abuse or neglect against a child vi. Significant emotional abuse or neglect against an adult vii. Domestic abuse of any kind (remember this can be woman against man, older child against parent, man against man, woman against woman or wider family violence as well as the most usual pattern of man on woman viii. Any other abuse of an adult. This can be financial, racial or institutional abuse of a vulnerable adult. It can also be sexual misconduct of a minister or someone else in a church role of authority, where the relationship with the adult 'victim' has developed from a pastoral bond ix. Accessing abusive / violent / pornographic images on screen - please stipulate where possible, whether these were of adults or children / young people. (Note: sexual / violent images of children and young people are always abusive) x. 'Marital breakdown' where this included domestic violence, or the abuse of children xi. Other concerns. (Please provide details below)
Other concerns detail:

5. INFORMATION ON VICTIM(S) (known or alleged) *It is not essential for you to give the victim's full name, initials will suffice*	
i. Name(s):	
ii. Age when concern occurred:	
iii. Address at time of concern and current:	
iv. Gender:	*Male / Female / Unknown (Please delete as appropriate)*
v. Current Age:	
vi. If the victim is an adult and you think they are/were vulnerable please say why.	

6. **INFORMATION ON SUBJECT / PERPERTRATOR(S) (known or alleged)** *It is essential we have the name of the subject/ perpetrator to help us crosscheck with other responses and link offenders.*	
i. Name(s):	
ii. Address(es) at time of concern and current if known. If you do not know details of current address please give as much information as possible.	
iii. Gender:	*Male / Female / Unknown (Please delete as appropriate)*
iv. Role in Methodist Church at time of concern:	
v. Current Role in Methodist Church:	
vi. Do you think the subject/alleged perpetrator is/was vulnerable and if so why?	

7. **DESCRIPTION OF CONCERN** Please provide as much information as possible answering the questions below if you can.	
i. Date of incident (if relevant)	
ii. Who raised concern, when and to whom?	
iii. What was the concern?	

iv. Who responded to concern and what did they do? *Please include any information on Methodist Church formal process if used eg safeguarding assessment, complaints and discipline.*	
v. What is the situation now? *Do you think anyone is currently at risk?*	
vi. What happened to the alleged perpetrator?	
vii. What support was provided to the victim?	
viii. What records were kept and where?	

8. List any statutory or voluntary authorities that were involved (Give details of location and official name where known.)	
Police	
Social services for children and families	
Social services for adults	
Health	
Education	
NSPCC / NCH / Action for Children, Lucy Faithful / Stop it Now! / MHA or other relevant organisation	

9. Other people involved (include family and close friends if relevant)

10. With the benefit of hindsight, do you feel... (tick any which are appropriate)	
a. I am left anxious that we did not leave matters arranged safely – there may still be risk to children or vulnerable adults.	
b. the Church did a good job in dealing with the risk	
c. the Church locally received good support in dealing with this	
d. the Church recognised the risk but tried to deal with it all internally without making referrals to other agencies	
f. it was a very difficult time and the people involved and / or the church community were badly affected by the process.	
e. the Church worked well in partnership with the external authorities	
g. Other (please explain)	
h. Feel unable to comment	

11. Please identify the lessons you learned from this experience – in particular what worked well and what worked less well.

Name/Signature ..... Date Completed .....

Please return the completed and signed form by email pastcasesreview@methodistchurch.org.uk[1]
or by post ***by Special Delivery*** to:

Past Cases Review / Safeguarding Team
Methodist Church House
25 Marylebone Road
London
NW1 5JR

Thank you for taking the time to complete this response.

[1]***Safe Return of the Information:***

- *The template should wherever possible be completed electronically.*
- *When sending via **email please 'Password Protect' your document***
- *For Password Protect, most Word Processing software has a provision to do this. The method varies for different packages. Ask Wizard or equivalent for help.*
- *If sending Password Protect please DO NOT create your own password. Please use the password that we will now send you in a separate email. (this will avoid chaos when we try to store and open the documents over time)*

APPENDIX 3. OPEN LETTER TO ALL METHODIST PEOPLE

The Methodist Church

The Revd Dr Martyn Atkins
General Secretary
and Secretary of the Conference

Methodist Church House
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The Methodist Church Safeguarding Past Cases Review: an open letter to the Methodist people.

As part of the commitment of the Methodist Church to creating safer spaces the Conference agreed to undertake a Past Cases Review across the Connexion. The remit of the Review is to look at any safeguarding cases connected to the Methodist Church over the last 60 years, involving children and/or vulnerable adults.

The Review has two main aims. First, to take any action that may still be necessary to ensure that children or vulnerable adults are protected in particular situations that are brought to the attention of the review team, and second, to ensure that learning from past cases is embedded in good practice across the Church in the future.

All ministers have been required to participate in the Review and with only a very few exceptions they have already responded with great thought and care.

The perspective of lay people within the Church is crucial however. Lay people often carry information in churches that may not be passed on to ministers, particularly in the past when the importance of recording information was not as well understood as it is now. It is vitally importantly that anyone who has experienced abuse within the Church context has the opportunity to tell their story to the Review.

The purpose of this letter is to remind any person within the Methodist Church of the opportunity to contribute to the Review.

Details of how to participate in the Review and the form to be completed are on the Methodist Church website www.methodist.org.uk. If you are not able to use the internet, response forms are available from the Connexional Safeguarding team by ringing 0207 467 5125 and speaking to the Past Cases Review Administrator.

It can be very difficult to relive painful experiences and there is therefore support available to anyone who wants it. Ministers will be more than willing to support members of their congregation in completing response forms for those who feel comfortable doing it this way. Others may not want to discuss it with someone they know or they may need more specialist help. Every Methodist District has a Safeguarding Officer and their names and contact details can be found on the Safeguarding page of the Methodist Church website. If they cannot help directly they can point people to where they might get the support they need. A list of organisations that offer specialist counselling or help with specific forms of abuse is also found on the Safeguarding page of the Methodist Church website.

In order to ensure that the learning can be analysed and properly presented to the Conference in June 2015, we need all responses to the Review to be received by 24th December 2014.

Yours sincerely,

Martyn Atkins
General Secretary of the Methodist Church and Secretary of the Conference

APPENDIX 4. REVIEWER FORM

PCR Ref No:

PAST CASES REVIEW METHODIST CHURCH 2013/14

Name: Gender: Role: Presbyter / Deacon / Employee / Volunteer / Member / Other Vulnerable: Yes / No / Not known
Category of alleged abuse/concern: Physical / Sexual / Emotional / Neglect / DV / Racial / Institutional / Ritual / Spiritual / Financial Date when alleged abuse/concern occurred: Age of victim(s): u 18yrs / Over 18 yrs Vulnerable adult: Yes / No / Not known Context of abuse: Abuse of church role / By Church Worker not in role / No role but church context / No Church context
Summary of allegations / concerns
Actions taken by the Church and Statutory Agencies
Recommendations for further action / enquiry
Findings: A - Internal Methodist processes satisfactory and external liaison with statutory authorities satisfactory. B - Internal Methodist processes satisfactory but external liaison with statutory authorities needs more work. C - Internal Methodist processes need more work but external liaison with statutory authorities satisfactory. D - Internal Methodist processes need more work and external liaison with statutory authorities need more work. E - Safeguarding processes not in place at time – needs more work. F - Safeguarding processes not in place at time – no further work needed. G - Insufficient information available to the Reviewer to categorise findings. H - Internal Methodist processes and external liaison with statutory authorities not satisfactory - but despite this, no further work is currently necessary.

Priority Grading: On the information available to the Reviewer: 1 – There is immediate and significant concern and an urgent response is required. 2 – There is immediate and significant concern and a planned response is required. 3 – There is concern but further information is required to establish the level of concern. 4 – There is no apparent current concern, irrelevant to the seriousness of the case and/or past risk.
Person referring details for PCR and position held <u>at time of referred incident / concern:</u>
Signed ..... Reviewer Date ..... / ..... / ..... Signed ..... S/G Adviser Date ..... / ..... / .....

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