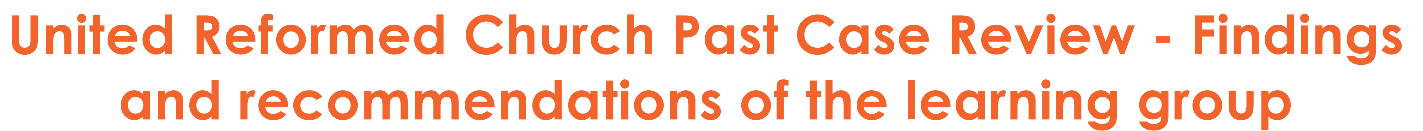

United Reformed Church Past Case Review - Findings and recommendations of the learning group

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This report contains the findings of the learning group. It also reports recommendations on the basis of these findings.

Acknowledgements

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Introduction and Structure of the Report

This report is primarily presented in two sections. The first section provides the background information to the past case review (PCR) in the United Reformed Church (URC) and describes the process. It includes a discussion of the role of the learning group. In the second section the key findings and recommendations are recorded. This section begins with an executive summary. The second section is comprised of two sub-sections. The first focuses on forms of abuse and key issues identified by the review of the cases. The second details complexities, challenges and failures related to documentation, process and response. The report finishes with recommendations for developing a safeguarding culture in the URC, a discussion of the challenges of the synod structure to this development and a summary of recent progress in safeguarding policies and practices in the URC.

Background to the Past Case Review (PCR) (Information for this section is directly drawn from documentation provided by the project manager at the United Reformed Church UCR)

In May 2015, Mission Council instructed the General Secretariat to put in place a safeguarding review and to report progress at each meeting of the Council until further notice. The review applied to both the Roll of Ministers and the Roll of CRCWs. This included all who had been added to the Roll from 1972 to the present. Those who have died were considered, as well as any who may have been removed from the Roll for any other reason during this period (e.g. retirement, resignation, disciplinary action or any other form of removal.) The aim of the review was to ensure that the URC appropriately addressed any cases of historical abuse and examined the processes and procedures at the time of any complaints or grievances.

The review consisted of two stages; Phase One and Phase Two. A summary of Phase one is below.

Phase One – Methodology

Recruitment of readers

Phase One consisted of a team of specialist readers completing a triage of all ministerial records, both held locally in the synods and at Church House. It was planned that the readers nominated from the URC would be paired with independent professionals who had safeguarding experience and were recruited via the Coalition of Survivors of abuse. Despite the efforts of the representative for survivors, who had initially secured five participants, they were unable to provide any independent readers for this stage of the review.

The readers were recruited via the synods and were tasked to read files from a different synod to where they resided or were usually based. The intention was to avoid any conflict of interest from the reader and introduce a level of impartiality; they would only be reading files of people to whom they were not in any way affiliated. To reinforce this, readers were coupled in pairs, with someone from a differing synod. Initially, 37 people were identified as willing participants and then, based on suitability and availability, two were chosen for each synod, totally 26 readers. A further four readers were identified for the review of files held at Church House. An Independent Safeguarding Consultant from the NHS was recruited to review all files which were referred for further scrutiny.

There was a clear person specification provided to identify the type of person who would be deemed suitable as a reader. This would ensure that the people tasked with this duty were of similar experience, ability and decisiveness. Equally these people were expected to have knowledge and experience of safeguarding issues and be highly committed to confidentiality. It was also a requirement that all readers had a satisfactory DBS clearance within the last six months. Where necessary, a new DBS application was completed via the URC.[1]

Brief

The readers had a wide but clear remit; to look for evidence of anyone who has behaved in a way that has caused harm, or who may have harmed a child or vulnerable adult.

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[1] It should be noted that DBS checks for this activity were not required by law but deemed appropriate for this activity by the URC

For the purpose of phase one, the working definition of a safeguarding concern was:

1. Physical, sexual abuse or spiritual abuse of a child or adult

2. Emotional abuse or neglect resulting in harm to a child or adult

3. Domestic abuse or violence of any kind

4. Any other abuse of an adult at risk, including financial and institutional abuse

5. Accessing, viewing, making or distribution of indecent images of children

In addition to the above safeguarding concerns, there were four further key criteria for a case being referred to the independent safeguarding consultant for further scrutiny and assessment;

- Files which suggest papers may have been removed or are missing
- Re-examination of previous investigations and enquiries, including those which when viewed by today's standards would result in other actions
- Poor documentation and/or follow through of recommendations
- Any general concerns felt by the reader

For files which were identified with any of the above criteria, the readers were required to categorise the concern using a matrix and refer as per process for each category;

1. There is an immediate and significant concern and an urgent response is required. Refer immediately. Safeguarding contact at URC to be telephoned, file then scanned and sent via secure email to the Safeguarding consultant.
2. There is an immediate and significant concern and a planned response is required. Refer at end of reading, file to be scanned and sent via secure email to the safeguarding consultant.
3. There is a concern but further information is required to establish the level of concern. Refer at end of reading, file to be scanned and sent via secure email to the safeguarding consultant.
4. There is no apparent concern, irrelevant of the seriousness of the case and / or past risk. Refer at end of reading, file to be scanned and sent via secure email to the safeguarding consultant.

Readers were provided with guidance packs, which had been compiled to provide clear, transparent instructions and expectations. Prior to launch, this pack was shared with CCPAS for consultation and independent review. Any recommendations regarding language and procedure made by CCPAS (Churches child protection advisory service nb CCPAS has recently rebranded to thirtyone:eight) were followed. The reader's pack contained:

- The aim and objective of phase one
- The working definition of a safeguarding case (as above)
- An aide memoire of referral criteria (as above)
- Proformas for readers' assessments, referral form to independent safeguarding consultant and final summary
- Explanation of the categories and process for referral (as above)
- Terms of reference

Referrals

A total of 1556 synod files were examined between October 2015 and January 2016[2]. A total of 54 files were referred for review by the Independent Safeguarding Consultant. Synods, on average, referred four cases for review. Of the 54 referred files, two were deemed as category 1 referrals and required immediate attention. For both of these files, the independent consultant made recommendations that these were immediately reviewed in line with the ministerial disciplinary process and appropriate liaison with external agencies was undertaken. There was one referral under category 2, 30 cases referred under category 3 and 21 under category 4.

A majority of the cases were referred for independent review due to concerns around boundaries or inappropriate relationships and behaviour (61%) and of these cases, 91% were stipendiary ministers. The second highest concern was the inconsistency in the files (42%); the lack of information, the evidence of missing documents and concerns that paperwork had been

[2] Subsequent reviews established that the total number of ministerial files read for the purposes of the Past Case Review was 2563. The report published in November 2018 cited 1556 read in the synods. Additionally, 1007 files were read at Church House and related primarily to those who were no longer on the Roll of ministers and deceased ministers.

removed. In one such case it stated that the synod moderator had removed papers from the file, without detailing when or why this occurred. Other reasons for referral were procedural concerns, financial discrepancies, previous Section O investigations, bullying, avoidance of safeguarding training and domestic abuse.

It is important to note that in a majority of cases, there was more than one reason cited for referral.

Reasons for referral;

- Concern around boundaries, inappropriate relationships, behaviour and bullying - **61%**
- Inconsistency in files, lack of information, evidence of missing documents and concerns that paperwork had been removed - **42%**
- Apparent failure to follow procedure – **18%**
- Previous Section O investigation – **11%**
- Domestic abuse – **5%**
- Financial discrepancies – **3%**
- Avoidance of training – **2%**

The demographic detail of the referred cases was requested on the reader referral form. In some cases, this information was not recorded or only partially complete. In 6 cases, readers did not specify the gender of the minister. In one case, the stipendiary status was not identified and in 10 cases activity status of the minister was not known. In 20% of all referred cases, there was no response as to whether the minister might be vulnerable, although the consensus of response to this question indicates that the readers were unable to determine vulnerability from reading the file alone (64% answered 'not known').

Of the files where the information was provided, the demographic was as follows;

- Stipendiary minister – **72%** Non Stipendiary minister **– 16%** Not recorded **- 12%**
- Active minister – **46%** Non Active minister **– 27%** Retired **– 9%** Not recorded **– 18%**
- Male minister – **81%** Female minister – **9%** Not recorded – **10%**
- Vulnerable – **7%** Not vulnerable – **7%** Not Known **– 64%** Not recorded **21%**

Phase Two Methodology

The material included in this section has been provided by the URC. The second phase of the PCR took place from October 2016 to March 2017. There was an extension to June 2017 to enable more people to report due to low numbers. The URC issued an open invitation for anyone to "raise concerns about the behaviour or conduct of anyone affiliated with the URC since its formation in 1972". The invitation was shared through URC Churches and there was a supporting pack provided including prayers and materials for notice boards and magazines. A church preparation sheet was also provided which gave information on how to respond to a disclosure if it was made within a congregation. The website **www.urc.org.uk/past-case-review** contained additional information. This included a list of pastoral care organisations and more information about each step of the Past Case Review Process. There was also material associated with worship. The material sent to Churches included the name of the URC Safeguarding Officer, PCR Adminstrator and Project manager and an invitation to make contact with any questions. The PCR email address was set up and provided to ensure secure intake of enquiries and safe communication strategies.

A process of recruiting listeners was set up to identify suitable people. Their role was to establish a safe situation in which to provide dutiful and active listening to those who wish to disclose concerns. The listener had to capture the allegation or concern, place this within a structured framework and, alongside confidentiality and data protection guidelines, share information as appropriate. Listeners could decide whether they wish to record the allegations in person or over the telephone and listeners were allocated to cases according to the complainants' preference for contact. Listeners were not to provide pastoral or substantial after care, and it was a requirement that all listeners had a clear enhanced DBS/PVG check within the last six months.

The process for responding to a disclosure was as follows. Firstly, a complaint was received and registered; then the appropriate listener was appointed and worked with the complainant to detail an allegation; that allegation was then examined and deliberated upon by an allegation panel; that allegation was then reviewed, and recommendations made by a specialist or by a reference group. Lastly the allegation was received by the appropriate synod to act and respond accordingly This process was summarised in a flowchart presented to General Assembly in July 2016, reproduced below (from *Book of Reports*, p.17):

Complaint arrives

Complaint registered by PCR team

PCR team allocates listener

Listener receives complainant contacts

Listener and complainant set up safe process for disclosure

Listener and complainant fill out allegation template

Allegation registered by PCR team

Allegation panel called

Allegation panel agrees type and urgency; recommends action

PCR team registers recommendation

PCR team allocates specialist

Specialist consultant assesses; recommends action

Synod Moderator receives case

Statutory agency engaged

Complainant pastoral care set in place

Alleged perpetrator pastoral care set in place

Case process is agreed

Case is handled

Case is closed

Key

Complainant contact

Listening

Allegation assessment

Case handling

Flow chart demonstrating the process of a complaint made during phase two of the PCR

A set of guidelines were sent to Synods to process cases when they had progressed to the stage of being referred to the Synod Moderator. It was noted in the guidelines that they were **not mandatory** as ‘all synods are different in structure and culture’. They were provided as examples of good practice, a means to establish common standards in handling past cases. Synods were asked to use them as a starting point in devising their own pastoral care plans for each case.

Synods were provided with the following information about forming a panel to handle a case.

- Synods need to have a panel in place ready to consider cases. This could be a single group who are intended to handle all cases or, as may be more effective, a larger group from whose number a subgroup can be selected to handle a particular case. This section will assume the latter scenario.
- Careful thought needs to be given both to the composition of the larger pool of people from whom panel members will be selected, and to the composition of a panel to handle a particular case. In the larger pool, there must be a mix of gender, ages, lay/ordained people, and if possible, ethnicities.
- In synods that have a Pastoral Committee (or Group), its members would form a good starting point for establishing the larger pool, and it might reasonably be expected that most of the members would form part of the pool. In synods without such a group, those who handle sensitive pastoral issues would be an alternative source for such people.
- Further sources of pool members will include those experienced in effective handling of church process, such as former synod clerks or some church secretaries
- A further source of pool members will be from ecumenical links within the area of the synod. Some other denominations have taken this question very seriously (especially the Methodists) and others will have local clergy or lay people with relevant experience.
- Once the Synod Moderator receives notification of a particular case, they (or the relevant synod appointee for this role) will need to establish a panel quickly from the pool members. Such a panel might consist of three to five members.

- Just as the larger pool needs to be diverse, so should the particular panel. It is extremely important to have a mix of genders (at least one male and one female member) and lay/ordained people, plus a mix of ages and ethnicities if possible.
- The panel should first meet as soon as possible after appointment, and thereafter as often as required until the case is closed. It may be helpful for synods to agree this in advance with panel members.
- In some Synods it may be appropriate for an office-holder of the synod to chair the panel meetings; others may find this unnecessary and leave it to panels to appoint their own chairs if required. The question should be decided in advance.

Synods were provided with the following information about pastoral support

- Careful and sensitive pastoral support needs to be offered to the alleged victim (the complainant). As discussed in paragraph 2.8, people may be very damaged by their experiences, and in some cases may experience the denomination as having being unhelpful or unsupportive in the past. Notwithstanding the difficulty of their experiences, the alleged victim may be (or have been) an active church member, without their experiences being widely known. It will be up to them whether, and when, any public discussion of their experiences happens.
- Equally careful and sensitive support needs to be offered to the alleged perpetrator, if that person is still alive. The alleged perpetrator may have served the church faithfully for many years, and they remain a child of God; however serious the allegations, they also require support.
- Either or both of these people may additionally have family members who have been affected by the alleged abuse or other misconduct, and it is possible that they too will require some degree of pastoral support.
- It is possible that either the alleged victim or alleged perpetrator may no longer live in the synod, and in this case support that is local to that person will be necessary.
- Pastoral support mechanisms for all people should continue for as long as necessary, potentially after the closure of the case.

- Those carrying out pastoral support should be selected with care for their experience and wisdom of pastoral matters. They will normally be part of the pool of potential panel members, and should either form a full part of the panel or meet with it regularly.
- It may be appropriate to contract in therapeutic counselling.

Synods were provided with the following information about establishing a process for investigation and action

- By the time a case reaches synods, it will have already been considered by an allegation panel, which will have formed a recommendation which in turn will have been reviewed by a specialist consultant (and statutory bodies will have been brought in, if appropriate). Thus the case will be received in the synod with a recommendation for action, including when to inform an alleged perpetrator.
- Synods however have to be able to own this recommendation and be prepared to implement it. Thus they will need to decide to what extent the panel will need further information and investigation.
- The synod investigation stage may reveal local knowledge which will bring further insights and potentially additional 'evidence', which could increase the severity of the alleged abuse or other misconduct (e.g. if others have suffered similarly) or could diminish it (if there are known mitigating circumstances which had not come to light).
- Synods will need to decide in advance whether the whole panel will be involved in investigating the case further, or whether some of their number will be delegated.
- Synod panels might usefully consider the following questions:
    - Who else do you need to speak to, to get a fuller picture?
    - Have you talked to people in the local church communities of the alleged victim and perpetrator, insofar as it is possible to do discreetly?
    - How confident are you of the facts of the case?
    - Do you need to know more to understand the recommendation and its implications?

    - Is there any reason not to proceed with the recommendation that has come to the synod?

- It may transpire that there are issues with the recommendation that has been received, or particular ways in which it needs to be implemented. However careful thought will be needed to decide what to do if the synod feels that a very different course of action is appropriate, and this could usefully be established in advance of any difficult decisions being required.

- The following guidance is part of the URC Human Resources complaints procedure, and may well be helpful to synods in establishing a way of carrying out their investigations:

    - Meetings should be conducted in a calm and objective manner. One individual should effectively act as the Chair and be ready to suspend or discontinue the meeting should the mood not be constructive.

    - Investigators should limit their investigations to establishing fact and not seek to express any opinions. This should be made clear at the start of the meeting.

    - The complainant should be helped to understand that complaints must be specific and relevant before they can be investigated effectively.

    - The complainant should also be helped to understand that the synod does not have the means to sanction all undesirable behaviour and for some issues it is the local church meeting that will need to act or for some matters there may be no effective sanction.

    - There is no requirement that people making statements should have a companion or friend with them. It is up to the investigator whether they permit this. However, any child or vulnerable adult must always be accompanied by a parent or other responsible adult.

    - All meetings should be documented, and the parties present should be asked to agree the minutes of that meeting. The minutes do not need to be verbatim but should include the salient points and comments. Agreed minutes should be circulated to the relevant parties.

- Once a course of action has been agreed by the synod panel, a process of putting that action into effect will need to be decided, and in particular who will carry it out and how it will be communicated to relevant parties. In many cases it will be helpful to carry out the action swiftly, but not in all cases.
- It may be appropriate to allow for an appeals process as part of the investigation and action. Typical grounds for appeal would include: the facts as recorded were inaccurate; or the procedure followed was inappropriate; or the conclusion was perverse. A process for appeal will need to be established, including who will hear the appeal. This may or may not be able to take place within the synod.

The following information was provided to Synods about establishing a process for resolution.

- Once an action has been decided upon, the case will still need to be resolved, in ways that allow everyone involved to feel that they have achieved as much closure as may be possible.
- The way in which the resolution process needs to occur will depend a lot on the action decided upon. In some cases, the action may be unsatisfactory to the alleged victim, not least because the church may be unable to rectify the harm done. The best that can be achieved in this case may be to help the alleged victim to come to terms with their situation, and to offer them whatever pastoral care they require appropriate.
- Panels should give serious thought as to whether reconciliation between the alleged victim and alleged perpetrator would be appropriate and helpful, not possible, or actively unhelpful.
- Thought should be given to one or more acts of worship to enable those involved (which may or may not include both the alleged victim and alleged perpetrator) to find peace, and to seek God’s love and guidance. Resources are available on the URC PCR web pages to help with such acts of worship, and material may also be available from other denominations or ecumenical bodies such as the Iona Community.
- Ultimately a point will need to be reached where the case can be declared closed, so that action has been taken and all involved reached some degree of emotional and

spiritual closure. This is an important procedural stage, but it is just as important for the wellbeing of those involved. At that stage the panel can be stood down.

- However, it must be recognised that for the alleged victim and possibly the alleged perpetrator, ongoing emotional pain will remain. In this sense resolution and closure is an ongoing process, not a stage. Synods need to consider whether they can offer ongoing pastoral care once the case is formally closed, and if so how it is offered, and whether it has time limits. It is possible that the local church will provide such care, but in no way can this be assumed.

Phase Two Referrals

In total 27 persons approached the URC and disclosed their complaints and concerns during Phase two of the PCR. This was substantially lower than may have been anticipated from previous PCRs and national statistics of abuse despite the extension from March to June 2017. Of the 27 enquiries, eighteen were identified as meeting the requirements of the review process. After three decisions for withdrawal made by the complainants, a final number of 15 cases went through the PCR process.

The Learning Group

The learning group consists of four members. Two members are internal to the URC and two are independent external safeguarding experts. The purpose of the learning group was not to act as investigators or case workers but rather to review all cases and to identify problems and challenges and on the basis of a systematic review to make recommendations for future safeguarding practice in the URC. As detailed in the background section, the files had already been reviewed by expert readers to identify any outstanding safeguarding issues. The learning group's objective is to support the URC towards a positive approach to safeguarding in the future and to establish more robust systems and procedures.

The learning group reviewed all available files from stage one and stage two of the PCR. Members reviewed files independently and then met to discuss the reflections and recommendations. There were three meetings in total the first on 7th February 2017 as an initial meeting led by the project manager to explain the purpose of the learning group and the process that had been undertaken by the URC to date. The second meeting took place over

two days in June 2017. At this meeting members discussed the work they had undertaken in reviewing the files and their preliminary findings. It should be recorded that at this time there was considerable difficulty in accessing papers relevant to the PCR. These difficulties were in terms of navigating through the systems to access the documents and connecting documents related to the same case. Some files had multiple copies of the same documents, whilst others had missing material. However, the learning group had been able to work through a number of cases and it was clear from detailed discussion of cases that there were repeated messages appearing and these have underpinned the interim report submitted to the URC.

Following this meeting the learning review group requested that the files were collated in a manner that would allow members of the learning group to be able to connect all files related to a specific case/individual. Work was conducted and in February 2018 files were made available for review. The ordering had significantly improved but it was still challenging to collate files. Different numbering of the same case restricted clarity. The learning group met again in April 2018 to review the files and findings. At this meeting the learning group requested to see the outcomes of all cases that had been graded a level 3 – in need of further action. However, this request was not actioned fully due to the Synod structure of the URC[3]. Synods were responsible for signing off their cases and the learning group was informed that it was not felt appropriate to ask for these files. The learning group was able to review the closure of 11 out of 18 cases from stage 2 of the PCR. Therefore, this report is based on files up until the expert reader made their evaluation and only on 11 cases to their completion. Of these 11 cases there were several that were unable to be verified as closed. This is due to the responsibility for these cases residing with Synods. The synod structure of the URC can sometimes present challenges in terms of the safeguarding process. As synods govern themselves, they cannot currently be required to report back. Therefore, there are some difficulties with establishing actions taken and case closure.

It is important to read this report recognising the constraints within which it has been written. The learning group have not been able to review most cases to their completion and

[3] Subsequent to the report being submitted we were informed that in fact it was the misplacing of files at Church House that prevented us from reviewing them for phase 1 rather than this being due to Synod structures.

documentation and collation of files presented considerable difficulty for the task of systematically reviewing and making recommendations.

The report considers safeguarding of both children and adults but the learning review group recognise that work around safeguarding adults has only relatively recently been a focus across churches.

Good Practice

This report focuses on the learning from reviewing the files on record. Predominantly, it provides a review of the limitations and in some cases failures to respond, report and record appropriately cases of abuse. However, it is important also to note good practice. The learning group has noted that in some cases there was effective response and action taken following disclosures of abuse. In two of the cases the group saw to completion there was evidence of excellent fast response and action following a disclosure. In these cases, care and attention had been paid to ensuring an effective process was in place to support and work with the individual disclosing in order that their needs were thoroughly understood and responded to. There was evidence of individualised care. These cases were appropriately referred on and there was evidence of the offer of counselling and in one case a personal apology. These examples of good practice should be used by the URC as models for any further cases of abuse disclosed.

Additionally, the learning group would like to put on record the excellent work conducted by the expert readers in collating material and writing considered and helpful reflections and recommendations.

Survivor Consultation

The information in this section has been provided by the URC. Survivor organisations were contacted from the early stages of the PCR phase one, these being the Church Reform Group and Minister and Clergy Sexual Abuse Survivors (MCSAS) and the Lantern Project. It appears that a model for the URC PCR was proposed by the Church Reform Group that would ensure direct involvement of survivors on the process of the PCR. However, it seems that a lack of trust and established partnerships, time feasibility and financial implications influenced the choices at the initial stages of planning the PCR process and the ongoing engagement with

survivors' organisations, such that this model was not adopted. Survivor organisations were approached and asked if they were willing to become listeners or readers or members of an advisory group, however even though considerable effort was made to engage survivors, the URC has concluded that no one came forward to volunteer.

It was also of concern to the URC that the preferred model was to work directly with survivors rather than through survivor organisations (although it should be noted that many such organisations have staff who are themselves survivors).

In phase two of the PCR survivors, who disclosed complaints were directly asked for their consent for this information to be shared. It is difficult to map out any other survivor involvement in phase two of the past case review as these cases were managed by synods and the URC structure does not require information to be shared centrally.

Therefore, there is evidence that the URC sought to engage with survivors and to include them in the PCR process. However, it should be recorded that the PCR had limited survivor engagement. It will be of great importance moving forward that survivor engagement and consultation is achieved as part of the future development of safeguarding practice in the URC.

Cultural and Historical Contexts

Before commencing the reading of the key issues and recommendations it is important to understand the cultural and historical lens (Burr, 2003) through which material is being read. That is to say that current understandings of safeguarding are shaped by our cultural and historical positioning. When reading the material, the learning group was cautious to identify key learning points from cases, whilst understanding the historical and cultural contexts in which initial decisions and recommendations on cases were made. Understandings of safeguarding have developed considerably over recent years. This is not to excuse any abuse experienced. Any experiences of abuse are harmful and must be responded to. However, the learning group recognises some of the responses and policies evidenced in the files are not current practice and have reflected on this accordingly.

Executive Summary

The learning review contains the key issues and recommendations for the United Reformed Church following the Past Case review. There are two key areas of focus. The first is on types of abuse and key issues identified by the learning group followed by recommendations for future practice. The second area is that of documentation, process and response. In both areas significant concerns and limitations were identified and the recommendations in the report seek to suggest how these may be addressed.

Types of Abuse and Development Needed.

The files contain evidence of cases of sexual abuse and neglect of children, sexual abuse and inappropriate behaviour, domestic violence and abuse, financial abuse and spiritual abuse of adults and lack of awareness of vulnerability and mental health.

The review identified a need to develop policy, practice guidance, support and training across all forms of abuse but specifically around the issues of domestic violence and abuse, spiritual abuse and financial abuse. It is suggested that work with survivors must underpin this development. Establishing and maintaining boundaries and understanding mental health and vulnerability should also be part of this development work.

Safeguarding Definition and Threshold

The review identified confusion over what constitutes a safeguarding concern and where the threshold is. There needs to be a clear definition and threshold for a safeguarding concern and standardised mandatory safeguarding training for those working with children, young people and adults at risk of harm. Survivor consultation in the development of training is essential.

There seems some disconnection between safeguarding and disciplinary processes. It is suggested that a new disciplinary process be developed, which prioritises safeguarding. As part of this mandated groups should be reviewed to ensure appropriate selection and training and the opportunity to build experience of cases.

Documentation, Process and response

There were many issues related to documentation, process and response. The quality and standardisation of record keeping was generally poor. There is evidence of inappropriate response, lack of action following disclosure and failures to refer to statutory agencies or to identify or monitor appropriate follow-up action.

A standardised record keeping system is required, with universal templates. The learning group recommends that the URC should move towards a centralised electronic records system over the next five years. Record keeping must include decisions made, actions required and identify the individual responsible for ensuring these have been undertaken. It must also include records of support offered and taken by victims. Additionally, more effective referral processes are required with greater relationship with statutory agencies.

Developing a safeguarding culture

Overall the URC should focus on developing a safeguarding culture where theology, teaching policy, practice guidance and training underpin a discourse of preventing abuse and effective response and support for victims. Consideration should be given to safeguarding transcending synod structures such that it can be standardised and centralised

KEY ISSUES AND FORMS OF ABUSE IDENTIFIED IN THE REVIEW

Sexual Abuse and Neglect of children

There are some accounts of sexual abuse of children in the files, the harmful and lasting impact of these experiences is very clear. It should be noted that the number of cases is smaller than that which would be anticipated, based on reported prevalence rates in the general population and past case reviews in other denominations. This raises the issue of if strategies used to publicise the PCR have been far reaching enough. It should be anticipated that new cases may arise once the PCR findings have been shared in a public format and these cases must be appropriately responded to, those disclosing should be offered support and the opportunity for learning must be extended to include any cases that are reported after the publication of the report from the learning review.

Some of the cases of sexual abuse involve multiple victims and repeated incidents of abuse. There is evidence that children tried to share their stories, but these were not acted upon or believed at the time of disclosure. In at least one case this failure to act upon a disclosure led to further victims of the same perpetrator. A number of these cases were non-recent. Non-recent cases often included lack of understanding about child sexual abuse and inappropriate response. In some of these cases ministers were allowed to return to ministry or to resign ahead of investigation.

In addition to cases of sexual abuse there are also some cases of neglect on file.

Recommendations

- **Disclosures of child abuse must be responded to appropriately and children must be supported through this process.**
- **All disclosures of alleged child abuse must be reported to the safeguarding lead and the URC policies and processes must be followed.**
- **Safeguarding training must ensure that all individuals working with children and young people understand the processes and policies of the URC. Additionally, those involved in such work must be aware of the necessity of referring cases to the safeguarding lead and not attempting to make decisions themselves. (It may be helpful to access sections 11 and 12 of the Good Practice handbook for**

Churches[4] and material on responding to allegations of abuse[5] and supporting a child who has been abused[6]).

- **Whenever an allegation of child abuse is made referral must be made to the appropriate statutory services and a full investigation must take place.**
- **Thought must be given to further cases of child abuse which may be reported on the publication of the past case review findings. It will be essential that these cases are responded to effectively and that any further learning from these cases is captured and incorporated in the development of good practice for the future. The URC will need to construct a process model to ensure further learning continues to inform the development of safeguarding policy and practice.**
- **Resignation of a minister cannot prevent the full investigation. The learning group recognises that this would not be allowed to occur now and that procedures have been put in place such that an investigation would continue even in the eventuality of a resignation.**

Domestic violence and abuse (DVA)

There are cases of domestic violence and abuse documented in the files. In some of the cases the behaviour reported does not appear to be recognised as abuse or to be responded to effectively. There seems to be a lack of robust policy and procedure in the area of DVA. In some cases, the response to disclosures appears to be victim blaming or involve minimisation of the abuse. In one case there is an assumption that the allegation of DVA is malicious but there is no evidence to **support** this. In some cases, there appears to be an issue of collusion rather than acknowledging the issue. In one case there was an allegation of domestic violence and the alleged perpetrator was allowed to resign and then commence work for another organisation.

[4] https://urc.org.uk/good-practice-policy-and-procedures.html.
[5] http://files.ccpas.co.uk/documents/05_HL_Allegation_Of_Abuse.pdf
[6] http://files.ccpas.co.uk/documents/20_HL_Supporting_a_child_who_has_been_abused.pdf

There is a tendency across files to believe a minister's accounts of events. Again, a number of these cases were non-recent and understandings and awareness of DVA have developed. However, this does not diminish the harm caused to the victims of DVA reported in the files.

The learning review group would like to emphasise the difficulty associated with disclosing DVA in a ministerial family. This is a highly complex and challenging issue for victims. There may be multiple consequences of this decision including personal safety, impact on children, financial and practical issues (i.e. housing). Further, the perceived impact on the local church community may be another barrier to disclosure. All these factors need to be better understood to promote a safeguarding culture in which disclosure of DVA is clearly supported and responded to effectively.

Recommendations

- **Policy, training and practice guidance about domestic violence and abuse must be developed and implemented at all levels of the URC. This must include discussion of male victims, child on adult DVA and DVA in same sex relationships.**
- **Understanding about domestic violence in the church must be developed in order to ensure better response to victims. Recent research by Restored about Cumbria, 'In Churches Too', explores the issue of DVA in Church and presents findings and recommendations and it is advisable for the URC to access this material in order to develop effective safeguarding practice in this area[7]**
- **Support needs to be developed for ministers and ministers' partners who are experiencing DVA, arrangements for housing, income etc must all be considered. Ministers and ministerial families are often isolated, and this must be recognised in the development of effective support.**
- **Careful consideration must be given to URC practice when an individual who is alleged to be involved in domestic violence seeks employment outside of the URC.**

[7] https://restored.contentfiles.net/media/resources/files/churches_web.pdf

Spiritual abuse and bullying

There are a surprising number of cases on file of behaviour that could be described as spiritual abuse[8] and other cases of bullying behaviour. The cases on file demonstrate victim blaming or accusing the individual of being a troublemaker, controlling through finance, anger issues of the perpetrator, cruelty to church members, individuals becoming stressed when challenged and being unable to deal with conflict.

Those disclosing the behaviour report being fearful and in one case in fear of their life and intimidation. There is evidence of significant damage to victims and victims feeling sidelined and punished.

The files demonstrate multiple victims of some perpetrators and sometimes the individual is moved to another synod. There is evidence that cases of spiritual abuse and bullying were often not fully investigated or followed up. In other cases, those disclosing the abuse were asked to attend voluntary reconciliation or facilitated discussion. In one such case the allegation was shared with the individual accused without the knowledge of the person making the disclosure.

The files also evidence cases where ministers are bullied significantly by members of the congregation or other ministers. Evidence shows that abuse of ministers and elders is often hidden and difficult to disclose.

Recommendations

- **A detailed understanding of spiritual abuse and bullying needs to be developed in the URC. This should include consideration of the distinction between unhealthy behaviour, bullying and spiritual abuse.**

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[8] Spiritual abuse is a form of emotional and psychological abuse. It is characterised by a systematic pattern of coercive and controlling behaviour in a religious context. Spiritual abuse can have a deeply damaging impact on those who experience it.

This abuse may include: manipulation and exploitation, enforced accountability, censorship of decision making, requirements for secrecy and silence, coercion to conform, control through the use of sacred texts or teaching, requirement of obedience to the abuser, the suggestion that the abuser has a 'divine' position, isolation as a means of punishment, and superiority and elitism (Oakley, 2018)

- **Policy, practice guidance and training should be developed around the issues of spiritual abuse and bullying. Clear guidance on when these issues cross the threshold to a safeguarding concern should be included in safeguarding policy and included in disciplinary policies.**
- **Any allegation of spiritual abuse or bullying must be thoroughly investigated and taken seriously. The URC needs to ensure that bullying or controlling behaviour is addressed and not minimised**
- **The power dynamic at work in bullying and spiritual abuse must be recognised such that it is not appropriate to suggest voluntary reconciliation or facilitate discussion where abuse has occurred.**
- **As with other forms of abusive behaviour allegations should not be shared with an individual who is accused without the knowledge of the individual who raised the complaint.**
- **Consideration must be given as to how to address these issues with perpetrators. As understandings of spiritual abuse are still emerging it is possible that individuals will be unaware of the impact of their behaviour on others. They may have established patterns of behaviour which have not been challenged previously. Therefore, attention must be paid as to how to challenge or discipline an individual for such behaviour.**
- **In developing policy and procedure consideration must be given to ministers, elders and moderators as possible victims of spiritual abuse and bullying.**

Inappropriate boundaries/relationships and behaviour

There are many cases reported on file of inappropriate relationships, behaviour and boundary crossing between ministers and members of the congregation. The learning group reflected on whether all of these cases constitute safeguarding concerns. A consenting relationship between two adults may constitute a breach of professional conduct for ministers but not necessarily cross the threshold into a safeguarding concern. However, it is also important to recognise the balance of power in relationships and the responsibility of those holding ministerial positions to ensure they do not misuse them.

Some of the cases on file report relationships between ministers and adults who may be considered vulnerable or at risk of harm.

There is at least one case of inappropriate behaviour towards a minister, which presents very challenging circumstances for the minister.

Recommendations

- **There needs to be a clear threshold for when an issue becomes a safeguarding concern. There may be consideration of inappropriate relationships as going against the ministerial code, but this is different from a safeguarding concern.**
- **Generally, the learning group would recommend that the URC consider the definition and understanding of a safeguarding concern and delineate these from matters of ministerial conduct that do not cross safeguarding thresholds.**
- **Further clarity is needed about how to define consensual relationships.**
- **The power differential in relationships must be recognised and the responsibility of a minister to ensure they do not misuse their position. This raises issues of establishing clear boundaries in ministry around appropriate relationships. These issues could be considered in safe spaces under protecting self and others.**
- **Work around boundaries should also include a focus on working with adults who are vulnerable/ at risk of harm.**
- **Consideration should be given to how to protect and support ministers who find themselves experiencing inappropriate behaviour from congregational members. This raises a larger issue of ministers having a safe space to raise concerns which can be responded to in a non-judgmental manner.**
- **The learning group suggests ongoing systematic pastoral supervision is needed for all ministers and that this should not be an opt in process but a standard part of ministerial life. This could be combined with a clear code of conduct for ministers.**

Gender

Many of the cases of inappropriate behaviour raise the issue of gender, how this is constructed, understood and responded to within some Church contexts.

Additionally, there is evidence in the files that some allegations made by females are more likely to be dismissed or seen as unsubstantiated. This is especially the case where the complainant is also vulnerable in some way.

Recommendations

- **Mandated groups and section O committees need to be trained to ensure that gender bias does not result in cases being minimised or dismissed.**
- **Gender assumptions in decision-making should be challenged by individuals in the relevant committees.**

Financial abuse

There is some evidence of financial abuse in some of the files on record. In one case the individual in charge of finance for a church is reported to use this position as a means of controlling the minister.

Recommendations

- **Safeguarding training should include the topic of financial abuse and fraud**
- **Developing an understanding and awareness of financial abuse and fraud is essential in order that the URC is better equipped to support its members.**
- **It is important to understand that finance can be used as a means of control, and that ministers can also be vulnerable to this form of abuse.**

Bournemouth University have undertaken a wide range of work on financial abuse and scamming and have free downloadable material that could be accessed as part of training and development in this area. [9]

[9] http://www.ncpqsw.com/publications/scamming-definitions/

Financial issues and ministerial wellbeing

In some of the files there is concern registered about the financial difficulties encountered by URC ministers. Although this is not a safeguarding issue as such it is an issue that should be considered as part of the well-being of ministers. The learning review group notes that there is consideration of financial issues on entry to ministry and that all ministers are paid the same amount and can choose to live in a manse, which most choose to do. However, guidance on managing finance and borrowing should be included in ministerial training. The financial challenges of ministry are recommended to be considered by the URC and reviewed with ministers as part of supporting ministerial wellbeing.

Vulnerability and mental health

There is evidence in a number of files of a lack of understanding about possible vulnerability of individuals and limited awareness of mental health issues. There are a number of cases where there is an inappropriate response to mental health issues. In at least one case on file there is evidence of inappropriate sexual behaviour towards an adult at risk of harm. There is an additional case where a vulnerable adult appears not to be believed as an allegation appears to have been dismissed due to their vulnerability. Risk assessment and management of risk to self and others seems noticeably absent in many cases.

Additionally, there is evidence that the mental health of ministers must be considered as part of an ongoing concern for their well-being.

Recommendations

- **There should be training about vulnerability, adults at risk of harm and mental health issues as part of the safeguarding training delivered in the URC.**
- **Risk assessments may need to be completed for individuals who pose a risk of harm due to mental health issues**
- **Consideration must be given to how to better support individuals attending URC churches who have mental health issues.**
- **Consideration should also be given to the support of ministers who experience mental health issues.**

- **All allegations of abuse should be taken seriously, vulnerability or mental health should not negate an effective response to an allegation. Allegations of abuse should be referred to the appropriate statutory and professional services.**

Responding to and supporting victims

There is evidence that some victims of abuse felt silenced or were unable to tell their story or express their emotions fully. There is evidence in the files of inadequate or inappropriate support for those disclosing.

Many files contain details of ministers as victims and it is unclear what support has been offered in these cases.

Recommendations

- **The URC should work with victims/survivors to determine how to better facilitate and support disclosures, recognising that each person is an individual and will require individualised support. As part of this consideration must be given to how to ensure that victims are heard and allowed to fully express their emotions and personal stories.**
- **With the survivor group, the URC should review the support available for individuals during their disclosures of abuse and following. A robust system of support must be in place.**
- **Separate support should be given and available to those making allegations and those who are the subject of allegations.**
- **Consideration should be given to ministers who experience abuse and the support offered to them.**

Social media/Internet

There are some allegations of inappropriate use of the Internet or social media sites to access pornography, dating sites or images

Recommendations

- **A clear policy for online activity and social media use should be in place and where concerns are raised checks should be made to ensure that ministers are abiding by this.**
- **Developing policy around social media use generally is recommended as this is a key safeguarding issue of the moment. (It may be helpful to draw upon guidance for this area, see 'Safeguarding & Digital communications[10]' in the URC safeguarding handbook for churches and material published by CCPAS[11])**

Ministerial retirement and wellbeing

- There are several accounts of ministers struggling to let go of ministry on retirement or seemingly refusing to. This may not in itself be a safeguarding issue but there is at least one case where a subsequent minister found their new position extremely difficult due to the former minister refusing to let go of their position and responsibilities.

Recommendations

- **Consideration should be given to how to further support retiring ministers. The learning group recognises that retirement courses do include discussions of this topic but that living out the decision to retire can be complex and may need ongoing support and reflection.**
- **Where concerns are raised monitoring of retired ministers may be required to ensure that new ministers are able to operate freely in their role.**
- **There are more retired than active ministers in the URC and this situation can lead to complexity as retired ministers may be asked to become active to cover where there is a ministerial shortage. Thus the boundary between 'retired' and 'active' ministers may not be clear. Consideration should be given as to how to support ministers who have some active ministerial role but this must be balanced with the need to allow active ministers to establish themselves in their new roles and contexts.**

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[10] https://urc.org.uk/good-practice-policy-and-procedures.html.
[11] http://files.ccpas.co.uk/documents/29_HL_Internet_safety.pdf

PROCESS, DOCUMENTATION AND RESPONSE

The review of files raised significant issues in terms of documentation, process and response and these are described in this section of the report together with recommendations for future practice to address some of the challenges and limitations identified.

Documentation and record keeping

Records within many files were limited by either missing or insufficient information. This included missing complaint letters or an absence of a recorded outcome of cases. There were many instances of files which did not contain a record of actions following an investigation. In some cases there was no ministerial file on record or files which contained time periods without documentation and therefore there were gaps in ministerial records. In some files the nature of the allegations made was not clearly detailed and therefore the allegation was ambiguous. Often it was not possible to ascertain if safeguarding training had been undertaken. Overall there was evidence of inconsistent record keeping across files.

In some cases a mapping exercise maybe needed where an individual may have worked across several synods. The Synod structure presents challenges for effective communication and information sharing. However, these are central aspects of a robust safeguarding system.

The use of language and terminology was a concern across some files. On one occasion, a safeguarding concern was referred to as a ‘hiccup’. This clearly minimises behaviour. On other occasions terminology was ambiguous and so ascertaining what had actually happened was difficult.

The current process for keeping records has clear limitations and challenges. These may become even more accentuated now that some Synods are moving towards electronic files and others maintain paper-based files.

For the learning review group, it was often difficult to collate together cases as there was incomplete information or different case numbers for the same individual or multiple copies of the same information. It was an interesting observation that all the files were of individuals of White British descent. This raised questions for learning group about whether this was an accurate reflection of all cases in the URC.

Recommendations

- **Every minister must have a personnel file.**
- **A standardised record keeping system is required which includes universal templates for reporting concerns and disclosures and recording investigations from the beginning of the process. This would enable standards or record keeping to improve. It would also ensure consistency of practice which is essential for the future, especially where an individual moves between synods.**
- **The learning group recommends that over the next 5 years the URC move towards a centralised electronic records system. (It is recognised that this recommendation might meet with some anxiety due to the Synod structure. However, this recommendation would underpin a positive approach to safeguarding).**
- **All material related to a minister should be included in their file. This includes letters of complaint.**
- **The same case number should be used for any information related to the same minister.**
- **Clear records of safeguarding training undertaken should be kept on file.**
- **Files should include a chronology in order that a clear overview of files on record can be seen.**
- **Files should include clear unambiguous details of any allegation made against a minister.**
- **There should be no time gaps in ministerial records.**
- **Consider whether a further mapping exercise is needed for individuals where allegations have been made and the Minister has moved across Synods.**
- **Thought should be given as to how to develop more effective communication between Synods. Records need to be carefully constructed using clear and unambiguous terminology.**

The Process

There were a number of aspects of the process of responding to allegations that raised concern. There were times at which the reputation of the URC or individual Church appeared to be prioritised over the safeguarding of the individual complainant. The files contain many examples of repeated patterns of behaviour which have failed to be addressed when first identified. Thus, a complaint is raised but not actioned or a decision is made that action is not required, then subsequent examples of the same behaviour occur. In some cases, there seemed to be a need for more investigation and critical thinking on concerns and more exploration and questioning was required. Assumptions can't be made about particular individuals or particular concerns raised.

Other challenges related to information sharing were identified in cases where individuals had moved denominations. It was clear in some cases that more detailed checks and follow up work was required to ascertain why an individual was moving and to be assured that there were no outstanding safeguarding concerns. Similarly, there are cases on record of individuals moving from the URC when concerns had been expressed and going to work for other external organisations. It was not clear what, if any, action had been taken to share relevant information in these cases.

There was some evidence of cases where references were not checked. There were other examples of cases where individuals own explanations of behaviour appeared to have been taken as factual, rather than being explored or investigated.

Concerns were raised by those in the learning group that members of mandated groups might lack the knowledge and experience of working on cases and this could impact the quality of decision making and the safeguarding process.

Recommendations

- **References must be taken up and checked**
- **It is important not to 'take the word' of someone about what happened but to ensure information is checked and appropriate exploration takes place.**

- **There should be a selection process for those on mandated groups. Mandated groups and section O committees should receive training on safeguarding children and adults to include consideration of mental health issues. Mandated groups should be offered the full range of training opportunities.**

- **Consideration should be given to developing a centralised process where all mandated group members are trained in detail including how to operate a systematic approach to cases and reviews. It may be more beneficial to consider having a smaller number of mandated group members but investing more time in training. A smaller cohort would also result in individuals hearing/reading more cases and therefore developing expertise in the area. Thought should also be given to possible payment of group members as relying on volunteers can be problematic.**

- **Safeguarding of an individual must take priority over the reputation of the URC or local Church.**

- **It is important that all concerns raised are investigated thoroughly and responded to effectively.**

- **In some cases, assumptions were made about individuals or concerns that required more investigation and critical thinking to fully explore the concerns, questions and provide fuller analysis**

- **It is important to build up dialogue with other denominations and to check the reasons why an individual has moved cross-denominationally.**

Actions in response to allegations

There is evidence that a number of allegations were not investigated or fully investigated at the time of disclosure and thus there is a lack of appropriate process and action. In a number of cases actions were requested following allegations but there is no written record of the actions having taken place. There is also no record of monitoring or disciplinary action for non-

compliance. Some cases required a risk assessment to be conducted but again there is no evidence of this on file. There are several cases of allegations followed by an individual choosing to transfer to another organisation.

There are some questions raised about the URC management responses to some cases. In other cases, allegations appear to have been dealt with 'in-house', rather than being referred to the appropriate statutory agencies. Where referrals to statutory agencies such as police and social services were recommended there is often no evidence of whether this occurred and what the outcome was. For example some cases should clearly have been referred to the local area designated officer (LADO). (The LADO works with Children's services and is responsible for coordinating the response to concerns that an adult who works with children may have or could cause them harm). There is evidence that better understanding of the role of the LADO is required.

There is at least one retraction of an allegation of file, the expert reader questions the authenticity of this retraction. Some of the expert readers have noted that moderators have written to ministers and requested a response but there is no record of a response being given. It is unclear what the process is for checking that responses have been received or to flag where they have not.

Reading the files showed some disconnection between the discipline process and consideration of matters as safeguarding issues. At times, the discipline process seemed to be prioritised. There was also some confusion at times as to what constituted a safeguarding issue. It is important that the URC does not adopt a 'bunker mentality' where it assumes that DBS checks are sufficient to ensure safety of those working in its contexts

Some of the cases on file suggest that ministers were allowed to continue working in ministry following allegations and in one case a minister was suspended and then reinstated but the evidence for the reinstatement is not on file. The learning review group recognises that some of these cases are non-recent and processes and procedures have changed since these occurred.

It should be noted that an apology has been requested by some of the individuals disclosing and there is no record of whether this has been offered or a reason for the decision not to provide an apology.

The expert reader in some cases has suggested there is a training need for mandated groups and for committees in section O cases. In many of these section O cases there is not a recorded outcome on file.

Recommendations

- **The URC needs to update safeguarding policies and procedures to ensure they are robust and standardised. The learning group recognises the challenge of this within the Synod structure and the desire to allow Synods to self-govern and monitor. However, it is important that a standard is set for training with regards to contents and requirements. This can only really effectively be achieved through a standard package, which can be delivered within Synods.**
- **It is essential that all allegations are investigated, and appropriate action is taken.**
- **Any actions required as a result of an investigation must be clearly detailed in the ministerial file. The actions should be dated and signed. An individual must be identified as the person responsible for the monitoring and recording of required actions and there should be clear time scales for these. This monitoring should encompass all actions proposed including explaining the timescale to the alleged perpetrator and victim, offering counselling to the victim and apologies. There should be a timescale for these actions also and a record on file of when they have been completed. Appropriate disciplinary response should be made to any non-compliance.**
- **There should be a consistent URC management process which is transparent.**
- **If ministers are reinstated, (either after suspension, resignation or having been removed from the roll), there should be a formal risk assessment and a clear process for this with a documented rationale for the decision to reinstate.**
- **Safeguarding training should include a more detailed understanding of the role of the LADO.**
- **Where it is appropriate cases must be referred to the LADO.**

- **Where allegations occur appropriate referrals should be made to statutory agencies such as the police and social services rather than a case being kept in house.**
- **Consideration should be given to developing a new disciplinary process. As part of this the link between safeguarding and disciplinary process needs to be carefully investigated and a clear model constructed for ensuring the two systems interface effectively. A simplified more streamlined, faster disciplinary and safeguarding process would benefit everyone.**
- **Safeguarding needs to be prioritised across the discipline process.**
- **Consideration should be given to retracted disclosures and those monitoring cases should fully explore the reasons why an individual may retract.**
- **There needs to be a universal process for checking that responses to requests have been received and for follow-up action where this has not occurred.**
- **The URC needs to develop a process for raising concerns where there are existing allegations or concerns about an individual who is choosing to transfer to a different denomination or organisation. The new data protection regulations will need to be taken into account when considering the development of this process. It is essential that the URC are compliant with the new data protection regulations (GDPR) and that all material on file is kept in accordance with these and clear file retention dates added. In respect of child protection cases there is currently a moratorium on destroying these until the Independent Inquiry into Child Abuse advises otherwise. GDPR, itself, does not stop the lawful sharing of safeguarding concerns without consent where there is evidence to demonstrate a serious safeguarding concern. Evidence must be recorded as to why information is being kept and shared, with or without consent.**
- **There should be a whistleblowing procedure to allow victims to raise concerns. It is important to note that whistleblowing procedures in other organisations have sometimes failed to protect the individual disclosing and actually resulted in them being further vicitimised. Therefore, careful consideration must be given as to how to develop a process which allows disclosures but does not cause further harm to the individual disclosing.**

SUMMARY RECOMMENDATIONS

The recommendations made throughout this report should facilitate the development of safeguarding practice for the future in the URC. The learning group recognise that there are over 50 individual recommendations. Below is a summary of the key recommendations that draw together the individual comments included throughout this report. These recommendations should provide a foundation for the continued development of a safeguarding culture in the URC.

1. **Improved survivor consultation. It is important that all safeguarding developments are underpinned with detailed survivor consultation.**
2. **Improved survivor support, this should be established and implemented from the time of disclosure.**
3. **Development of a definition of a safeguarding concern and shared awareness of when behaviour crosses this threshold.**
4. **Development of standardised safeguarding training and policy. This should include training and policy on child and adult safeguarding. Further, the URC should seek to develop training and awareness of Domestic violence and Abuse, Spiritual Abuse, Financial abuse and mental health issues.**
5. **Improve safeguarding processes including response to allegations, referral to statutory agencies, raising concerns with other organisations and whistleblowing procedures.**
6. **Development of a centralised, standardised electronic record keeping system which includes universal templates for reporting concerns and disclosures and recording investigations from the beginning of the process.**
7. **Improvement in record keeping and guidance on good and effective recording practice, in particular in terms of the level of detail provided, unambiguous terminology and accurate recording of actions taken and monitoring of required actions.**

8. **Develop safer spaces training around boundaries in ministry and appropriate behaviour.**
9. **Consider the development of a new disciplinary process, which clearly prioritises safeguarding.**
10. **Standardise the recruitment and safeguarding training of all mandated group members, including section ‘O’ committees. Ensure the opportunity to serve regularly to build expertise.**

THE WAY FORWARD - CREATING A SAFEGUARDING CULTURE

Overall developing a safeguarding culture across the URC is essential for the future. In this culture reporting abuse would be seen as the appropriate and right action to take. Responding quickly and referring effectively would become common practice and investigation would not be stigmatised but rather seen as the correct way to respond, being fair to all concerned. Whole denomination awareness of all forms of abuse would be increased through safeguarding training and in the language, symbols, hymnody and liturgies used in worship and meetings held in URC Churches. A theological basis for safeguarding would be shared with URC Churches emphasising this as an aspect of Christian love and care for others. Training would be audited and recorded to ensure the best practice in children, young peoples and adults work. Recruitment of ministers would follow safer recruitment practices. Known offenders, including previously ordained individuals, would be respected but appropriate contracts and risk assessment would be in place to ensure the safety of all. A culture would be developed in which safe and healthy behaviour is understood and where unhealthy and unsafe behaviour is recognised, challenged and reported. In looking forward the URC would be aware of new and emerging safeguarding issues such as child sexual exploitation, child abuse linked to faith or belief and other harmful cultural practices. Where appropriate independent training and expertise in these areas would be drawn upon to better equip the URC to safeguard individuals in the future. To underpin this, policy, training and procedures need to be streamlined, standardised and disseminated across all synods. To facilitate the development of these processes clear, standardised record keeping is required as a matter of urgency.

Creating a Safeguarding Culture – The Challenge of the Synod Structure

The theological and ecclesiological structure of the URC is in many ways a strength. It allows individual synods ownership, responsibility and a good degree of freedom to operate independently. This model can have clear advantages. However, for safeguarding it presents significant challenges. Throughout the work of the learning group, the synod structure often

seemed to prohibit thorough review of cases and outcomes. It was clear that synods could not be required to share information or to standardise processes or training.

The learning group recognise the history of this structure in the URC and would not seek to suggest changes to the underlying structure. However, the current position of non-standardisation or centralisation of safeguarding is a precarious arrangement for the future of safeguarding. A situation of different practices and processes will continue. At worst, someone experiencing abuse may receive different response and support depending on where this occurs. There needs to be a degree of monitoring and accountability built into the safeguarding strategy.

A solution may be that synod moderators work with the URC's denominational safeguarding adviser who has an oversight of all safeguarding matters related to children and adults at the URC. This would help establish standardised practice, policy and protocol in the area of safeguarding, whilst maintaining the synod structure and independence in other areas of Church life. There is a clear argument for why safeguarding should be a special topic area that transcends synod structures. A standardised and centralised approach would offer much improved survivor experience and ensure the URC can present robust evidence of good practice in safeguarding.

Creating a Safer Culture – Progress to date in the URC

This report contains a review of the cases of abuse currently on file or reported in phase two of the past case review. Much of the report focuses upon the limitations, and in some cases failures, to response, report and action allegations of abuse. The report contains a series of recommendations for future practice. It is important to note that there has already been progress in safeguarding within the URC over recent years. The learning review group felt that it was important to reflect this at the end of the report. This provides a more accurate picture of the current status of safeguarding in the URC and recognises a commitment to developing safeguarding policy and practice for the future. This section draws upon material provided by the URC.

In 2013 the Safeguarding Advisory Group was set up by the Mission Council with the mandate to nurture good standards of safety around the Church as a whole. Over recent years there

has been a focus on the development and implementation of policies, system and practices to underpin the creation of a culture in which “every child and adult is treated with dignity and respect, whatever their circumstances”. All Synods now have arrangements to organise safeguarding matters and to provide advice, guidance and training to local churches. Twelve synods have employed or assigned designated professionals to act as single points of contact and respond appropriately to any safeguarding concerns. The Synod of Scotland has agreed an on-going service for aspects of their safeguarding practice with the Church of Scotland. The Mission Council’s Safeguarding Advisory Group (SAG) has been intent on reviewing development and implementation of safeguarding policies, to conform to best practice approach to safeguarding. In addition to ‘Good Practice 4’ (GP4) guidance and the Past Case Review, the publication of supplementary guidance on ‘Safeguarding Adults at Risk’ was added to current safeguarding practice to empower and support adults in maintaining independence and wellbeing. The URC’s Safeguarding Strategic Plan (2017-2022) was agreed by the Safeguarding Advisory Group (SAG) and is being further developed in consultation with Synod Moderators, Synod Safeguarding Officers and external experts. A joint meeting of the Synod Safeguarding Officers and the Safeguarding Advisory Group (SAG) in June 2018 will finalise the strategic plan for the attention of the next Mission Council and activate a collective effort to put specific standards and actions into practice in years to come. Safer Recruitment Guidance for the whole Church will be produced by the end of 2018 to reflect new laws and regulatory requirements and protect children, young people, and adults from abuse, harm or neglect.