Response by the Diocese of London and Lambeth Palace to the Regulation 28 Report (9 July 2021) to the Church of England in relation to the death by suicide of Fr Alan Griffin on 8 November 2020.

1. Introduction

The Diocese of London and Lambeth Palace wish to thank the Coroner for writing to the Archbishop of Canterbury and bringing to our attention the various matters of concern that were prompted by her investigation into the tragic death of Father Alan Griffin.

Those concerns have been shared with and considered carefully by the various Church Institutions. We have formed a Case Steering Group, with representatives including the Diocese of London, the National Safeguarding Team (NST), Lambeth Palace, and an independent professional member of the Diocese of London's Safeguarding Steering Group to oversee both this response and our next steps.

This report is our collective response on behalf of the Church of England to your Report to Prevent Future Deaths dated 9 July 2021, in accordance with the provisions of the Coroners and Justice Act 2009.

2. Aims

The Diocese of London and Lambeth Palace express their deep regret and sorrow at the death of Fr Alan Griffin. We acknowledge that there were either poor processes or systems, or mistakes, that led to unreasonable pressures on Fr Alan and we take responsibility for what went wrong. This response is prepared to assure the Chief Coroner of the Diocese's commitment to change, ongoing learning and improvement.

We will seek to respond to the key points that have been raised by the Coroner in criticism of the Diocese of London's handling of the concerns relating to Fr Alan, to set out current and future actions to improve our handling of conduct and safeguarding concerns, and to set out measures to mitigate the risk of any future suicide by someone who is the subject of such concerns within the Church of England.

We are also committed to undertaking a Lessons Learned Review and implementing any necessary actions (see section 5).

3. Other parties

We are committed to doing whatever we can in partnership with our colleagues in the Roman Catholic Church to improve our joint management of matters that affect people within both our Churches.

4. Immediate first steps

We had already made a Serious Incident Report to the Charity Commission, and this has been updated since the publication of the R28 Report.

As a result of the concerns that the Coroner raised in her report, we have revised the terms of reference initially proposed for the Lessons Learned Review and have taken steps towards appointing

an experienced, independent reviewer,[1] not previously known to or associated with the Diocese of London, who is able to give rigorous external scrutiny to the safeguarding systems and processes of the Diocese of London as applied in this case.

To ensure good process, we have consulted the independent professional members of the Diocese of London's Safeguarding Steering Group (part of the governance of the Diocese of London) and are engaging with the close family and friends of Fr Griffin who were registered as Interested Parties for the purposes of the Inquest, about these Terms of Reference.

5. Lessons Learned Review

We aim to agree the Terms of Reference by early September with the intention of the Lessons Learned Review ("the Review") beginning in September 2021. The purpose and objectives of the Review are currently as follows:

5.1 This Review will examine the Diocese of London's handling of information relating to the late Fr Alan Griffin in the light of the ten specific concerns and three further issues set out in Section 5 of the Coroner's Regulation 28 Report. The Review will set out a simple and accessible chronology of events.

5.2 It will identify lessons to be learned and how they should be acted on, which will enable the Diocese of London and the Church of England to take steps to enhance and improve their handling of matters relating to conduct and safeguarding.

5.3 The Review will consider the effectiveness of procedures, areas of service improvement and development needs and will establish what lessons can be learned regarding the way in which information is responded to, recorded, assessed, shared, and managed.

5.4 The overall purpose of the Review is to promote learning and improve practice, not to apportion blame.

5.5 It will make recommendations about what could be done better in the Church of England to help prevent such a death taking place again.

5.6 With the cooperation of the Roman Catholic Diocese of Westminster, it will seek to understand how information was shared and acted upon between the Diocese of London and the Roman Catholic Diocese of Westminster and set out lessons that should be learned to improve this.

The full Terms of Reference (subject to consultation) will be published on the Diocese of London website when consultations are complete (anticipated early September 2021).

6. Initial actions

Although we do not wish to pre-empt the findings of the independent Lessons Learned Review, and appreciate that we will need to make decisions about any recommendations that the Reviewer makes, we have recognized and are making the following early improvements to our capacity, capability, and practice:

In the Diocese of London:

- The newly appointed Head of Safeguarding began in post at the beginning of August. He has over 30 years policing experience and extensive experience of safeguarding, multi-agency working, leadership and systems and performance improvement.
- In September 2021 a new Diocesan Safeguarding Advisor (DSA) will begin, filling the remaining vacant post. An additional Safeguarding Advisor has also been appointed who will begin in October, taking our DSA headcount from 3.6 to 4.6 FTE.

[1] This will not now be the Independent Chair of the Diocese of Exeter Safeguarding Steering Group as set out in the Diocese's legal submissions of 28 June 2021 to the Coroner.

- Our new Head of Safeguarding has already started working with the team to design and implement new systems of information capture, triage, recording, assessment and appropriate sharing of safeguarding and conduct matters. These issues will form part of our overarching improvement plan.
- Specific initial actions include:
    1. Ensuring a single safeguarding referral line and inbox, to enable capture and triage of information.
    2. The development of a referral/triage system, with supervision from the Head of Safeguarding, to ensure that matters are separated out into safeguarding, non-safeguarding conduct, and "other" issues, ensuring an initial and ongoing assessment of risk (including mental health) and with appropriate follow up action by a designated case holder.
    3. The development of a casework management tracking system for all referrals into the safeguarding team to record timely progress against key milestones and ensure a structured review process (including risk and mental health) during the lifetime of a case.
    4. Delivering additional GDPR training specific to safeguarding to ensure staff in the Diocesan Safeguarding Team are competent and confident to ensure information that is shared is recorded and audited, and that the principles of information sharing are applied lawfully and proportionately. In due course this will be delivered to senior staff involved in handling personal and safeguarding related data to support their practice and decision making.
    5. A protocol for the management of possible serious incidents, both by the Diocesan Safeguarding Team and the Diocese as a whole.
- The Head of Safeguarding will also be working with the Director of HR and Safeguarding to identify additional resource requirements to ensure necessary support for these areas of activity and improvement.

- The role of Head of Operations for the Two Cities Area was restructured prior to the appointment of a new Operations Manager. This now ensures that the post holder relates only to financial and property matters, with clear accountability and supervision.

- Informed by these initiatives and by our own experience, the Diocese of London has continued to develop our approach to clergy wellbeing. A range of support groups, sources of therapeutic support, (and grants to pay for it) have been made available, and we have developed web resources relating to physical and mental wellbeing for clergy and their households https://www.london.anglican.org/clergy-wellbeing/.

  In addition to diocesan support, the Diocese has offered parishes a framework for supporting their clergy https://www.london.anglican.org/clergy-wellbeing/#2_Tools_for_Reflection_and_Action_on_Clergy_Wellbeing.

  This has been communicated via focussed messages from the Bishop to her clergy, and via training events, especially during the pandemic. We know that we have more to do and recognise the need to develop these tools with our clergy. Our website invites those making use of the resources to suggest additions and amendments.

- The specific circumstances of this case were such that Fr Griffin no longer considered himself to be a member of the Church of England and had retired from the Diocese of London in 2011. As a result, is it is hard to say whether these improvements would have been accessed by Fr Alan, nevertheless, the wider Church has instigated a number of support tools which are accessible to all clergy. We will continue to work with clergy to improve our support for clergy about whom concerns are raised.

- Over the last two years, the Diocese of London, along with all other dioceses in the Church of England, have been undertaking a Past Cases Review of safeguarding cases in line with the House of Bishop's Practice Guidance. In total, over 5000 files have been reviewed in the Diocese of London: in parishes, in diocesan offices, and those held by the Diocesan Safeguarding Team. We are investigating any information or allegations that appear not to have been dealt with satisfactorily in the past, and, where possible, providing support for both those about whom concerns have been raised and those who are survivors of or complainants about historic abuse. Following implementation of the initial actions by the new Head of Safeguarding relating to this matter, we aim to ensure good management of these cases.

  Our project team, working with an Independent Reviewer, has gathered data about casework management and practice and has made recommendations that will be reviewed by the new Head of Safeguarding as we develop an Improvement Plan. Key areas for improvement include consistency of practice, ongoing risk management and oversight, and ensuring ongoing timely progress regarding the management of cases.

In and with the National Safeguarding Team:

The National Safeguarding Team (NST) has responsibility for delivering and improving safeguarding across the Church of England. The NST is leading on several projects which will address some of the issues raised in the R28 report.

- **National Casework Management System**

A national case management system which has a wide range of specifications which will bring the following benefits to how safeguarding information/investigations are recorded and managed.

- A consistent approach to quality case work practice and recording in line with agreed House of Bishops' expectations.
- Identify and record risks and support required for victims/survivors and those that have been accused.
- Integration with the clergy data from the HR system to ensure accurate records.
- The ability to improve the information available to key safeguarding professionals in relation to individuals and any risk issues that are identified.

The pilot phase for this project starts in November 2021 and will be implemented across the Church of England in 2022.

- **Information Sharing Project**

This project seeks to strengthen information sharing arrangements by putting in place an information sharing protocol and information sharing agreement in place for safeguarding information. The project was established as a result of a recommendation from the Independent Inquiry into Child Sexual Abuse (IICSA) to focus on sharing information with the Church of Wales and statutory agencies. We will work with the Roman Catholic Church to implement a similar information sharing agreement.

- **Engagement with Diocesan Safeguarding Advisors**

Learning from Fr Griffin's death has been shared with Diocesan Safeguarding Advisors along with a reminder of the House of Bishops' Safeguarding guidance and support that is available for people who are vulnerable or at risk of suicide.

- **Engagement with Diocesan Bishops**

The National Safeguarding Team will write to all Diocesan Bishops and Chairs of Diocesan Independent Safeguarding Panels in England to remind them that they should be meeting together at least once a year and, among other matters, receiving assurance that safeguarding processes are working well.

- **Policy Review**

The NST is in the process of reviewing the suite of safeguarding policies which includes the policy covering the management of actions to be taken when safeguarding concerns are received. The current managing allegation policy does detail the support offered to a respondent in a safeguarding investigation Responding PG V2.pdf (churchofengland.org)

7. A note on IICSA and our response in the context of its findings

The Independent Inquiry Child Sexual Abuse (IICSA) was a wide-ranging inquiry into many British Institutions. Its conclusions pertain not only to the protection of children but to all aspects of the safeguarding of children and vulnerable adults. It reported in October 2020 in relation to Safeguarding in the Church of England and Church in Wales The Anglican Church - Safeguarding in the Church of England and the Church in Wales - Investigation Report | IICSA Independent Inquiry into Child Sexual Abuse.

The Church of England accepted the recommendations made by the inquiry in full. The Church of England has published a detailed response to the recommendations focusing on response to victims and survivors including redress, structure and independence, information sharing, revision of the Clergy Discipline Measure and external audits. 15.04 IICSA - Response to recommendations FINAL AC Council.pdf (churchofengland.org) [2] To deliver these recommendations successfully, an IICSA safeguarding programme has been set up by the National Safeguarding Team.

The implications of these recommendations for the matters considered in this response are important. Both the IICSA recommendations and the existing House of Bishop's Guidance to clergy are strong and clear in their instruction that all safeguarding concerns or allegations should be reported to the Diocesan Safeguarding Team in the first instance and in any event within 24 hours, and that it is those professionals who should decide, independently, whether investigation or action needs to follow.

This is to ensure untrained clergy are not investigating or using their own judgement, and to establish consistency of process. Although elements of our response to and handling of the concerns about Fr Griffin fell well short of good practice and need improvement, the principle of reporting, without investigation or filtering, of safeguarding concerns to qualified professionals, is one which is well established and one which we defend. See also section 7, additional matters.

[2] IICSA Response: Recommendation 1, Part 1, role of the Diocesan Safeguarding Officer. P1.

Responding to Safeguarding Concerns or Allegations that relate to Children, Young People and Vulnerable Adults 2018. "Inform DSA/nominated safeguarding officer and seek advice within 24 hours. Record all conversations and actions taken and retain securely." P19

8. Initial responses to the Coroner's Criticisms

Although we do not wish to pre-empt the findings of the Lessons Learned Review as we are committed to learning from the Reviewer's findings and recommendations, it is important that we offer an initial factual response to the Coroner's findings, both to acknowledge obvious failings and to correct any misperceptions which may be barriers to full learning.

The Coroner's key points are summarized here, and the full table can be found in her Regulation 28 Report.

Coroner's finding - summary	*Response*	*Action already completed*	*Action proposed*
1. The purpose of the meetings with the Head of Operations was not made clear to all who attended. The nature and origin of the allegations was not clear, and they were not evidenced/ witnessed.	The purpose of the meetings was stated in the meetings and the notes of those meetings. However, it is accepted that not all those present may have understood this. Although some of the concerns relating to other people were evidenced and had been dealt with, we accept that the concerns raised in respect of Fr Griffin were unsubstantiated.	We have created a single safeguarding referral line and inbox, to enable capture and triage of information and to ensure that these are the single points of entry for referrals into the safeguarding team. We now make sole use of the safeguarding inbox for referrals, preventing information being sent to individual recipient's inboxes. Both of these actions will ensure better oversight of any potential safeguarding referral, and ensure appropriate handling, including seeking evidence and witnesses.	The concern reporting form is being updated and will be reissued shortly. This will prompt full disclosures including pointing to relevant evidence and witnesses. We will identify additional training and communications for the safeguarding team and senior staff regarding the handling of safeguarding disclosures or receipt of safeguarding concerns. Further actions will be informed by the Review and will be developed by the new Head of Safeguarding, who has extensive experience of managing allegations, supervising staff, and keeping track of casework.

2. The Head of Operations' allegations were never clearly listed at the outset or appropriately verified with him, yet were passed on to the Roman Catholic Church	We accept that the information shared by the Head of Operations was not verified with him. We accept that good practice around evidence gathering, verification, and evaluation of information prior to action was lacking.	We have recruited a new Head of Safeguarding with high level experience of investigation, supervision, and quality assurance. Legal advice has been taken on Data Protection issues arising. GDPR training is being given to the safeguarding team in September 2021 by the National Church Institutions.	The Head of Safeguarding will ensure staff are competent and confident to risk assess any information to be shared and that future decisions are recorded and audited. The National Safeguarding Team have been developing formal information sharing protocols for all dioceses. These will be implemented in the Diocese of London once completed and will facilitate appropriate sharing of information with statutory services and also other trusted partners, such as faith organisations. Further actions will be informed by the Review and will be developed by the new Head of Safeguarding.
3. Lack of clarity about the use of the term "rent boys".	Whilst this was the term used in the initial disclosure, it is unacceptable for it to have been used in subsequent communications; we should have challenged and corrected its use. We accept that there was clarification neither of the term used nor of its origin (ie by whom it was used) in the meetings that took place.	The single referral form for all safeguarding concerns will prompt those recording disclosures to be clear, as much as is practicably possible, as to the origin of information and to take steps to ensure that it is appropriately verified or investigated by the safeguarding team. We will also ensure that appropriate terminology is used.	We will continue to ensure that any relevant background information stored on clergy blue (HR) files is made available to members of the safeguarding team, that DBS and safeguarding training records are up to date and accessible, and that we have better systems for tracking file access and transfer.

4. Lack of interrogation of the Head of Operations' recollections, leading to lack of clarity about allegations, sources, or evidence.	We acknowledge the inherent challenge in deciding what is a safeguarding concern, and what degree of evidence is needed in order to investigate. However, the Diocese of London and Church of England is bound by House of Bishops' Guidance which signposts all safeguarding concerns to the Diocesan Safeguarding Team (DST). The presumption in favour of reporting to a safeguarding professional is strong. We fully accept that there was no subsequent verification of the information shared by/with the Head of Operations.	New Leadership and Senior Leadership Development Pathway training equips leaders better for handling disclosures and discerning how professional judgement might best be exercised. This is currently being delivered in the Diocese of London as part of the delivery across all dioceses. This process will be further commented on by the Review but is informed by the Church of England's response to IICSA findings and remains wider Church of England policy. In addition, see above re skillset of new Head of Safeguarding.	Further actions will be informed by the Review and will be developed by the new Head of Safeguarding.
5. No one took responsibility for triaging, verifying, or assessing the allegations and deciding how they should be acted upon.	We agree there was not a clear system for tracking progress or assigning responsibility for oversight. This must be corrected.	A case work tracking system has been developed for all referrals into the safeguarding team. This includes a clear process for the receipt and triage of allegations and concerns, and for recording timely progress against key milestones.	We will further develop systems for tracking and monitoring actions. Further actions will be informed by the Review and will be developed by the new Head of Safeguarding.
6. The introduction of an error recording "concerns of possible child exploitation."	We agree this was mistake and is a matter of regret. This description was entered into the spreadsheet referred to above as part of the Two Cities report, which was an internal document. It was not shared with the RC church as part of the referral.	It is not possible to quality assure all internal documents; however, we will ensure good working practices and closer supervision are established.	We will ensure the appropriate resourcing of the safeguarding team to enable this to take place.
7. That no one took legal advice before proceeding and that no one developed an overarching, coherent strategy for dealing with the concerns relating to Father Alan.	We agree that this did not happen. It had been recommended that legal advice should be taken, but this was not followed up.		See section 2 above This will also prompt the offer/provision of support for those about whom concerns have been raised. We will further develop systems for tracking and monitoring actions.

8. That the Diocese of London DSA referred information about Fr Griffin to the Roman Catholic Church, including disclosure of his HIV status. That checking of this referral took place by the Safeguarding Manager and Archdeacon, but no one recognized this passing on of information as inappropriate.	We fully accept that further steps should have been taken to verify this Information before it was shared, even though it was being shared with a trusted safeguarding professional in the Roman Catholic Church. We accept that there was no written record of a risk assessment or of the wellbeing issues arising. Legal advice was not taken regarding the detail of the disclosure, and we also recognize that no information sharing protocol was in place that would have prompted further reflection.	Legal advice has been taken on Data Protection issues arising and learning from this has been identified. GDPR training is being given to the safeguarding team in October 2021 by the data protection lead from the National Church Institutions (NCIs). The National Safeguarding Team has been developing information sharing protocols between dioceses, statutory services, and other faith organisations which will form a basis for practice across the Church of England including the Diocese of London.	We will ensure development of a Diocesan Suicide Action Plan and ensure that this is actioned as appropriate.
9. That welfare and investigation were confused in the DSA's referral to the Roman Catholic Church.	Whilst planning conversations did take place between the Diocese of London and the Roman Catholic Diocese of Westminster prior to the proposed meeting with Fr Griffin to agree the nature of that meeting (which was in part to verify the information which had been passed on), this was not recorded. Opportunities to establish a clear plan for joint investigation and pastoral care between the two denominations were missed.	We have recruited a new Head of Safeguarding with high level experience of investigation, supervision, and quality assurance. Oversight from the Head of Safeguarding will ensure that DSAs are more closely supervised, and clear case management strategies are put in place.	Agreement to be developed about good practice for joint investigations between denominations. Record keeping needs to be further improved and practices will be overseen by the new Head of Safeguarding. Improved plans developed for ensuring pastoral care

10. That the allegations passed on had no complainant, no witness, and no accuser; that no concern had been raised by a victim of abuse, a child, parent, teacher, youth worker, or other witness; and that these led to an investigation lasting over a year, with the allegations and their source never being plainly put to Fr Griffin.	The way the information was documented and passed to the Roman Catholic church is a matter of deep regret for the Diocese of London. Whilst initial actions were completed in a timely way, we recognise the contribution of the Diocese of London to subsequent delays once Father Alan had been made aware of this matter. We also recognise that the strategy for managing the case was not clear.	The single Referral Form coupled with the process for triage and safeguarding verification will support improvement, together with the information sharing protocols and training referred to above See above comments in section 9. There have been resilience and capacity issues in the Diocesan Safeguarding Team, relating to illness, bereavement, and the pandemic, which are being addressed. Once the new Diocesan Safeguarding Advisors begin in September and October, there will be increased safeguarding team capacity.	Case management and tracking need to be further improved to ensure timely handling, communications, and resolution. Further actions will be informed by the Review and will be developed by the new Head of Safeguarding. We are further reviewing resource requirements to ensure future resilience.

Additional matters

In addition to the ten matters of concern set out above, the coroner made specific criticisms in respect of the following matters to which the Diocese of London offers responses as follows:

- The Diocese of London's lack of engagement with the inquest process until June 2021

We apologise for the delay and for the points at which we did not engage as effectively as we could have done. Whilst we had initially confirmed to the Coroner's office that a legal representative was being instructed, we now recognise that the details were not subsequently confirmed to them. This was an oversight. As a result, we did not request Interested Party status until 3 June 2021. Despite this, we were actively engaged in preparation for the Inquest. We will ensure that learning is drawn from this, and appropriate actions taken.

- Lack of any meaningful attempt at improvement until later June 2021.

It is a matter of significant regret that, even following the death of Father Griffin, there were a number of lost opportunities to review learning from the handling of this case prior to the Inquest. By the time of the inquest, the Diocese of London had agreed a Lessons Learned Review and had begun the process of drafting Terms of Reference. The scope of that review has now been extended and the Diocese of London has taken steps towards appointing an experienced, independent reviewer who is able to give rigorous external scrutiny both to this case and to any attendant issues within the safeguarding systems and processes of the Diocese of London.

- Finally, the coroner responded to the legal submissions made on 28 June 2021 in these terms:

  I then received submissions on behalf of the Church of England regarding any prevention of future deaths report. These submissions impressed upon me that referrals to child protection and safeguarding professionals must not be reduced and urged me not to include any

concerns that may be taken as a criticism of clerics or staff for not filtering or verifying allegation.

The aim of making this submission to the Coroner was not to deflect criticism away from clergy or staff if they had acted inappropriately. It was made in the context of the IICSA recommendations and in the light of existing House of Bishop's Guidance to the clergy that state that clergy must refer all safeguarding concerns or allegations to the Diocesan Safeguarding Team in the first instance and in any event within 24 hours (see 6, above). This is to ensure untrained clergy are not investigating or using their own judgement, and to establish consistency of process. We believe that our clergy and staff acted in accordance with this Guidance and we were concerned that any criticism of them for following it might deter others from the appropriate reporting of safeguarding concerns

Our submission, therefore, was intended to ask the Coroner to bear in mind when making her findings that all clergy and staff are obliged to follow this Guidance. The Guidance is clear that it is inappropriate for clergy and staff to filter or investigate any apparent or alleged safeguarding related concerns and instructs them to refer these directly to safeguarding professionals. The Church of England has worked hard to ensure that all clergy and staff are clear about their reporting obligations. We were and are keen that this good work is not undermined.

For completeness the relevant Diocese of London submission is included here:

If, despite these submissions, the learned coroner remains minded to issue a regulation 28 report, she is urged not to include any concerns that may be taken as a criticism of clerics or staff for not filtering or verifying allegations. The learned Coroner has heard that the events in question took place in the context of the Independent Inquiry into Child Sexual Abuse (IICSA). The purpose of the Inquiry, as set out in its terms of reference, is to consider the extent to which State and non-State institutions have failed in their duty of care to protect children from sexual abuse and exploitation. The Diocese of London is deeply committed to child protection and wishes to avoid anything that may have the unintended consequences of reducing referrals to child protection and safeguarding professionals.

Case Steering Group:

[redacted], General Secretary of the Diocese of London
[redacted], Bishop of Stepney
[redacted], Interim National Director of Safeguarding
[redacted], Bishop at Lambeth (alternate [redacted])
[redacted], independent member of the London Diocesan Safeguarding Steering Group

Date: 24 August 2021

Appendix 1

Church of England Structures and Safeguarding Policy

This information is offered to demonstrate the Church of England and each individual diocese's framework for dealing with safeguarding and conduct matters. It explains how leadership is exercised in the Church and sets individual actions in Fr Griffin's case in the light of church structures and policies.

The Church of England is made up of 42 dioceses. Each diocese has a lead bishop, known as a diocesan bishop, who works alongside a diocesan synod and a structure of boards and councils responsible for different aspects of the diocese's work including ministry, mission, and education. Each diocese, including the Diocese of London, is a separate structure. The London Diocesan Fund (LDF) exists as the legal entity for the management of the assets and operations of the Diocese and is an independent charity.

The General Synod is an assembly of bishops, clergy, and laity, which meets at least twice a year to debate and decide the Church's laws and to discuss matters of public interest. The General Synod is a legislative body whose Measures when passed by the Ecclesiastical Committee of Parliament become statute. The House of Bishops is one of the three houses of the General Synod. All diocesan bishops are members of the House of Bishops, along with a small number of other elected bishops.

Seven National Church Institutions work together to support the mission and ministries of the Church. See https://www.churchofengland.org/about/leadership-and-governance/national-church-institutions and https://www.churchofengland.org/sites/default/files/2021-01/NCI%20structure%20chart%20-%20Jan%202021%20-%20website.jpg.

Safeguarding in the Church of England centrally is led by the NST, under the oversight of the Archbishops' Council. See https://www.churchofengland.org/safeguarding/reporting-abuse-and-finding-support. The NST plays a key role in developing strategy, policy, and training, and overseeing casework which has national implications, crosses diocesan boundaries, or involves bishops. They work in supportive partnership with dioceses as they manage their own casework.

Safeguarding policy and practice guidance is developed by the NST but is approved by the House of Bishops and must, where relevant, be followed by all church bodies and church officers. In particular, all clergy have a duty to operate within and pay due regard to the policy and practice guidance and to disclose any safeguarding related concerns to diocesan or national safeguarding staff. Indeed, failure to do so by a member of clergy could be considered grounds for a complaint under the Clergy Disciplinary Measure.

Each diocese has its own Safeguarding Team, made up of professionals with appropriate safeguarding experience, drawn from social work, police, probation services, or similar backgrounds, and with administrative support. It is the Safeguarding Team that handles all safeguarding related case work. Senior clergy, e.g. Bishops of a diocese have oversight of ministry generally and specific clergy such as Archdeacons work closely with the team on matters of safeguarding and potential clergy misconduct. However, it is the safeguarding team (along with a Core Group where appropriate) that has operational responsibility for cases and would make decisions/form judgements about the progression of safeguarding matters with appropriate consultation with senior staff.