

STRICTLY CONFIDENTIAL

Safeguarding Case Review Report

A report on the management of the safeguarding case concerning Tim Storey.

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Another month passes by before a further email is received on 29th July 2009 stating that contact with the victims has still not been confirmed.

August 2009

On 22nd August 2009 further written statements are received from the victims [redacted] and [redacted] detailing large amounts of information relating to the conduct and 'grooming' behaviour of TS towards them. A further two months passes by before these accounts are verified and demonstrably acted upon by the diocese.

November 2009

On 16th November 2009, a file note reads (at para 5) that discussions have been held with the police concerning whether a criminal offence has or has not been committed by TS. It is unclear whether this is a second contact or a later reference to the original contact being made. Despite this, the apparent need to clarify this point is continuing to cloud the judgement and actions of the diocese in both supporting the victims and progressing matters to conclude a disciplinary case against TS.

January 2010 onwards

12 months following the initial allegation, a referral is made to the Independent Safeguarding Authority (ISA) by the diocese concerning the behaviour of TS.

No further information is contained on file regarding the support being provided to the victims, although a (undated) letter from Bishop Richard Chartres was sent to them. It is assumed that this is sent around the same period as the ISA referral. There is no evidence of any offer from the diocese to meet with the victims and no reasonable explanation regarding the unacceptable length of time that had passed in dealing with the matter.

Learning Points

1. Numerous opportunities were missed by the diocese, the home parish and [redacted] DPA to make an appropriately early referral of concerns relating to TS to the statutory agencies (Police and/or Children's Services).
2. An inappropriate level of intervention was undertaken by both the diocese and [redacted] DPA in trying to establish the case. This is contrary to good safeguarding practice and against statutory guidelines in force at the time within *Working Together to Safeguard Children*, 2006. These actions delayed proceedings being undertaken appropriately and may arguably have created greater risk for both the known victims and others.
3. Serious breaches of good safeguarding practice are apparent, including contact being made with the alleged perpetrator to share detail regarding the allegations.
4. Too much time was spent by the diocese trying to establish whether or not a criminal offence had occurred and in doing so further delay in reporting the matter to the authorities followed.

5. Opportunities to share information both internally (i.e. between the diocese and the parish) and externally (i.e. with statutory partners) formally through meetings of key individuals has probably contributed towards a fragmented picture of what was known and by whom in relation to TS. This was a distinct failure on the part of the local authority and the diocese to work collaboratively and effectively for the protection of vulnerable people.
6. Either poor information was given to the LADO by the BACP or a poor decision was made by the LADO regarding that information. A clear failure to pay full regard to the position of trust held by TS (regardless of whether this met the legal definition for such a position or not) and the consequent potential risk posed to other young people was seen in the LADO's response to the matter. This is a matter of significant concern and may benefit from further discussion regarding the nature of youth ministry in a faith context with the Local Authority.
7. It is likely that information of concern regarding the conduct of TS was known within the parish/diocese even prior to the allegations being made within this report. This indicates poor understanding or a lack of confidence of clergy (and potentially others) in making such concerns formally known to reduce risk to young people or vulnerable others.
8. Although not detailed greatly within the file, it is known that TS was given a role within his local church at St. Margaret's following his resignation from ordinands training. Albeit an administrative role, file notes indicate that the boundaries of this role were being stretched by TS to include some direct contact with young people and other parishioners. This appointment shows a distinct lack of awareness and discernment on the part of the incumbent and arguably created unnecessary and ongoing risk to young people posed by a manipulative and risky individual about whom there was existing and known concern.
9. Rather than the appointment at St. Margaret's, the diocese missed a key opportunity to effectively make it clear that TS should not be afforded any role giving him a perceived level of responsibility within the church.
10. Further, the diocese missed the opportunity to ensure that TS complied with an attendance agreement based upon a risk assessment of the known concerns; all of which should have followed some form of disciplinary process that dealt with his misconduct and made the risks he posed clear for those that legitimately should have been informed at a much earlier stage (e.g. the ISA).
11. Perhaps most importantly, numerous opportunities were missed in communicating updates with the victims and the entire process took far too long to conclude, which can only have prolonged the emotional pain of the situation for the four victims.
12. Finally, the manner in which the victims were (or were not) supported in this case can only lead to serious questions about how the diocese perceived the legitimacy and validity of the allegations made by these four young women. Ongoing (face-to-face if necessary) contact should have been made with the victims to legitimise their positions and to assure them of action being taken. This was a woeful inadequacy on the part of the diocese who had assumed responsibility for progressing the matter at that time.