



PCR 2 Review for the Channel Islands on behalf of Salisbury Diocese.

Independent Reviewer

Tracy Hawkings

June 2021

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1.0 INTRODUCTION – OVERVIEW AND GOVERNANCE

1.1 **Organisational structure of PCR 2**

1.1.1 This is the PCR 2 report for the Channel Islands which was originally initiated by Bishop Trevor Willmott from the Diocese of Winchester. Due to the circumstances which are outlined below, responsibility for the completion of the Channel Island PCR 2 was transferred to the Bishop of Salisbury, Nicholas Holtam, in late 2020. The PCR 2 Review for Salisbury Diocese was completed in February 2020 and this review document should be read in conjunction with the Salisbury report. This is not a full Diocesan review but a review of safeguarding arrangements for the Channel Islands past and present.

1.1.2 The Independent Reviewer believes it is important to detail the history of the Channel Islands from a safeguarding perspective as it will add some context to the current arrangements. From 1569 the Channel Islands – comprising of the Deaneries of Guernsey and Jersey - were attached to the Diocese of Winchester. The relationship between the Deaneries and the Bishop of Winchester broke down in March 2013 over the suspension of the then Dean of Jersey (relating to the handling of a safeguarding matter which was reported in 2008). This led to an interim arrangement formalised on 25 March 2014 by which delegated episcopal oversight of the two Deaneries was granted by the Bishop of Winchester to the Bishop of Dover.¹ From a legal perspective, however, the Channel islands still remain part of Winchester Diocese.

1.1.3 Between 2014 and 2020, the Diocese of Canterbury provided support services for the Deaneries in respect of their safeguarding arrangements and Ministry training; with legal services remaining with the Winchester Diocesan Registry. In addition, some legal support is provided locally on the Islands. At the time of the transference from Winchester to Canterbury, the Archbishop of Canterbury signalled that he would appoint a Commission to look at the relationship between the Islands, the Diocese of Winchester and the wider Church of England. The Archbishop subsequently appointed a Commission in June 2018.

1.1.4 The Commission published its findings in October 2019 and recommended that the Channel Islands should be attached to the Diocese of Salisbury. The recommendations were

¹ Bishop Trevor Willmott was the Bishop of Winchester at the time the review was commissioned. He has now retired but has retained interim responsibility for the Channel Islands until responsibility is legally transferred to the Bishop of Salisbury.

approved by the General Synod in 2020, but have not yet been put before the Privy Council, which will happen following the respective Island legislatures approving the transfer. Safeguarding arrangements for the Channel Islands were transferred to Salisbury in late 2020 and with it the responsibility of completing the PCR 2 Review. The overwhelming majority of the material reviewed in the form of clergy blue files and the electronic case management system 'SafeBase' therefore relates to material generated from those involved in safeguarding from either Winchester or Canterbury Diocese.

Structure of the Channel Islands

- 1.1.5 The Bailiwicks of Guernsey and Jersey are self-governing dependencies of the Crown. They each have their own directly elected legislative assemblies and their own administrative, fiscal, legal systems and Courts of Law. They have never been part of either the United Kingdom or the European Union – their special relationship with the European Union being covered in a Protocol to the Treaty of Accession in 1972, which formally came to an end on 31st December 2020 as a result of the UK's decision to leave the European Union. The Government of the United Kingdom takes the view that by convention Parliament does not legislate for the Islands, but English legislation may, after consultation with the Islands' authorities and obtaining their consent, be extended to the Islands through an agreed "permissive extent clause" or by Order in Council (via The Ministry of Justice and Privy Council).
- 1.1.6 The Church of England is the established Church in the Islands. Both Deaneries are made up of parishes which have historically been largely coterminous with the civil parishes which form the basis for local administration in the two Islands. In Jersey, there are twelve ancient parishes; there are also seven district churches, two daughter churches and two chapels of ease and one proprietary chapel. In Guernsey there are ten ancient parishes and four ecclesiastical parishes created in the nineteenth century, grouped into eleven benefices. There are also three other churches in Guernsey where Anglican worship is held. Occasional services are held in the chapel in Herm.
- 1.1.7 Both the Dean of Jersey and Dean of Guernsey are leaders of the Church of England on the respective islands. The Dean fulfils the role of Archdeacon and Bishop's Commissary for the Deaneries and have additional roles unique to the Channel Islands for which there is no equivalent within the wider Church of England. In relation to safeguarding arrangements,

the Bishop of Salisbury now has ultimate oversight and accountability for safeguarding whilst the Deans are responsible for ensuring safeguarding best practice is implemented and maintained on their respective Islands. Both Deans remain accountable to the Bishop to whom they owe canonical obedience.

1.1.8 The Deaneries of Jersey and Guernsey adhere to all national safeguarding practice guidance published by the House of Bishops. They have local safeguarding policies in place which cater for some legislative differences which are unique to the Channel Islands.^{2 3}

1.2 Governance and Oversight of PCR 2

1.2.1 A PCR 2 reference group was set up to oversee the Channel Islands Review. The membership consisted of the following:

- Chair of the Diocesan Safeguarding Management Group (now known as the Diocesan Safeguarding Advisory Panel or DSAP for short)
- Diocesan Secretary/Chief Executive
- Dean of Guernsey
- Dean of Jersey
- Lead DSA for Salisbury Diocese
- PCR 2 Project Officer
- Representative from Splitz Survivor Support charity (representing victims)
- Local Church Safeguarding Officers from Guernsey and Jersey Deaneries
- Representative of Guernsey Caring for Ex-Offenders
- Salisbury Diocese Independent DSAP member
- Director of Communications

1.2.2 In addition to the above, arrangements were put in place for the Independent Reviewer (IR) to meet with the Lead DSA and Project Officer on a weekly basis to discuss the progress of the review. This was the forum to discuss individual cases which required follow up work. Outside of this, the IR was in regular contact with the DSA and Project Officer which provided the facility to discuss urgent matters if required. The review did not identify any cases of a

² Jersey has a Safeguarding Policy called "Safeguarding children and vulnerable adults from harm in Jersey – published July 2020.

³ Guernsey Church safeguarding Handbook [second edition] – Published February 2021

serious nature which required immediate action but the lines of communication that were put in place would have catered for this eventuality.

- 1.2.3 The Independent Reviewer provided weekly statistics to the Project Officer which provided the numerical numbers of cases and categories reviewed.

1.3 Commissioning arrangements for the Independent Reviewer

- 1.3.1 The reviewer selected to conduct the Channel Island Review was Tracy Hawkings. Tracy was part of the initial recruitment drive for associates to support the National Safeguarding Team and was placed on the approved Independent Reviewers list for PCR 2. Tracy is a retired Police Officer having served 30 years with Essex Police. She retired from the Police Service in 2017 as a Detective Chief Superintendent and Head of Public Protection Command. Tracy was an accredited Senior Investigating Officer and held the National Review Officers accreditation.
- 1.3.2 Tracy was one of the two Independent Reviewers selected to conduct the PCR 2 Review for Salisbury Diocese but prior to that had no previous involvement with either Salisbury Diocese or the Channel Islands.
- 1.3.3 The review began in December 2020 and concluded in May 2021. It was delayed by the restrictions put in place as a result of the Covid pandemic which made it impossible to review the clergy blue files until such times as the restrictions were relaxed. The Reviewer worked to the terms of reference set by the PCR 2 Reference Group.

2.1 Purpose and objectives of PCR 2

2.1.1 In May 2007, the House of Bishops decided on the need for a review of past cases of child abuse. This followed court appearances by several clergy and church officers who had been charged with committing sexual offences against children. What became known as the Past Cases Review 2007-2009 (PCR) was considered necessary in order to ensure that:

- Any current or future risk to children was identified,
- Action was taken to address these concerns,
- Where cases were identified support could be provided for the survivors of abuse where these people are known and still in contact with the church,
- Lessons from the past could be learned to inform the work of the Church in the present and in the future.

2.1.2 The Past Cases Review 2007-2009 was a large-scale review of the handling by the Church of England child protection cases over many years and a scrutiny of the files of clergy and Church Officers to identify any persons presenting on-going risks to children which had not been acted upon appropriately. The process for conducting the PCR was based on a House of Bishops Protocol. It was carried out during 2008 and 2009 by all dioceses (44 at the time) and a similar process was undertaken for the Provinces in relation to information and files held at Lambeth and Bishopthorpe Palaces.

2.1.3 In 2015, concerns were expressed to the newly appointed National Safeguarding Adviser about how well the PCR had been conducted. Consequently, in consultation with the National Safeguarding Steering Group, he commissioned an independent assessment of the adequacy of the PCR. The assessment was conducted by an Independent Scrutiny Team (IST) led by Sir Roger Singleton. They reported to the National Safeguarding Steering Group in April 2018. Following consideration by the Archbishops' Council and the House of Bishops, its full report was published and submitted to the Independent Inquiry on Child Sexual Abuse on 22 June 2018.

- 2.1.4 The IST made a number of recommendations which included the fact that seven Dioceses needed to repeat their PCR due to “some serious shortcomings in the implementation” of the original review.
- 2.1.5 The National Safeguarding Steering Group (NSSG) for the Church of England accepted the recommendations and agreed that the PCR should be repeated in the seven Dioceses concerned. This included both Winchester and Salisbury Dioceses. They also concluded that the review needed to be brought up to date in every other Diocese nationally and the parameters of the PCR 2 were extended to include Vulnerable Adults (and domestic abuse).
- 2.1.6 At the time of the original PCR in 2008, safeguarding arrangements for the Channel Islands came under the Diocese of Winchester. The Channel Islands did not form part of the original Winchester 2008 PCR, but the files were reviewed in 2014 by an Independent Reviewer. In the intervening period between PCR 1 and PCR 2, safeguarding arrangements for the Channel Islands came under Canterbury Diocese and more latterly Salisbury Diocese.
- 2.1.7 There was evidence contained within the clergy files that demonstrated they had been reviewed again by Canterbury Diocese in 2015 when responsibility for the Channel Islands was transferred. In addition to this, a Social Care Institute for Excellence (SCIE) audit of the Diocese of Canterbury and the Channel Islands was conducted in March 2017. As part of their findings, SCIE reported that “casework in the Diocese is of a good standard, befitting the experience and skills of the DSAs. There was an overall sense of safety – that whenever safeguarding concerns were presented, the response was timely, thorough and professional”.⁴

2.2 Parameters and scope of the review

- 2.2.1 As with the original PCR, the key purpose of PCR2 is to try and ensure that risks to children and vulnerable adults which are known about within the Church, or which can be identified from files, are assessed to ensure that appropriate action was taken at the time the incident came to light. In cases where it transpired that appropriate action had not been taken, the

⁴ See SCIE Audit report March 2017, section 2.5, page 11.

reviewers brought the matter to the attention of the DSA with appropriate recommendations.

2.2.2 The parameters set for the Channel Island PCR 2 was to identify cases which included abuse against children, vulnerable adults and domestic abuse.

2.2.3 The definitions of cases which fall into these categories are detailed below:

- A **child** is defined in “Working Together to Safeguard Children – July 2018” as:
“Anyone who has not yet reached their eighteenth birthday”.
- **Vulnerable Adult** means a person, aged 18 or over whose ability to protect himself or herself from violence, abuse, neglect or exploitation is significantly impaired through physical or mental disability or illness, old age, emotional fragility or distress, or otherwise; and for that purpose, the reference to being impaired is to being temporarily or indefinitely impaired.
- The reviewer used the criminal definition of domestic abuse when considering cases which fell into this category which is defined as “Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality”.

2.3 Files which were in scope and reviewed

2.3.1 The Protocol and Practice guidance for the Past Cases Review issued guidance on the files which needed to be reviewed as⁵:

*“All clergy blue files and the equivalent personal files of diocesan staff, readers and other lay ministers and (where they exist) the files of other church officers, which **were not** reviewed*

⁵ Protocol and Practice Guidance Past Cases Review 2 (PCR 2) – Published July 2019.

as part of the original PCR and where the individuals are required to have substantial contact with children, within their church roles.

*All clergy blue files and the equivalent personal files of diocesan staff, readers and other lay ministers and (where they exist) the files of other church officers, where these individuals are required to have direct contact with adults at risk of abuse as part of their church role and: where those files have not been previously reviewed **with a focus on identifying incidents of abuse of adults, including domestic abuses.***

Particular attention must be paid to identifying and reviewing:

*The files of those individuals whose behaviour has been identified as potentially posing a risk to children whose file/information **was not** considered as part of the original PCR or whose behaviour has become of concern **since** the original PCR.*

Files relating to any, lay minister, diocesan staff or church officer whose behaviour has been identified as being potentially harmful or abusive to adults including domestic abuse which is not caught by the above three categories”.

A Church Officer is anyone appointed/elected by or on behalf of the Church to a post or role, whether they are ordained or lay, paid or unpaid.

2.3.2 The blue files which were in scope and reviewed for the Channel Islands Review were:

All current clergy files

Clergy files for those with Permission to Officiate

Files for unlicensed clergy

Files for deceased clergy

Files for Readers

2.3.3 In addition, the electronic case management system known as ‘SafeBase’ which was first introduced by Canterbury Diocese was also reviewed. This is a secure system and contains details of all safeguarding referrals recorded by the DSAs in post at Canterbury since 2015. Some retrospective entries linked to Winchester were also placed on to the system dating back to 2013/14. The system has been retained by Salisbury and is still being used to record referrals made from the Channel Islands.

2.3.4 The parish returns were reviewed and compared to entries within the blue clergy files or on SafeBase relevant to the named individual.

2.3.5 Prior to 2014 and the introduction of SafeBase, Winchester Diocese had another case management system which is now archived. Enquiries with the Winchester DSA revealed it might be possible to reload the system, but the Channel Islands referrals were integrated with all of Winchester referrals and it would not be possible to identify them without accessing each individual record. A decision has been taken it would be disproportionate to follow this up further.

3.0 DIOCESE FILE ADMINISTRATION SYSTEM

3.1 An overview of the filing and administrative system

3.1.1 All clergy files held at Salisbury Diocese are kept in locked filing cabinets in a locked room at South Canonry. They are overseen by the Bishops Chaplain and an Administrator. They are currently filed in categories – current clergy, clergy with permission to officiate, unlicensed and deceased clergy. In addition, there is a separate drawer for those files where there have been serious safeguarding concerns or those subject to CDM matters. The Diocese is currently considering whether to change this system to an alphabetical filing system. All safeguarding matters are recorded electronically by the DSAs and retained on a secure drive. A decision was made not to integrate the Channel Island files with the Salisbury Diocese files until after the review had concluded.

3.1.2 The Salisbury DSAs have adopted the ‘SafeBase’ system which was previously used by Canterbury and are continuing to record Channel Islands safeguarding concerns within this secure system. Salisbury is hoping to be one of the dioceses/cathedrals used to pilot a new national case management system but, in the interim, will continue to use SafeBase.

3.1.3 If a safeguarding referral is made in relation to a member of the clergy or Church Officer, the details should be recorded on to SafeBase and a note placed in the blue file to indicate there has been a safeguarding concern and additional information is held elsewhere by the DSA.

3.2 The management of the filing and administrative system

3.2.1 The clergy blue files reviewed were generally in good order and there was evidence contained within them that they had been subject of previous reviews. Some of the newer files were separated by tabs and divided to distinguish between relevant categories. Others had papers which were filed in date order and had no obvious organisation to them. There was a degree of duplication and repetition amongst the papers and these files would benefit from being weeded to address this issue. There were a handful of files which contained details of safeguarding concerns or CDM matters where papers had been placed in sealed envelopes and marked as “sensitive” or “confidential”. These were accessed and examined by the Independent Reviewer. In one file, the sensitive papers were not sealed securely and

would therefore have been accessible to anyone reading it. This was addressed by the Independent Reviewer who secured the papers.

- 3.2.2 In a limited number of blue files which contained safeguarding concerns there was not always a corresponding retrospective entry on SafeBase. This meant, until PCR 2 and the formation of the Known Cases List, there was not a central record of safeguarding concerns documented in relation to members of the clergy or Church Officers. A good example of this, to demonstrate the point, related to allegations of interfamilial sexual and physical abuse made in 2017, which was reported both to the police and the Health and Social Care Department. The review identified that between November 2017 and August 2018, there were no referrals entered on to SafeBase and this would have coincided with the timing of the above-mentioned case coming to light. The name of the individual concerned has been placed on the Known Cases List.
- 3.2.3 The SafeBase system was developed in mid 2014 to meet the needs of Canterbury Diocese to record and evidence safeguarding practice. SafeBase is made up of a number of different sections/tabs and is used to record key information to evidence the quality and effectiveness of the safeguarding practice being delivered. In summary, details of all safeguarding referrals should be recorded on to SafeBase and then a record maintained of all subsequent action and key decisions. It also has the facility to record details of all those persons subject to risk management plans. The SafeBase system is used by the DSAs and it is they who are responsible for recording the detail of all referrals and uploading relevant documents such as emails, reports, risk management plans and for keeping a chronology of the progress of each referral.
- 3.2.4 The Independent Reviewer was given full access to the SafeBase system and reviewed the detail of all referrals placed on to the SafeBase system since 2014 (157 in total). Like any electronic system, it is a repository for the storage of documents and written dialogue and relies on the conscientiousness of the user to accurately record the details of the relevant referral. The Independent Reviewer found the system cumbersome and slow to use and it took an absolute age to retrieve the documents contained within it. The DSA at Salisbury is aware of the system's limitations and Salisbury Diocese is to be involved in the development of a new national safeguarding database.

3.2.5 There is no facility within SafeBase to maintain a clear written chronology of key facts. Some DSAs made an attempt at doing so by utilising the front section of the referral sheet whilst others did not. The only way to obtain a complete overview of what happened was to enter every tab and read every entry and open all documents. Whilst this would need to be done in order to conduct an effective review, it would have been helpful to the IR to have had access to a summary page which provided a chronology of key events.

3.2.6 This is not a review of SafeBase and the current DSAs are aware of the limitations of the system, but other issues with it include:

- Many of the documents uploaded and contained in individual case files were password protected and could not be accessed, although the case files were accessible,
- There is a significant amount of duplication, particularly when e-mail trails are uploaded,
- The original source documents which were uploaded by previous DSAs have not been reviewed and so there may be more material available than that which was uploaded onto the system,
- Some of the recordings particularly in 2014/15 are limited and it was not possible to get a full understanding of all the facts,
- Many of the referrals did not have full updates, particularly those that were referred to other agencies,
- Not all safeguarding concerns contained with clergy files are recorded on SafeBase.

3.2.7 There were some positive aspects of this system which include:

- It is a secure system which affords access to DSAs only,
- The system is used to record and review those persons on risk management plans and the system flags up when reviews are due,
- The system when used effectively provides a comprehensive record of key events,
- The system allows the user to filter the referrals into various categories. e.g. Open referrals, Closed referrals, All referrals, Watchlist.

3.2.8 The general standard of recording within SafeBase has improved dramatically since the system was first introduced. The IR was particularly impressed with one of the Canterbury DSAs and both current DSAs at Salisbury.

4.0 METHODOLOGY

4.1 The preparation undertaken prior to the Review

- 4.1.1 At the time PCR 2 was announced, the Channel Islands were under the interim safeguarding management of the Bishop of Dover and so it was he who wrote the initial letter to the Deans of Jersey and Guernsey, notifying them of the review and requesting that they identify all current or historic safeguarding concerns within the Parishes across the Channel Islands. In total, forty replies were received, which represents a hundred percent return. All the information relating to the Parish Returns was transferred to Salisbury Diocese from Canterbury or from the Parish representatives.
- 4.1.2 Every attempt was made to ensure that all files held previously, within both Winchester and Canterbury Diocese linked to the Channel Islands, were located and reviewed. All clergy files were boxed up by Canterbury Diocese and transferred to Salisbury. Each box was numbered and labelled and contained within it was a spreadsheet which detailed each individual clergy member. Upon receipt at Salisbury the project lead checked all the files and compared them to the spreadsheet. If a file folder was empty or contained limited information, further attempts were made to locate missing content. The deceased files had been retained by Winchester Diocese and arrangements were made to transfer the files to Salisbury. The enquiries to identify the missing files have been extensive and all replies have been documented for accountability purposes. At the conclusion of the review, only one reader file could not be accounted for.
- 4.1.3 A letter was prepared by the Project Officer and sent to all organisations which were known to have employed Chaplains or had them work on a voluntary basis. The respective Deans provided the detail of Chaplain secondments known to them. This letter requested that the organisations should reply if they had any safeguarding concerns about either their present or previous Chaplains. In total five organisations replied, one of whom raised a concern which was previously known about. (This case has been the subject of a National Learning Event.) No other concerns have been raised. In order to be thorough, further attempts have been made to chase up the organisations that had not replied, however these have been unsuccessful. All contact has been recorded to ensure that there is an audit trail of decisions.

- 4.1.4 After each blue file was reviewed, an electronic check list form was completed, and a copy placed within each file signed and dated by the Independent Reviewer. In addition, electronic copies of the checklist forms were maintained and are stored within the Diocesan safeguarding folder for the Channel Islands. The corresponding spreadsheet was endorsed by the Reviewer which denoted the fact that a file had been reviewed. This process enabled the Reviewer to identify missing files and make arrangements for the files to be located.
- 4.1.5 When a safeguarding concern was identified, the Independent Reviewer wrote a case report for the DSA with recommendations to be considered when appropriate. This included a recommendation for consideration to place the individual's name on the Known Cases List.
- 4.1.6 Regular meetings were held with the DSA to discuss these cases, and to review the recommendations in relation to follow up action and/or to make a decision with regards to the Known Cases List. Outside of this process, the Reviewer was able to contact the DSA if a matter was felt to be time critical.
- 4.1.7 At the end of the review, a Known Cases List had been drawn up. Each KCL entry has a corresponding report, written by the Independent Reviewer, which is stored within the electronic safeguarding folder.
- 4.1.8 The statistics for number of files reviewed and key information can be found at appendix one of this report.

4.2 Briefing and guidance which was provided to Independent Reviewer

- 4.2.1 The Independent Reviewer had previously conducted the PCR 2 for Salisbury Diocese and was familiar with the PCR 2 process. Notwithstanding that, the IR was provided with a comprehensive briefing by the DSA and Project Officer at the commencement of the review. In addition, there were supplementary briefings provided by the NST PCR2 Project Manager and Stakeholder Engagement Officer which the IR attended.

4.2.2 The IR familiarised herself with the PCR 2 reference documents and the PCR toolkit prior to the commencement of the Review. In addition, she conducted open research on the history of the Channel Islands, researched the Deanery websites and read their respective safeguarding policies.

4.3 Recording methods used by Independent Reviewers/Project Officer

4.3.1 As far as the Reviewer has been able to determine, there has never been a definitive list maintained by Winchester or Canterbury Diocese of all clergy members who have practised on the Channel Islands historically. This review, therefore, has been confined to those files which were transferred from Winchester/Canterbury and those records on the electronic case management system. Prior to the commencement of the review, Canterbury Diocese prepared checklists in the form of spreadsheets, recording the personal details of each category of clergy blue files. The Project Officer for Salisbury then reviewed the spreadsheet to ensure all the files were accounted for. In some cases, there was an empty tab and no file, and in other cases, a bundle of papers as opposed to a file. During the review, every effort was made to locate the missing files. In some cases, the files were located and sent to Salisbury for review and, in others, an agreement was reached for the files to be reviewed as part of the PCR 2 process in the Diocese where the file was located. This agreement was put in place in circumstances where the clergy member was still actively practising in the relevant Diocese.

4.3.2 A file checklist sheet was completed for all clergy blue files reviewed. This was the templated checklist prepared for the PCR 2 process. Where a safeguarding concern was identified within a blue file, the Independent Reviewer provided a report to the DSA with recommendations, if appropriate. A copy of the report was placed on each of the relevant records in the electronic case management system. The report which provided a summary of the referral, remedial action taken and, in some cases, made recommendations to the DSA for follow up enquiries.

4.3.3 In cases where further enquiries/actions needed to be completed, the DSA would provide the IR with a written update which was then included on the individual case report. A Known Cases List has been drawn up for all cases of concern.

4.4 Methods used by IR to standardise and quality assure methodology

- 4.4.1 In conducting the review, PCR 2 guidance documents were referred to as well as guidance contained within the PCR 2 toolkit. In cases where additional detail was needed, Crockford's Clerical Directory was referred to and open research conducted to try and ascertain further detail on certain individuals.
- 4.4.2 During PCR 2, the Independent Reviewer, DSA and Project Officer held meetings with the current DSAs from both Winchester and Canterbury and the Independent Reviewer had a separate meeting with the Winchester IR who conducted PCR 1 in an effort to understand previous safeguarding arrangements and to ensure, as far as it was possible, that all clergy files and other information had been transferred to Salisbury Diocese.

5.0 SAFEGUARDING ACROSS THE CHANNEL ISLANDS

5.1 The Infrastructure/Policy and Practice

- 5.1.1 The Deaneries of Guernsey and Jersey have been extremely proactive in seeking to improve the service and support they provide to survivors and victims of abuse. Both Islands have identified an experienced member of Clergy as a “Deanery Safeguarding Officer” (DSO) who act as a tactical lead on their respective Islands for safeguarding matters, whether this is providing the initial response or ensuring the Church of England’s standards with regards to responding to survivors are adhered to.
- 5.1.2 Since the recent move to Salisbury, the DSOs have become standing attendees on the Diocesan Safeguarding Advisory Panel (DSAP) on which there is representation from an independent survivor advocacy service, whom they are able to access for advice and support when needed.
- 5.1.3 The safeguarding infrastructure of both Jersey and Guernsey (incorporating Alderney and Sark) adheres to all practice guidance issued by the House of Bishops. Each of the Islands have their own published safeguarding guidance documents which are comprehensive and detailed. Guernsey Deanery has published “The Church Safeguarding Handbook” (Vs 2 and most recent edition was published February 2021). Jersey Deanery has published “Safeguarding Children and Vulnerable adults from Harm (Published July 2020)⁶. These policies can be found on the Deanery websites together with a significant amount of information devoted to safeguarding.
- 5.1.4 Both policies translate the Church of England’s National Safeguarding Policy into a framework that reflects their respective Islands legislature and statutory guidance.
- 5.1.5 The Deanery of Guernsey comprises three jurisdictions within the Bailiwick of Guernsey: Alderney, Guernsey, and Sark. In Guernsey, there are fourteen ecclesiastical parishes, grouped into eleven benefices. There are four other churches devoted to Anglican worship, three on Guernsey and one on Herm.

⁶ Since writing the report, version 4 of this document was published on 3rd February 2022.

- 5.1.6 The Deanery of Jersey consists of 18 benefices comprising 12 Ancient Parishes and 6 District Churches and Proprietary Chapels in addition to Daughter Churches.
- 5.1.7 There is a Deanery safeguarding lead for both Jersey and Guernsey who report to the respective Deans who retain ultimate responsibility for safeguarding practice. Every church must appoint a Church Safeguarding Officer (CSOs)⁷ and a Church Disclosure Officer.⁸ The IR saw evidence of regular contact between the CSOs and safeguarding leads/DSAs and the arrangement appears to be working well.
- 5.1.8 Both Islands have a Multi-Agency Safeguarding Hub (MASH) and a multi-agency set up which is similar to that found within any Diocese. Both Islands have Multi-Agency Public Protection Arrangements (MAPPA) in place and the communication between the Probation Service and safeguarding leads/DSAs was excellent. The IR saw several examples of good practice which are detailed below.
- 5.1.9 Salisbury Diocese has two safeguarding advisors. One is the principal lead for Guernsey and the other for Jersey. There appears to be a very good working relationship in place which has developed quickly between the Salisbury DSAs and the respective safeguarding leads. The IR saw several examples of prompt and thorough communication between professionals and appropriate referrals made to the statutory agencies.

5.2 The Initial response to safeguarding concerns (both children and adult)

- 5.2.1 The respective safeguarding policies set out very clearly the initial response required for all safeguarding referrals for both emergency and non-emergency situations. This is the same process for both Jersey and Guernsey and accords with National Guidance set by the House of Bishops. This is recorded in appendix 2 of this report. In summary, in emergency conditions where a child or adult is in immediate danger, the police should be contacted. The information should be recorded and reported to the CSO who in turn should record and discuss with the DSA as soon as possible but in any event within 24 hours. In non-emergency conditions, the process is slightly different – the initial information about the concern should be recorded and reported to the incumbent or straight to the CSO and agree who will contact

⁷ Since writing the report - CSO's are now known as Parish Safeguarding Officers

⁸ Church Disclosure Officers are now known as Verifiers.

both the Deanery safeguarding officer and DSA. The DSA must be contacted for advice and guidance within 24 hours. Decisions will then be made as to next steps which may include referral to statutory agencies, formation of a Core Group or provision of pastoral care. At each stage the DSA must be kept informed, and all key decisions recorded.

5.2.2 There is no facility for a diocesan hotline, but all means of contact for the DSAs and safeguarding leads are published on the Deanery websites and within safeguarding policies. The response for victims including pastoral support, authorised listeners or more specialist support is set out clearly in the safeguarding guidance documents.

5.2.3 In addition, both Deaneries have access to out of hours safeguarding support including weekends from an organisation called 31:8 which is an independent Christian charity which provides support to various agencies and organisations from a safeguarding perspective.

5.2.4 The safeguarding concerns found in clergy blue files were overwhelmingly historical concerns which had come to light prior to the Church of England setting up its structure for safeguarding as it is now, and before safeguarding leads and advisers were put in place.

5.2.5 The electronic case management system SafeBase has been used to record safeguarding referrals since 2014. The standard of recording across the system is variable and was particularly poor in the early days. The standard has improved significantly over time and there is clear adherence to safeguarding practices.

5.3 The quality of investigation into safeguarding concerns

5.3.1 The SafeBase system records the detail of all referrals and therefore contains a wide variety of content within it, which can range from criminal investigation/prosecutions at the most serious end of the spectrum, to concerns of a minor welfare nature at the lower end. With one or two exceptions, where there simply was very little information recorded, whenever a CSO or safeguarding lead had cause to refer a case to a DSA (across all 3 dioceses), there was always a prompt and positive response. Appropriate referrals were made to statutory agencies when required, pastoral support was put in place in other cases and, overall, the input of the DSAs was professional and relevant. There are some referrals which have insufficient information recorded and require an update. These usually involved cases which were referred to other agencies via the MASH or directly to the police. When other agencies

assumed the lead in dealing with the referral, there was a lack of update on SafeBase in some instances.

5.3.2 There is evidence contained within the records which demonstrate that the safety of the victim is always considered and steps are frequently taken to protect others from abuse. The Deans and NST should be reassured in relation to the current service provided by the Salisbury DSAs. The standard of recording of case files is detailed., thorough and comprehensive.

5.3.3 There does not appear to be any formal review periods set for open cases and the IR believes this would be beneficial and would allow the DSAs to identify cases where further action is required, or updates are needed. This will form the basis of a recommendation.

5.4 The quality of case management into safeguarding concerns

5.4.1 As previously stated, there is a wide variance in the standard of recording on SafeBase between 2014 and 2021. From reviewing all of SafeBase, the IR can say that in the vast majority of cases, referrals have been managed well with support provided to the person subject of the referral. What was sometimes lacking was an update. For example, if a case had been referred to the MASH that a child might be the subject of concerns around neglect, the recording ended at the point the referral was made and social care agreed to intervene. Whilst it is highly likely that support was put in place and the situation was monitored locally within parishes, the referral record does not demonstrate this to be the case. There are other cases, when exceptional support has been provided by the pastoral teams within parishes, which was fully documented and audited.

5.4.2 As can be seen from those cases which feature within the KCL, there have been some serious allegations or concerns relating to clergy members or Church Officers. There are a variety of historical allegations reported in recent times, [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED].

5.4.3 Conversely, there are other cases on the KCL where immediate and prompt action was taken by all the professionals involved which ultimately led to the prosecution and conviction of the perpetrator.

5.4.4 Importantly, there were no new cases of safeguarding concerns found by the IR within the Blue Files or as a result of the parish returns. All cases were previously known about and had involvement of DSAs and other professionals. Any recommendations made by the IR in the individual case report in the main related to requests to try and ascertain updates, matters of policy or decisions in relation to eligibility for a case to be placed on the Diocesan KCL.

5.5 The management of those who pose a risk

5.5.1 The management of those who pose a risk is taken extremely seriously by all those involved in safeguarding roles across both Deaneries and there were several examples whereby individuals were made subject of risk management plans which were actively monitored and regularly reviewed.

5.5.2 One aspect of SafeBase which is very effective is the capability to place individuals on to the system's watchlist. This flags up within the database a list of all those subject to risk management plans and gives early warning of the dates on which reviews are due.

5.5.3 The IR saw a number of action plans, risk management plans and letters of agreement which were detailed and comprehensive. There was a high percentage of adherence to the conditions set, and non-adherence was dealt with efficiently, with proactive action taken against the person subject to the plan.

5.5.4 There is one organisation on Guernsey called Guernsey Caring for Ex-Offenders (GCFEO) who provide a complementary support to the Probation Service for all people released from prison who return to the Island. They run all sorts of initiatives and activities for ex-offenders to try and integrate them back into society. Some of the GCFEO provision is delivered at one of the major church premises on the island. There is always a full risk assessment conducted with information provided by MAPPAs before any individuals are allowed to attend. This process provided a good insight into how seriously risk management is taken and the good relationship that exists between the Church and other professionals.

5.5.5 GCCEO work very closely with the Diocese, the local church and Guernsey Probation Service between which there is excellent co-ordination and co-operation.

6.0 SURVIVORS

6.1 Survivor Strategy

6.1.1 At the present time, a Survivor Strategy for Salisbury Diocese is still being developed. The IR has seen a draft copy of this and a current action plan called 'Championing Survivors Voices' which shows a programme of work devised to complement the Strategy and ensuring a strong focus is maintained on this vital area of work, which is one of this year's Diocesan safeguarding priorities. This includes actions to consult with survivors to gain feedback on processes, locating a suitable organisation to sit on the DSAP who can ensure the 'Survivor's Voice' is heard and assisting in identifying referral pathways across statutory and charitable organisations. The IR has discussed the progress of this with the DSA and was reassured to learn how seriously this piece of work is being taken. The DSA has a future meeting planned with the NST, as it is important to ensure consistency across the whole organisation, rather than one Diocese operating unilaterally.

6.2. Incorporating survivors' lived experience in PCR 2

6.2.1 This aspect was discussed between the DSA and the IR prior to the commencement of the review. A member of an organisation called 'Splitz' was invited to sit on the review Reference Group to represent the voice of the victim/survivor. During the review a decision was made by the Reference Group to actively market the fact the PCR 2 was taking place for the Channel Islands. A communications strategy was agreed and included: publishing the detail of the planned PCR 2 on both Deanery websites local media interviews taking place with both Deans, and local newspaper coverage and an open letter from the Deans distributed across all parishes. The independent advocacy service representative on the DSAP and PCR 2 Reference Group assisted with shaping the marketing material used to promote this project across both Islands.

6.2.2 There was a positive response to the strategy which included two survivors coming forward and engaging with the DSAs to discuss their experiences in more detail. The plan is to engage one of them in the work on the Survivor Strategy going forwards. One of the cases was not previously known about; the survivor came forwards as a direct result of the media strategy. A record of the referral has now been placed on SafeBase and the DSA is progressing the matter with the complainant and the case remains open. The survivor wanted her

experience recorded and accepts little can be done as the abuser has been deceased for several years. In the second case, the survivor was known and there was a record of the safeguarding concern recorded on SafeBase. The feedback received from her was that her initial experience was poor, as following her disclosure she heard nothing and had to initiate further contact. It was only at this point that the matter was taken seriously and reported to the police. Thereafter, she stated she felt listened to and her complaint was taken seriously. The survivor felt encouraged by the fact the Church was taking active steps to further improve their response and was keen to assist with this important piece of work going forwards.

- 6.2.3 In addition, to the above, the local police contacted one of the Deans to inform him they had received information about [REDACTED]. One of these cases involving a Church Officer was known about and there was a record of the concerns. The other concern related to [REDACTED]. The police were progressing both cases and information was shared with them.
- 6.2.4 In addition, as a direct result of the media interviews, a representative from the Pan Island Safeguarding Board made contact and will engage with both Deaneries and DSAs going forwards. The plan is for the Channel Islands safeguarding team to become associate members of the Safeguarding Board. This is seen as a very positive step forward.
- 6.2.5 The IR saw lots of examples where the pastoral care offered by pastoral teams across the parishes was exceptional and well documented. There were many occasions when there were attempts to gain further support from statutory or voluntary organisations from either the DSAs or members of the local pastoral teams.
- 6.2.6 With the implementation of the 'Safe Spaces' initiative across the Church in England and Wales, the DSA team have recently approached the National Safeguarding Team and this important service for victims and survivors of faith base abuse has been extended to include

the Channel Islands and this is now widely advertised across local churches and on Deanery websites.

- 6.2.7 Jersey has developed some local on Island arrangements with regards to Authorised Listeners and Guernsey is currently engaged in negotiating a similar arrangement. Where necessary, both Deaneries are able to access similar services 'Off Island' through their Diocesan Safeguarding Team.
- 6.2.8 The PCR 2 review for the Channel Islands was a paper review. It is clear from the files reviewed, both electronic and blue clergy files, that in the overwhelming majority of cases the survivors were listened to and their concerns raised taken seriously. There are some gaps in recording, particularly in the older cases but this aspect has significantly improved over time. In cases where the IR identified further work was required, a report was provided to the DSA for follow up action. In some cases this included the fact that updates were required with regards to progress of the referrals. Invariably these were the cases which had been referred to the MASH and other statutory partners involved.
- 6.2.9 The IR has discussed the subject of survivor care at length with the lead DSA for Salisbury Diocese and is reassured about how seriously the Diocesan Safeguarding team take this subject. It is a difficult area to get right, particularly in cases where the statutory agencies are involved, and it is imperative that an early decision is made with regards to who the lead agency should be in maintaining contact and how information should be shared with all the other partners involved with the case. This subject forms the basis of a recommendation in the wider Salisbury Diocesan PCR 2.

7.0 STATUTORY AGENCIES

7.1 **The Structure and contribution to multi-agency working**

- 7.1.1 A very good relationship has been established with a number of local partner agencies across both Islands. For example, a Guernsey charity which works with survivors of domestic abuse has recently agreed to support some church training on the subject of domestic abuse for local Safeguarding volunteers.
- 7.1.2 As a direct result of PCR 2 work, a relationship has developed with Dewbury House in Jersey which is the Island's Serious Sexual Assault Referral Centre (SSARC). This Centre supports victims and survivors of both recent and past abuse. A meeting has taken place with the DSAs from Salisbury and work is on-going to develop this relationship.
- 7.1.3 There is a MASH set up to oversee safeguarding concerns for children and young people in both Jersey and Guernsey. The membership is made up from representatives from a number of States' departments and other bodies whose work includes care for vulnerable children and young people. It provides a single point of contact for any concerns you may have about a child, including enquiries from professionals such as teachers and doctors, or from members of the public and family members. The MASH allows agencies to work together more closely, ensuring that information is shared appropriately, and that responses are timely and coordinated.
- 7.1.4 The States' Health and Social Care are responsible for dealing with concerns relating to Vulnerable Adults. There are Safeguarding Adults teams within the Health and Social Care departments and referrals are made to those teams in respect of any concerns.
- 7.1.5 There are MAPPA arrangements across the Channel Islands for the management of dangerous offenders.
- 7.1.6 There is a pan island Safeguarding partnership board which was set up in 2019 and has an independent Chair. Both Deaneries have recently been invited to become associate members of the Board, which will further assist with cementing these relationships as well

as developing others. This is an extremely positive development and will assist in further improving our interactions and support to survivors.

- 7.1.7 There is an independent service known as Jersey Domestic Abuse Support (JDAS) which was developed to support victims of domestic and sexual abuse. The service has a number of IDVAs who provide support to women, men and their families.
- 7.1.8 “Safer” is the bailiwick of Guernsey’s domestic abuse charity supporting all victims of domestic abuse whether they be adults, children, women or men and regardless of age, race, religion, sexual orientation or disability They run the Island’s Women’s Refuge and provide the Independent Domestic Violence Adviser service for adults and children.
- 7.1.9 It is clear from the review, that the Channel Islands’ safeguarding leads and DSAs have developed a good working relationship with other professionals within the safeguarding environment. There were several examples on SafeBase which demonstrate the fact referrals were made into the MASH, Health and Social Care.
- 7.1.10 There are information sharing protocols agreed by the safeguarding boards for members and associations. This enables organisations to share information from a safeguarding perspective. This again will enhance and assist local processes.
- 7.1.11 The DSA from Salisbury is in the process of trying to formalise ISAs with any relevant and willing agencies across the Channel Islands. They have in place an information sharing agreement with Guernsey probation service and make regular contributions to the risk management discussions about offenders who join the Church of England worship community on their release from prison. It is an excellent example of partnership working between statutory and non-statutory agencies.

8.0 DOMESTIC ABUSE

8.1 The management of domestic abuse

- 8.1.1 There were a few examples of domestic abuse concerns reviewed on the SafeBase database. Apart from one example, the cases involved referrals relating to congregation members as opposed to Church Officers. In all cases the concerns were taken seriously and appropriate referrals made to statutory agencies. The pastoral team were heavily involved in supporting victims and there were one or two examples where they assisted victims to relocate in order to escape the danger they were in.
- 8.1.2 There are support services available across the Channel Islands who provide an IDVA service to victims of domestic abuse. The work of “Safer” and “JDAS” is referred to in section seven of this report.
- 8.1.3 There was one case where it was suspected a Church Officer was abusing and neglecting [REDACTED]. A Vulnerable Adult referral was made and a swift response provided by Health and Social Care. [REDACTED]. The pastoral team provided additional and on-going support. There were no disclosures made, and the police did not proceed with the case. However, the fact there was intervention by agencies, reduced the level of concern and the victim was seen to improve. This case has been placed on the KCL.

9.0 CONCLUSION

- 9.1.1 Following the events which stemmed from the safeguarding matter in 2008 which led to the Korris, Steel and Gladwin reviews and the Archbishop of Canterbury's Commission, the Channel Islands and the wider Church of England were motivated to improve and formalise the safeguarding practices and structure. There has been a lot of information in the public domain about this matter which remains a sensitive issue, and the IR does not intend to comment further on this point.
- 9.1.2 The safeguarding policies and infrastructure adopted by the Channel Islands based on national guidance published by the House of Bishops has been a huge step forward. It is clear from the evidence reviewed, safeguarding is taken extremely seriously by the Deans, CSO/Safeguarding leads and DSAs.
- 9.1.3 The Independent Reviewer was welcomed into the Diocese by the Bishop of Salisbury, Diocesan Safeguarding Adviser, Project Officer and administrative staff. Files were made readily available and suitable accommodation and equipment was made available.
- 9.1.4 The atmosphere within the Diocese was one of openness and complete transparency. The Reviewer had free access to all the files and to the electronic Safebase system. A significant amount of pre-work had been completed and comprehensive spreadsheets drawn up in advance and arranged into the relevant categories. Administrative staff were made available to assist the review with any queries and weekly meetings were held with the DSA.
- 9.1.5 The review found the clergy files to be in generally good order (subject to learning points) and categorised in such a way that access to them was easy. There was a system in place to identify the whereabouts of missing files and by the end of the review, only one reader file could not be found.
- 9.1.6 The standard of recording on referrals held within the electronic SafeBase system was initially variable but there has been a significant improvement over time.
- 9.1.7 All the cases where concerns were identified were already known about and no new cases were found as a result of the review. The cases where poor safeguarding practice was found

related to the older historical cases, which took place before the current infrastructure and policies were put in place.

9.1.8 In cases where the Reviewer identified that further action was required, the DSA responded in an efficient and effective manner.

9.1.9 In total, 23 cases were placed on the KCL for the Channel Islands. 17 cases linked to safeguarding concerns relating to children and 6 safeguarding concerns relating to vulnerable adults.

10.1 GOOD PRACTICE FOUND

- 10.1.1 Safeguarding leadership in the bailiwicks of Jersey and Guernsey falls to the Deans in the first instance. It is obvious from the information reviewed that both Deans are actively engaged with safeguarding matters and are well supported by their respective safeguarding leads and Church Safeguarding Officers.
- 10.1.2 The Channel Islands Safeguarding Officers are extremely well supported by the Diocesan Safeguarding Advisors and the review found clear evidence of excellent communication between them and a professional working relationship.
- 10.1.3 The current Bishop of Salisbury Diocese takes his safeguarding role extremely seriously and is a good source of guidance and support to all. Although he is due to retire imminently, he has left a strong legacy in his approach to safeguarding.
- 10.1.4 The relationship with statutory partners in a multi-agency set up seems to be working well and there are lots of examples of appropriate referrals being made and information shared between agencies.
- 10.1.5 Both Jersey and Guernsey have safeguarding policies in place which are accessible, detailed and easy to understand. Their policies adhere to national guidance published by the House of Bishops but also cater for some legislative differences within the Channel Islands.
- 10.1.6 Both Deanery websites have sections dedicated to safeguarding and there is lots of valuable information around sources of support, policy and support services. The websites are up to date and current.
- 10.1.7 There were lots of examples of cases on SafeBase which clearly demonstrate the excellent work of the church pastoral teams who actively engage with those experiencing difficulties. They seem to be a group of dedicated individuals who are there to serve their communities.

- 10.1.8 The general standard of casework was good. The referrals to the DSAs were made in a prompt fashion and in accordance with policy. Many of the referrals from CSOs included detailed initial reports of information disclosed or concerns identified. The DSAs responded well and in a supportive manner. Decisions were made as to who was to take the lead with regards to on-going support or referrals to other agencies.
- 10.1.9 There were not many recent concerns linked to members of the clergy or Church Officers and this may be a good indicator that safeguarding practices are working well across the Channel Islands.
- 10.1.10 The approach to the management of risk was very good. There is clear guidance and templated forms with regards to risk management plans, which should be seen as best practice. The quality and management of safeguarding agreements, by which the church attendance of people with convictions is monitored, and any risk minimised, is effective. The agreements are clear and are well-monitored, with reviews taking place at least annually. There was evidence of planned reviews being brought forward on the discovery of new information. Some risk management plans were ended at the point the subject stopped their involvement with the church. There was one case in which the terms of a safeguarding agreement were softened and ended early due to the compliance of the person subject of the agreement. This demonstrates a flexible and pragmatic approach to risk management. A strength of the system is that people who present a safeguarding concern, but who do not have a conviction, are given what the Diocese calls a 'letter of understanding'. This serves a similar purpose to the safeguarding agreements by setting boundaries around a person's church attendance and/or engagement with their parish.
- 10.1.11 There is an abundance of evidence to demonstrate the excellent working relationship that exists between the Channel Islands, DSAs and the Probation Service. This demonstrates a really solid multi-agency approach to risk management.
- 10.1.12 There was evidence of good information sharing between agencies. On the occasions when information could not be shared, for example by the police, there was always an explanation as to why. It is clear that good links exist between the Channel Islands safeguarding teams and their multi-agency partners.

- 10.1.13 There was evidence that information was shared between dioceses when a either a Church Officer, clergy member or other person who presented a risk had moved on in order that the risk could continue to be monitored.
- 10.1.14 There were no new cases found as part of the review. All cases were known about and have involvement of safeguarding practitioners.
- 10.1.15 There are good links with the NST. There were a small number of cases which had been referred to the NST. One case in particular attracted a learning review which is shortly due to be published and the NST have involvement with other matters which are on-going. This provides an additional layer of support to the Diocese and Channel Islands.

10.2 POINTS OF LEARNING

10.2 Some areas for improvement were identified by the review and these can be summarised as follows:

Clergy files

10.2.1 There is not a standardised format with regards to how the files are maintained and the papers appear to be randomly placed within. Some of the more recent files did have dividers and a greater degree of organisation. There was not a specific section for complaints, CDM process or safeguarding issues. (Recommendation One)

10.2.2 There were cases where there was no information within the blue files to signpost the reader to the fact that an electronic safeguarding record was held elsewhere or information on SafeBase to indicate a clergy blue file was in existence. To a degree this has now been rectified by the completion of checklist templates which denote a file note exists on SafeBase and a report prepared for the DSA. (Recommendation Two)

10.2.3 There is a degree of duplication of documents contained within clergy blue files. It does not appear as though the files have been weeded or that the Diocese has a formal policy on weeding clergy files. (This was a recommendation in the wider Salisbury Diocese review and will therefore not form the basis of a recommendation.)

SafeBase

10.2.4 The SafeBase system has its limitations and there is no facility to maintain an on-going chronology of the progress of a case (Salisbury Diocese hope to be one of the pilot dioceses to trial a National Case Management System and therefore this will not form the basis of a recommendation). In the interim period, however, the DSAs could consider maintaining a chronology on a word document which could be uploaded on to SafeBase at the end of an enquiry. This may assist them in their day-to-day work.

10.2.5 There are many documents on SafeBase which could not be accessed as they are password protected. Attempts were made to identify the passwords with limited success. This cannot be progressed any further (the current DSAs do not use the facility of password protecting

documents as SafeBase as it is a secure system and this is not required. This does not therefore form the basis of a recommendation). The fact that certain individual documents within a safeguarding record could not be accessed did not obstruct the review as it was still possible for the IR to gain a full understanding of the concern and action that had been taken.

10.2.6 The material held on SafeBase contained documents in the form of emails, reports and media articles which have been uploaded by various DSAs. That being the case, it must mean the original source material was held elsewhere originally. This has made it impossible for the reviewer to determine whether SafeBase contains a comprehensive record of **all** available information which may have been available at the time the enquiry was on-going. This aspect has been discussed with the current DSA, who will ensure going forwards all available relevant information is uploaded to SafeBase so that accurate records are maintained. (Recommendation Four)

10.2.7 There are several records on SafeBase which require an update, some of which has been resolved by the review, but other matters remain outstanding. The Salisbury DSA is aware of those records which require an update and will endeavour to pursue this with partner agencies (this will not form the basis of a recommendation because work is already on-going)

10.2.8 Not all safeguarding concerns contained within clergy files have a corresponding entry on SafeBase. (Recommendation Five).

10.2.9 Safebase does not allow for a review period(s) to be set for open cases. The DSAs will need to devise a formal process to ensure they conduct regular reviews for all open cases which should be recorded. This is both a local and national issue, but until this matter is considered by the NST, it is recommended that the DSAs agree a formal process. (Recommendation Six)

General

10.2.10 A formal Victim/Survivor Strategy is currently being devised albeit the DSA fully complies with the recommendations in the Practice Guidance and records are well maintained. The DSA has devised a comprehensive action plan to progress this matter and is liaising with the

NST with this piece of work (this was a recommendation made as a result of the wider Salisbury Diocesan review and will therefore not form the basis of a recommendation as it already forms a programme of work).

11.0 RECOMMENDATIONS

11.1.1 Recommendation One

It is recommended that the Diocese adopt a process to have a section within each file to denote areas of concern – i.e. Complaints, CDM process or Safeguarding concerns. This should be based on guidance contained within House of Bishops Policy (June 21) on “Personal Files Relating to Clergy”.

11.1.2 Recommendation Two

It is recommended that a template form is placed at the front of each file to highlight the fact that information is held by the Diocesan Safeguarding Advisor. As part of the main Salisbury review, a form was provided to the Diocese by the Reviewers for their consideration.

11.1.3 Recommendation Three

It is recommended that 1) Canterbury Diocese is contacted to ascertain if there are any other records available (electronic or paper) which contain any information in relation to safeguarding referrals for the Channel Islands which have not been uploaded on to SafeBase. 2) That previous DSAs from Winchester and Canterbury are contacted and enquiries made with regards to passwords used to protect documents to see if any existing documents can be accessed 3) The Salisbury DSAs to devise a process to ensure all relevant information is uploaded on to the SafeBase system for all new enquiries.

11.1.4 Recommendation Four

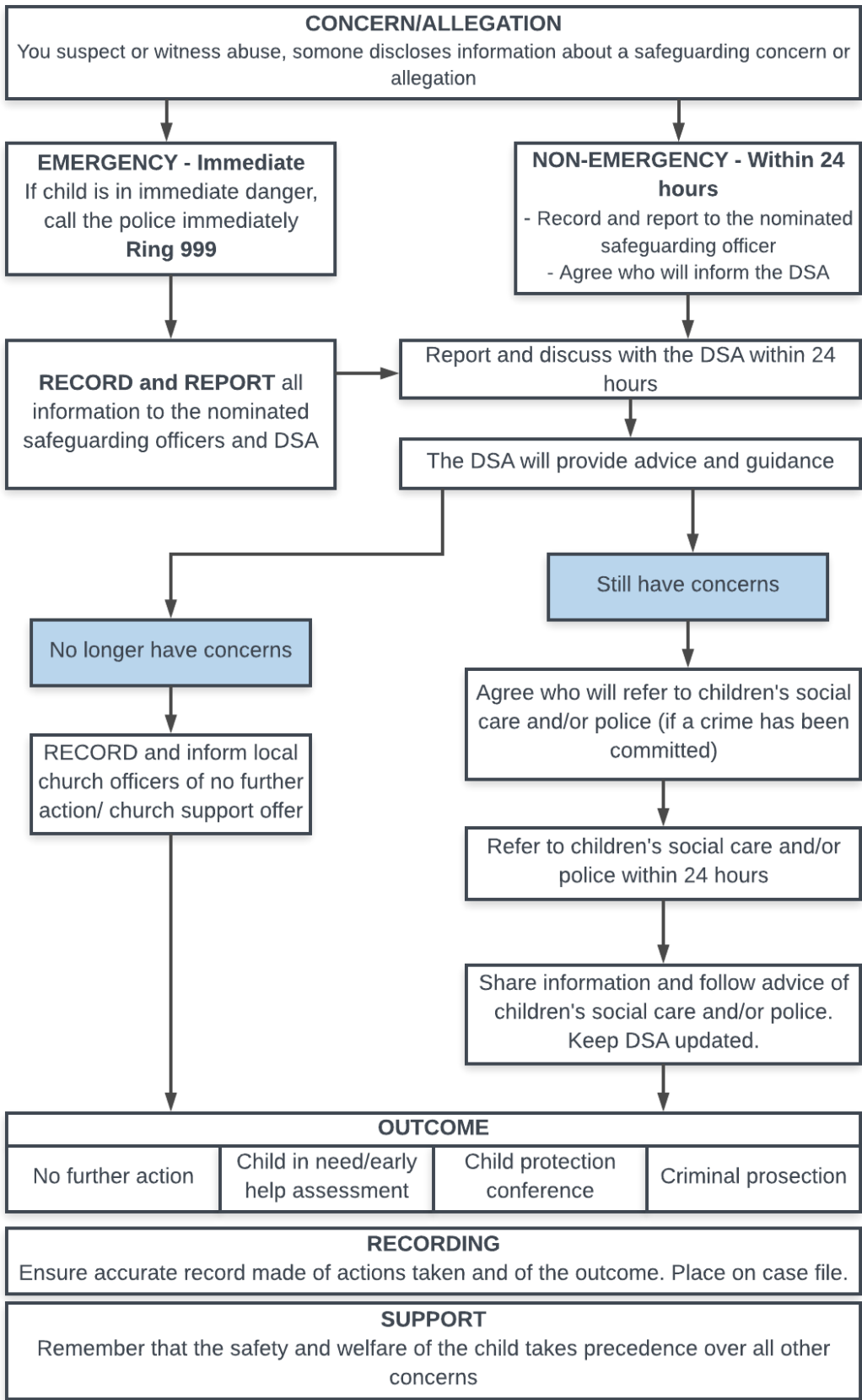
It is recommended that the DSA review the Known Cases List for concerns relating to Church Officers and clergy members and ensure there is a corresponding record entered on to SafeBase.

11.1.5 Recommendation Five

It is recommended that the Salisbury DSAs implement a formal review process for open cases to ensure the cases are being progressed in a timely manner.

Appendix One – Statistics for Channel Island Review.

Review Category	Number of Files Reviewed.
Licensed Active Clergy	48
Inactive Clergy	21
Clergy with Permission to Officiate	25
Readers	36
Deceased Clergy	29
SafeBase Entries	157
Total Number of files reviewed.	316
KCL Entries	23 Children – 17 Adults – 6
FILE REPORTS TO DSA	160



Appendix Three - Reporting safeguarding concern or allegation – Adult

