THE CHURCH OF ENGLAND

DIOCESE OF SALISBURY

PCR 2 Review Salisbury Diocese Executive Summary

Report prepared by:

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1.0 INTRODUCTION

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

1.2 The Past Cases Review 2007-2009 was a large-scale review of the handling by the Church of 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.

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.

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.

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. They also concluded that the review needed to be brought up to date in every other Diocese and the parameters of the review should be extended to include vulnerable adults. This was to become known as PCR 2.

1.5 The Diocese of Salisbury was one of the seven Dioceses required to repeat the original Past Cases Review. In 2019, two independent reviewers, selected from the approved list of reviewers, maintained by the National safeguarding team, were appointed to conduct the Salisbury's Past Cases Review 1 Repeat and PCR 2 (the Review) as determined by the requirements of the National Safeguarding Team (NST).

1.6 The review began in April 2019 and concluded in February 2020. A PCR 2 report was prepared which contained a number of recommendations for the Diocese to consider. In 2022, an addendum report was prepared which provided an update to the NST with regards to the progress that had been made.

1.7 The PCR 2 process for Salisbury Diocese was overseen by the Diocesan Safeguarding Advisory Panel (Formerly called the Diocesan Safeguarding Management Group (DSMG) who appointed a project manager and the independent reviewers. Regular updates were provided to the DSAP and they agreed the final report and recommendations before submission to the NST. They are the group responsible for ensuring the recommendations are progressed and implemented across the Diocese.

PARAMETERS OF THE PCR 2 REVIEW

2.1 The reviewers were required to examine all the clergy files in the following categories: 'Current, Permission to Officiate (PTO), Retired, Unlicensed, Resigned and Deceased' held at the South Canonry. In addition, the reviewers were required to examine all personnel files of lay staff and LLMs and volunteers' files. Files held by related Church bodies within the Diocese (i.e., Sarum College, Salisbury Cathedral, and the Diocesan Education Centre) were also reviewed.

2.2 Before the review began, the Bishop of Salisbury wrote a letter which was sent to all parishes within Salisbury Diocese requesting that they identify all current or historic safeguarding concerns. In total

five hundred and four replies were received. Any safeguarding issues raised were reviewed and cross checked with current and historic files. There was only one case identified which was not previously known to the diocesan safeguarding team and required follow up action.

2.3 Every attempt was made to ensure that all files held within Salisbury Diocese at the time of the 2008 PCR were located and reviewed, in addition to the files which were held there in 2019. In order to ensure that this was accurate, a review was conducted to identify all clergy working in the Diocese in 2008 (using the Diocese directory for the period). In total seven hundred and eighty-six individuals were identified. Of these five hundred and ninety-one were reviewed in 2008. Of the remainder (one hundred and ninety-five) enquiries were made to ensure that files were tracked down and reviewed. These files were either reviewed by the PCR2 reviewers or completed by DSA leads in the relevant areas where the files were located. Some clergy did not have blue files due to their age or they were deceased. At the date of completing this report only fifteen files remain unaccounted for. The enquiries to identify these files have been extensive and all replies have been documented for accountability purposes.

2.4 Of the five hundred and ninety-one files reviewed in the Diocese in 2008, 402 were reviewed as part of PCR 2.

2.5 In relation to Chaplains, a letter was sent to twenty organisations where clergy would have been either employed or working on a voluntary basis. 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 stating that they had no concerns. No other concerns have been raised. In order to be thorough numerous attempts have been made to chase up the organisations that had not replied but these have been unsuccessful. All contact has been recorded to ensure that there is an audit trail of decisions.

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

2.7 The parameters set were for the Salisbury PCR 2 was to identify cases which included abuse against children, vulnerable adults, and domestic abuse.

2.8 The data set which illustrates the details of the total number of files viewed can be found at Appendix one of this report.

3.0 VICTIM STRATEGY

3.1 At the commencement of the Review, the Diocesan Communications Team published the fact that the review was taking place and subsequent follow up articles were published. These included the contact details for the Independent reviewers once they had been appointed. This was done to enable anyone with information/concerns to make direct contact with them.

3.2 The reviewers saw lots of examples within the case files which demonstrated the fact, complainants were treated with sensitivity, compassion and respect. They were well supported in a pastoral sense and where appropriate referred for counselling or other forms of support.

3.3 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 which has been devised to complement this 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 a process, 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 about 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.

4.0 FINDINGS FROM THE REVIEW

4.1 The reviewers were welcomed into the Diocese by the Bishop of Salisbury, Diocesan Safeguarding Officer, Project Manager, and administrative staff. Files were made readily available and suitable accommodation and equipment was made available to the reviewers.

4.2 The atmosphere within the Diocese was one of openness and complete transparency. The reviewers had free access to all the files and to the electronic safeguarding folders maintained by the DSA. A significant amount of pre- review work had been completed and comprehensive spread sheets drawn up in advance arranged into the relevant categories. Administrative staff were made available to assist the reviewers with any queries and weekly meetings were held with the DSA. Access was given to Crockfords and the Salisbury Diocesan Information Management System (SALDIMS) to assist with administrative functions.

4.3 The reviewers found the 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 fifteen files could not be found.

4.4 The files were maintained securely in locked cabinets within a secure room and the keys located in a key safe. The electronic files are maintained on a drive which has restricted access. Similar arrangements were found for files held in other areas of the Diocese. It is clear, file security is taken seriously.

4.5 The files held within the electronic safeguarding folders were comprehensive and thoroughly documented. The work of the DSA, is detailed, well evidenced and in-depth. The reviewers noted a significant improvement in the standard of recordings since the current DSA has been in post. The Diocese should be reassured by this.

4.6 The majority of the cases, where concerns were identified, were already known to the current DSA. There was documented detailed evidence of prompt, sensitive and clear communication with complainants; appropriate referrals to other agencies; convening of core groups when appropriate; and risk management plans been put in place.

4.7 In cases where the reviewers identified further action was required, the DSA responded in an efficient and effective manner. It was clear to the reviewers, the DSA had an in-depth and detailed knowledge of the cases they had been involved with.

4.8 There was a case previously unknown to the DSA which was identified as a result of a parish return report. The initial report received, described historic serious sexual abuse on several young females by a youth leader (Now deceased). The DSA discussed this case at length with the independent reviewer. A victim strategy was drawn up and a core group convened. It was clear, victim communication had to be addressed in a sensitive and professional manner. The DSA took this aspect of the enquiry very seriously.

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

- 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.
- There was no information within the blue files to signpost the reader to the fact an electronic safeguarding record was held elsewhere.
- There is no case management system in place within the Diocese. Files are kept at various locations and there is no central record of what files are held where.
- There does not appear to be a retention policy or weeding policy in place which has led to a high degree of duplication within the files. In some cases, there is information held which dates back to the 1950/60's.
- There is a lot of personal information held within the files about the person subject of the file, but also in relation to other named individuals on occasions.
- The LLM files held at Church House are partial duplicates of files held at South Canonry. The files are not cross referenced and there is a significant amount of duplication with this process.
- There is clear guidance and templated forms with regards to risk management plans, which should be seen as good practice.

- There is no formal Complainant strategy in place, albeit the DSA fully complies with the recommendations in the Practice Guidance and records are well maintained.
- There appears to be a significant amount of work for one FTE post holder. The Diocese needs to consider, whether appropriate resources are dedicated to this important function.

5.0 RECOMMENDATIONS AND UPDATE ON RECOMMENDATIONS SINCE REVIEW COMPLETED.

5.1 Recommendation One

It is recommended the Diocese adopt a process to have a section within each file to denote areas of concern – IE Complaints, CDM process or safeguarding concerns.

Update on Recommendation One

This recommendation was written because there was no obvious section within the clergy blue files where matters of concern were recorded. This was particularly relevant to the older files. Some files were tabulated but not all. There is now clear guidance on this subject issued by the House of Bishops in June 2021. Due to the restrictions imposed by Covid, it has not been possible for the Diocese to address this matter fully, yet, and work is continuing.

5.2 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.

Update on Recommendation Two

This recommendation was written because there was no indication within a file that safeguarding material was held by the Diocesan Safeguarding Team. Most of the sensitive information was placed in sealed brown envelopes, but in some cases, information was held electronically with no indication in the blue file that this was so. The IRs provided the Diocese with a template form which was used with great effect in other Dioceses. The House of Bishops guidance, clearly states, that safeguarding material should be retained in files to assist with the CCSL process but also (Where relevant papers are not held by the bishop (for example, minutes of meetings of a diocesan safeguarding panel) a cross-reference should be kept on the file with a note that such material should also be consulted if a request for information about safeguarding issues is received".

There has been very little progress, made on this recommendation, largely due to restrictions put in place, because of Covid and church buildings not being accessible to staff. The IR has discussed with the DST and has been assured this will now be progressed as a matter of urgency. In the interim, the Diocese has implemented a process by which mandatory checks are made with the Diocesan Safeguarding Team prior to completing the CCSL letter.

5.3 Recommendation Three

It is recommended the Diocese consider investing in a single case management system to assist with the tracking of files and movement of personnel.

Update on Recommendation Three

This recommendation was written because the Diocese did not have an adequate case management system to record and retain safeguarding matters. The DSA's utilised a secure safeguarding drive and created a folder for each individual case file which were created annually and categorised to denote clergy/church officers and other subject areas.

The Diocesan Safeguarding Advisors who were in place at the time of the review were keen to identify a case management system which was fit for purpose and affordable. The new DSA's in post have put the Diocese forward to pilot a National Safeguarding Case Management System which is due to be implemented in March 2022.

5.4 Recommendation Four

It is recommended the Diocese consider adopting a formal retention/weeding policy which is compliant with the seven principles of the General Data Protection Regulations (GDPRS).

Update on Recommendation Four

This recommendation was written because it was evident from reading the files, they had not been weeded for several years and contained material that was unnecessary to have on file.
The Diocese has a privacy notice which was issued in May 2018 and states it retains data in Accordance with National Guidelines" Save or delete – the care of Diocesan Records". The Diocese have a Data Protection Advisor who is considering this matter. The scale of this piece of work should not be underestimated due to the size of the Diocese and the number of files held.

5.5 Recommendation Five

It is recommended there should be a complete review of files held at Church House and papers to be reconciled with those held at South Canonry. Any duplicated material should be weeded.

Update on Recommendation Five

This recommendation was written because it became apparent there was material in the ordinands' files which were replicated/duplicated in the blue files. This recommendation has been passed to the Ministry Team and File Administrator/Bishop Chaplain to progress. The restrictions imposed by Covid has had a significant impact in practical terms and progress has been slow.

5.6 Recommendation Six

It is recommended the Diocese should consider implementing a formal "Complainant" strategy in line with the recommendations contained within the "Practice Guidance – Responding to, assessing and managing safeguarding concerns or allegations against Church Officers" and Practice Guidance "Responding to Safeguarding Concerns that relate to Children, Young People and Vulnerable Adults'. (This is perhaps a matter for the National safeguarding team to consider ensuring a consistency of approach across all Diocese).

Update on Recommendation Six

This recommendation was made on the basis; the Diocese did not have a formal policy in place or links to outside organisations which could assist with supporting survivors of abuse. The Diocese has made significant progress in relation to this recommendation. They have written an overall strategy entitled: Championing Survivors' Voices" which sets out initiatives put in place to listen and support survivors of abuse. These include securing funding for the services of an ISVA/IDVA. This post is jointly funded by "Splitz" which is an advocacy service supporting victims of domestic and sexual abuse. In addition, having a dedicated section for survivors on the Diocesan website, inclusion of survivors' voice in all training courses and victims advocate becoming a permanent member of the DSAP.

5.7 Recommendation Seven

It is recommended the Diocese needs to consider whether or not there are sufficient resources dedicated to the safeguarding advisory role.

Update on recommendation

This recommendation was written because the Independent Reviewers felt the Diocesan Safeguarding Team were under resourced. At the time of the review, there was one DSA working four days a week with a second recruited but not in post which would have meant there was just over one full time equivalent. There are now two DSA's working four days each. In addition, they are in the process of recruiting a full-time administration post. This has increased the safeguarding team's capacity significantly.

APPENDIX 1 – TABLE OF FILES REVIEWED

Review Category	Number of Files Reviewed
Licensed Active Clergy	334
Unlicensed Clergy	30
Clergy with Permission to Officiate	434
Non-Practising Clergy	174
Deceased Clergy	181
Sarum College Staff	399
Cathedral Staff	141
Church House	
Current Employees	155
Ex-Employees	112
LLM Emeritus	45
LLM Deceased	57
LLM Current	77
IME Curates	32
Volunteers	695
Electronic Safeguarding Folders	149
Diocesan Education Centre	73
Training Files	
South Canonry	48
Church House	34
Total Number of files reviewed.	**3170**
KCL Entries placed on the Diocesan Known Cases List as a result of PCR 2 Review.	59 Children & Young Persons – 49 Adults At Risk – 8 Domestic Abuse - 2
File notes prepared for DSA	196