THE CHURCH OF ENGLAND

DIOCESE OF SALISBURY

PCR 2 Review Salisbury Diocese

(Repeat PCR 1)

Independent Reviewers

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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.

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. They also came to the conclusion 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.

2.0 REVIEWERS

2.1. The Diocese of Salisbury was one of the seven Dioceses required to repeat the original Post 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).

2.2. The reviewers selected were Tracy Hawkings and Paul Northcott. Both reviewers had similar backgrounds in policing having been the Head of Public Protection in their respective Forces and accredited Senior Investigating Officers. They also held the National Review Officers accreditation.

2.3 The review began in April 2019 and concluded in February 2020. The reviewers worked to the terms of reference set by the Project Group.

3.0 PARAMETERS SET FOR THE REVIEW

3.1 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 held at Church House and volunteers' files held at at Wyndham House. Files held by related Church bodies within the Diocese(i.e. Sarum College, Salisbury Cathedral and the Diocesan Education Centre) were also reviewed.

3.2 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.

3.3 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.

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

3.5 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 decsions.

3.6 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.

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

3.8 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 reviewers used the criminal definition of domestic abuse when considering cases which fell in to 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”.

3.9 At the commencement of the Review, the Diocesan Communications Team published the fact that the review was taking place and subsequent follow up stories 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.

4.0 METHODOLOGY

4.1 The reviewers assessed every file held at South Canonry, Church House, Sarum College, Salisbury Cathedral, the Diocesan Educational Centre and Wyndham House. In addition, a number of electronic files held within the safeguarding folder were reviewed.

4.2 Electronic check list forms were completed, and a copy placed within each file signed and dated by the reviewers. In addition, electronic copies of the check list forms were maintained and stored within the safeguarding folder. The corresponding spreadsheet was endorsed by the reviewers which denoted the fact a file had been reviewed. This process enabled the reviewers to identify both missing files, and files which did not have a corresponding entry on the master spreadsheet.

4.3 Where a safeguarding issue was identified, the reviewers completed a file note for the DSA which included a recommendation with regards to eligibility for the named person to be placed on the Known Cases List (KCL).

4.4 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 reviewers were able to contact the DSA if a matter was felt to be time critical.

4.5 The reviewers completed a weekly progress report for the Project Manager.

4.6 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 Reviewers, which is stored within the electronic safeguarding folder.

4.7 The statistics for number of files reviewed and key information can be found at appendix one of this report.

5.0 FINDINGS

5.1 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.

5.2 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.

5.3 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.

5.4 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.

5.5 The files held within the electronic safeguarding folders were comprehensive and thoroughly documented. The work of the current DSA, Heather Bland, 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.

5.6 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.

5.7 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 she had been involved with.

5.8 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 IR. 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.

5.9 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.

6.0 RECOMMENDATIONS

6.1 **Recommendation One**

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

6.2 **Recommendation Two**

There should be a template form placed at the front of each file to highlight the fact that information is held by the Diocesan Safeguarding Advisor.

6.3 **Recommendation Three**

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

6.4 **Recommendation Four**

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

6.5 **Recommendation Five**

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.

6.6 **Recommendation Six**

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 to ensure a consistency of approach across all Diocese).

6.7 Recommendation **Seven**

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

Appendix One – Statistics for Salisbury Diocese Review.

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	**59** CYP – 49 AAR – 8 DA - 2
File notes for DSA	196