



# THE CHURCH OF ENGLAND

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## DIOCESE OF SALISBURY

PCR 2 Review – Channel Islands Executive Summary (Salisbury Diocese)

Independent Reviewer

Tracy Hawkins

May 2022.

## 1.0 INTRODUCTION – OVERVIEW AND GOVERNANCE

### 1.1 Organisational structure of PCR 2

- 1.1.1 This is the PCR 2 Executive Summary Report for the Channel Islands. 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 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.<sup>1</sup> From a legal perspective, however, the Channel Islands still remain part of Winchester Diocese.
- 1.1.2 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.
- 1.1.3 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 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 them 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.

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<sup>1</sup> Bishop Trevor Wilmott was the Bishop of Dover 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.

### Structure of the Channel Islands

- 1.1.4 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 31<sup>st</sup> 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).
- 1.1.5 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.
- 1.1.6 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.

1.1.7 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.<sup>2</sup> <sup>3</sup>

## 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 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.

1.2.3 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.

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

<sup>3</sup> Guernsey Church safeguarding Handbook [second edition] – Published February 2021. The handbook was updated and republished in Feb 2022.

1.2.4 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 PURPOSE OF THE REVIEW

### 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”.<sup>4</sup>

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

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<sup>4</sup> See SCIE Audit report March 2017, section 2.5, page 11.

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

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 as<sup>5</sup>:

*"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 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 abuse.*

*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

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

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 The numbers of files reviewed can be seen in a data table at Appendix One.

### **3.0 SURVIVOR STRATEGY**

- 3.1** 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 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.
- 3.2** Incorporating Survivors lived experience in PCR 2
- 3.2.1** 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 took place with both Deans, local newspaper coverage and an open letter from the Deans was 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.
- 3.2.2** 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.

- 3.2.3 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.
- 3.2.4 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 DSA's or members of the local pastoral teams.
- 3.2.5 With the implementation of the 'Safe Spaces' initiative across the Church in England and Wales, the DSA team has recently approached the National Safeguarding Team and this important service for victims and survivors of faith-based abuse has been extended to include the Channel Islands and this is now widely advertised across local churches and on Deanery websites.
- 3.2.6 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.
- 3.2.7 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 the 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.

- 3.2.8 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 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.

#### 4.0 FINDINGS - GOOD PRACTICE

4.1 The review found some areas of good practice and also identified some areas for improvement. These are summarised below:

- 4.1.1 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.
- 4.1.2 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.
- 4.1.3 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.
- 4.1.4 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.
- 4.1.5 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.
- 4.1.6 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.
- 4.1.7 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.

- 4.1.8 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 the Channel Islands' Community Safeguarding Officers (CSO's)<sup>6</sup> included detailed initial reports of information disclosed or concerns identified. The DSA's 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.
- 4.1.9 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.
- 4.1.10 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.
- 4.1.11 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.
- 4.1.12 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

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<sup>6</sup> CSO's are now referred to as Parish Safeguarding Officers.

as to why. It is clear that good links exist between the Channel Islands Safeguarding teams and their multi agency partners.

4.1.13 There was evidence that information was shared between Dioceses when 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.

4.1.14 There were no new cases found as part of the review. All cases were known about and have involvement of safeguarding practitioners.

4.1.15 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.

## 5.0 FINDINGS - POINTS OF LEARNING

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

### Clergy files

- 5.1.1 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)
- 5.1.2 There were cases where there was no information within the blue files to signpost the reader to the fact 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)
- 5.1.3 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

- 5.1.4 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.
- 5.1.5 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.

- 5.1.6 The material held on ‘SafeBase’ contained documents in the form of emails, reports, 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)
- 5.1.7 There are several records on ‘SafeBase’ which require an update, some of which have 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. Not all safeguarding concerns contained within clergy files have a corresponding entry on SafeBase. (this will not form the basis of a recommendation because work is already on-going to remedy these points).
- 5.1.8 Safebase does not allow for a review period(s) to be set for open cases. The DSA’s will need to devise a formal process to ensure they conduct regular review 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 DSA’s agree a formal process. (Recommendation Five)

#### General

- 5.1.9 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).

## 6.0 RECOMMENDATIONS

### 6.1.1 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).

#### Update on Recommendation One since the Review.

Processes with regards to ‘blue files’ and how they our administrated/managed are mandated nationally as opposed to something a Diocese or Deanery can change unilaterally. It is anticipated this recommendation will feature in the National PCR2 report, leading to new guidance being issued, which the Deaneries of the Channel Islands will follow. Blue files for the Channel Islands Deaneries were received by the Bishop’s Office for Salisbury Diocese during the course of the PCR2 audit (the Deaneries are currently going through the necessary legal processes to be formally linked to Salisbury). These have now been tidied up, re-catalogued and a suitable secure facility identified for their storage. The COVID pandemic has of course limited the amount of progress that has been made so far regarding this recommendation.

### 6.1.2 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.

#### Update on Recommendation Two since the Review

As detailed above a suitable proforma template has been designed for this purpose, as this was similarly raised with the Diocese concerning their blue files. Now that buildings and access have opened up post COVID it is now hoped this can be progressed, subject to any other direction re this provided at national level. To ensure that CCSL references are suitably robust and comprehensive a new process has also been introduced whereby the Diocesan Safeguarding Advisers are consulted on each and every occasion one is required. This is working very effectively.

#### 6.1.3 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 onto 'SafeBase' 2) That previous DSA's 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 onto the 'SafeBase' system for all new enquiries.

#### Update on Recommendation Three since the Review

Canterbury Diocese has confirmed that all material they have ever held re Channel Island Safeguarding issues is contained with the Safebase database records – which have been passed to the Salisbury Safeguarding team. Previous DSAs have been contacted re passwords they may have routinely used to protect documents when in role and a number have been received. These have not however assisted in opening the small number of documents on Safebase which are clearly password protected. The Independent Reviewer has confirmed that when they did come across documents that are protected in this way there has been other material in the relevant case papers that enabled them to conclude matters had been suitably dealt with.

Safebase is now the only storage platform used in Salisbury Diocese by the DSAs for retaining any material pertinent to a case. Later this year (Summer-time) Salisbury Diocese will become an early adopter of the new National Safeguarding Case Management System – to which all Channel Islands and Diocesan/Cathedral records will be migrated. This is a bespoke state of the art system – which provides a gold standard in terms of records management.

#### 6.1.4 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.

#### Update on Recommendation Four since the Review

Relevant updates and reports from the Independent Reviewer have now been added to the cases in Safebase that sit within the Channel Islands' Known Cases List (KCL).

#### 6.1.5 Recommendation Five

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

#### Update on Recommendation Five since the Review

A new Chair of the Salisbury Diocesan Safeguarding Advisory Panel (DSAP) has recently taken up post. Safeguarding leads from the Channel Islands sit as members of this forum – given that their Safeguarding advice now comes from the Salisbury Diocesan Safeguarding team (albeit the formal link between the Channel Islands is still going through the necessary legal processes). Within this forum it has been decided to set up a risk oversight group – which will, on a regular basis look at the live caseload of the Diocese/Deaneries, to ensure matters are being progressed with suitable robustness and in a timely way. This will include suitable subject matter experts, as well as representative(s) specifically looking at Survivor related issues. Recruitment is currently underway for persons suitable to sit on this group – which will be suitably vetted so that the operational detail of cases can be discussed in what will be a closed forum. Trend information and themes for additional focus will be fed back to the main DSAP group.

**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