Independent Safeguarding Audit of Chichester Diocesan Board of Finance and Chichester Cathedral

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Introduction

1 Introduction

1.1 The Independent Safeguarding Audit programme for the Church of England (CofE) was commissioned by the Archbishops' Council and is overseen by the CofE's National Safeguarding Team (NST). Led by the INEQE Safeguarding Group and working to a consistent framework, the audits test the sufficiency of safeguarding arrangements within Diocese Boards of Finance (DBFs) and Cathedrals. They have a particular focus on the CofE's new National Safeguarding Standards that provide the structure for this report.[1]

1.2 Audit findings have taken account of the Social Care Institute for Excellence (SCIE) audits, Past Cases Review 2 (PCR2) outcomes, other relevant material as well as evidence from surveys, focus groups, direct correspondence and interviews. For Chichester DBF and Chichester Cathedral, this involved the following:

- Over 600 documents being collated and analysed prior to the Audit's fieldwork.
- A range of interviews being held with Church Officers (staff and volunteers), external partners, victims, survivors and other stakeholders.
- 630 anonymous survey responses being received, which gathered input from key communities connected to the Church. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the DBF, the Cathedral and parishes.
- Seven focus groups
- A confidential contact form being made available via a dedicated webpage.

[1] https://www.churchofengland.org/sites/default/files/2023-10/national-safeguarding-standards-and-quality-assurance-framework_sep23.pdf

- In total, the Audit undertook 61 separate engagement sessions reaching 137 people.

1.3 The Audit report is separated into Part One, Chichester DBF and Part Two, Chichester Cathedral. This has been done to ensure that each audited body is able to focus on their own strengths and areas for identified improvement.

1.4 The report has been reviewed for factual accuracy by both the DBF and the Cathedral.

Part One - Chichester Diocesan Board of Finance

2 Context

2.1 Situated in the county of Sussex, the Diocese of Chichester is a predominantly rural area in the South of England. It spans both large towns and coastal dwellings, encompassing the local authority areas of East and West Sussex and Brighton and Hove. Covering approximately 1,459 square miles, it comprises four archdeaconries, and 21 rural deaneries. There are 347 parishes and 465 places of worship.

2.2 Sussex is a reasonably affluent county, with clusters of wealth being seen across its centre and within Brighton and Hove. However, some areas face substantial economic deprivation, such as Whitehawk (in Brighton) which places 65th of the poorest parishes in England. A predominantly older population is in residence, with 26.1% and 23.2% being over 65 in the East and West of the county respectively.

2.3 In terms of culture, a marked characteristic is the significant Anglo-Catholic presence and the 14 'Society' parishes in Sussex. Two of the eight Bishops of the ecclesiastical body, 'The Society', are from Chichester. There are also several Holy Trinity Brompton-connected churches across the Diocese (HTB Network), with St Peter's Church in Brighton being one of the largest. Indeed, of the children and young people who attend church within the Deanery of Brighton, approximately 90% of this cohort attend St Peter's.

2.4 The most recent Census data reports a population of approximately 1.7 million in the Chichester Diocese area. According to the national church statistics team, average all age weekly attendance for worship stands at 38,000.

2.5 Locally, there have been several investigations into historic child sexual abuse involving the Diocese and a number of independent reports and reviews have previously been undertaken. This work includes that of the Independent Inquiry into Child Sexual Abuse (IICSA), which examined abuse within the Anglican Church in England and the Church in Wales.

3 Progress

3.1 Overall, the SCIE safeguarding audit and PCR2 made 60 considerations / recommendations for the DBF in Chichester. These covered a range of issues, including capacity, safeguarding resources, file management and support for victims and survivors. Most recommendations have been met, whilst a small number have been integrated into other workstreams and some reliant upon national developments such as the digitisation of Clergy (Blue) Files, updated guidance regarding managing allegations, Clergy Disciplinary Measure (CDM) processes, and risk assessments.

3.2 The SCIE audit was published in March 2017 and resulted in 19 considerations, all of which were accepted. The current Diocesan Safeguarding Advisor (DSA) primarily took ownership of the accompanying action plan, along with the Diocesan Secretary. At the time, decisions relating to the implementation of actions were overseen by the Diocesan Safeguarding Advisory Panel (DSAP).

3.3 The Audit is satisfied that the majority of the SCIE considerations have been met, although some processes continue to require routine attention (such as training compliance, Diclosure and Barring Service (DBS) checks and case management).

3.4 The PCR2 was published in December 2021. The review resulted in 41 recommendations which were collated into a comprehensive action plan. The Audit saw evidence of PCR2 being discussed within DSAP as a standing agenda item, with the PCR2 action plan being hosted centrally on DSAP's action spreadsheet. The Audit believes that the majority of actions have been completed. It was noted within PCR2 that the Diocese had *'vastly improved the way it has managed safeguarding concerns over recent years'*. This Audit

concurs and believes that significant progress has been made in this context, especially when compared to historical practices.

3.5 Moving forward, the DBF remains committed to strengthening its safeguarding efforts. The Audit heard that the DBF plan to focus on raising awareness of domestic abuse and moving towards implementing the Parish Safeguarding Dashboards in 2025. This commitment reflects a dedication to fostering a safe and supportive environment for all.

4 Culture, Leadership and Capacity

4.1 The Audit saw and heard evidence that the Diocese of Chichester has made significant progress with regards to its safeguarding journey. An overwhelming majority of survey respondents from the Diocesan Board of Finance (DBF) workforce, parish workforce, and parish community expressed agreement that safeguarding has improved. They also reported feeling safe and that a safeguarding culture is now firmly embedded. This is echoed in the most frequent descriptions of the culture in the Diocese being "supportive," "welcoming," and "respectful."

4.2 In order to build and maintain the positive reflections on safeguarding the DBF should continue to seek and monitor feedback.

Recommendation D1: Conduct regular (e.g., annual) surveys across the Diocese to monitor the safeguarding culture and identify any emerging trends or concerns. These surveys should specifically include questions about individuals' comfort in raising concerns and challenging leadership.

Recommendation D2: Conduct regular focus groups and interviews with a diverse range of individuals across the Diocese (including clergy, staff, and volunteers) to gather qualitative data on the safeguarding culture, identifying areas for improvement.

Recommendation D3: Establish clear and accessible feedback mechanisms for individuals to share their concerns or suggestions regarding safeguarding, anonymously if preferred.

4.3 Whilst the DBF does not directly run frontline services (like food banks or youth groups), it plays a vital role in providing the resources and infrastructure that enable these activities to take place. This supportive commitment is demonstrated through various initiatives, such as the Diocese-wide unconscious bias training in 2021, a recent internal survey to test and enhance the workplace culture at Church House, and the recent appointment of a dedicated HR Officer for Clergy.

4.4 There is effective collaboration by the Diocesan Safeguarding Team (DST). The Diocesan Safeguarding Advisor (DSA) described it as "*the main part of the job*", with engagement being evidenced across 'internal' teams (such as parishes and the Cathedral) and with external agencies, such as the police, probation services, Independent Sexual Violence Advisors (ISVA), Local Safeguarding Partnerships and Local Authority Designated Officers (LADO). Indeed, when interviewed, representatives of all these agencies reflected high levels of confidence in the competence of the DST.

4.5 Reassuringly, the Audit also found a high level of awareness about whistleblowing procedures and evidence that reports are taken seriously, recorded, and followed up. However, whilst the majority of those engaged by the Audit were very positive about the safeguarding culture and believed that leaders acted with integrity, some felt that leaders didn't always listen carefully to their opinions. In fact, a few individuals felt that the atmosphere within the Diocese was overly deferential, particularly when it came to approaching and engaging with the Diocesan Bishop.

4.6 The auditors carefully reviewed the Bishop's handling of several cases (pre-dating the Audit) and saw evidence of authoritative action, coupled with appropriate compassion. However, there are concerns that the Diocesan Bishop's leadership style may inhibit

people's willingness to speak up and challenge him. The Audit raised this with the Diocesan Bishop, who agreed he needed to do more to ensure people feel they can engage with and, when appropriate, challenge him. It is also important to note that the Diocesan Safeguarding Officer (DSO) stressed that this was not their experience. They reported a very good working relationship with the Diocesan Bishop and other senior staff across the Diocese.

Recommendation D4: The DBF should facilitate training for the Diocesan Bishop and other senior leaders on fostering a culture of open communication and psychological safety, where individuals feel comfortable speaking up and challenging authority.

Recommendation D5: The Diocesan Bishop and senior leaders should create more informal opportunities for engagement with staff and volunteers (e.g., informal gatherings, open-door sessions) to foster more open communication and reduce the perception of hierarchical barriers.

Recommendation D6: The DBF should implement mentoring systems to support individuals who may feel less confident in raising concerns or challenging those in authority.

Recommendation D7: Cultural surveys should consistently include questions that gauge perceptions of deference to authority, the approachability of senior figures, and individuals' confidence in challenging those in power. This feedback should be collated and tracked at governance level, enabling the identification of any trends or concerns and informing appropriate action.

Leadership

4.7 The Diocesan Bishop came to Chichester at a time when it was synonymous with clergy offending and breaches of trust at all levels. There is neither doubt about the challenges that he and his team faced, nor the legacy of pain and distrust felt by victims and survivors to this day.

4.8 When scrutinising material, the Audit saw substantial evidence that the Diocesan Bishop has relentlessly driven the Diocese of Chichester's safeguarding improvement journey. He has done so with a firm grip, a safeguarding focus and at pace. In fact, there is strong evidence that both he and the DSA have done much good work to reposition the Diocese (amongst statutory agencies) as a responsible partner.

4.9 During discussion with him it was clear that he unambiguously accepts his individual accountability and responsibility for safeguarding, and the Audit saw and heard evidence of his approach and relentless focus over many years.

4.10 Given the impressive progress made from a very low starting point, it may now be time to reflect on how best to ensure a collegiate approach moving forward. To this end, the Audit welcomes and supports the Diocesan Bishop's reflection that he needs to proactively address issues of approachability and inclusion.

4.11 Beyond the Diocesan Bishop, those in key roles also have a firm focus on safeguarding and are able to explain how what they do relates to it. They demonstrated an understanding of pathways for advice and support.

4.12 The Bishop of Horsham supports the Diocesan Bishop's safeguarding functions and striking the right balance with delegation is key. This is important so as not to diminish the Diocesan Bishop's oversight and influence on safeguarding matters. In this respect, the Audit was reassured that the Bishop of Horsham's role does not dilute, but in fact complements, the Diocesan Bishop's oversight. Furthermore, it has the potential to provide continuity of leadership, reinforcing and retaining corporate memory.

4.13 The Diocesan Secretary demonstrated an impressive insight regarding safeguarding, including the challenges of balancing demand. It was clear that they understood the strengths and limitations of the current model, not least when it comes to responding to emerging risks, key priorities and day-to-day business.

4.14 The Archdeacons are integral to safeguarding within the Diocese. They provide consistent support and focus through their daily engagement across their areas of responsibility. Their relationship with the DST should ensure effective collaboration and communication. Safeguarding is already incorporated into their functions, particularly during visitations, and they are committed to enhancing this aspect. To further strengthen their contribution, providing specific training and integrating safeguarding prompts into their daily routines would be beneficial. Archdeacons attendance at Core Groups is positive and whilst the Audit was told they are required to attend to ensure Core Group meetings are quorate, an examination of minutes and attendance does not reflect this position. This is an issue which should be addressed as should consideration of utilising the Archdeacon’s expertise to chair such meetings as this would remove any perception of a conflict of interest.

Recommendation D8: The DBF should amend the role description for Archdeacons, formally setting out their safeguarding roles and responsibilities. This should include:

a) Proactive monitoring of safeguarding practices in parishes.
b) Notwithstanding the primary role of the DST, Archdeacons should be able to provide general safeguarding support, prompts and non-casework specific guidance to Parish Safeguarding Officers (PSOs) and their Parochial Church Council's (PCCs).
c) Conducting snap-shot safeguarding audits (in consultation with the DST) during parish visitations.
d) Consideration of Archdeacons being utilitised to chair Core Group meetings.

Recommendation D9: A schedule of regular meetings between Archdeacons and the DST should be implemented to ensure:

a) Structured two-way communication and information sharing.
b) Early identification of potential issues.
c) Briefs and debriefs regarding visitations and inspections.
d) Effective cascading of safeguarding information, updates, and resources to parishes.

Recommendation D10: Working in partnership with the DSA and NST, the DBF should develop context and role specific training for Archdeacons. Beyond basic safeguarding training, this should include:

a) Formal training for Core Groups (chairing Core Groups)
b) Recognising subtle signs of abuse.
c) Understanding different forms of abuse (physical, emotional, spiritual, neglect).
d) Responding appropriately to disclosures.
e) Conducting sensitive inquiries.
f) Current legislation and best practices.

Governance

4.15 The DBF operates a range of appropriate governance and oversight meetings. These reflect the expectations of the CofE and the relevant requirements, such as those issued by the Charity Commission. In the opinion of the Audit, safeguarding could be better embedded within governance meetings.

4.16 The most authoritative governance and oversight meetings include the Bishops' Council and Bishop's Staff meetings. Because of this, both forums should ensure their meetings are appropriately structured, that agendas are set up to encourage challenge and that whenever possible they facilitate alternative voices. Moreover, that their discussions and agreed actions / decisions are captured in minutes. To this end the Audit recommends the following:

Recommendation D11: All governance forums operating within the DBF should:

a) Carryout a skills, inclusion and diversity audit. The results of which should be shared at DSAP.

b) Adopt a thematic approach (regarding safeguarding and SIRs) to oversight and preparation for Charity Commission reporting.

c) Complete a review of Risk Registers on the basis of the outcomes of the Audit and key strategic areas which may impact on the stability, health and wellbeing of the workforce.

4.17 The Bishop's staff meeting is frequent, routine and a key element of the DBF's safeguarding architecture. Pending the introduction of a Director of Safeguarding, the DSA / DSO is invited when it is thought necessary, although in the Audit's opinion, the DSA / DSO should be a formal member of this group (and always present as the ultimate safeguarding advisor on Bishop's Council) by right rather than by invitation.

4.18 The Diocesan Bishop demonstrates active engagement in safeguarding through quarterly meetings with key safeguarding personnel (i.e. the DSA / DSO and Registrar). These meetings provide a dedicated forum for in-depth review of critical safeguarding matters, fostering professional curiosity and informed decision-making. This collaborative approach ensures accountability and direct communication between the Diocesan Bishop, the DSA / DSO and the Diocesan Registrar. This meeting has the potential to represent good practice and could be strengthened by the construction of a formal agenda, detailed minutes and agreed actions.

Recommendation D12: The Diocesan Bishop's quarterly meeting should be formalised to reinforce its role in governance and oversight of safeguarding. It should:

a) develop clear terms of reference and membership.

b) create an appropriately focused and relevant agenda, producing minutes and agreed actions.

c) adopt an appropriate naming convention, e.g., Safeguarding Strategic Oversight Group.

DSAP

4.19 The Diocesan Safeguarding Advisory Panel (DSAP) serves as an independent advisory body that provides oversight and scrutiny of safeguarding practice within the Diocese. It can play a vital role in amplifying the voices of victims and survivors, analysing serious incident reports and case reviews and engaging with various stakeholders, including statutory agencies. It is led by a chair with credible and relevant experience.

4.20 Whilst the DSAP includes some external members, the Chair believes more are needed to bolster its independence and strengthen its ability to effectively scrutinise and oversee practice. The Audit agrees and supports the Chair's intention to reach out to victim and survivor forums to ensure their voices are heard. Furthermore, it agrees that the DSAP should continue to press for more engagement from the statutory and voluntary sectors, whether by inviting representatives to join the DSAP or by proactively attending their forums.

Recommendation D13: The DSAP should actively reach out to and collaborate with victim and survivor forums to ensure their perspectives are central to the DSAP's work.

Recommendation D14: The DSAP should complete a skills, inclusion and diversity audit to assist the expansion of DSAP membership to include more independent voices.

Recommendation D15: The DSAP should strengthen relationships with statutory and voluntary sectors by inviting representatives to join the DSAP and / or proactively participating in their forums.

4.21 As part of their reflection on membership, the Chair also highlighted their desire to increase representation from parishes. The Audit supports this approach and makes the following recommendations in this regard.

Recommendation D16: The DSAP should increase parish representation and work with the DST, Archdeacons and PSOs to construct a PSO skills register.

4.22 The DSAP currently operates as advisory on the basis of its influence, rather than delivering scrutiny on the basis of its authority. This is a national issue that the Audit is addressing at the appropriate levels. That said, the DSAP could adopt a number of recommendations to reinforce its independence and evidence the impact of its scrutiny functions. To this end, the Audit welcomed the Chair's thinking regarding restructuring the DSAP and creating an operational subcommittee. Such a move could facilitate more focused, strategic oversight and challenge alongside quality assurance of operational safeguarding activity.

Recommendation D17: The DSAP should adopt a three-year thematic approach to scrutiny based on the National Safeguarding Standards.

Recommendation D18: The DSAP should add the recommendations of this Audit to their routine tracking process.

Recommendation D19: The DSAP should delegate the quality assurance of operational matters to an Operational Quality Assurance Subgroup. This subgroup should meet monthly, be populated by those with operational responsibility and chaired by an appropriate member of DSAP.

Recommendation D20: The DSAP Chair should invite the Diocesan Bishop to the DSAP's end-of-year meeting to discuss key issues, facilitate mutual challenge and end of year reporting themes.

Recommendation D21: The DSAP Chair should ensure that the DSA / DSO is not the only authoritative voice considered when scrutinising safeguarding. Whilst they are key, the DSAP should be in a position to demonstrate that they have tested and verified what they are being told.

Clergy (Blue) Files

4.23 The Clergy Blue Files are efficiently administered and secured within the current framework by the Bishop's Office. Examination of several of these files evidenced authoritative safeguarding practice by the Diocesan Bishop.

4.24 That said, the Audit takes the view that 'incoming' Blue Files (where clergy are joining the Diocese) should be subject to a greater level of scrutiny by an appropriately qualified / nominated member of the Bishop's team and the DSA / DSO.

4.25 This will provide verification of the Clergy Current Status Letter (CCSL) statement and ensure that those who support new appointments are sighted on their experience and aware of any areas of development or potential vulnerability

Recommendation D22: A qualified member of the Bishop's team and the DSA / DSO should conduct a thorough review of each incoming Clergy Blue File. This review should verify the accuracy of the CCSL statement and ensure those supporting the appointment are fully informed of the individual's experience, including any areas for development or potential vulnerability.

Diocesan Safeguarding Team (DST)

4.26 The DST is highly experienced, and with the recent appointment of a new member (focused on Learning and Development), is poised to benefit from an even greater set of skills and a wider multi-agency perspective. This team is undoubtedly an asset to the Diocese as a whole.

4.27 The team is exceptionally well led by an individual with significant operational and strategic experience. The DSA / DSO has championed significant work at a national level and been a key influencer concerning next steps for the CofE. Whilst the Audit recognises that this participation at a national level comes at a local cost (extraction), the overarching benefit from a safeguarding perspective should not be underestimated. That said, this position (given current capacity) is not sustainable.

4.28 There is significant evidence of effective collaboration with external agencies and authorities, specifically the police, who have worked with the DST in highly complex and sensitive investigations. During interviews with personnel from across the Diocese, there was also a strong sense of the value placed on the DST and its investment in building positive working relationships.

4.29 Overall, the DST works well within the limits of current capacity across the DBF, parishes and the Cathedral.

Capacity

4.30 Capacity remains a challenge within the DST. Whilst goodwill and dedication are exemplary, the current workload is not sustainable. Despite the recent and welcome investment in a new member of staff, the team has faced capacity constraints for a significant period. They are overburdened with a high volume of cases, leaving little bandwidth to manage critical incidents or unexpected extractions.

4.31 To ensure clear strategic representation of safeguarding at the highest levels of governance and to address the supervision, support, and capacity issues within the DST, the Audit makes the following recommendations.

Recommendation D23: The DBF should establish a Director of Safeguarding role. This post and its line management should be structured to provide the highest levels of operational independence and be acknowledged as the authoritative voice on safeguarding. This will give the role more autonomy and credibility when challenging senior clergy. In order for this role to operate effectively it requires:

a) To subsume the authority vested in the DSO post.
b) Clearly defined reporting lines and decision-making authority. The Director should be present as of right rather than by invitation and report to the Bishop's Council, Chapter and Senior Leadership Team (SLT).
c) All church bodies within the geography of the Diocese to sign up to a single Memorandum of Understanding (MoU) regarding the safeguarding expectations. In particular, the roles and responsibilities of the Director of Safeguarding, i.e. to provide insight, oversight, advice and support to any church body within the geography of the Diocese. This would include the DBF, Parish PCCs and the Cathedral. Consideration could also be given to the national provision of a '*Measure*' applicable to all Diocese.
d) The ability to escalate concerns directly to higher church authorities (including the National Director of Safeguarding (NST)) if needed.
e) The resources and staffing to effectively deliver and oversee safeguarding across the Diocese, including the Cathedral. Such resources would include all professional safeguarding staff (including any deployed in the Cathedral) and additional resources to backfill the post of DSA / DSO and at least one additional Assistant DSA (ADSA).
f) The amalgamation of all safeguarding resources into an operationally independent Diocese Safeguarding Directorate.

To be clear, these recommendations would require three new posts, A Director of Safeguarding and an additional ADSA (this would facilitate a geographic approach to case management) as well as the proposed CSA based at the Cathedral.

4.32 Given the emphasis on reporting and follow-up in the aftermath of the Makin Review[2], the Audit is sharing an anonymised overview of a case handled by the Chichester DBF. Whilst information that the Audit can share is limited, it is appropriate to record that the auditors were reassured by the actions of the Diocesan Bishop and DSA / DSO.

4.33 During the Audit's scrutiny of safeguarding records, a complex case surfaced involving an individual investigated by the police for a child abuse-related offence. Whilst the investigation revealed substantial circumstantial evidence, the Crown Prosecution Service (CPS) ultimately decided not to prosecute, as the offence had become statute barred. Consequently, the police took no further action. However, the Diocesan Bishop, DSA / DSO, and DST, recognising the potential risks, remained steadfast in their commitment to safeguarding and insisted on implementing further protective measures including challenging the decision and sharing information regarding the potential risks. The Audit highly commends them for this safeguarding-first approach.

[2] https://www.churchofengland.org/media/press-releases/independent-review-churchs-handling-smyth-case-published

5 Prevention

5.1 The DBF has implemented a variety of preventative measures to ensure the safety and well-being of its community. These measures include a strong focus on safer recruitment practices, codes of conduct, and mechanisms to raise awareness and engagement around safeguarding issues.

5.2 Safer recruitment is a key priority, with processes aligned to relevant legislation, policies, and national Safer Recruitment and People Management guidance issued by the CofE. Staff responsible for recruitment receive appropriate training and parishes are provided with clear information on how to recruit safely, what DBS checks are necessary and the required training for various roles.

5.3 Whilst the DBF only has a small number of volunteers, the Audit identified the potential to strengthen practice and create consistency in how volunteers are safely recruited. At present, there is no defined process setting out how this is undertaken by the DBF.

Recommendation D24: The DBF should develop a clear process for the safer recruitment and onboarding of volunteers at the DBF. This process should align with the House of Bishop's guidance 'Safer Recruitment and People Management'.

5.4 At the time of the Audit, a small number of staff DBS renewals were outstanding and in the process of being renewed by the DBF. Whilst acknowledging local challenges[3] with long delays to DBS processing (beyond the control of the DBF), the Audit makes the following recommendations.

[3] BBC News Sussex, 21 October 2024, 'DBS check delays preventing people starting work' https://www.bbc.co.uk/news/articles/c2kdl9pq0ndo

Recommendation D25: Action should be taken to reassure the DBF that all eligible staff and volunteer's roles are up to date with DBS checks and are within the three-year cycle.

Recommendation D26: The DBF should conduct enhanced DBS checks on the team of therapists commissioned through the Wellbeing for Clergy and Families service. As a minimum this should include an enhanced DBS check for those who work with under 18s.

5.5 At the local level, appointments within parishes are overseen by the PCC. The DBF provides support to PCCs to ensure that parishes can follow good practice in respect of safer recruitment within their settings. This includes briefings for PSOs on administering DBS checks and access to further support materials via the Diocesan website.

5.6 The Simple Quality Protects (SQP) is a safeguarding initiative available across the Diocese. It provides a clear checklist of good safeguarding practices for parishes, helping them understand and meet expectations. SQP has been well-received by parishes, improving their safeguarding practices, with one respondent to the Audit's parish workforce survey commenting:

"The Simple Quality Protects Scheme helped us to focus on key issues and put many structures in place"

5.7 That said, SQP is being replaced by the Parish Dashboard system in 2025 to provide more real-time information and enhanced monitoring capabilities. The Audit suggests continuing the transition to the Parish Dashboard and supporting its implementation to ensure consistency and ongoing effectiveness.

5.8 Safeguarding is a high priority within the DBF, as evidenced by its prominent inclusion in discussions at various levels. It is a regular topic within both Bishop's Council and Bishop's Senior Staff meetings. Further emphasising this commitment, the DBF facilitates direct engagement with PCCs to foster relationships and increase awareness. This can be seen through the well-attended PSO "drop-in" events, providing practical support and addressing immediate concerns. That said, the Audit believes support to parishes could be further enhanced through expanding these activities.

Recommendation D27: The DBF should facilitate regular face to face sessions and / or networking events for PSOs to learn and share good practice.

Recommendation D28: The DBF should consider facilitating an annual networking event where PSOs can come together and hear from leading safeguarding professionals on new and emerging themes as they relate to their role.

5.9 The DBF provides various opportunities for promoting learning and sharing best practice. A monthly ‘Link Up’ networking event for youth and children's workers across Sussex represents strong practice and it is noteworthy that safeguarding featured as a recent topic of discussion. Furthermore, evidence of the DBF sharing best practice was seen through the active role the DSA / DSO plays in the CofE’s sqational Senior Leadership training, contributing to curriculum development and delivery. This involvement allows for the valuable exchange of knowledge with other Dioceses, helping the DBF to stay informed and proactive in its safeguarding efforts.

5.10 The Audit acknowledges the critical importance of effective communication in safeguarding, recognising that individuals require information at various stages, in diverse formats, and across different locations. To this end, the DBF promotes safeguarding awareness and educates individuals about the various forms of harm that can occur. The DBF utilises a range of communication methods, including a Diocesan E-Bulletin, a dedicated safeguarding website (with resources such as "What Do I Do If" and "How To" guides), and targeted direct emails. Furthermore, safeguarding is emphasised to the worshipping community through initiatives such as ‘Safeguarding Sunday’ sermons.

5.11 The Audit acknowledges the commendable efforts of the DBF in raising safeguarding awareness with key stakeholders, particularly the PSO cohort. However, it believes that opportunities exist to strengthen this further. As one respondent to the Audit’s Parish Workforce survey stated, *"there is always more work to be done in promoting safeguarding awareness."* Whilst the Audit notes the DBF's intention to focus on domestic abuse in 2025, it believes the DBF should seek to develop a more structured and forward planned communication schedule.

Recommendation D29: Using its knowledge about the unique safeguarding issues facing the Diocese, a plan for awareness raising (based on themes and identified need) should be implemented that is tailored to those who work, volunteer or worship across the Diocese.

Recommendation D30: To ensure consistent, effective, and transparent communication with all stakeholders, the DBF should develop a comprehensive Communication Strategy. This strategy should serve as a guiding document for all internal and external communications, outlining key objectives, target audiences, messaging, and channels.

The strategy should include a plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of the followers, adopting different techniques specific to the platform and utilisation of relevant awareness days, campaigns and events to amplify the message.

5.12 The DBF website serves as the primary communication platform for the Diocese of Chichester. Within this website, safeguarding information is separated through a dedicated subdomain[4]. A dedicated microsite houses information specifically related to safeguarding.[5] This safeguarding webpage provide a range of resources: it directs users to external support, clarifies the DBF's responsibilities, offers access to training, and provides resources to help parishes strengthen practice. However, whilst the website offers a wealth of information, there are usability issues. The website's structure is somewhat difficult to navigate, which hinders users from efficiently accessing the information they need. One example of this is demonstrated through a safeguarding document library[6] which provides useful resources, although this is not featured as a 'menu item' within the primary navigation nor easily accessible through a secondary menu

[4] In web architecture, a subdomain is a prefix added to a domain name to create a distinct section within a website. This allows for the organisation and management of diverse content types or functionalities under the umbrella of the primary domain. While subdomains can function as independent websites, they remain intrinsically linked to the main domain, offering a hierarchical structure for presenting information.

[5] https://safeguarding.chichester.anglican.org/

[6] https://safeguarding.chichester.anglican.org/documents/

structure. Another instance is when performing a 'search' through the main domain name for 'Simple Quality Protects'. This search returned two results neither of which directs to the dedicated page[7] for this topic.

5.13 Notwithstanding that website analytics viewed by the Audit highlight the positive reach and extensive engagement that visitors have with safeguarding material, the Audit believes that some adjustments could be made to optimise user experience.

Recommendation D31: The DBF should scope and consider options for improving website accessibility and navigation.

5.14 As with all good communication, this needs to be a two-way process and actively engaging children, young people and vulnerable adults is an important part of successful prevention planning and implementation. The DBF acknowledges that efforts to hear the voices of children and young people have been limited and the Audit supports its intention to do more in this respect. Whilst responses to the Audit's children and young person's survey were low, feedback positively reflected one child's experience and the value of gathering their input, *"I would like to have more classes to go to as well as Church, as my communion classes were really fun!".* In regards to hearing the specific voices of victims / survivors of abuse and how the DBF learns from their experiences, see the Victims and Survivors' section of this report.

5.15 The DBF has a Lone Working policy which, at the time of the Audit, is a draft version still in development. At the parish level, guidance is provided through the Code of Safer

[7] https://safeguarding.chichester.anglican.org/sqp/

Working Practice[8], and Safer Environment and Activities, accessible through the Diocese's website.

5.16 Safeguarding considerations as they relate to Church buildings are, in part, addressed through the use of a "Safe Space Checklist," a component of the SQP self-assessment tool.

5.17 The Audit observed that the DBF demonstrates a broader understanding of safeguarding, evidenced by its facilitation of the annual "May Camp" event. This event, which hosts 350 to 450 young people, incorporates practices designed to cultivate a safer environment for church members, volunteers, and attending youth. This is good practice.

[8] https://safeguarding.chichester.anglican.org/the-code-of-safer-working-practice/

6 Recognising, Assessing and Managing Risk

6.1 Safeguarding arrangements across the Diocese help to ensure the effective recognition, assessment and management of risk. They include a committed and highly experienced multi-disciplinary DST, a dedicated safeguarding website with good materials, regular communication and relevant policies and procedures. Importantly, safeguarding also features in recruitment practices and is embedded in the training programmes for volunteers, staff and clergy.

6.2 There are well defined reporting pathways for concerns, which increase the likelihood of early risk detection, collaborative decision making, and timely interventions. This guidance extends to complex issues such as if someone is worried about their own thoughts and behaviours, or if someone is concerned the Church is not following proper safeguarding practice. The Audit consider this good practice.

6.3 The DBF maintains a Risk Register that addresses a wide range of corporate issues, with risks and mitigating factors clearly documented. The Audit was sighted on comments indicating that it was last reviewed in May 2024. The Risk Register only briefly touches on safeguarding, indicating the need for a more comprehensive approach in this regard. Indeed, the Audit believes the process could be significantly enhanced by creating a dedicated safeguarding Risk Register. This would allow the DBF to articulate risk based on the national standards, isolate risks more effectively and mitigate them as required. The Audit believes that the DBF's approach to risk management would be further strengthened by considering broader societal issues, such as the exponential rise in mental health issues across society.

Recommendation D32: The DBF should ensure its overarching Risk Register is reviewed and updated regularly, with clear documentation of review dates. For example, the minutes of relevant meetings should reflect when risk registers have been considered, reviewed and/or agreed.

a) That it develops a standalone safeguarding Risk Register. Risks should be identified and defined against the National Safeguarding Standards.

b) That the proposed safeguarding Risk Register takes account of wider societal issues impacting upon safeguarding, particularly at a local level.

Recommendation D33: The DBF should develop a standalone safeguarding Risk Register.

a) Risks should be identified and defined against the National Safeguarding Standards.

b) The proposed safeguarding Risk Register should take account of wider societal issues impacting upon safeguarding, particularly at a local level.

6.4 The DST has set clear criteria that determines the appropriate pathways for cases brought to its attention. Outcomes typically involve one or more of the following:

- Onward referrals to statutory authorities.
- The management of individuals within the worshipping community.
- The provision / signposting to support.
- The initiation of disciplinary processes, such as Clergy Disciplinary Measures (CDM).
- Initiation of the Safeguarding Case Management procedure (formerly Core Groups).

6.5 The DBF has an annually reviewed Service Level Agreement (SLA) with Chichester Cathedral. This outlines clear safeguarding arrangements, stipulating that the DST provides support to the Cathedral for core safeguarding activities. Whilst these arrangements seem to work well, it generates additional work demand for the DST and the

geographical distance between the Cathedral and the DST office presents time management challenges for an already busy team. These challenges are discussed further in Part One and Part Two, Culture, Leadership and Capacity sections of this report.

6.6 Systems are in place that help facilitate prompt referrals to the DST, including a dedicated safeguarding inbox and voicemail system. These systems incorporate an automated escalation process for urgent cases, ensuring immediate notification to the police if necessary. This is good practice. That said, whilst the overwhelming majority of comments recognise the good work and support from the DST (being described as 'incredible and responsive' by many), there have been occasions when it has been difficult to get a response from them via phone or email. The Audit believes this is linked to capacity.

6.7 The DST has implemented a 'low threshold' approach to raising concerns and reporting to the team is encouraged through various channels such as training, maintaining a visible presence across the Diocese, communicating about high profile cases, and offering face-to-face interactions. The online drop-in sessions with PSOs is a positive initiative that fosters collaboration and knowledge exchange. That said, there seemed to be confusion amongst some PSOs around the scheduling for these events and increasing awareness will likely optimise their effectiveness.

6.8 The overall approach of the DST ensures that potential risks are identified and addressed promptly, even when the reporting person may not fully understand the severity of the situation. It also reinforces the DST's role as a reliable source of information and support for those seeking assistance. This proactive strategy facilitates early intervention and promotes a safer environment for all.

6.9 Indeed, the Audit observed that several enquiries were resolved through, guidance and signposting. Positively, the team's approach in this context enables them to foster relationships, build trust and create an environment where concerns are more likely than not to be escalated. Interviews and Audit surveys indicated there was a high degree of confidence in how the DST operates.

6.10 All casework is undertaken by the DST. It employs an informal, collaborative approach to triaging cases. The team manages a varied caseload, including Safety Plans and cases or referrals with varying risk levels. This process, whilst functional, would benefit from a more formal structure. Currently, case allocation is determined by several factors, including staff availability, collaboration amongst the DST, geographical considerations and specific roles such as ownership of Attendance Agreements (formally known as Safety Plans). The process relies heavily on informal discussions and professional judgement during a daily meeting. Whilst the current process provides a basic framework for triage, allocation is largely *ad-hoc*, and there is no structured method for assigning ownership or assessing risk.

Recommendation D34: To enhance the triage process and ensure timely and appropriate responses to safeguarding concerns, it is recommended that the DBF implements a more structured approach to allocating the level of risk and ownership of cases in the DST.

6.11 The DST is in the process of fully integrating the MyConcern system into its workflow, including its reporting functionality. Whilst the team's daily meetings and collaborative approach provide a degree of oversight and shared responsibility, recording practices are evolving with the introduction of the new case management system. When fully implemented, the DST should be able to fully utilise the MyConcern system to record triage

decisions, allocate cases, and monitor progress.

6.12 A secure audit trail is maintained for all correspondence. Records not meeting the safeguarding threshold are stored in a separate, designated folder. This system ensures that all communication is documented and readily retrievable, enabling comprehensive risk assessment should further safeguarding concerns emerge. The Audit considers this approach as good practice for information management and safeguarding more generally.

6.13 At the time of the Audit, there were 26 new concerns that had been reported in the month, 906 open cases and 52 filed cases. The Audit was advised this was not a true reflection of the current status of investigations as the DST continue to familiarise themselves with the functionality of the newly implemented MyConcern Case Management System. Within these cases, the Audit saw evidence of effective responses to both routine and emergency referrals. This included collaboration with other Dioceses and statutory agencies, appropriate convening of safeguarding case management groups, (Core Groups) and providing support to those involved.

Recommendation D35: The DST should prioritise cleansing the data on MyConcern and archive any outstanding cases that are ready to be 'filed'.

6.14 Risk assessments conducted by the DST are initiated in response to safeguarding concerns involving Church Officials, members of the religious community, or individuals from specific high-risk categories seeking participation in Church events or services. These assessments are well documented, and prioritise the safety of victims, potential victims and vulnerable individuals.

6.15 The Audit observed good communication and collaboration between a parish, the DST and the police whereby the DST engaged with the police to discuss the church attendance of a known individual subject to a Sexual Offences Prevention Order (SOPO). This proactive approach facilitated effective management of the situation to ensure awareness of the individual's presence within the Church community. This collaborative strategy is an example of the good practice seen within the DST.

6.16 The Audit also saw convincing evidence of the effective use of Safeguarding Case Management Groups (Core Groups) in managing complex cases involving Church Officers. The DST effectively and quickly organises these meetings, as evidenced by the example of a high profile case convened within three hours.

6.17 The Audit found that Core Group meetings are routinely chaired by the DSA / DSO and adhere to a structured agenda. This practice facilitates effective collaboration, thorough scrutiny of information, and efficient information gathering. The DSA / DSO's role as Core Group Chair aligns with national guidance, provided they are not directly involved as the key worker, though they may supervise those who are. Core Groups have included external organisations including the LADO and police. This is also good practice.

6.18 The Audit saw evidence of solid and authoritative decision-making resulting in clergy being permanently removed from ordained ministry in the CofE via the Clergy Discipline Measures and promptly suspended from the point of arrest.

6.19 The Audit did not observe Archdeacons attending Core Group meetings (see paragraph 4.14) . Whilst this practice is evident in other Dioceses, it does not appear to be consistent practice in the Diocese of Chichester. The Audit suggests that requiring an Archdeacon to

attend relevant meetings would provide numerous advantages. Firstly, it would introduce an additional level of impartial oversight and scrutiny. Secondly, the Archdeacon's expertise and knowledge, especially regarding Church Officers, would be invaluable. Finally, this mandatory attendance would ensure that Archdeacons remain up-to-date on emerging safeguarding concerns and trends relating to clergy conduct.

Recommendation D36: Archdeacons (one at a minimum) should participate in Core Group meetings to provide additional independent scrutiny, insight and knowledge in safeguarding situations involving Church Officers.

6.20 Overall, the Audit saw examples of good record keeping and proactivity in information sharing with statutory partners. Minutes of Core Group meetings evidenced a consistency of approach, challenging and difficult conversations and robust decision making.

6.21 There was good use of Safety Plans to manage the risk of convicted offenders or others who may pose a risk. There are listed prohibitions, positive requirements and regular reviews documented. These in-person reviews are done within Church premises with members of a selected support group who ensure compliance with the agreed arrangements. This is good practice.

6.22 At the time of the Audit, 36 active church Attendance Agreements (Safety Plans) were in place. The Audit met with a support group for those subject to Safety Plans who clearly demonstrated a thorough knowledge of the process, recognising the severity of the situation and equally, the need to support all involved parties.

6.23 The number of plans in place provides an indication of the extensive time invested in this

process by the DST. The team has good experience in managing offenders based on their professional backgrounds, but have not had specific sex offender behaviour training within their current roles. The Safety Plans process also extends to safeguarding personnel in parishes. The Audit recommends enhanced training for those who work directly with this cohort of offenders. This is an issue being addressed by the NST.

6.24 The Audit conducted a discussion with an individual 'respondent' who was subject to a Safety Plan due to a conviction related to child sexual abuse. The conversation explored the individual's newfound faith while in prison, their desire to attend Church upon release, and the details of the Safety Plan. The respondent discussed the restrictions in place to protect others in the Church community, the support team available to them, and the process of regular reviews to assess the plan's effectiveness. When tested, the individual demonstrated a clear understanding of the Safety Plan's conditions and acknowledged the associated risks. They expressed appreciation for the support received from the Church community and recognised the necessity of the monitoring arrangements for their own well-being and the safety of others.

6.25 The Audit was informed of an informal process, referred to as a "*watching brief*", used to address situations where concerns about an individual's behaviour do not meet the threshold for a formal Safety Plan. This process is typically employed when a person's conduct causes unease or discomfort in others (e.g., perceived "overly friendly" behaviour). In such cases, a designated individual, such as a Church Warden, may discreetly monitor the individual's behaviour to provide reassurance to those expressing concern and to prevent potential escalation. This informal process demonstrates how the low threshold for reporting concerns is operationalised and a proactive approach to maintaining a safe and welcoming environment. Practice aligns with the DBF's

commitment to addressing concerns promptly and effectively. The maintenance of records for these "watching briefs" further strengthens this positive practice.

6.26 The risk assessment process for those on Safety Plans is reportedly limited due to the strict adherence to the national template, which the DST believe could be strengthened to ensure other risk areas are considered. For instance, the possibility of persons of concern visiting other Churches or Church establishments. The DST referred to adapting or tweaking the national template to meet their risk assessment requirements. The Audit supports the DSTs position and is aware that the NST is alert to the issue.

6.27 The DBF, as a registered charity, is required to submit Safeguarding Serious Incident Reports (SIRs) to the Charity Commission. The Audit was informed that the DBF follow the House of Bishop's national guidance on this issue. The DBF submitted four SIRs to the Audit for review. These were appropriate and evidenced timely submissions, report updates and sufficient case details being shared with the Charity Commission. There was also evidence of swift decision making regarding suspensions, consideration to reputational risk, and a multi-agency approach involving the police and LADOs as required. The Audit noted good practice whereby the DSA advised the Charity Commission to amend its public records regarding the role of a clergy member displayed on a website.

6.28 The DSA receives formal structured safeguarding supervision from the Regional Safeguarding Lead on a six weekly basis. The Audit was sighted on supervision records and noted the welfare support being provided to the DSA. Whilst good practice, the Audit believes these sessions could be further strengthened with more emphasis on case management.

6.29 For example, cases discussed tend to focus on the more complex. Whilst relevant, there is no real oversight regarding lower-level cases or any reflection about the DSA / DSO's judgement against those cases that result in no further action. This has been a common theme for the Audits and will be addressed at a national level with the NST.

Recommendation D37: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DST and NST. This will also be raised by the Audit with the NST.

6.30 The DSA / DSO conducts yearly reviews with the team, but daily supervision is ad-hoc and not recorded. Cases discussed and actions arising from these discussions are not reflected in the chronology of events on case records. Doing so would strengthen oversight, ensure an audit trail and provide better information should cases need to be covered during periods of absence. Structured supervision sessions in case management would allow for essential oversight and scrutiny and minimise the potential for gaps in risk management.

6.31 For instance, the Audit noted a domestic abuse case where the response could have been strengthened. Referrals to external support agencies such as the National Domestic Abuse Helpline, Victim Support, Citizens Advice or a solicitor would have enhanced support for the alleged victim. Regular supervision sessions could have identified this. Maintaining impartiality and factual accuracy in safeguarding logs is crucial. The Audit recognise and welcome the emphasis to be placed on Domestic Abuse training in 2025.

Recommendation D38: Where cases are discussed during supervision:

a) The recording of the discussion and the actions agreed / decision made should be included on individual case records. These should follow a consistent format and be uploaded as soon as practical after the supervision session has taken place.

b) Supervision entries on case referrals recorded on MyConcern should be consistent and occur on a monthly basis.

c) The DSA / DSO should routinely record the rationale for decisions when cases are closed.

6.32 Measures are in place to ensure that personal information is stored and shared in ways which are compliant with the Data Protection Act 2018, and relevant regulations, including General Data Protection Regulation (GDPR). These include national Information Sharing Agreements (ISA), work email addresses, GDPR training and the use of the national case management system, MyConcern. Data Protection is also a feature on the DBF Risk Register.

6.33 Findings from the Audit's survey indicate that the vast majority of the DBF and Parish workforce are aware of the Diocese's privacy policy in respect of data protection. Most of the Parish community are also aware. That said, the Audit was informed that some PSOs use their own private email addresses. Considering the personal and sensitive matters they may be dealing with, this is not good practice and should be actively discouraged.

Recommendation D39: Parishes should create a bespoke safeguarding email address (e.g. safeguarding@examplechurch.org.uk) to be used by the PSO, which will prevent them from using personal email addresses to process sensitive personal data.

7 Victims and Survivors

7.1 Victims and survivors of abuse often endure profound trauma as a result of their experiences. Many may not report the abuse at the time it takes place, perhaps due to a lack of awareness, isolation, shame, or fear of reprisal.[9] Disclosing abuse can be a daunting and unfamiliar process, fraught with challenges. [10] In light of this, Church bodies must cultivate and maintain supportive environments where victims and survivors feel heard, taken seriously, and reassured they will receive effective help and protection.

7.2 The Audit collected valuable feedback from victims and survivors through an anonymous online survey, the results of which revealed a diverse range of experiences, both positive and negative. One victim / survivor was spoken to directly. This in-depth conversation provided essential context and nuanced perspectives, with the participant helping the Audit to develop a more comprehensive understanding of the issues.

7.3 The DST recognises the importance of engaging with victims and survivors, listening to their experiences, and learning from their perspectives. That said, survey respondents felt that their input was not being sufficiently considered in the local efforts to improve safeguarding. Such views are reinforced by the fact there are currently no formal mechanisms in place for specific engagement with victims and survivors.

7.4 The DBF adheres to the House of Bishops' guidance set out in '*Responding Well to Victims and Survivors of Abuse*'. Therapeutic assistance is available locally and via

[9] No one noticed, no one heard, NSPCC 2013, https://learning.nspcc.org.uk/research-resources/2013/no-one-noticed-no-one-heard
[10] 'Why disclosing abuse can be difficult' in the House of Bishop's 'Responding Well to Victims and Survivors of Abuse' https://www.churchofengland.org/safeguarding/safeguarding-e-manual/responding-victims-and-survivors-abuse/section-1-responding-well

national CofE programmes, such as Safe Spaces, the Interim Support Scheme and the Redress Scheme.

7.5 That said, survey responses identified a general lack of familiarity with this guidance and as such, the Audit makes the following recommendation.

Recommendation D40: To ensure optimal communication approaches are employed in victim support initiatives, the DBF should conduct a review of its digital and offline communication channels. This evaluation should focus on identifying areas where communication can be enhanced concerning broader support arrangements for victims.

7.6 It is positive that the DBF maintains a formal SLA with the Survivor's Network, securing an embedded Independent Sexual Violence Advisor (ISVA) within the DST. This ISVA service is specifically designed for victims of church-based sexual abuse. Operating under the established principle of '*with but not for*' the Diocese of Chichester, the ISVA ensures an appropriate and compassionate response to victims while maintaining fundamental independence. The ISVA service prioritises a swift response to the immediate and ongoing needs of victims and survivors. This is good practice.

7.7 It is also positive that the DSAP benefits from the ISVA as one of its members, incorporating the inclusion of their perspectives. Currently, the DBF is exploring options to modify and potentially expand this representation, with ongoing developments expected. This initiative reflects the DBF's commitment to prioritising the needs and experiences of victims and survivors. The Audit supports this focus.

7.8 Various pages on the Diocese's website highlight a range of relevant support services. For example, there is a dedicated webpage for 'Sexual Violence Services'[11] and hyperlinks to specialised organisations such as the Saturn Centre and Lifecentre, support services through Mankind Counselling and Counselling Plus, and support groups such as the Eastbourne Survivors Group and Survivors Network. Whilst acknowledging the user experience could be improved (see Part One, Prevention section), the Audit notes the provision of this broad range of signposting as good practice.

Recommendation D41: The DBF should scope and develop a formal plan about how it will engage, consult and collaborate with victims and survivors. Any related initiatives should be meaningful, trauma-informed and developed in accordance with '*Responding Well to Victims and Survivors of Abuse.*'

Recommendation D42: The DSAP should work to establish or connect with networks of victims and survivors. It should also map the opportunities available to reach out to other existing groups to request opportunities to engage in listening events.

7.9 The Audit's engagement with a victim / survivor of non-recent Church related abuse provides important insights. This individual described the impact of the abuse on their life and the contrast between the support they received in the past and that received more recently from the Chichester DST. The individual was positive about the DST, characterising their approach as compassionate and approachable. They emphasised the DST's genuine commitment to providing support, evidenced by their proactive efforts at

[11] https://safeguarding.chichester.anglican.org/sexualviolencesservices/

keeping the individual informed and addressing their concerns. The DST demonstrated advocacy by pursuing action within the Church and exploring all available avenues for support, even when constrained by legal barriers. Crucially, the DST maintained open communication channels and respected the individual's boundaries throughout the process, ensuring a safe and supportive environment. The provision of counselling, which the individual described as "*life-changing*" further underscores the DST's dedication in achieving good outcomes.

7.10 Whilst initially hesitant to engage with the Church due to their past experiences, the individual eventually met with the current Bishop of Chichester after undergoing counselling. The meeting proved positive, with the individual and their partner finding the Diocesan Bishop approachable and understanding. He offered a genuine apology and acknowledged the harm that had been caused. Financial assistance from a discretionary fund was also provided as a gesture of goodwill and an acknowledgment of past failures.

7.11 The Audit found positive working relationships with the relevant local authorities.

7.12 The Audit gathered valuable insights from clergy into their understanding and application of forgiveness within the context of their ministry and safeguarding. Whilst acknowledging the theology of forgiveness, it was articulated that this isn't *in lieu* of accountability nor does forgiveness mean that the person should be placed in services or activities where risk is neither considered nor mitigated. This input outlined positive practice by the clergy. Whilst no recommendations are made in this respect, it is a reminder of the inherent tensions between the pastoral and safety aspects of Church life and the need for these to be managed carefully.

7.13 The Audit identified a clear recognition and prioritisation of the needs of victims and survivors amonst senior leaders across the Diocese. The Diocesan Bishop told the Audit he was profoundly shaped by his interactions with victims and survivors of abuse. He explained that these formative encounters, marked by deeply emotional and humbling exchanges, instilled in him a strong sense of personal accountability for the Church's past failings and current actions.

8 Learning, Supervision and Support

8.1 In recent years, safeguarding learning across the Diocese has been sustained, but progress has been somewhat impacted by the heavy focus on casework, a direct consequence of the Dicoese of Chichester's history and the recommendations from PCR2. In reality, the DBF is only now beginning to gain momentum in this area. The recent appointment of a Training and Development Officer has been a critical step towards ensuring training is both responsive to needs and future-focused. This role will lead on Parish support, deliver training, and adapt content based on casework insights.

8.2 Whilst there is no local written strategy for training and development, the DBF follows national guidance and its activities are aligned to the CofE's learning and development framework.

8.3 Training was conducted in person pre-COVID but shifted online during the pandemic. Since then, it has predominantly remained online. However, the DBF now plans for a blended learning approach. Two face-to-face Authorised Lay Ministry (ALM) training sessions are scheduled for January 2025 with others to follow. The DSA acknowledged the need for both types of training and there are plans to explore how they can facilitate role-specific training to make learning more contextual. A heatmap is also being developed to identify areas where leadership training uptake is low, allowing for more strategic planning. The Audit supports this new approach.

8.4 A gap identified in PCR2 involved the absence of references to domestic abuse in casework. The DBF believes that its history may have led to a stronger emphasis on child

sexual abuse at the time, but plans to broaden training are in place that will include a full focus on domestic abuse in the new year. This will sit alongside the decision to invite a domestic abuse expert to sit on DSAP, using an upcoming domestic abuse conference as a springboard for the new training.

8.5 Parishes within the Diocese of Chichester are utilising the online learning package for basic and foundation safeguarding training. In some cases, PSOs have led coffee mornings to deliver the training in-person and foster discussion, which has reportedly enhanced learning outcomes.

8.6 The DBF provides regular updates on training compliance to DSAP and the Bishop's Council. As of June 2024, compliance figures show a steady increase in participation across Basic, Foundation, Leadership, Safer Recruitment, Domestic Abuse, and Modern Slavery modules. Although the DSA / DSO reports little evidence that individuals are unable or unwilling to complete online training, manuals have been created to support those with IT challenges to access learning. This is good practice.

8.7 Whilst clergy and readers show high compliance rates for safeguarding training, this is notably lower amongst PSOs. An analysis conducted ahead of a recent DSAP meeting revealed several reasons for this, including capacity issues, some being new, some being unaware of the requirement, and for a small number, IT issues or other reasons. The analysis also found that some PSOs have not completed safeguarding training as they have undertaken similar work-based training. There appears to be an acceptance of this by the DSA / DSO, which does not reflect the training requirements table outlined on the Diocese of Chichester training web page, which indicates that such training is a

compulsory part of the role. If the Diocese accepts work-based training (thereby operating outside Church of England guidelines) in exceptional circumstances, this should be addressed with the NST and the criteria, if agreed, included within their policy and requirements table.

Recommendation D43: The DBF should consult with the NST to establish if they can, in exceptional circumstances, accept work-based training as an alternative to the national CofE safeguarding training. If they operate such practice without NST agreement this should be made clear in their policy with a definition for 'exceptional circumstance' and criteria for relevant work-based training.

8.8 The need for context specific safeguarding training remains critical. Vulnerability can exist in any congregation, and it's important to prepare for future risks, not just current ones. Safeguarding within the Church requires specific knowledge that cannot be assumed based solely on professional experience in other fields. Although adaptations can be made, overall PSOs must meet the requirements of the role, regardless of their qualifications, prior experience or the perceived risk level.

8.9 The Audit heard acknowledgement that this should be included in the induction pack for PSOs, an area currently under development by the new Training and Development Officer.

8.10 The DBF use a 'remind and support' approach for PSOs who have not completed their training, which recognises that support is often needed for those facing technical difficulties or minor barriers. For clergy, the model is 'remind and chase', as without up-to-date training, they can no longer hold their position. To complement this, a recent decision to

include PSOs in rolling training reminders for renewals should help to improve compliance. This is good practice.

Recommendation D44: Unless an exception has been agreed (see Recommendation D43), the DST should ensure that PSOs complete CofE mandated safeguarding training. Whilst some individuals will have the benefit of professional safeguarding experience, this does not replace the need for Church-based contextual safeguarding training. This should be clearly outlined in the induction pack.

8.11 The Audit noted a lack of focus on evaluating the impact of training on practice. The recent appointment of a Training and Development Officer marks a shift, with feedback now being collated from Leadership training to identify key themes and issues. Early observations indicate a need to retain a line of sight on culture. Additionally, a survey focused on youth work is being developed.

8.12 Whilst post-course evaluations are completed for Leadership training, some local scepticism was expressed about the value of feedback processes for Basic and Foundation training due to the complexity of measuring changes in practice, the nature of the training being set by the NST and the capacity of the team in carrying this out. The Audit finds this approach somewhat cautious and potentially restrictive in terms of gathering valuable insights. In this regard, the Audit makes the following recommendation. Whilst a national issue to consider, a light-touch approach led by the Training & Development Officer could yield good intelligence for the DST in terms of impact and local need.

Recommendation D45: The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers about how training has helped their practice. As part of this process questions about unmet training needs should be asked.

8.13 Over the last two years, safeguarding training within the Diocese has been delivered by two former members of the DST and a volunteer training team. These trainers were not provided with formal CPD, although they participated in periodic meetings. Parishes have also engaged with safer recruitment and people management training with Thirtyone:eight.

8.14 The DBF has a defined induction process that includes safeguarding elements. All new clergy attend an induction day at Church House, which includes input from the DST. During this session, attendees are referred to the safeguarding website, reminded of their training requirements, and informed of how to report safeguarding concerns. Beyond this, responsibility for induction lies with individual parishes. The Audit found that over half of respondents to the parish workforce survey had not undergone an induction or could not recall.

Recommendation D46: The DBF should develop an audit for PCCs to establish compliance levels with induction training. Where individuals are identified who have not had induction training this should be addressed within a specific period of time, i.e. three to six months. Furthermore, this issue should be addressed on any forthcoming visitations (known as Triennial Inspections).

8.15 Those in safeguarding roles at the DBF report feeling well-supported, part of a team, and connected with other safeguarding professionals. There is a general sense of a healthy work-life balance, though some pressure points remain.

8.16 Indeed, maintaining a work-life balance remains a challenge. The DSA/DSO acknowledged that while the team does its best, the reality is that safeguarding work is often pressured, and the team has limited capacity to alleviate workloads.

8.17 Members of the DST have accessed individual clinical and therapeutic supervision as well as external support over the past twelve years to manage the emotional demands of their work. There is no specific service designed to help clergy manage the trauma of safeguarding. However, the Diocesan Wellbeing Service for Clergy and Families provides support for clergy involved in safeguarding situations. The DST regularly refers clergy to this service.

8.18 Given the DSTs workload and its routine exposure to trauma, independent psychological support should be more defined within the DST's support systems. By this, the Audit believes that access to such support should be mandatory as opposed to 'available on request'.

Recommendation D47: The DBF should consider implementing mandatory counselling sessions for members of the DST to ensure they are sufficiently supported in the challenging role they do.

8.19 Pastoral and specialist therapeutic support is offered to Church Officers facing allegations, often through the Clergy Wellbeing Scheme. The specific form of support is decided during a Core Group process, with spiritual and pastoral support for clergy determined by the Diocesan Bishop. The offer is typically extended by the Archdeacon involved in the Core Group, who also directs individuals to the Clergy Wellbeing Service.

8.20 The DBF runs a support initiative for the spouses of clergy, including curates, newly licensed in the Diocese. This includes a welcome card offering contact information for confidential support, ensuring they feel safe at home, in Church, and in wider life.

8.21 The DST frequently interacts with other safeguarding professionals in relation to casework, such as the police or LADOs. Currently, no DST members participate in local safeguarding groups or multi-agency forums. The DSA acknowledged that this could be revisited, particularly with the input of the new Training Officer.

Recommendation D48: The DBF should engage in discussions with relevant safeguarding children and adult partnerships about the potential for Church Officers to be formally engaged in their arrangements (as relevant members of key groups / sub-groups).

8.22 Safeguarding is a standard topic in all MDRs. The MDR form is periodically reviewed, and safeguarding has its own dedicated section, ensuring that an '*update on safeguarding training, including non-core but mandatory modules*' is captured in each review.

8.23 During MDRs, the DBF ensures that areas for growth and development are identified. Typically, two or three objectives are set for each review, with room for more if both the reviewer and the cleric agree. These objectives are designed to be achievable within two years, include a target completion date, and specify an individual to whom the cleric will be accountable. Progress on these objectives is assessed in the subsequent MDR, ensuring a continuous focus on improvement.

8.24 Previously, MDRs focused more on compliance, but there are discussions towards incorporating goals from the action plan created during Leadership training into the MDR process. The Audit supports this approach as it enables learning to be tracked. The Audit will raise this with the NST.

9 Conclusion

9.1 The DBF continues to prioritise safeguarding and works hard to ensure that leaders, staff and volunteers across the Diocese recognise their responsibilities and provide effective help and protection. This commitment is evident through the DBF's ongoing efforts to improve practice and its clear focus on making people safer.

9.2 A strong safeguarding culture is helping to deliver impact in this context, supported by the foundations of strong leadership, a competent workforce and an appetite to learn. It is being sustained through robust policies, effective procedures, enhanced awareness raising and a strong training offer that empowers all stakeholders to question, challenge and act on concerns.

9.3 Underpinning all this activity is a well-led and highly professional DST. This team of experienced professionals is central to managing risk and providing essential support to victims and survivors. They are committed to learning from past failings and the Audit saw evidence of their dedication to keeping children and vulnerable adults at the forefront of their work.

9.4 To sustain and build on its success, the DBF must reinforce the DST, continue to embed safeguarding within its senior leadership and governance framework, and ensure that everyone engaged with the church feels empowered to speak truth to power.

9.5 The achievements of the Diocesan Bishop and his team over the last twelve years should not be underestimated. The Audit identified courageous approaches where the church

went beyond expectations, setting an example of how to manage risk, even when statutory partners were unable or unwilling to do so.

Part Two - Chichester Cathedral

10 Context

10.1 Chichester Cathedral was founded in 1075 after the bishopric moved from Selsey to Chichester. It began as a Norman Romanesque structure (being completed and consecrated in 1108), although has undergone many periods of transformation since, with key historical events and disasters altering its fabric. After fires in the 12th century, the Cathedral was rebuilt with a blend of Romanesque and early Gothic features. The 15th century saw the addition of the Cathedral's distinctive bell tower and spire, which collapsed in 1861 and was later restored. In the 20th century, it gained fame for its modern art, making the Cathedral a unique blend of medieval architecture and contemporary art, while continuing to serve as a place of worship and community gathering.

10.2 Today, the Cathedral upholds a vibrant liturgical tradition with daily services and a strong musical program. It continues to be both a spiritual hub and a cultural landmark. Governance has been modernised under the Cathedral's Measure 2021 and in 2023, the Cathedral formally registered as a Charity with the Charity Commission for England and Wales.

10.3 According to the most recent census data, Chichester has an estimated population of approximately 124,100 residents. The Cathedral receives 500-1500 visitors daily, with the majority of these being tourists.

10.4 From June 2024, Chichester Cathedral and the Prebendal School in Chichester became separate entities.

11 Progress

11.1 The Social Care Institute for Excellence (SCIE) audit of the Cathedral was published in December 2021 and resulted in 29 ‘considerations’. With regards to the Past Cases Review 2 (PCR2) process, whilst being involved in the Diocesan review, there were no specific recommendations arising for the Cathedral itself.

11.2 Oversight of the response to the SCIE audit has been led by the Cathedral’s Safeguarding Management Committee (SMC), and whilst there is evidence of change and improvement, there have been some noted challenges impacting upon the Cathedral’s response. These have been due to a combination of factors, such as legacy safeguarding failures impacting upon culture (culminating in the 2021 IICSA case study and the controversy surrounding Bishop George Bell), staff turnover and the impact of COVID-19.

11.3 That said, the Audit did see good evidence of progress, such as the strengthening of theological leadership on safeguarding, training compliance and responding to conflict. The Cathedral is aware of the key areas requiring further work covering victim / survivor engagement (a priority for 2025), embedding operational leadership and ensuring safeguarding policies and procedures are easily accessible and widely understood.

12 Culture, Leadership and Capacity

12.1 The Cathedral is actively focused on improving its safeguarding culture and has engaged in several initiatives to help build confidence and reinforce opportunities to capture feedback. This work is accruing benefits and there is evidence of impact.

12.2 For example, the Audit's discussions with many at the Cathedral reflected an environment where most people felt welcomed, supported and respected. Such views were mirrored in the survey returns. Indeed, many of the Cathedral's workforce reported an improving safeguarding culture and just over half the worshipping community agreed. The majority (from both cohorts) felt a safeguarding culture is now embedded and for those working at the Cathedral, they were confident they could approach, question and challenge their line managers. That said, some stubborn challenges remain, with less than a third of the workforce (engaged via surveys) being aware of whistleblowing procedures.

Recommendation C1: The Cathedral should take additional immediate steps to raise awareness, signpost and promote the Whistleblowing procedures.

12.3 The Cathedral has engaged in a number of positive initiatives, including the *TICK* awards (designed to celebrate inclusivity, effective communication and teamwork) and the Volunteer Forum, which provides an overview of many positive activities and future plans. As part of these activities, the HomeTech project is acknowledged as good practice, as is their approach to providing updates on safeguarding, associated policies and training activities.

12.4 This Cathedral is developing a multi-layered approach to safeguarding built on strong collaborative relationships and there is evidence of good partnership working both within and outside of the Cathedral. This is seen through the activities of independent members of the Safeguarding Management Group (SMC) (such as the Head Teacher of a local secondary school and the Mayor of Chichester), the wider voluntary support networks, and critically via the Service Level Agreement (SLA) with the Diocesan Board of Finance (DBF) and Diocesan Safeguarding Team (DST).

12.5 Notwithstanding the good work undertaken, the Audit makes the following recommendations to help ensure that success is consolidated and that the positive trajectory is sustained.

Recommendation C2: To further embed, monitor and improve organisational culture, the Cathedral should:

a) Conduct regular (e.g. annual) surveys across the Cathedral to monitor the safeguarding culture and identify any emerging trends or concerns. These surveys should specifically include questions about individuals' comfort in raising concerns and challenging leadership.

b) Conduct regular focus groups and interviews with a diverse range of individuals across the Cathedral (including clergy, staff, and volunteers) to gather qualitative data on the safeguarding culture, identifying areas for improvement.

c) Establish clear and accessible feedback mechanisms for individuals to share their concerns or suggestions regarding safeguarding, anonymously if preferred.

12.6 Triangulation of information from written materials, surveys, one-to-one discussions, and

focus groups indicates that the new Dean fosters a culture of safeguarding. He stated that he views the care of vulnerable people as integral to Christian faith, a belief which he is determined reflect in his leadership.

12.7 The Audit saw evidence that the Dean actively engages with the SMC and seeks reassurance when appropriate. For example, when a minor issue arose with day chaplain checks, he took immediate action to rectify it, demonstrating his commitment to compliance. Furthermore, his openness about past experiences and their impact on his current role helps to amplify the importance of transparency and learning within the context of the Cathedral.

12.8 Given the inherent power dynamics within a Cathedral setting, with its history and traditional deference towards senior clergy, it is crucial for the culture to be one where everyone, regardless of their position, role, or connection to the church, feels empowered to speak openly and honestly. To diminish any residual barriers in this respect, the Audit makes the following recommendations.

Recommendation C3: The Cathedral should facilitate training for the senior clergy and other senior leaders on fostering a culture of open communication and psychological safety, where individuals feel comfortable speaking up and challenging authority.

Recommendation C4: Senior Clergy and other senior leaders should create more informal opportunities for engagement with staff and volunteers (e.g., informal gatherings, open-door sessions) to allow for more open communication and reduce the perception of hierarchical barriers.

Recommendation C5: The DBF should implement mentoring systems to support individuals who may feel less confident in raising concerns or challenging those in authority.

Recommendation C6: Cultural surveys should consistently include questions that gauge perceptions of deference to authority, the approachability of senior figures, and individuals' confidence in challenging those in power. This feedback should be collated and tracked at Chapter level, enabling the identification of any trends or concerns and informing appropriate action.

Leadership

12.9 Despite his recent appointment, the Dean possesses a nuanced understanding of the Cathedral's challenges, having previously served as an Archdeacon in the Diocese of Chichester. This experience provides him with a valuable insight into the historical issues underpinning these challenges, both within the Cathedral itself and in its relationship with the Diocese. He has a good working relationship with the Diocesan Bishop.

12.10 Those in key roles demonstrate a firm grasp of safeguarding and can clearly articulate how their responsibilities relate to it. Furthermore, they exhibit a strong understanding of the appropriate pathways for seeking advice and support.

12.11 The Cathedral Chief Financial Officer (CFO) currently also serves as the Chief Operating Officer (COO), balancing two complex and demanding roles. Whilst this dual responsibility may be a necessary short-term solution (due to financial constraints), it is not sustainable in the long term. Given the breadth of the COO's responsibilities, not least those related to safeguarding, this matter warrants prompt attention.

12.12 The Cathedral Safeguarding Lead (CSL) is also the Cannon Chancellor. They ensure that the Cathedral's safeguarding policy and procedures are up to date and in line with the latest national standards, and take the lead on providing safeguarding training to all staff and volunteers. The CSL is the key point of contact for safeguarding in the Cathedral and works closely with the DSA / DSO and DST.

12.13 They also provide support to the Cathedral's SMC. The CSL occupies a demanding role and, despite an admirable level of commitment and well-developed safeguarding ability, they are currently under-resourced. The Audit therefore welcomes the fact that the Cathedral has agreed to employ an interim Cathedral Safeguarding Advisor (CSA). This is a welcome stop-gap, but to ensure the sufficiency of safeguarding, the Cathedral should appoint a full-time, professional CSA as soon as possible. To this end, the Audit makes a recommendation in the section dealing with capacity.

Governance

12.14 Following a period of challenge and change, the Cathedral's Chapter is strengthening. It has some excellent trustees, who bring significant strengths through their oversight role and their ability (and willingness) to appropriately test and challenge the decisions made by the most senior clergy.

12.15 The Chapter Lead for Safeguarding has a credible senior safeguarding background and brings rigour and professional curiosity to the safeguarding issues raised at Chapter. Minutes of Chapter meetings reflect an appropriate emphasis on safeguarding and proactive engagement from some members seeking to strengthen their knowledge and understanding. For example, in early 2024, a group comprising Chapter members, the safeguarding team, staff, and volunteers visited York Minster. This visit provided a valuable

learning opportunity, which they plan to repeat next year. Feedback highlighted a clear focus on safeguarding, with participants reflecting on lessons learned and the practice observed, including bell-ringing policies, new learning and engagement approaches, and the development of a survivor's charter. This proactive approach to learning and development represents good practice.

12.16 Chapter is supported by the SMC. This group is chaired by a member of Chapter who has significant experience in both senior leadership and safeguarding. It is populated by an impressive group of individuals and has significant potential to scrutinise safeguarding and drive further improvement going forward. As a small, yet significant example of the SMC's impact, its work resulted in a Cathedral-wide mandate that identification lanyards are worn by everyone.

12.17 The Audit also heard that the SMC is considering the creation of a subcommittee to separate strategic oversight from the scrutiny of day-to-day safeguarding practice. The Audit supports this approach and makes the following recommendations.

Recommendation C7: To enhance the effectiveness of safeguarding oversight and ensure a clear division of responsibilities, the Audit recommends that the SMC formally establish a dedicated Safeguarding Operations Subcommittee with the following remit:

a) Working with the CSL, DSA/O and key Cathedral staff, the SMC should differentiate strategic and operational issues, the latter being used to set an agenda and terms of reference for the Safeguarding Operations Subcommittee.
b) The subcommittee should meet monthly and report to the SMC quarterly, providing updates on key operational activities, emerging risks, and recommendations for improvement.

12.18 The Senior Leadership Team (SLT) has executive responsibility for the day-to-day running of the Cathedral. It holds operational authority. The Audit saw evidence of an appropriate level of safeguarding insight and direction, including but not limited to, risk assessments and the requirements placed on visiting organisations through to escalation and conflict resolution linked to safeguarding.

12.19 The CSL is clear that in order to consolidate the progress made, the Cathedral needs to establish a robust, transparent, and accountable safeguarding governance structure with a clear delineation between strategic oversight and operational delivery. The Audit agrees.

Recommendation C8: Once the function, roles, and responsibilities of the Safeguarding Operational Subcommittee (SOS) are clearly defined, Chapter should convene a roundtable session with representatives from the SMC, SOS, and Senior Leadership Team (SLT). This session should aim to ensure absolute clarity regarding the distinct roles of strategic oversight, scrutiny, and governance, as differentiated from executive and operational responsibilities.

Recommendation C9: As part of the clarification process, the Chapter, SMC and SOS should:

a) Carry out a skills, inclusion and diversity audit.

b) Adopt a thematic approach (regarding safeguarding and SIRs) to oversight and preparation for Charity Commission reporting.Whilst Charity Commission reporting requirements will invariable feature as a theme for end of year reporting, the overarching approach to thematically examine National Safeguarding Standards should be set out over a three year period.

c) Complete a review of Risk Registers on the basis of the outcomes of the Audit and key strategic areas which may impact on the stability, health and wellbeing of the workforce.

Capacity

12.20 The Cathedral operates under a Service Level Agreement (SLA) with the DBF for safeguarding support. However, given the existing pressures on the DST by way of staffing levels and workload, this arrangement is suboptimal.

12.21 Currently, an Assistant DSA (ADSA) oversees and supports safeguarding cases at the Cathedral, working closely with the CSL. Concerns are initially received via a central inbox, enabling a timely team response. The ADSA and CSL meet quarterly to review cases and ensure their proper management.

12.22 The Cathedral manages less serious concerns internally, escalating more serious cases to the DST through the 'MyConcern' reporting system. Despite a positive working relationship and good communication, geographical distance presents a challenge, hindering the ADSA's ability to be physically present on a regular basis.

12.23 Given the capacity challenges highlighted in this report, the following recommendations are made. The first addresses professional safeguarding support at the Cathedral, whilst the remaining recommendations, reproduced here for ease of reference, mirror those in the DBF audit concerning a potential new model.

Recommendation C10: To ensure robust and sustainable safeguarding, the Cathedral should appoint a full-time, permanent Cathedral Safeguarding Advisor (CSA). The successful candidate should be:

a) Professionally qualified for the role and preferably have experience in Adult or Children's social care (this will add to the blend of the overall DST).
b) Deployed in the Cathedral but be part of the DST, professionally supervised by the DSA/DSO or nominated ADSA.

Recommendation C11: (mirrored from the DBF Report) The DBF should establish a Director of Safeguarding role. This post and its line management should be structured to provide the highest levels of operational independence and be acknowledged as the authoritative voice on safeguarding. This will give the role more autonomy and credibility when challenging senior clergy. In order for this role to operate effectively it requires:

a) Clearly defined reporting lines and decision-making authority. The Director should be a member of and report to the Bishop's Council, Chapter and SLT.
b) An MOU between the DBF, Parish PCCs and the Cathedral, that the Director of Safeguarding has the responsibility and authority to provide insight, oversight, advice and support to any church body within the geography of the Diocese.
c) The ability to escalate concerns directly to higher church authorities (including the National Director of Safeguarding (NST)) if needed.
d) The resources and staffing to effectively deliver and oversee safeguarding across the Diocese, including the Cathedral. Such resources would include all professional safeguarding staff (including any deployed in the Cathedral) and additional resources to backfill the post of DSA/O and at least one additional ADSA.
e) The amalgamation of all safeguarding resources into an operationally independent Diocese Safeguarding Directorate.

To be clear, these recommendations would require three new posts, A Director of Safeguarding and an additional ADSA (this would facilitate a geographic approach to case management) as well as the proposed CSA based at the Cathedral.

Chorister Safeguarding

12.24 The safeguarding arrangements involving choristers are well-defined, understood by staff and practice is largely effective. Much of this can be attributed to the dedicated music team and the collaborative efforts between the school and the Cathedral.

12.25 Discussions with both choristers and probationers confirmed their confidence in approaching any member of staff if they were worried about something. This was particularly true for the Master of the Choristers. Interactions with the children were observed to be positive, and it is clear he has cultivated a trusting rapport with them. This sense of security is reinforced by posters displaying images of staff members around the Cathedral, although these could be strengthened with additional child-friendly safeguarding messages being displayed in key chorister areas.

Recommendation C12: The Cathedral should display child-friendly safeguarding posters and messaging in chorister areas, including the Song School.

12.26 An Independent Listener is employed by the school, providing choristers with a designated person with whom they can voice their concerns. This aligns with the recommendations for boarding schools from the IICSA report. Whilst no significant concerns were raised in relation to the listener's work, there was an indication of issues relating to workload and wellbeing, which will be addressed later in this section.

12.27 Information sharing between the Cathedral and Prebendal School is robust, standing out as a clear strength during the Audit. Despite the school's legal and operational independence from the Cathedral, both institutions demonstrate a cohesive and

collaborative approach to safeguarding. Low-level concerns are regularly communicated, with the Master of the Choristers proactively seeking clarification from the school when necessary, which helps to maintain transparency and trust.

12.28 A structured weekly meeting that considers low-level pastoral matters is held within the music department. The outcomes of these meetings are effectively relayed to the Chorister Tutor, who acts as the central link between the school and the Cathedral. Although this individual plays a pivotal role, it is encouraging that the relationships across the broader team appear strong and supportive, ensuring that information flow is not overly reliant on a single person.

12.29 Overall, parents spoke positively about the collaborative efforts of the music and school staff in safeguarding their children and of the communication systems in place. There was a preference for the introduction of virtual meetings that may offer a more practical solution for parents who live further away. Parents are consulted directly for any comments or suggestions regarding safeguarding and they are engaged via mechanisms such as questionnaires. Through an example involving changes to the supervision arrangements of probationers during services, the Audit saw how the Cathedral listens to and responds to the views of parents.

12.30 The supervision of choristers at the Cathedral is conducted with a clear focus on safeguarding, even in the absence of dedicated facilities. For example, whilst there are no specific toilets for the choristers, Cathedral toilets are closed off to the public during chorister use, with chaperones supervising the doorway. This is good practice.

12.31 Further good practice is demonstrated in the process of moving rehearsals to Prebendal

School when chaperone availability or staff-to-chorister ratios fall short. The move to a less private setting with greater staff presence ensures better visibility.

12.32 The rule that two staff members must be present in the organ loft when a child is there, is well understood and practiced. However, the Audit recommends the implementation of CCTV in the organ loft to further enhance visibility and safety.

Recommendation C13: The Cathedral should install CCTV in the organ loft to further enhance visibility in these areas.

12.33 The Cathedral was reactive in its approach to safeguarding during a recent incident involving protesters entering the quire during Evensong. Staff responded in a sensible and measured manner at the time of the incident and since then, have adjusted their position during services to prioritise the safety of the choristers over their view of the performance. They have also designated a specific area for evacuation if necessary.

12.34 Staff at the Cathedral receive appropriate training through the CofE. It is encouraging to note that Cathedral staff also model their behaviour management practices on those of Prebendal School and both the Organist and Master of Choristers has recently undertaken the schools safeguarding training. This alignment promotes consistency in expectations and approaches to managing behaviour, which benefits the choristers by providing a consistently supportive environment.

12.35 In the case of new staff who work directly with choristers, it may be beneficial for them to participate in some of the school's specific safeguarding and behaviour management training to further strengthen this unified approach. This would ensure that any new

personnel are fully integrated into the established safeguarding culture.

Recommendation C14: Whenever possible, relevant staff from the Cathedral should participate in school-specific safeguarding and behaviour management training.

12.36 The demands placed on choristers, particularly during peak seasons like Christmas and Easter, can be substantial, and managing these pressures effectively is crucial for their overall wellbeing. Chichester Cathedral and Prebendal School collaborate closely to manage the choristers' schedules, with one parent praising the *"excellent management of their time and duties."*

12.37 This effective coordination is evident in several areas, such as the practice of delaying the start of lessons until after morning rehearsals, and scheduling sports matches on Wednesdays (which is typically a day off from chorister duties). Additionally, the occasional 'late-start Saturday' enables choristers to go home on Friday evenings, providing them with a brief, yet much-needed break on Saturday mornings.

12.38 However, it is important to recognise that whilst Wednesday is designated as a day off from choir duties, it is still a school day, which does not provide choristers with a full rest period. Some choristers are also required to catch up on schoolwork during this time, which further limits their opportunity for rest. This continuous workload, extending across seven days a week, can take a toll on their physical and mental wellbeing and was noted by choristers themselves and parents.

12.39 Looking ahead, a national recommendation is anticipated, aiming to ensure that choristers receive the rest they need whilst being afforded the opportunities to maintain their high

standard of musical excellence. In the meantime, the Audit makes the following recommendation.

Recommendation C15: The Cathedral should work alongside Prebendal School to ensure that school catch up work does not encroach on chorister free time or rest time.

12.40 The Cathedral demonstrates a clear and ongoing commitment to the implementation of robust safeguarding policies and procedures. These policies are effectively communicated to parents, with safeguarding materials sent out at the beginning of each year and again when new choristers join.

12.41 The Missing Child Policy is noted as being strong and well-developed, providing clear guidance on procedures. Additionally, the Safeguarding and Pastoral Care of Choristers document offers comprehensive guidance on vetting procedures.

12.42 The Chorister Handbook is regularly reviewed in collaboration with both Cathedral and school staff. This document serves as a concise and accessible guide to choristership. The Audit views the inclusion of a detailed section on the school's structure as particularly beneficial in clarifying the roles of key staff involved with the choristers, while offering reassurance to parents about the support network in place around their children. This is good practice.

13 Prevention

13.1 The Cathedral's safer recruitment processes align with the House of Bishops guidance, with the Audit seeing evidence of robust arrangements and secure practice. For example, the Cathedral routinely promotes safeguarding via its recruitment literature, has a thorough application process (that uses 'confidential declarations'), and ensures DBS checks (and repeat checks) are carried out on those who need them. Furthermore, consistent referencing verifies previous employment details, new starters receive the necessary induction and training, and more recently, the Cathedral has been scoping a central database for its volunteer records.

13.2 The Cathedral uses a government tool to help determine the appropriate level of DBS check for those in its workforce. However, a volunteer group currently active within the Cathedral (which the Audit identified as needing DBS checks) has only recently been asked to complete them. The Audit therefore makes the following recommendations.

Recommendation C16: Cathedral leaders should seek reassurance that all eligible staff and volunteer's roles have been identified, are up to date with DBS checks, and are within the three-year cycle.

Recommendation C17: In line with government and CofE guidance on safer recruitment, the Cathedral should develop an eligibility matrix that defines the type of DBS check and the level of training required for specific roles.

13.3 The Cathedral has implemented a range of approaches to maintain a focus on safeguarding across different levels of the organisation. These include discussions during

regular meetings, scenario-based training, and appropriate engagement with the congregation. The Audit saw evidence of senior leaders regularly engaging in debate about safeguarding and this being a standing item on committee agendas. Routine sessions were also noted as being held with volunteers to promote dialogue and reinforce best practice. These events included case studies and group discussions to facilitate learning and encourage active participation. Additionally, the Congregational Forum provides a platform for conversation about safeguarding within the wider Cathedral community.

13.4 The Cathedral is planning to establish an education programme for schools to visit from 2025. The Audit found evidence of a considered and thorough approach to implementing this initiative, with proper attention being paid to safeguarding requirements. Work has covered the procedures for managing school visits, including aspects such as booking forms, staff-to-pupil ratios, and health and safety assessments. Furthermore, to ensure the programme is adequately resourced, the Cathedral is establishing a team of trained volunteers to support its delivery. The Audit acknowledges the good practice in this respect, although to further strengthen the Cathedral's arrangements, the following recommendation is made.

Recommendation C18: The Cathedral should engage with other Cathedral settings that deliver schools programmes, to help them learn from their experiences and share good practice in regard to safeguarding, program delivery, and impact assessment.

13.5 'Home Tech' is a particularly noteworthy initiative at Chichester Cathedral which encompasses key preventative practice. Home Tech is a volunteer-led program that aims

to help individuals experiencing social isolation due to a lack of digital literacy. Meeting once a month, Home Tech provides digital skills training and social interaction to help people connect and engage with technology.

13.6 Through Home Tech, participants have been educated about a range of digital platforms, such as WhatsApp, BBC Sounds, a local car parking app and online library services. Positively, sessions have also included a focus on risk and online safety. For example, the group benefited from hearing from a police officer who discussed online scams, including how to identify potentially harmful emails. This is good practice.

13.7 The Cathedral employs a variety of methods to raise awareness about safeguarding, including an annual 'Safeguarding Sunday', monthly newsletters, safeguarding posters and relevant issues being addressed within sermons. The Audit saw examples of the newsletter featuring guidance on reporting crime and antisocial behaviour and encouraging staff to utilise mental health first-aiders.

13.8 The Cathedral's Strategic Safeguarding Plan acknowledges the importance of actively promoting information about different types of abuse. Social media platforms and the newsletter are used as a mechanism to share news, stories, and resources with a wider audience, whilst internal communications (like the *Monthly Team Newsletter*) reinforce key messaging for staff and volunteers. The Audit acknowledges the Cathedral's efforts to raise the profile of safeguarding through its social media channels. However, whilst there are general statements in the plan the execution lacks frequency, novelty and local context that generates audience engagement and growth. To this end, the Audit makes the following recommendation.

Recommendation C19:

The Cathedral should enhance its communication planning by:

a) Implementing mechanisms to measure input, output, and impact of communication efforts. This will allow for data-driven evaluation and improvement of strategies.

b) Moving beyond simply mirroring national themes and ensuring that messaging is locally contextualised. This ensures relevance and resonance with the specific community the Cathedral serves.

c) Optimising its use of various communication platforms. This includes developing a clear strategy outlining how each platform is utilised and why.

d) Exploring podcasting opportunities. Podcasts can address contemporary local and national issues related to safeguarding within a faith context, featuring interviews with relevant personnel, such as a worshipper, volunteer, verger, Dean or Safeguarding Lead.

e) Embedding key safeguarding messages throughout its social media channels. This ensures consistent and frequent reinforcement of important information.

f) Understanding the needs of its followers on each platform and adopting platform-specific techniques. This includes using strong visuals on Instagram and tailoring content appropriately.

g) Utilising relevant awareness days, campaigns, and events to amplify its message. This helps to leverage broader public discourse and increase reach.

13.9 The Cathedral provides a useful resource of safeguarding information on its website[12]. Easily accessible from the main menu, the dedicated safeguarding webpage features a

[12] https://www.chichestercathedral.org.uk/safeguarding

clear and logical layout. This user-friendly design ensures that visitors can quickly find information about reporting concerns, accessing past reports, and relevant resources. The page also offers helpful links to both internal and external services within the wider community. The website has been optimised for accessibility and is designed to be mobile responsive. This is good practice.

13.10 The Cathedral actively seeks the views of children and young people through various channels. This includes feedback via daily interaction with choristers, formal consultations (like the Education Consultation Report), and surveys with worshippers at the Children and Family Service. The Audit supports the Cathedral's plans for the development of a Youth Council to further empower young voices.

13.11 Via its surveys, the Audit received positive feedback from those worshipping at the Children and Family Service at the Cathedral, particularly regarding its child-friendly and inclusive atmosphere. Children are welcomed and encouraged to participate, with the needs of all being taken into consideration. The clergy handle difficult biblical / theological topics sensitively and provide a safe space for discussion. Further feedback emphasised how the Cathedral's commitment to safeguarding has fostered a culture of safety, further enhanced by approachable staff and effective communication with parents / carers on safeguarding matters. The Cathedral also demonstrates a willingness to listen and respond to the views and suggestions of parents and children.

13.12 Importantly, the Cathedral recognises the needs of vulnerable adults and survivors of abuse, ensuring their experiences inform safeguarding policies and procedures. This is address further in the 'Victims and Survivors' section of this report.

13.13 In relation to the arrangements for lone working, the Cathedral has a Lone Working Policy that includes risk assessment and personal safety assessment tools. This is good practice.

13.14 Chichester Cathedral adheres to the House of Bishops' Safeguarding Policy "Promoting a Safer Church," and there is also a Behaviour Code Policy in place outlining appropriate boundaries. This policy requires individuals to acknowledge their understanding of the code through signature, with an additional signature from their line manager to ensure accountability. Furthermore, service booklets for Eucharistic services include a rubric, reminding worshippers to be mindful and respectful of personal boundaries when exchanging the Peace. This is good practice.

13.15 The Audit found that the Cathedral is adaptive to risk and has the capability to respond to unforeseen events. For example, the Audit was made aware of recent challenges caused by unannounced school visits. These visits disrupted planned activities and posed potential risks as large groups of students had to be quickly accommodated. Staff and volunteers managed these situations effectively.

13.16 Via the use of Safeguarding Risk Assessments (SRAs), the Cathedral has processes and guidance in place for managing activities involving children, young people and vulnerable adults. SRAs are subject to regular reviews and updates as necessary. At the time of writing, the Cathedral Safeguarding Lead had recently conducted an audit of all activities at the Cathedral to establish whether SRAs are required. This is good practice.

14 Recognising, Assessing and Managing Risk

14.1 A dedicated team of staff and volunteers manage the diverse operational requirements of the Cathedral, such as providing hospitality and support to visitors, addressing safeguarding concerns, dealing with disruptions and facilitating religious services. In terms of the response to risk, the Audit found a good understanding across the Cathedral's workforce about their respective roles and responsibilities. Importantly, there was an acknowledgement that safeguarding was everyone's responsibility.

14.2 The Cathedral maintains a corporate Risk Register and a separate safeguarding Risk Register that is aligned to the CofE's National Safeguarding Standards. The safeguarding Risk Register was implemented earlier this year and is good practice. The Audit's recommendations for the DBF Risk Register in terms of incorporating broader contextual issues are set out in Part One of this report and have equal relevance to the Cathedral. The Audit also recommends that the SLA between the DBF and Cathedral should reference the requirement for the Cathedral to record safeguarding risks on their safeguarding Risk Register.

Recommendation C20: The existing SLA which facilitates support from the DST to the Cathedral should be updated. The revised SLA should explicitly state the Cathedral's duty to identify and document any safeguarding risks unique to its environment within its own safeguarding Risk Register. This includes outlining measures to manage and mitigate those risks, ensuring the Cathedral proactively addresses its specific safeguarding needs while retaining access to DST support and guidance.

14.3 The current safeguarding processes facilitate the effective triaging of referrals within the Cathedral. The process involves oversight and scrutiny from relevant safeguarding leads and audit trails secure available evidence and provide an account of decision making.

14.4 For low-level concerns, staff are required to report these within 24 hours using a designated form submitted to the Cathedral Safeguarding Lead (CSL) and Chapter Clerk. The concern is recorded in a centralised register by the CSL or Deputy, with all evidence securely stored. Each concern is reviewed by the relevant area manager, and the CSL (or Deputy) determines the appropriate action. This is good practice.

14.5 The Cathedral has also established multiple channels for reporting safeguarding concerns of a more serious nature, including a dedicated email address which is monitored by key safeguarding personnel including the CSL and DST. All safeguarding concerns, whether received verbally or in writing, must be formally documented and submitted within 24 hours, allowing for a timely response and accurate record-keeping. Anonymised summaries and feedback regarding safeguarding concerns are shared within governance meetings such as the Safeguarding Management Committee and Chapter. The Audit were advised the CSL will on occasion acknowledge and thank individuals submitting safeguarding reports. This is good practice.

14.6 Safeguarding reports are reviewed by the DST, with decision making for further action and subsequent case management being retained by the DST in line with the SLA. The CSL and Chapter Clerk maintain regular contact with the DSA and Cathedral Safeguarding Officer for guidance and support in decision-making. Case management is handled by the DST, ensuring consistent application of safeguarding procedures.

14.7 The Cathedral SLA with the DBF is reviewed annually and allows for a strong working relationship regarding case management, although concerns regarding the capacity of the DST were noted.

Recommendation C21: The Cathedral should prioritise the review of the SLA between the DBF and Cathedral to ensure it reflects any new safeguarding arrangements.

14.8 The Cathedral maintains strong external partnerships with charities, educational and cultural institutions, including Chichester District Foodbank and Stonepillow, which enhance the opportunities to detect risks, support collaborative decision making, and enable the quick implementation of safeguarding responses when required.

14.9 It is relevant to note the findings from the Audit's survey involving the Cathedral staff and volunteers. Whilst the overwhelming majority of respondents indicated they understood how to escalate a safeguarding concern, only two thirds had confidence in the process itself.

Recommendation C22: The Cathedral should work in partnership with the DST to engage staff and volunteers in building confidence in the safeguarding escalation process and to understand any barriers to swift and effective reporting.

14.10 The Audit was advised there have been no Core Groups or disciplinary processes at the Cathedral over the past 12 months. That said, Cathedral colleagues were invited to a Diocesan Core Group ensuring appropriate sharing of information. This is good practice. The findings in relation to Core Group procedures are outlined in Part One of this report.

14.11 The current safeguarding procedures outline a process for escalating disagreements or disputes regarding safeguarding practices. The DSA/DSO and CSL can raise concerns to the Chapter and Dean. However, it is important to reinforce the fact that the DSA/DSO should have the final authoritative word on safeguarding decisions.

Recommendation C23: The DBF and Cathedral should raise awareness regarding the current process for escalating disagreements or disputes regarding safeguarding decisions and reinforce the primacy of the DSA/DSOs role in safeguarding decision-making.

14.12 At the time of the Audit, there was one attendance agreement (Safety Plan) in place relevant to the Cathedral. The risk assessment conducted by the Cathedral (in collaboration with the DST) adhered to national guidance and prioritised the safety of victims, potential victims and vulnerable individuals. The welfare of the respondent had also been actively considered. The broader effectiveness of the management of Attendance Agreements (Safety Slans) is set out in Part One of this report.

14.13 The Cathedral has recently become a registered charity (November 2023). The Audit saw evidence of compliance with the House of Bishop's guidance regarding the statutory requirement to report serious incidents to the Charity Commission and was advised that copies of SIRs are also shared with the NST. The findings regarding SIRs in Part One of this report have equal relevance to the Cathedral.

14.14 The Cathedral has several arrangements in place which demonstrate compliance with UK data protection legislation and GDPR. These include joint Data Sharing Agreements and Privacy Notices, IT and Security policies and the use of the MyConcern case management

system for handling personal information related to safeguarding cases. The Audit was advised Church Officers and volunteers only share safeguarding information through non-personal forms of communication and Cathedral staff receive training on data protection, including how to identify data subject requests. The Audit was advised the communications team is currently exploring advanced GDPR training for specific job roles. The Audit noted GDPR sensibly features in the Cathedral Risk Register. This is good practice.

14.15 The Audit was advised that volunteers are offered data protection training depending on their roles and recommend this process is strengthened by making it a requirement for any volunteer involved in safeguarding to be trained in data protection legislation and GDPR.

Recommendation C24: Data protection and GDPR training should be a requirement for all relevant staff and volunteers, including any person whose role includes responsibility for safeguarding.

14.16 Notwithstanding the efforts of the Cathedral to raise awareness of its data protection privacy notice via the website, responses to the Audit's survey (from the Cathedral's workforce) indicated that slightly more than a quarter of respondents were unaware of it.

Recommendation C25: The Cathedral should continue to raise awareness with its workforce regarding the privacy notice in respect of data protection.

15 Victims and Survivors

15.1 The Cathedral follows the House of Bishops' guidance set out in '*Responding Well to Victims and Survivors of Abuse.*' Whilst formal support to victims and survivors is provided by the DST, the Cathedral appropriately raises awareness to emphasise the importance of safeguarding, including disclosure routes and reporting procedures. To enhance this commitment, the Cathedral will offer specialist-led training to staff and key volunteers in early 2025, focusing on effective responses to disclosures.

15.2 The Cathedral acknowledges that further efforts are required to effectively engage with victims and survivors, and this will be a focus in 2025. Whilst the intention to include representation from a Survivor Support Organisation on the Safeguarding Management Committee is welcomed, the Audit suggests this could be developed further by tighter collaboration with the DBF.

Recommendation C26: The Cathedral should seek to extend its SLA with the DBF and be included in the proposed recommendation for the DBF that will cover how victims and survivors are engaged, consulted and collaborated with. This should include how the Cathedral and DBF could attend listening events (at victim and survivor forums) and how they could facilitate such events in consultation with victims / survivors, by offering the use of Church premise for such purposed to victim and survivor organisations.

15.3 The Cathedral benefits through a network of local support services for broader safeguarding issues. This includes City Ambassadors trained in first aid, a dedicated Community Warden addressing vulnerability and anti-social behaviour, and emergency support for people who require housing through the District Council. Collaboration extends

to groups such as the Joint Action Group and Security Action Group, alongside specialist services such as WORTH Domestic Abuse Service and the WSCC Adult Reporting Portal. Strong partnerships with Citizens Advice, providing guidance and supporting initiatives like HomeTech, and the Neighbourhood Policing Team, contribute to community safety and well-being. Furthermore, recent collaborations with Sussex Police on Safe Spaces Sussex and Project Servator enhance safeguarding measures.

15.4 The Cathedral website's safeguarding page prominently signposts to relevant resources, such as Safe Spaces, Childline, and the DST, and explicitly reinforces the Cathedral's dedication to prioritising engagement with victims and survivors. This commitment is further emphasised through the display of Safe Spaces signage within the Cathedral itself, ensuring accessibility to vital support information for all visitors.

16 Learning, Supervision and Support

16.1 Despite some capacity challenges, the Cathedral continues to prioritise safeguarding training, learning, and development. Clergy, staff, and volunteers have access to safeguarding training delivered by the NST, Cathedral staff, the CSO, the DST, and external charitable organisations. A range of learning opportunities are available, albeit reduced by the absence of a dedicated safeguarding trainer.

16.2 This capacity issue has impacted the Cathedral's ability to fully align with National Safeguarding Standards by developing and adopting a comprehensive training strategy. However, efforts are ongoing to manage these limitations and ensure safeguarding training remains a priority. To this end, the Audit makes the following recommendation.

Recommendation C27 The appropriate governing body(ies) should reivew, if necessary, amend, and thereafter agree the current draft safeguarding training strategy.

16.3 Most Basic Awareness and Foundation training is delivered online via the CofE's portal. However, the Cathedral also runs face-to-face sessions for volunteers and employees who are digitally excluded. Leadership training is conducted in person and the CSL and Deputy CSL offer Cathedral-specific scenario-based safeguarding training for staff teams. These sessions, held in small groups, are designed to address specific safeguarding scenarios, including those involving domestic abuse. Trigger warnings were provided in advance, and support was offered to those who found the content challenging. This is good practice.

16.4 The Cathedral recently surveyed the impact of its in-house safeguarding training on behaviour and practice. The results were mixed and whilst many comments were positive

about the impact of this training, other responses indicated that some of the participants reported feeling ‘trapped’ or ‘triggered’. The CSL reflected that this feedback was valuable, particularly in understanding the effectiveness of the training for future improvements.

16.5 Learning opportunities mirror those available for other Church officers across the Diocese. In this sense, much of the detail set out in Part One of this report is of equal relevance. Although not directly beneficial for all Cathedral staff, Chichester Cathedral intend to host a CPD event for PSOs, either as a high-quality webinar or an in-person event.

16.6 The Diocese of Chichester provides clergy with the necessary support to address the emotional and psychological impact of their work, particularly in relation to safeguarding and other traumatic situations. This includes individual clinical and therapeutic supervision for members of the DST when required. This support is provided on an as-needed basis, with the need identified in consultation with the relevant line manager.

16.7 Clergy also have access to psychological support and clinical supervision when necessary. The process for identifying this need is collaborative, with pastoral support offered at the earliest possible stage. For clergy, these discussions occur with the Bishop of Chichester, while for parish staff, support needs are identified in consultation with the incumbent.

16.8 The Cathedral ensures that MDRs are conducted regularly, with a strong emphasis on safeguarding and identifying areas for growth and development. These reviews take place every two years for clergy holding licensed posts under Common Tenure, as required. Although clergy with Freehold posts are not obligated to participate in MDRs, the Cathedral extends the offer in the same manner.

16.9 MDRs are episcopally led and the Cathedral does not use external consultants for these reviews, respecting the clergy's sense of accountability to Bishops and Archdeacons, which is seen as an integral part of their theological identity.

16.10 Each MDR sets two or three objectives tailored to the reviewed clergy member's role and development needs. These goals are designed to be achievable within two years and include a specified person to whom the clergy member will be accountable. A national recommendation to include action plans from Leadership training is considered in Part One of this report.

16.11 The DBF provides an induction programme designed to equip individuals in safeguarding roles with the confidence and knowledge required. This was confirmed by the Audit's survey results, where a majority of respondents recalled undergoing an induction process, feeding back that it included sufficient information on safeguarding. This process begins with pre-read material, available both online and in hard copy, to establish foundational knowledge before direct engagement. New staff also participate in targeted one-to-one meetings with key personnel, allowing them to familiarise themselves with essential contacts and resources within the Cathedral and wider Diocese.

Recommendation C28: All staff and volunteers working at the Cathedral who were not given an induction at the commencement of their role should be required to undertake one within the next twelve months. This retrospective induction session can be undertaken in groups and should be mandatory (regardless of a person's length of service and the training received).

16.12 Additionally, CofE safeguarding training is completed at the appropriate level, typically on the individual's first day or even beforehand. All new clergy attend an induction day at

Church House, where the DST provides guidance on essential safeguarding practices. During this session, clergy are directed to the Safeguarding website and SQP, reminded of their training obligations, and informed on how to report any safeguarding concerns.

16.13 Whilst the induction programme itself is not formally evaluated, there are steps in place to ensure its quality and relevance. Moving forward, the induction process will undergo an annual review each October by the People, Remuneration and Nominations Committee (PRNC) to ensure it remains updated and aligned with safeguarding standards. Furthermore, all new employees undergo a Probationary Review, allowing managers to provide regular feedback on their induction experience. The Audit views this as good practice.

16.14 Despite not having access to specific supervision records, the Audit was advised that adequate supervision arrangements are in place for the CSL, Deputy CSL and the Priest Vicar (which of itself is good practice). Whilst this provides the safeguarding team with essential oversight, support and guidance, the adoption of specific supervision records would evidence and strengthen this practice.

Recommendation C29: The provision of supervision should always be supported by the creation of timely and accurate records, agreed and signed off by all parties involved.

17 Conclusion

17.1 The new Dean has a clear vision for safeguarding across the Cathedral and is well supported by his leadership team and a highly active and engaged Cathedral Safeguarding Lead. Discussions, focus groups, and survey feedback confirmed an improving safeguarding culture amongst both staff and the worshipping community.

17.2 Current strengths identified by the Audit range from an increasingly safeguarding-aware and competent Chapter, a developing Safeguarding Management Committee, and the launching of a range of initiatives that engage people of all ages. The excellent children and family services and the outstanding HomeTech project are particularly noteworthy.

17.3 The collaborative relationship between the Cathedral and Prebendal School is a significant strength, ensuring a cohesive approach to safeguarding choristers. Furthermore, the Cathedral has taken steps to enhance communication and training, empowering staff and volunteers to identify and respond to concerns effectively.

17.4 That said, safeguarding practice could be further strengthened by adopting the recommendations in this report. As priorities, the Cathedral should reinforce its provision by recruiting a suitably qualified Cathedral Safeguarding Advisor, further formalise safeguarding within its wider governance structures, increase collaboration with the DBF, and accelerate engagement and support for victims and survivors.

17.5 The Audit is in no doubt that under the current leadership, the Cathedral has every opportunity to develop further and advance its safeguarding improvement journey at pace.

Appendices

18 Appendix 1 – DBF Recommendations

Recommendation D1: Conduct regular (e.g., annual) surveys across the Diocese to monitor the safeguarding culture and identify any emerging trends or concerns. These surveys should specifically include questions about individuals' comfort in raising concerns and challenging leadership.

Recommendation D2: Conduct regular focus groups and interviews with a diverse range of individuals across the Diocese (including clergy, staff, and volunteers) to gather qualitative data on the safeguarding culture, identifying areas for improvement.

Recommendation D3: Establish clear and accessible feedback mechanisms for individuals to share their concerns or suggestions regarding safeguarding, anonymously if preferred.

Recommendation D4: The DBF should facilitate training for the Diocesan Bishop and other senior leaders on fostering a culture of open communication and psychological safety, where individuals feel comfortable speaking up and challenging authority.

Recommendation D5: The Diocesan Bishop and senior leaders should create more informal opportunities for engagement with staff and volunteers (e.g., informal gatherings, open-door sessions) to foster more open communication and reduce the perception of hierarchical barriers.

Recommendation D6: The DBF should implement mentoring systems to support individuals who may feel less confident in raising concerns or challenging those in authority.

Recommendation D7: Cultural surveys should consistently include questions that gauge perceptions of deference to authority, the approachability of senior figures, and individuals' confidence in challenging those in power. This feedback should be collated and tracked at governance level, enabling the identification of any trends or concerns and informing appropriate action.

Recommendation D8: The DBF should amend the role description for Archdeacons, formally setting out their safeguarding roles and responsibilities. This should include:

e) Proactive monitoring of safeguarding practices in parishes.
f) Notwithstanding the primary role of the DST, Archdeacons should be able to provide general safeguarding support, prompts and non-casework specific guidance to Parish Safeguarding Officers (PSOs) and their Parochial Church Council's (PCCs).
g) Conducting snap-shot safeguarding audits (in consultation with the DST) during parish visitations.
h) Consideration of Archdeacons being utilitised to chair Core Group meetings.

Recommendation D9: A schedule of regular meetings between Archdeacons and the DST should be implemented to ensure:

e) Structured two-way communication and information sharing.
f) Early identification of potential issues.
g) Briefs and debriefs regarding visitations and inspections.
h) Effective cascading of safeguarding information, updates, and resources to parishes.

Recommendation D10: Working in partnership with the DSA and NST, the DBF should develop context and role specific training for Archdeacons. Beyond basic safeguarding training, this should include:

g) Formal training for Core Groups (chairing Core Groups)
h) Recognising subtle signs of abuse.
i) Understanding different forms of abuse (physical, emotional, spiritual, neglect).
j) Responding appropriately to disclosures.
k) Conducting sensitive inquiries.
l) Current legislation and best practices.

Recommendation D11: All governance forums operating within the DBF should:

d) Carryout a skills, inclusion and diversity audit. The results of which should be shared at DSAP.
e) Adopt a thematic approach (regarding safeguarding and SIRs) to oversight and preparation for Charity Commission reporting.
f) Complete a review of Risk Registers on the basis of the outcomes of the Audit and key strategic areas which may impact on the stability, health and wellbeing of the workforce.

Recommendation D12: The Diocesan Bishop's quarterly meeting should be formalised to reinforce its role in governance and oversight of safeguarding. It should:

d) develop clear terms of reference and membership.
e) create an appropriately focused and relevant agenda, producing minutes and agreed actions.
f) adopt an appropriate naming convention, e.g., Safeguarding Strategic Oversight Group.

Recommendation D13: The DSAP should actively reach out to and collaborate with victim and survivor forums to ensure their perspectives are central to the DSAP's work.

Recommendation D14: The DSAP should complete a skills, inclusion and diversity audit to assist the expansion of DSAP membership to include more independent voices.

Recommendation D15: The DSAP should strengthen relationships with statutory and voluntary sectors by inviting representatives to join the DSAP and / or proactively participating in their forums.

Recommendation D16: The DSAP should increase parish representation and work with the DST, Archdeacons and PSOs to construct a PSO skills register.

Recommendation D17: The DSAP should adopt a three-year thematic approach to scrutiny based on the National Safeguarding Standards.

Recommendation D18: The DSAP should add the recommendations of this Audit to their routine tracking process.

Recommendation D19: The DSAP should delegate the quality assurance of operational matters to an Operational Quality Assurance Subgroup. This subgroup should meet monthly, be populated by those with operational responsibility and chaired by an appropriate member of DSAP.

Recommendation D20: The DSAP Chair should invite the Diocesan Bishop to the DSAP's end-of-year meeting to discuss key issues, facilitate mutual challenge and end of year reporting themes.

Recommendation D21: The DSAP Chair should ensure that the DSA / DSO is not the only authoritative voice considered when scrutinising safeguarding. Whilst they are key, the DSAP should be in a position to demonstrate that they have tested and verified what they are being told.

Recommendation D22: A qualified member of the Bishop's team and the DSA / DSO should conduct a thorough review of each incoming Clergy Blue File. This review should verify the accuracy of the CCSL statement and ensure those supporting the appointment are fully informed of the individual's experience, including any areas for development or potential vulnerability.

Recommendation D23: The DBF should establish a Director of Safeguarding role. This post and its line management should be structured to provide the highest levels of operational independence and be acknowledged as the authoritative voice on safeguarding. This will give the role more autonomy and credibility when challenging senior clergy. In order for this role to operate effectively it requires:

g) To subsume the authority vested in the DSO post.
h) Clearly defined reporting lines and decision-making authority. The Director should be be present as of right rather than by invitation and report to the Bishop's Council, Chapter and Senior Leadership Team (SLT).
i) All church bodies within the geography of the Diocese to sign up to a single Memorandum of Understanding (MoU) regarding the safeguarding expectations. In particular, the roles and responsibilities of the Director of Safeguarding, i.e. to provide insight, oversight, advice and support to any church body within the geography of the Diocese. This would include the DBF, Parish PCCs and the Cathedral. Consideration could also be given to the national provision of a '*Measure*' applicable to all Diocese.
j) The ability to escalate concerns directly to higher church authorities (including the National Director of Safeguarding (NST)) if needed.
k) The resources and staffing to effectively deliver and oversee safeguarding across the Diocese, including the Cathedral. Such resources would include all professional safeguarding staff (including any deployed in the Cathedral) and additional resources to backfill the post of DSA / DSO and at least one additional Assistant DSA (ADSA).
l) The amalgamation of all safeguarding resources into an operationally independent Diocese Safeguarding Directorate.

To be clear, these recommendations would require three new posts, A Director of Safeguarding and an additional ADSA (this would facilitate a geographic approach to case management) as well as the proposed CSA based at the Cathedral.

Recommendation D24: The DBF should develop a clear process for the safer recruitment and onboarding of volunteers at the DBF. This process should align with the House of Bishop's guidance 'Safer Recruitment and People Management'.

Recommendation D25: Action should be taken to reassure the DBF that all eligible staff and volunteer's roles are up to date with DBS checks and are within the three-year cycle.

Recommendation D26: The DBF should conduct enhanced DBS checks on the team of therapists commissioned through the Wellbeing for Clergy and Families service. As a minimum this should include an enhanced DBS check for those who work with under 18s.

Recommendation D27: The DBF should facilitate regular face to face sessions and / or networking events for PSOs to learn and share good practice.

Recommendation D28: The DBF should consider facilitating an annual networking event where PSOs can come together and hear from leading safeguarding professionals on new and emerging themes as they relate to their role.

Recommendation D29: Using its knowledge about the unique safeguarding issues facing the Diocese, a plan for awareness raising (based on themes and identified need) should be implemented that is tailored to those who work, volunteer or worship across the Diocese.

Recommendation D30: To ensure consistent, effective, and transparent communication with all stakeholders, the DBF should develop a comprehensive Communication Strategy. This strategy should serve as a guiding document for all internal and external communications, outlining key objectives, target audiences, messaging, and channels.

The strategy should include a plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of the followers, adopting different techniques specific to the platform and utilisation of relevant awareness days, campaigns and events to amplify the message.

Recommendation D31: The DBF should scope and consider options for improving website accessibility and navigation.

Recommendation D32: The DBF should ensure its overarching Risk Register is reviewed and updated regularly, with clear documentation of review dates. For example, the minutes of relevant meetings should reflect when risk registers have been considered, reviewed and/or agreed.

a) That it develops a standalone safeguarding Risk Register. Risks should be identified and defined against the National Safeguarding Standards.
b) That the proposed safeguarding Risk Register takes account of wider societal issues impacting upon safeguarding, particularly at a local level.

Recommendation D33: The DBF should develop a standalone safeguarding Risk Register.

a) Risks should be identified and defined against the National Safeguarding Standards.

b) The proposed safeguarding Risk Register should take account of wider societal issues impacting upon safeguarding, particularly at a local level.

Recommendation D34: To enhance the triage process and ensure timely and appropriate responses to safeguarding concerns, it is recommended that the DBF implements a more structured approach to allocating the level of risk and ownership of cases in the DST.

Recommendation D35: The DST should prioritise cleansing the data on MyConcern and archive any outstanding cases that are ready to be 'filed'.

Recommendation D36: Archdeacons (one at a minimum) should participate in Core Group meetings to provide additional independent scrutiny, insight and knowledge in safeguarding situations involving Church Officers.

Recommendation D37: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DST and NST. This will also be raised by the Audit with the NST.

Recommendation D38: Where cases are discussed during supervision:

a) The recording of the discussion and the actions agreed / decision made should be included on individual case records. These should follow a consistent format and be uploaded as soon as practical after the supervision session has taken place.

b) Supervision entries on case referrals recorded on MyConcern should be consistent and occur on a monthly basis.

c) The DSA / DSO should routinely record the rationale for decisions when cases are closed.

Recommendation D39: Parishes should create a bespoke safeguarding email address (e.g. safeguarding@examplechurch.org.uk) to be used by the PSO, which will prevent them from using personal email addresses to process sensitive personal data.

Recommendation D40: To ensure optimal communication approaches are employed in victim support initiatives, the DBF should conduct a review of its digital and offline communication channels. This evaluation should focus on identifying areas where communication can be enhanced concerning broader support arrangements for victims.

Recommendation D41: The DBF should scope and develop a formal plan about how it will engage, consult and collaborate with victims and survivors. Any related initiatives should be meaningful, trauma-informed and developed in accordance with '*Responding Well to Victims and Survivors of Abuse.*'

Recommendation D42: The DSAP should work to establish or connect with networks of victims and survivors. It should also map the opportunities available to reach out to other existing groups to request opportunities to engage in listening events.

Recommendation D43: The DBF should consult with the NST to establish if they can, in exceptional circumstances, accept work-based training as an alternative to the national CofE safeguarding training. If they operate such practice without NST agreement this should be made clear in their policy with a definition for 'exceptional circumstance' and criteria for relevant work-based training.

Recommendation D44: Unless an exception has been agreed (see Recommendation D43), the DST should ensure that PSOs complete CofE mandated safeguarding training. Whilst some individuals will have the benefit of professional safeguarding experience, this does not replace the need for Church-based contextual safeguarding training. This should be clearly outlined in the induction pack.

Recommendation D45: The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers about how training has helped their practice. As part of this process questions about unmet training needs should be asked.

Recommendation D46: The DBF should develop an audit for PCCs to establish compliance levels with induction training. Where individuals are identified who have not had induction training this should be addressed within a specific period of time, i.e. three to six months. Furthermore, this issue should be addressed on any forthcoming visitations (known as Triennial Inspections).

Recommendation D47: The DBF should consider implementing mandatory counselling sessions for members of the DST to ensure they are sufficiently supported in the challenging role they do.

Recommendation D48: The DBF should engage in discussions with relevant safeguarding children and adult partnerships about the potential for Church Officers to be formally engaged in their arrangements (as relevant members of key groups / sub-groups).

19 Appendix 2 – Cathedral Recommendations

Recommendation C1: The Cathedral should take additional immediate steps to raise awareness, signpost and promote the Whistleblowing procedures.

Recommendation C2: To further embed, monitor and improve organisational culture, the Cathedral should:

d) Conduct regular (e.g. annual) surveys across the Cathedral to monitor the safeguarding culture and identify any emerging trends or concerns. These surveys should specifically include questions about individuals' comfort in raising concerns and challenging leadership.

e) Conduct regular focus groups and interviews with a diverse range of individuals across the Cathedral (including clergy, staff, and volunteers) to gather qualitative data on the safeguarding culture, identifying areas for improvement.

f) Establish clear and accessible feedback mechanisms for individuals to share their concerns or suggestions regarding safeguarding, anonymously if preferred.

Recommendation C3: The Cathedral should facilitate training for the senior clergy and other senior leaders on fostering a culture of open communication and psychological safety, where individuals feel comfortable speaking up and challenging authority.

Recommendation C4: Senior Clergy and other senior leaders should create more informal opportunities for engagement with staff and volunteers (e.g., informal gatherings, open-door sessions) to allow for more open communication and reduce the perception of hierarchical barriers.

Recommendation C5: The DBF should implement mentoring systems to support individuals who may feel less confident in raising concerns or challenging those in authority.

Recommendation C6: Cultural surveys should consistently include questions that gauge perceptions of deference to authority, the approachability of senior figures, and individuals' confidence in challenging those in power. This feedback should be collated and tracked at Chapter level, enabling the identification of any trends or concerns and informing appropriate action.

Recommendation C7: To enhance the effectiveness of safeguarding oversight and ensure a clear division of responsibilities, the Audit recommends that the SMC formally establish a dedicated Safeguarding Operations Subcommittee with the following remit:

c) Working with the CSL, DSA/O and key Cathedral staff, the SMC should differentiate strategic and operational issues, the latter being used to set an agenda and terms of reference for the Safeguarding Operations Subcommittee.

d) The subcommittee should meet monthly and report to the SMC quarterly, providing updates on key operational activities, emerging risks, and recommendations for improvement.

Recommendation C8: Once the function, roles, and responsibilities of the Safeguarding Operational Subcommittee (SOS) are clearly defined, Chapter should convene a roundtable session with representatives from the SMC, SOS, and Senior Leadership Team (SLT). This session should aim to ensure absolute clarity regarding the distinct roles of strategic oversight, scrutiny, and governance, as differentiated from executive and operational responsibilities.

Recommendation C9: As part of the clarification process, the Chapter, SMC and SOS should:

d) Carry out a skills, inclusion and diversity audit.

e) Adopt a thematic approach (regarding safeguarding and SIRs) to oversight and preparation for Charity Commission reporting.Whilst Charity Commission reporting requirements will invariable feature as a theme for end of year reporting, the overarching approach to thematically examine National Safeguarding Standards should be set out over a three year period.

f) Complete a review of Risk Registers on the basis of the outcomes of the Audit and key strategic areas which may impact on the stability, health and wellbeing of the workforce.

Recommendation C10: To ensure robust and sustainable safeguarding, the Cathedral should appoint a full-time, permanent Cathedral Safeguarding Advisor (CSA). The successful candidate should be:

c) Professionally qualified for the role and preferably have experience in Adult or Children's social care (this will add to the blend of the overall DST).

d) Deployed in the Cathedral but be part of the DST, professionally supervised by the DSA/DSO or nominated ADSA.

Recommendation C11: (mirrored from the DBF Report) The DBF should establish a Director of Safeguarding role. This post and its line management should be structured to provide the highest levels of operational independence and be acknowledged as the authoritative voice on safeguarding. This will give the role more autonomy and credibility when challenging senior clergy. In order for this role to operate effectively it requires:

f) Clearly defined reporting lines and decision-making authority. The Director should be a member of and report to the Bishop's Council, Chapter and SLT.

g) An MOU between the DBF, Parish PCCs and the Cathedral, that the Director of Safeguarding has the responsibility and authority to provide insight, oversight, advice and support to any church body within the geography of the Diocese.

h) The ability to escalate concerns directly to higher church authorities (including the National Director of Safeguarding (NST)) if needed.

i) The resources and staffing to effectively deliver and oversee safeguarding across the Diocese, including the Cathedral. Such resources would include all professional safeguarding staff (including any deployed in the Cathedral) and additional resources to backfill the post of DSA/O and at least one additional ADSA.

j) The amalgamation of all safeguarding resources into an operationally independent Diocese Safeguarding Directorate.

To be clear, these recommendations would require three new posts, A Director of Safeguarding and an additional ADSA (this would facilitate a geographic approach to case management) as well as the proposed CSA based at the Cathedral.

Recommendation C12: The Cathedral should display child-friendly safeguarding posters and messaging in chorister areas, including the Song School.

Recommendation C13: The Cathedral should install CCTV in the organ loft to further enhance visibility in these areas.

Recommendation C14: Whenever possible, relevant staff from the Cathedral should participate in school-specific safeguarding and behaviour management training.

Recommendation C15: The Cathedral should work alongside Prebendal School to ensure that school catch up work does not encroach on chorister free time or rest time.

Recommendation C16: Cathedral leaders should seek reassurance that all eligible staff and volunteer's roles have been identified, are up to date with DBS checks, and are within the three-year cycle.

Recommendation C17: In line with government and CofE guidance on safer recruitment, the Cathedral should develop an eligibility matrix that defines the type of DBS check and the level of training required for specific roles.

Recommendation C18: The Cathedral should engage with other Cathedral settings that deliver schools programmes, to help them learn from their experiences and share good practice in regard to safeguarding, program delivery, and impact assessment.

Recommendation C19:

The Cathedral should enhance its communication planning by:

h) Implementing mechanisms to measure input, output, and impact of communication efforts. This will allow for data-driven evaluation and improvement of strategies.

i) Moving beyond simply mirroring national themes and ensuring that messaging is locally contextualised. This ensures relevance and resonance with the specific community the Cathedral serves.

j) Optimising its use of various communication platforms. This includes developing a clear strategy outlining how each platform is utilised and why.

k) Exploring podcasting opportunities. Podcasts can address contemporary local and national issues related to safeguarding within a faith context, featuring interviews with relevant personnel, such as a worshipper, volunteer, verger, Dean or Safeguarding Lead.

l) Embedding key safeguarding messages throughout its social media channels. This ensures consistent and frequent reinforcement of important information.

m) Understanding the needs of its followers on each platform and adopting platform-specific techniques. This includes using strong visuals on Instagram and tailoring content appropriately.

n) Utilising relevant awareness days, campaigns, and events to amplify its message. This helps to leverage broader public discourse and increase reach.

Recommendation C20: The existing SLA which facilitates support from the DST to the Cathedral should be updated. The revised SLA should explicitly state the Cathedral's duty to identify and document any safeguarding risks unique to its environment within its own safeguarding Risk Register. This includes outlining measures to manage and mitigate those risks, ensuring the Cathedral proactively addresses its specific safeguarding needs while retaining access to DST support and guidance.

Recommendation C21: The Cathedral should prioritise the review of the SLA between the DBF and Cathedral to ensure it reflects any new safeguarding arrangements.

Recommendation C22: The Cathedral should work in partnership with the DST to engage staff and volunteers in building confidence in the safeguarding escalation process and to understand any barriers to swift and effective reporting.

Recommendation C23: The DBF and Cathedral should raise awareness regarding the current process for escalating disagreements or disputes regarding safeguarding decisions and reinforce the primacy of the DSA/DSOs role in safeguarding decision-making.

Recommendation C24: Data protection and GDPR training should be a requirement for all relevant staff and volunteers, including any person whose role includes responsibility for safeguarding.

Recommendation C25: The Cathedral should continue to raise awareness with its workforce regarding the privacy notice in respect of data protection.

Recommendation C26: The Cathedral should seek to extend its SLA with the DBF and be included in the proposed recommendation for the DBF that will cover how victims and survivors are engaged, consulted and collaborated with. This should include how the Cathedral and DBF could attend listening events (at victim and survivor forums) and how they could facilitate such events in consultation with victims / survivors, by offering the use of Church premise for such purposed to victim and survivor organisations.

Recommendation C27 The appropriate governing body(ies) should reivew, if necessary, amend, and thereafter agree the current draft safeguarding training strategy.

Recommendation C28: All staff and volunteers working at the Cathedral who were not given an induction at the commencement of their role should be required to undertake one within the next twelve months. This retrospective induction session can be undertaken in groups and should be mandatory (regardless of a person's length of service and the training received).

Recommendation C29: The provision of supervision should always be supported by the creation of timely and accurate records, agreed and signed off by all parties involved.

20 Appendix 3 – Glossary of Abbreviations

ADSA	Assistant Diocesan Safeguarding Adviser
CCSL	Clergy Current Status Letter
CCTV	Closed-circuit TV
CDM	Clergy Discipline Measure
CFO	Chief Financial Officer
CMS	Case Management System
CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
CPS	Crown Prosecution Service
CSA	Cathedral Safeguarding Advisor
CSC	Cathedral Safeguarding Committee
CSL	Cathedral Safeguarding Lead
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
DSL	Designated Safeguarding Lead
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
GDPR	General Data Protection Regulation
HR	Human Resources
HTB	Holy Trinity Brompton

IICSA	The Independent Inquiry into Child Sexual Abuse
ISA	Information Sharing Agreement
ISVA	Independent Sexual Violence Advisors
LADO	Local Authority Designated Officer
LLR	Learning Lessons Reviews
MDR	Ministerial Development Review
MOSOVO	Management of Sexual or Violent Offenders
MoU	Memorandum of Understanding
NST	National Safeguarding Team
OGS	Operational Group for Safeguarding
OSG	Operational Safeguarding Group
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PRNC	People, Remuneration and Nominations Committee
PSO	Parish Safeguarding Officer
PTO	Permission to Officiate
SCIE	The Social Care Institute for Excellence
SCMG	Safeguarding Case Management Groups
SET	Senior Executive Team
SIR	Serious Incident Report
SLA	Service Level Agreement
SMC	Safeguarding Management Committee
SOPO	Sexual Offences Prevention Order
SOS	Safeguarding Operational Subcommittee
SPOC	Single Point of Contact

SQP	Simple Quality Protects
SRPM	Safer Recruitment and People Management

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