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SAFEGUARDING GROUP

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

2024

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Introduction

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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 CofE dioceses 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 SCIE audits, PCR2 outcomes, other relevant material as well as evidence from surveys, focus groups, direct correspondence and interviews. For the Gloucester Diocesan Board of Finance (DBF) and Gloucester Cathedral, this involved the following:

- 255 documents being collated and analysed prior to the Audit's fieldwork.
- A range of interviews with church officers (staff and volunteers), external partners, victims and survivors and other stakeholders.
- 434 anonymous survey responses which gathered input from key communities connected to the Diocese and Cathedral. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the parishes, Cathedral and Diocese.
- Seven focus groups. Two engaged children and young people, one was conducted with chorister parents, two focus groups drew input from Parish Safeguarding Officers (PSOs), one with parish trainers and one with clergy within the diocese.
- A confidential contact form accessible via a dedicated webpage.
- In total, the Audit undertook 47 separate engagement sessions reaching 556 people.

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

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1.3 The Audit report is separated into Part One, Gloucester Diocesan Board of Finance (DBF) and Part Two, Gloucester Cathedral. This has been done to ensure that each audited body is able to focus on their own strengths and areas for identified improvement. Given the relationship between the two bodies, there are areas where activity, strengths, and opportunities align. Because of this, some of the narrative will be reflected in both Part One and Part Two.

1.4 This report has been reviewed for factual accuracy by the Diocese of Gloucester and Gloucester Cathedral.

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Part One - Gloucester Diocesan Board of Finance

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2 Context

2.1 The Diocese of Gloucester encompasses nearly the entirety of Gloucestershire, a substantial part of the Unitary Authority of South Gloucestershire, and extends into villages in Worcestershire, Warwickshire, Oxfordshire, and Wiltshire. With a population of approximately two-thirds of a million people, 380 churches are divided into approximately 320 parishes, including 100 benefices; these are further divided into two Archdeaconries, that of Gloucester and Cheltenham, and further divided into 9 Deaneries. Difference areas of the Diocese have their own individual identity; for example the Forest is proud of its history yet faces particular issues of decline, the Cotswolds is generally more affluent but the pressure of tourism and the number of second and weekend homes brings its own challenges. Additionally, there are pockets of hidden rural poverty in Diocesan areas.

2.2 The Diocese is led by the Bishop of Gloucester The Rt Revd Rachel Treweek supported by the Bishop of Tewkesbury the Rt Revd Robert Springett. All those staff referred to in this report employed in the central offices are within the charitable entity of the Gloucester Diocesan Board of Finance (DBF). Where the report mentions parish staff these are employed directly by their PCC.

2.3 Approximately 11,100 adults and 1,300 children make up the total weekly attendance across the Diocese. The average Sunday attendance stands at 9,700 adults and 1,000 children under 16. Notably, 39,900 people attended services during the Christmas period. Key life events within the Diocese include 1,370 baptisms, 910 weddings, and 2,480 church-led funerals.

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3 Progress

3.1 The DBF was subject to a Social Care Institute for Excellence (SCIE) audit in 2016 and PCR2 in 2020. The SCIE audit resulted in 13 recommendations, all of which were accepted. The examination of minutes of meetings, correspondence and lines of enquiry addressed during interviews have established that all were considered, actioned, managed, and appropriately overseen. The DSAP provided oversight of actions, which were also captured within the Board Plan and Strategy Statement. Those still in progress relate to issues that cannot be addressed locally in isolation, i.e., national policy or are part of other projects in development, or only recently completed, for example, the new DBS project, the integration of 'MyConcern' and restructuring of the blue files.

3.2 The implementation of the SCIE recommendations has had a positive impact on the development of policy and the application of practice. The findings of this Audit reflect that this progress continues and where appropriate, additional recommendations are made to support the DBF's ongoing improvement journey.

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4 Culture, Leadership and Capacity

4.1 The Audit found a strong and tangible focus on safeguarding with a clear leadership commitment to create and support a culture that enables everyone engaged with and by the church to flourish.

4.2 The success of this approach was reinforced in the Audit's independent survey results. Most of those engaged believe that a safeguarding culture is now firmly embedded within their respective areas. There was slightly less confidence amongst worshippers, although the significant majority feel safe and know who to contact if they are concerned. Many said that leaders listen to them and that their respective churches are supportive, welcoming, and collaborative environments. A good degree of confidence was expressed about raising concerns and acting without a fear of reprisal.

4.3 This theme was also reflected in the responses from most of the individuals and groups engaged in one-to-one discussion and focus groups. Safeguarding is now routinely a topic of conversation between and amongst leadership and staff groups and a common language is used when referring to their aspiration to be, '*relational and about creating spaces where people can flourish.'*

4.4 Auditors saw evidence of this philosophy in practice. The DBF have developed and adopted a variety of supportive approaches and initiatives. These range from their menopause and domestic abuse policies to Mental Health First Aid Training and practices that facilitate flexible working, support for carers and professional counselling.

4.5 The Audit examined a range of communication material that signposted to resources and promoted safeguarding. This included initiatives where the diocesan safeguarding team work collaboratively with the DBF Communications Team, to produce a regular newsletter and support and promote specific events. For example, Safeguarding Sunday and 16 days of activism.

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4.6 Many of the leaders used conversations, sermons and publications to helpfully place their commitment to safeguarding in the context of faith. An example that resonated with some of the people spoken to by the Auditors was quoted on a number of occasions.

4.7 *"Having a proper process rooted in a culture that gives safeguarding the priority it requires, not only therefore protects us all, but is a fundamental expression of who we are as a Church under God."* [2]

4.8 From a leadership perspective the Audit found that the overall accountability of the Bishop was both understood and unambiguously accepted.

4.9 The Bishop's Staff Team which is the senior leadership team had a firm focus on safeguarding as it related to their individual and collective roles and responsibilities, and each was able to explain and signpost relevant pathways for advice and support.

4.10 The Head of the Property Team provided a good example of this wider grasp of more nuanced safeguarding needs. He was able to clearly explain his responsibilities and the key safeguarding issues as they relate to housing stock and the provision and maintenance of DBF managed accommodation.

4.11 The Audit saw and heard evidence of critical safeguarding interventions by the Bishop, examined records that reflected the Suffragan Bishop's unequivocal approach regarding the need for training and heard about the supportive engagement provided by the Archdeacons across their areas of responsibility.

4.12 The Archdeacon of Gloucester understood their role with regards to safeguarding (they have a

2 https://gloucester.anglican.org/2021/message-from-bishop-robert-14-september-2021/

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previous background in education and have trustee level experience in a charity). This experience is well applied in their role as Chapter lead for people and safeguarding, and as Vice Chair of the DSAP. During their visitations to Deaneries, the Archdeacons are alert to safeguarding issues and the Audit heard evidence of their efforts to promote and encourage good practice. This support could be further enhanced by a more structured approach. For example, in preparation for such visits using information (when available) from the Safeguarding Dashboard and advice from the DST to raise awareness on themes or potential needs relevant to the areas to be visited. This could be carried out by the Archdeacons or one of their assistants.

Recommendation D1:

a) Prior to visitations to Deaneries and the parishes, relevant Safeguarding Dashboards should be considered, and advice taken for the DST about any safeguarding specific issues, trends or general themes that should be addressed. This should include recognition of progress and good work done, as well as prompts and encouragement about issues that need to be addressed.

b) Updates on the safeguarding themes should be circulated via visitation news sheets.

4.13 The Audit believes the current approach whereby the DBF has a Director of People and Safeguarding is a strength. The role provides a positive influence and support at a strategic level. Given the fact that the current post holder will shortly move on, there is an opportunity to reflect on how the role could be developed and adapted in future. The Audit is aware that this is something the current senior leadership team is considering. From the Audit's perspective, such options should take account of the need to ensure an ongoing strategic safeguarding focus as well as capturing the opportunity to provide direct professional support to the operational safeguarding team. To this end, the Audit makes the following recommendation.

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Recommendation D2: The DBF should consider options to appoint a Director of Safeguarding. This strategic role, if agreed, should cover the Diocese (parishes) and Cathedral providing the capacity to proactively promote safeguarding and support the operational safeguarding team, as well as strategic leadership for implementing national standards and driving coordinated improvement across both the Diocese and Cathedral.

4.14 The Diocesan Safeguarding Team (DST) is universally recognised and appreciated at all levels across the DBF and parishes, as well as the Cathedral, with whom they are engaged on a Service Level Agreement (SLA).

4.15 The small team has built significant relevant experience, working to a remit that primarily relates to providing advice, managing casework and training. They are supported in the latter regard by an experienced external consultant and smart use of a 'train the trainer' approach across a network of volunteers. The Audit noted confidence in the team regarding their engagement and collaboration with key statutory agencies such as the police, MOSOVO and probation.

4.16 That said, in the opinion of the Audit there are significant capacity issues. This does not mean that cases requiring immediate attention are not addressed. It does however reflect that the demand placed on such a small team means they are largely reactive and vulnerable if faced with an unforeseen reduction in their strength. Additional resource would result in a greater proactive safeguarding capability across both the Diocese and Cathedral.

Recommendation D3: Additional resource should be invested in the DST. This should complement the recommendation regarding a Director of Safeguarding and is additional to a dedicated resource for the Cathedral.

4.17 See also **Recommendation C1**.

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4.18 The safeguarding arrangements across the DBF are defined. They are supported by a clear strategy and a range of strategic and operational meetings to manage oversight and delivery. The Diocesan Safeguarding Advisory Panel (DSAP) provides thoughtful leadership from an experienced independent chair. They have a clear vision and utilise an appropriately focused and structured agenda and there was evidence of active oversight in respect of reviewing cases, learning and actions for improvement.

4.19 The DSAP currently provides an advisory role for the DBF and Cathedral. In the opinion of the Audit, this represents a risk that one will overshadow the other and dilute a Cathedral focus. Indeed, when interviewed some members of the DSAP could talk with insight and expertise about the Diocese but were much less fluent or informed about the Cathedral. The Audit takes the view that whilst the DSAP should have a representative from the Cathedral to ensure strategic join up, its primary focus should be on insight, oversight, and support to the DBF.

4.20 Sportily, a wholly owned subsidiary charity, delivers sporting activities, games, and clubs, particularly targeting young people. The organisation's objective is to promote increased physical activity and encourage an exploration of faith through sports. Sportily holds a service level agreement with the DBF and safeguarding team, who offer safeguarding casework management advice and guidance, including all necessary DBS checks for Sportily staff. The Audit revealed a robust and effective relationship between Sportily and the DBF staff. It highlighted a well-structured system for managing safeguarding concerns and commends the approach to sharing information between the two organisations, as well as extending to wider communities such as schools and churches

4.21 The DSAP also benefits from the insights provided by a member with lived experience and there is evidence of good levels of challenge and reflection. One interviewee reflected on whether the group could be more diverse and representative of the local community and the benefits this

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would bring. The Audit agree that this would be a positive and beneficial step.

Recommendation D4: The DSAP should, consider how it could widen its membership to include a more diverse range of individuals, reflective of the wider community within which it serves.

4.22 Whilst there are some vacancies on the DSAP at present, the meetings generally benefit from good attendance from key internal participants. The Audit noted that the DSAP, in line with national policy has been endeavouring to encourage statutory agencies to join. Given the pressure such agencies are under, the Audit takes the view that this is unlikely to happen or at least to happen with any level of consistency.

4.23 However, when the Audit spoke to the Chair of the Gloucester Safeguarding Adults Board (GSAB) it became apparent that a relationship had previously existed where the Director of People and Safeguarding sat on the GSAB and the GSCB for some years until local authority restructures. The Chair of GSAB would be keen to re-establish this relationship and the Audit supports this. Their most recent agenda included a range of relevant topics, including an update on the multi-agency public protection arrangements and the homeless audit findings. Furthermore, the Chair agreed that membership would facilitate participation in multi-agency audits focused on the Church, these could (amongst other subjects) include safer recruitment, offender management and the application of thresholds.

4.24 The manager of the Gloucester Safeguarding Children Partnership was aware that a previous relationship had existed and that at one time a member of the local authority had attended DSAP. However, there were concerns about a possible conflict of interest in that the attendee was the LADO. This issue was overtaken by pressure of work and demand for services, which resulted in the Local Authority representative being withdrawn. That said, he had previously invited

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members of the DST to join what he believed to be the most appropriate forum, the Quality Improvement and Practice Subgroup. He thought that capacity within the DST may have prevented them from being able to attend. These meetings are held quarterly and cover issues such as case reviews and wider learning from audits. The manager of the Local Authority Designated Officers (LADO) also sits on this group. Furthermore, faith-based organisations are designated by the LSCP as 'relevant agencies' under their safeguarding arrangements and formal engagement would ensure that both parties are able to engage and support one another.

4.25 The Audit acknowledges the pressure on the small DST and if capacity (mentioned elsewhere in this report) is addressed or suitable alternative options in relation to attendance can be achieved, attendance and participation in the wider safeguarding community would accrue significant benefits.

Recommendation D5:

a) The DBF should seek to engage/re-engage in local safeguarding partnership arrangements.

b) The DSAP Chair should also reach out (one to one) to engage key statutory leads and other relevant potential partners by routinely visiting them for short, focused meetings.

c) DSAP should continue to comprise key roles from the Diocese that have a responsibility for local arrangements – those that have responsibility and can report on local issues and be independently challenged and scrutinised by the Chair.

4.26 The Audit recognises that the structure, functions, and responsibilities of the DSAP regarding providing advice versus delivering scrutiny and oversight are national Church of England policy matters. To this end, the Audit will make specific representations to the appropriate national body.

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5 Prevention

5.1 Safer Recruitment is a priority in the DBF. The House of Bishops' guidance (Safer Recruitment and People Management) is followed and processes are aligned to legislation. In general, practice exhibits many strengths. Personnel who are engaged in recruitment undergo relevant training, and information is readily accessible through the DBF's website. Specialist advice for criminal records checks is available from the contracted Disclosure and Barring (DBS) provider.

5.2 Several improvements could be made to strengthen the overall arrangements for safer recruitment. These are set out below and include updating relevant policies, alongside reinforcing key messages about safeguarding at the various stages of recruitment.

Recommendation D6: The DBF should review and update all relevant policies and handbooks to reference the most recent House of Bishops guidance.

Recommendation D7: The DBF should ensure that its commitment to safeguarding is embedded in all job adverts, application forms and job descriptions.

5.3 The Audit saw evidence of practice and policy which encourages discussion and a developed understanding of appropriate boundaries within a range of contexts. Whilst many of those who engaged with the Audit understood the importance of a code of conduct, there was a degree of ambiguity about what codes were relevant to which roles. This may be due to governance arrangements being in place across the Diocese, as well as national codes that relate to particular roles.

Recommendation D8: The DBF should develop a single guidance document that sets out the codes of conduct applicable to the various roles in place across the Diocese.

5.4 The DBF demonstrate good practice in raising awareness around safeguarding. Safeguarding is

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included as a standing item within Episcopal reviews and reported regularly to the Diocesan Synod and features in regular discussions with the Bishop's Staff Team. Safeguarding is annually presented to the Diocesan Synod by the People and Safeguarding Director and the Independent Chair; and DBF serious incident reporting and matters of staffing capacity and resource are considered by Bishops Council within its budget management and oversight responsibilities and delegations.

5.5 Staff and volunteers commented positively about the quality of the training, engagement and support provided by the DST. PSOs were also positive about the leadership support from the Bishop and the impact that the Parish Dashboard and other resources have had.

5.6 The Diocese employ a variety of communication initiatives and appropriately adapt their language when engaging with specific audiences. These approaches include face-to-face briefings and sermon content, as well as the use of virtual delivery, such as online newsletters, and social media channels. Such communication has included information and resources on stalking, mental health, modern day slavery and domestic abuse.

5.7 The Youth Connector Team demonstrated good practice in their work to support young people and their families via youth ministry. That said, they recognised the need to strengthen practice by establishing networks between parishes and deaneries as this would help to facilitate learning and improve their understanding of the contemporary needs of the young people they engage and support. See also 4.19 in relation to Sportily.

Recommendation D9: A needs analysis should be developed to enhance their understanding of the contemporary needs of the young people they engage and support. This should be subject to regular review to ensure contemporary insights and the outcome(s) made available to, amongst others, the DST, DSAP and Chapter.

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5.8 The Diocese of Gloucester's website presents a strong, modern theme that loads quickly, performs well with search engine optimisation (SEO) and is mobile-responsive. The 'safeguarding' section is prominently featured and is easily accessible. There is guidance directing users to internal assistance, external support, safeguarding training, and a range of DBS guides, tools, and policies. That said, some changes could help strengthen the safeguarding webpage.

Recommendation D10: Re-design the safeguarding webpage to align with hierarchy principles; information being organised in order of importance to users. A section on how to report a safeguarding concern should take primacy followed by a re-ordering of other sections that are most frequently accessed. The page should also include a mechanism for visitors to subscribe to the monthly safeguarding newsletter.

5.9 A central email address is used to manage communication to the DST. This is positive in that it, improves response times and provides a single point of contact. This channel could be further strengthened by the integration an 'auto-reply' message.

Recommendation D11: The DST should set-up an auto-reply message for any communication sent to safeguarding@glosdioc.org.uk. This message should be used to provide signposting to support for urgent and non-urgent concerns for both adult and child safeguarding matters.

5.10 When questioned about the use of posters, (required as part of the national Church safeguarding policy) some children and young people from the five parishes engaged by the Audit were aware of their use. Notably, the children at the church where the meeting took place could identify the pertinent signs within the premises. The posters exhibited signs of aging, suggesting they were not newly displayed in anticipation of the Audit. This is good practice. Young people also spoke

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about how they had been positively engaged by various individuals within the DBF and wider Diocese to discuss safeguarding more generally.

5.11 There is a Lone Working Policy in place for DBF staff and separate guidelines for PCCs in a Church Guidance Note 'Working Alone'. This is also supported by national Church guidance.

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6 Recognising, Assessing and Managing Risk

6.1 Arrangements are in place that support the recognition, assessment and management of risk across the Diocese. These include the designation of key safeguarding roles, the availability of relevant policies and the provision of training and awareness raising. Overall, the structures increase the likelihood of early risk detection, collaborative decision making and effective assessment. Clear pathways exist to support timely interventions and a new case management system has been introduced which will support improved recording and quality assurance.

6.2 The Audit examined the DBF Risk Worksheet (at the time of the Audit the risk register was being overhauled). The Risk Worksheet covers, as would be expected, key corporate issues. Safeguarding is addressed in the compliance and risk (law and regulation) section. To provide greater oversight and reassurance, safeguarding could helpfully be set as a section in its own right. This would enable focus to be provided on key issues / risks relevant to the five national safeguarding standards as they apply to the DBF. For example, capacity, communication and Safety Plans.

Recommendation D12: The DBF should review its Risk Register, consider setting safeguarding as section in its own right and populate the section with the specific safeguarding risks it judges to require ongoing oversight.

6.3 Safeguarding concerns are appropriately triaged and routinely involve discussions with a range of stakeholders, such as the police and probation. During the triage process, the DSA applies what he termed as a '*low threshold*'. Working to the statutory definitions of safeguarding, this approach helps to ensure that all relevant concerns are shared with the DSA. This is good practice and makes people safer. Audit findings from the DBF workforce survey demonstrate that most respondents are confident they know when and how to escalate a concern.

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6.4 At the time of the Audit, there were 42 open cases held by the DST. As some data was still in transition from the old case management system to the national My Concern system, this figure might not fully account for the current workload. The nature of these cases represent a range of threats, risks and harms. Some involve contemporary concerns whilst others related to non-recent abuse and / or serious criminal conduct. Of the cases managed by the DST, decisions typically involved one or a combination of four general outcomes:

a) Onward referrals to statutory authorities.

b) The management of individuals within the worshipping community.

c) The provision / signposting to support.

d) The initiation of disciplinary processes, such as the Clergy Disciplinary Measures (CDM).

Whilst decisions on cases are ordinarily timely, particularly for those where risks are high, the size of the team means that there can be some delays on those requiring advice and guidance.

6.5 Risk assessments conducted by the DST are initiated in response to 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 adhere to national directives and prioritise the safety of victims, potential victims, and vulnerable individuals.

6.6 For safeguarding agreements, these set clear prohibitions and actions regarding expected behaviours, consistently record review dates and list key stakeholders. Agreements are well-defined, proportionate and authorised appropriately. They evidence a multi-agency approach, with there being routine information sharing with the police and probation service. Alongside mitigating the risk derived from an individual, the safety and welfare of those posing the risk is also properly considered.

6.7 For some safeguarding agreements, reviews are not always completed on time. The Audit believes this is largely due to the DST's capacity. Furthermore, whilst signed agreements existed,

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some had yet to be saved onto the new recording system. Again, this might link to capacity, but should be resolved once full transition to the new system is complete.

6.8 An Auditor met with an individual bound by a safeguarding agreement (the respondent), who had been convicted of a crime involving children. They expressed a desire to participate in public worship at a nearby Church. Following multi-agency engagement, including the MOSOVO and probation services, a risk assessment was undertaken and a safeguarding plan implemented. This plan outlines expected behavioural requirements and prohibitions. There is also a focus on the wellbeing of the respondent and regular reviews are defined. There is clarity that if the respondent relocates to another Church or Diocese, information will be shared with the new settings. This is good practice.

6.9 Whilst the incumbent is the key contact, they clearly articulated the significant and appropriate levels of support provided by the DST. During the discussion, a question was posed to the subject of concern regarding some of the requirements outlined in their agreement. The agreement clearly stipulated strict conditions regarding contact with under 18 year olds in church, and before and after services. The arrangements are strong. The respondent advised that this situation has never arisen. Whilst this is positive the audit believe the safeguarding agreement could be strengthened to include that the SoC has to report any breach of the agreement to the incumbent should such a situation unintentionally occur.

Recommendation D13: Safety Plans should always include requirements to report when a respondent unexpectedly finds themselves in a position that would breach the non-enforceable Safeguarding Agreement / Safety Plan.

6.10 Response Groups are routinely facilitated and are effective at overseeing individual safeguarding cases. They are well structured, well attended and comprise relevant representation. Auditors

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saw evidence of these groups actively addressing risks, considering the support needs of all involved parties and making plans that were trauma informed and sensitive.

6.11 The Audit was advised that, on occasions, the lead DSA chairs the Response Group meeting. The Audit believe this position could represent a conflict of interest. If it is considered to do so, for example, when the DST is involved in decision making or providing advice on a particular case, an appropriate person who is not linked to the case should be delegated to chair the group.

Recommendation D14: Where a conflict of interest exists or is perceived to exist, an appropriate other person should be appointed to chair the Response Group.

6.12 The Gloucester DBF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. The Audit was informed that no cases had met the threshold for a SIR in the last 12 months, although arrangements are in place to consider potential cases.

6.13 In terms of local parishes, PCCs can submit SIRs directly to the Charity Commission, although the Audit was advised that the DST would always be informed. Support and guidance is available at a national level and via the DBF website for PCCs regarding SIR referrals to the Charity Commission.

Recommendation D15: The DBF should raise awareness with PCCs regarding Charity Commission guidelines as to what constitutes a serious incident.

Recommendation D16: A central register containing all SIR submissions across the Diocese should be maintained to allow for the quick retrieval of SIRs and the ability to monitor patterns and trends at a local level.

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6.14 The Audit was told that an escalation process is in place to manage differences of opinion about the decisions and action taken on safeguarding cases. Where such incidents occur there is access to guidance in the Diocesan Casework Model and the Diocesan Safeguarding Complaints procedure. In the first instance, complaints can be raised with the Director of People and Safeguarding and escalated to the Independent Chair of the DSAP.

6.15 The newly implemented national My Concern safeguarding case management system in Gloucester covers the DBF and Cathedral. Adopted in January 2023, this system is a centralised secure database. It is user friendly and allows for safeguarding concerns to be reported, recorded and managed with the facility to attach relevant case reports, correspondence and documentation in one place. Existing processes allow for data collection on a quarterly basis which can be reported to the DSAP.

6.16 Whilst seen as a positive development, there is room for improvement both in terms of the national system itself and the application of its functionality. For example, some of the system's terminology is outdated, referring to historic abuse as opposed to non-recent abuse. There is no simple mechanism to identify SIRs reported to the Charity Commission. Furthermore, when records are migrated, reporting dates in some of the records are understood to be altered automatically by the system.

Recommendation D17: Due to the transition to a new safeguarding system, short term administrative capacity should be made available to help update records, assist with case closures and allow the DST to focus on new and ongoing safeguarding concerns.

6.17 There is a defined process in place to support the quality assurance of safeguarding cases. This involves supervision meetings (every six weeks) chaired by the NST Regional Safeguarding Lead. Minutes of these meetings reflected discussions on safeguarding agreements and risk assessments.

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6.18 Whilst the NST lead is sighted on cases that the DST are working on, there is no scrutiny of cases where the DST have directed no further action or disposal by advice or guidance. To further support the DSA and to quality assure practice in the context of accurate decision making and thresholds, the following recommendation is made.

Recommendation D18: Referred cases resulting in no further action 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.

6.19 Whilst the arrangements with the NST are broadly positive, there is no daily oversight of the DSA by a suitably qualified manager with safeguarding expertise. This leaves the DSA role exposed. Whilst much of the casework seen was good, everyone is prone to human error and a few cases seen by the Audit required improvement, by way of the quality of recording and the actions taken. More routine management oversight is likely to have helped identify these shortfalls. The proposed Director of Safeguarding should help address this issue.

6.20 The storage of personal information held by the DST on MyConcern is compliant with data protection legislation and the General Data Protection Regulations (GDPR). The SLA in place across the DBF and Cathedral sets out clear parameters governing the legal and best practice requirements for information sharing. Both bodies are signed up to relevant agreements issued by the CofE and there is a defined agreement in place with the police covering the work of the DST.

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7 Victims and Survivors

7.1 Experience from many cases reinforces how difficult and challenging it can be for a victim or survivor to come forward. Some may carry the pain of their abuse by the perpetrator and the failure to act by others to their grave. Others will come forward, but only when they are ready. This may occur after a key moment in their own lives or after a public appeal, response to a non-recent enquiry or following an incident. The right time and place are issues for a victim or survivor. The key is creating the circumstances and environments for them to do so and being ready to help and support them if they do.

7.2 The DSAP benefits from the participation of a member with lived experience. Whilst they reinforced the point that no survivor's experience exactly mirrors that of another, and that they cannot and do not attempt to speak for all, they are able to ensure that the voice of a survivor is included in the reflection of cases, development of policy and the oversight of practice. This also includes a survivor's perspective on communications and new or developing initiatives.

7.3 There is no proactive outreach in the Diocese as such. That said, given the fact that Peter Ball, the disgraced former Bishop of Gloucester, was in office there between 1992 and 1993, the DST continues to support/have significant experience via contact with victims and survivors of church-based abuse.

7.4 During interviews, it was clear that many across the Diocese, not least senior leaders and the Bishop herself, were keenly aware of the legacy of pain carried by victims and survivors. On appointment to the role, the Bishop led by example, publicly accepting the need to address and ensure a survivor-centric culture. The Audit found that there is a commitment to acknowledge the harm done, learn from the mistakes that were made and work to help victims and survivors obtain whatever level of engagement and / or response they seek.

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7.5 The DBF's current approach is to ensure that any victim or survivor that is engaged is supported with care and compassion, signposted to relevant support and provided with the information and assistance they require. The Auditor's engagement with the DSAP member (and others who identified as being victims of Church based abuse) largely reflected this position. That said, the views of the two people who responded to the Audit's victim and survivors survey provide another perspective. Both felt that there was not a person centric and trauma informed approach to their disclosures and whilst one was neutral on the issue of survivors' voices being prioritised and considered, the other disagreed that it was. Both strongly disagreed that their views were sought to improve safeguarding practice and neither felt that their feedback had led to a change in leadership behaviour or safeguarding practice. Furthermore, neither felt that they received appropriate support, including signposting to external bodies nor did they think there was good collaboration between the safeguarding teams and external agencies. This feedback, uncomfortable as it is, reinforces the need to maintain engagement and person-centred support whenever and wherever possible.

7.6 To their credit the DST carried out an anonymous survey in October 2023 of those who had contacted them for a variety of reasons over the last year. This is good practice. Of the 26 respondents, seven were identified as a victim / survivor. Five were in a voluntary or paid role within the Diocese of Gloucester and two were not. Three reported some delay or challenge in making contact when attempting to get hold of a team member, and three responded with a ranking of 'average' to their experience with the team. That said, four reported that their access was easy, with no problems and the same number reflected on their experience with the team as being 'excellent' (3) or 'good' (1). These findings are used by the team to help reflect upon and shape practice.

7.7 The Bishop has met with a number of victims and survivors who engaged either via the DST or who had written in directly. In two cases, the Bishop met with the victim / survivor and in one

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case someone represented them. Each sought a different outcome, one to visit the places associated with the abuse, one wanted to be listened to and another sought a written apology. All three requests were facilitated in a compassionate and sensitive manner.

7.8 Pathways to help and support for victims and survivors are available via the DBF webpage *'Support for Victims and Survivors.'*[3] It provides an easily accessible summary of *'Responding Well'* to victims and survivors of abuse, access to information about the Interim Support Scheme and signposts other pathways to help such as Safe Spaces. It also includes comprehensive contact information for the DST and relevant external (non-church) organisations. The external organisations are well established with acknowledged expertise in a range of areas including child and adult sexual abuse, elder and domestic abuse and gender-based violence. The webpage also provides a link (albeit this could be more prominent) inviting victims and survivors to contribute to the DBF's ongoing development with links to the DST and the Independent Chair of the DSAP.

7.9 The DBF makes good use of video content in its communications on a range of other issues. However, its messaging and outreach on this subject could be enhanced if key content was consolidated and delivered via a 'video explainer' outlining the help and support available for victims and survivors.

Recommendation D19: The DBF should consider creating a video explainer that sets out their position on support to and for victims and survivors.

7.10 The DBF use the four 'Rs' (Recognise, Respond, Report, Record) in training to provide church officers with the information they need to respond to and process a disclosure. This is reinforced using case studies during training. Other materials produced at national and local levels are also

3 https://gloucester.anglican.org/about-us/safeguarding/support-for-victims-survivors/

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provided to clergy, staff, volunteers and congregations, including the Parish Safeguarding Handbook and the Pocket Guide to Safeguarding in the Diocese of Gloucester. However, whilst the Audit saw generic safeguarding material posted in and around buildings, none related directly to support for victims / survivors. This is an area the DBF should consider as part of a more proactive outreach to encourage victims to come forward.

Recommendation D20: The DBF should consider how it could proactively enhance its ability to encourage victims to engage with them. This could include the use of victim / survivor specific signposting in appropriate spaces and places where the material can be accessed and read.

7.11 There was clear evidence of a strong support network for those affected by safeguarding incidents, whether as a complainant or a respondent. This included the assignment of a 'Link Person' for a respondent and the provision of a support person for a complainant as well as pastoral care. The Audit also noted good practice in the provision funded survivor counselling.

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8 Learning, Supervision and Support

8.1 There are good arrangements in place that support a variety of training, learning and development opportunities across the Diocese. A clear strategy aligns to the CofE's Safeguarding Learning and Development framework and appropriately reflects the importance of culture, survivor engagement, content and effective delivery. A dedicated and experienced DSA provides the strategic and operational leadership for this agenda, with the DSAP providing oversight and scrutiny.

8.2 Safeguarding training includes a mix of online and face-to-face delivery, with the NST's programme being supplemented by local courses, events and awareness raising. The Audit noted many examples of excellent practice including the launch of Mental Health First Aid training, the running of bespoke sessions for Lay Clerks and targeted training for those working with children and young people prior to the 3 Choirs Festival.

8.3 The routine availability of face-to-face courses is a particular strength. This provides choice for participants based on their preferred learning style and the availability of 'on-hand' support if needed. The DSA has also made significant progress in developing a 'pool' of over 30 volunteer trainers, providing for both capacity and expertise. Whilst undoubtedly positive, there is an inherent fragility to this model in that it relies on the goodwill of volunteers and the substantial efforts of the DSA to maintain it. In this respect, the emerging strategy for deaneries could possibly help. Embedding expectations for volunteer trainers as part of the formal architecture in deaneries could provide a framework for both the equity and resilience of provision.

Recommendation D21: The DBF should explore how the commitment, resourcing and arrangements for volunteer trainers could be integrated into the emerging strategic plans for deaneries.

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8.4 Feedback to the Audit on the administration, quality and delivery of training has been positive. This was reflected in survey results, interviews and the routine evaluation reports received by the DSAP. For a small number of survey respondents, they felt that training could be repetitive. Others thought that training content should focus more on the local context for safeguarding.

8.5 Overall, the Audit is reassured that both the DSA and DSAP are sighted on this (and other) feedback and use it to promote reflection, amend content and develop new initiatives as and when necessary. They horizon scan to identify and promote particular themes, such as the Diocese's work on 16 Days of Action and domestic violence. The DSA also maintains good connections and collaborates with a range of colleagues locally, regionally and nationally.

8.6 In terms of potential improvements, the Diocese is in a position of strength, both in terms of delivering the nationally mandated training pathway requirements and innovating to widen the reach and impact of learning. The following narrative should be read in that context.

8.7 As part of the Audit's surveys, a small number of parish staff / volunteers struggled to recognise the unambiguous concerns that were set out in one particular scenario[4]. The majority of this cohort had yet to complete basic training. Whilst no recommendations are made, this finding clearly illustrates the importance of prioritising training in all contexts of the Church.

8.8 The Audit believes the current use of 'role specific' training could be developed further. Some excellent practice already exists in this space, such as through the creation of bespoke courses for bellringers (developed jointly with the Diocese of Bristol with the course content having been ratified by the NST. Widening opportunities that are unique to particular roles could accrue further benefits.

4 Scenario 1' from Audit Survey, asks 'You are at an activity within the [church body] and notice a mother strike her seven-year-old child across the face. The child cowers away from the mother and appears very timid in her presence. Do you believe this is a safeguarding issue?'

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Recommendation D22: The DBF should review its training needs analysis process to ensure this adequately covers the full range of roles in place across the diocese. The analysis should be used to identify where additional 'role specific' training might be of benefit.

8.9 The Audit also believes there should be a concentrated focus on two areas of 'theme specific' training. Firstly, there should be opportunities for Church Officers to develop a much more detailed understanding about the nature of sex offenders. Whilst noting the inclusion of this topic within NST training, detailed learning about predators and the nature of offending is both a relevant and contemporary issue for the Church. The PSO focus group engaged by the Audit agreed. Secondly, given the growth in incidents across all of society where social media and technology are being used to either abuse or facilitate abuse, a greater understanding of digital safeguarding is also likely to make people safer.

Recommendation D23: Theme specific training sessions focused on the topics of sex offenders / predators and digital safeguarding should be introduced into the training programme and accessible to relevant church officers in the DBF, Cathedral and parishes. The Audit recognises that overarching responsibility for training in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the DBF with the opportunity to apply interim mitigation measures.

8.10 In terms of training evaluation, the DSA routinely collates and analyses this information, providing regular updates to the DSAP. That said, beyond the leadership sessions, the evaluation process itself is primarily focused on the quality of courses as opposed to any longer-term testing of impact. This leaves a gap in the understanding of whether training is directly influencing practice.

Recommendation D24: 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.

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8.11 Random cohorts of staff and volunteers (and their managers) working in the DBF, the Cathedral and for parishes should be approached three months after attending training to identify specific ways in which they have used what they learnt and to provide examples of how this has made individual people and the Diocese safer.

8.12 Over the last year, there were 3228 recorded attendances at safeguarding training across the Diocese. All clergy were reported as having completed the required levels and for the DBF, the Audit was advised that there were no members of its staff who were '*out and about in parishes*' who had not completed their required training level within the last three years.

8.13 A single view of training data covering each role in the DBF, Cathedral and at parish level is, however, difficult, if not impossible, to establish. There is an absence of a singular Learning Management System and responsibilities for tracking compliance are spread. The DBF maintains training records for the clergy, PTO, readers and centrally employed DBF staff and volunteers at governance levels. The Cathedral maintains its own staff training log and volunteer training log. PCCs are responsible for parish-based staff and the NST has a centralised system recording attendance at its national training. The Audit understands that systems are changing nationally, and this may provide an opportunity for improved oversight in the future.

8.14 In terms of its own learning needs, there is clear support in place for the DST. Team members are part of the NST training and development programme, they access external training opportunities (such as through the Local Authority) and attend regional peer support groups with other DSAs. There are networking days provided by the NST, and attendance at other meetings such as the South West Ecumenical Safeguarding Forum and CofE South West safeguarding trainers group.

8.15 The DSA for training has already completed significant academic study supported by the DBF;

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currently the DSA role for casework and Assistant DSA are both engaged in supported academic studies outside of the Church and through their respective roles, the team can 'learn through practice'. The DSA for casework has been involved in supporting local Safeguarding Adults Reviews and there is active engagement with Gloucestershire's Anti-Slavery partnership. As one of the 'pathfinder diocese', the team receive support from the NST. This includes the DSA for casework receiving supervision from the NST's Regional Safeguarding Lead every six weeks.

8.16 Notwithstanding the comprehensive learning opportunities that members of the DST have access to, the DBF staff records identified that not all were up to date with the mandatory NST training.

Recommendation D25: The Director of People and Safeguarding will ensure that all training records are up to date.

8.17 For those in other safeguarding roles across the Diocese, beyond the core training programme, some have accessed safeguarding training outside of the Church or have attended events with guest speakers. These appear to have been ad-hoc opportunities as opposed to part of any structured offer. Whilst acknowledging that the DSA routinely signposts available training, there is merit in exploring this area further.

Recommendation D26: The DBF should engage in discussions with the Gloucester Safeguarding Children Partnership (GSCP) and the Gloucester Safeguarding Adults Board to explore options for joining any associated training membership schemes.

8.18 The Diocese has in place a range of mechanisms to support its clergy through 'organisational' processes (such as HR and occupational health) alongside broader arrangements delivered by the Bishop(s), Archdeacon and local ministry structures (such as pastoral, practical and spiritual assistance). Continued Ministerial Development is embedded and there is access to a Diocesan

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Professional Counselling Service. and specialist therapeutic support if required. Furthermore, when an allegation is made against a member of the clergy, as per national Church policy, they will be helped by a designated Link Person who will have received national church module training (as will the Support Person). Support from the DST can also be provided when clergy are working as part of a 'Response Group' (and where space is created to reflect with others, including their Archdeacon) or through the DST facilitating 1:1 sessions to discuss/debrief a particular case.

8.19 That said, the Audit recognises that the clergy at all stages of their ministry within the Diocese, will be face a range of pressures arising from their exposure to safeguarding issues. As a matter relevant to all Dioceses, the Audit will address this in more detail as part of its annual evaluation.

8.20 There is a good range of support in place for curates. The '*Into Incumbency*' programme includes sessions on the skills needed to support curates such as supervision, how to handle disagreement and conflict and looking at the specific role of the incumbent in respect of safeguarding. Ordinands receive safeguarding training at leadership level before they start their new curacy role. New incumbents are provided with a checklist to help them review the safeguarding arrangements in their new parish or benefice. New incumbents have a six-month review with their Archdeacon.

8.21 Good practice in another Diocese involved ordinands being required to undertake a safeguarding audit whilst on placement and to then complete a theological reflection about trustworthiness (based on their safeguarding audit). Whilst no recommendation is made, the DBF may wish to give this consideration.

8.22 Ministerial Development Reviews (MDRs) add value to the clergy through facilitating reflection, learning and improvement. That said, an enhanced focus on safeguarding within this process is needed. Whilst no MDRs were made available to the Audit, discussions about their content

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suggests they could better explore what is working well from a safeguarding perspective, the outcomes being achieved, and future areas for growth and development.

Recommendation D27: There should be a structured focus on safeguarding practice within the MDR process. In collaboration with the DST, arrangements should be revised to ensure that discussions cover a review of safeguarding (in line with the national safeguarding standards) and that these are formally recorded within MDRs.

8.23 Arrangements for induction are in place across the Diocese, although content and application vary depending on the post-holder's role. Positively, the majority of DBF staff engaged by the Audit confirmed they had received an induction and that this covered what they needed to know about safeguarding. For PSOs, there are defined induction sessions and a meeting with a DSA on their appointment. The arrangements for other parish staff directly employed by a PCC appear to be less well-defined, with only a third of respondents to the parish workforce survey confirming they had received an induction.

8.24 For clergy new to an incumbent post‐in the diocese‐a safeguarding checklist is provided. The DST also meets with new clergy as part of a scheduled lunch that take place quarterly. Where deemed necessary, the DST can arrange a 1:1 induction. This could be in circumstances where the new incumbent needs to be made aware of specific safeguarding issues relevant to their new position. In the opinion of the Audit, whilst recognising the benefits of this 'relational model' of induction, arrangement should be strengthened to facilitate more structured and timely conversations.

Recommendation D28: All new clergy should receive a formal, face to face induction session with a member of the DST.

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8.25 The DST forms a small, close-knit team where there is support, enthusiasm and good working relationships. Team members demonstrate a strong commitment to their roles, prioritise their own CPD and understand the nature of the work they are exposed to. Where required, the team has access to a good range of support, including the availability of psychological support. That said, given the context of the DSTs workload and its routine exposure to trauma, psychological support should be more defined within its arrangements. By this, the Audit believes that routine access to such support should be an expectation as opposed to 'available on request'.

Recommendation D29: 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.

8.26 Dedicated support for PSOs via targeted training, newsletters and regular '*safeguarding drop in sessions*' are also positive. The latter allows for PSOs to catch up on news, connect with others and to discuss relevant issues, such as the Parish Dashboard. Some of the PSOs engaged by the Audit thought that circulating a summary of the drop-in discussions would be helpful for those not able to attend.

Recommendation D30: The DST should consider circulating a summary of safeguarding drop in discussions to the PSO cohort.

8.27 For others, they thought that more structures should be in place at a local level to support PSOs with face-to-face meetings across parishes. Online sessions were largely seen as valuable, but for some PSOs, IT access and IT literacy are real barriers to engagement. Notwithstanding the good work done over many years, including hosting thank you and other events to for PSOs. The Audit takes the view that a PSO network could help mitigate the risk of isolation, encourage shared learning experiences and maintain the confidence and enthusiasm of PSOs.

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Recommendation D31: The DBF should review what else could be done to help support PSOs, with a focus on increasing access to face-to-face peer support, mentoring and supportive supervision.

Recommendation D32: The DBF should review the ways in which it recognises the contribution of PSOs. Consideration should also be given to sponsoring an annual PSO conference to highlight the good work undertaken, expose PSOs to external speakers providing an insight on survivor's experiences and deliver scenario based contextualised training.

8.28 As a related issue, the advertising of drop-in sessions (and other online events) also attracts one recommendation. This has the aim of mitigating the risk of unauthorised access (i.e. 'Zoom bombing') given that joining details and passwords are being sent to participants in one communication.

Recommendation D33: The DBF should review the advertising of digital / online training to ensure privacy and settings are configured in line with good digital safeguarding practice.

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Part Two - Gloucester Cathedral

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9 Context

9.1 With origins dating back to around 679AD, Gloucester Cathedral is a centre of worship, music, and learning, becoming one of the most significant heritage destinations in the South West of England. Standing as one of Britain's greatest buildings, it symbolises over 1,300 years of Christian faith and heritage, with many of its stories intricately intertwined with Britain's rich history. The monks who initially inhabited and worshipped here adhered to The Rule of St Benedict, emphasising the welcoming of all as if they were Christ himself. This timeless spirit of inclusivity continues to resonate, embracing all who visit the Cathedral today.

9.2 The Cathedral receives around 400,000 visitors each year, with approximately two-thirds identified as day tourists, while the remainder participate in worship services or events. Weekly visitor figures (averaging around 7,700) vary based on factors such as the time of year, seasons, and the ongoing activities hosted by the Cathedral.

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10 Progress

10.1 The Cathedral was subject to a SCIE audit in 2019. This resulted in 19 recommendations and considerations, all of which were accepted, The Chapter provided governance and oversight supported by the DSAP's scrutiny. All the recommendations and considerations have been actioned with the exception of two that are still in progress. These relate to aspects of the delivery of the training programme and the provision of multi-lingual leaflets and signs. The implementation of the SCIE recommendations and considerations has yielded a positive impact resulting in improved practice and higher levels of awareness and confidence.

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11 Culture, Leadership and Capacity

11.1 The SCIE audit (2019) found that the Cathedral had a culture where people could learn, ask questions, and escalate concerns. This Independent Audit has found that the Cathedral has consolidated this position, and it mirrors the SCIE finding.

11.2 The Dean upon his recent appointment set out a vision for safeguarding in the context of the Cathedral. In doing so he reached out to key safeguarding leads including the DST, the chair of DSAP and the Nominated Safeguarding Person for the congregation. The Audit recognises this as good practice, leading by example.

11.3 The Dean works closely with the Bishop as they collectively endeavour to sustain a safeguarding culture that enables people across the Cathedral and beyond to flourish. Their Equality, Diversity and Inclusion Policy is comprehensive, they champion Mental Health First Aid, and their Welcome Values convey a real sense that the Cathedral is committed to creating a positive safeguarding culture.

11.4 The promotion of this philosophy is positively reflected in the responses to the independent workforce safeguarding survey. Out of 73 respondents, made up of clergy, staff and volunteers, a significant majority stated that a safeguarding culture is now embedded across the Cathedral, describing the environment as being welcoming, supportive and inclusive. A similar number reflected improvements in levels of awareness concerning safeguarding and an overwhelming majority (69) said that they felt safe in the community.[5]

11.5 The Audit saw significant evidence of good collaboration between and across the DST (with whom the Cathedral has an SLA) and clergy, staff and volunteers in the Cathedral. Activities ranged from bespoke sessions for teams, training and direct support to those involved in oversight and

5 Three people were neutral and one strongly disagreed.

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governance. The Dean also chairs the Faith Alliance Violence Reduction Group in Gloucester working with faith and community partnership organisations in the city.

11.6 Termly meetings are held with Kings School regarding support for choristers and the Audit saw records that reflect attendance by senior leaders from the Cathedral including the Dean and Chief Operating Officer (COO). The content was focused on safeguarding issues and outlined the level of preparation and reflection that takes place prior to a choir-based event, including proactive identification and mitigation of risk (safeguarding choristers is considered in full later in this report).

11.7 There is a strong and tangible focus on safeguarding demonstrated through the leadership and governance arrangements in the Cathedral with the overall accountability of the Dean being both understood and unambiguously accepted.

11.8 The Audit saw evidence of excellent instances of authoritative practice. For example, decisions made by the Dean, COO, Canons (Precentor and Chancellor) to pause, review, and reflect on activities that represented potential concerns. For example, the management of school visits and teacher pupil ratios, safer recruitment practices for volunteer stewards and the provision of operational staff supporting access and adapting to specific scenarios and demands.

11.9 Chaired by the Dean, the Chapter, as governing body is appropriately configured and benefits from experienced membership. The Archdeacon of Gloucester, who is their safeguarding lead has previous relevant experience in education and as a Trustee of a charity. The current senior non-executive member is an ex-Director of Social Care with experience chairing boards that focus on safeguarding. Their participation represents a strength, as is their commitment to periodic '*skills audits*' to ensure that they have the right lay people around the table to address the key skills and abilities they require. Under the new measure, they now operate a nominations committee when a new member of chapter is sought.

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11.10 The Chapter recognises its additional responsibilities as a registered charity. The Chair and Trustees with whom the Audit spoke, all acknowledged their individual and collective responsibilities in this regard.

11.11 The Chapter agenda includes safeguarding as a standing item and as part of their oversight continue to monitor actions. They seek reassurance from safeguarding briefings and the Annual Report from the Diocesan Director for People, Pastoral and Safeguarding, which provides an overview of casework, training, and the overarching Safeguarding Action Plan. The Dean also meets annually with the Chair of the DSAP to discuss and reflect upon relevant issues.

11.12 The Cathedral operates a comprehensive Risk Register. It appears to be well managed and overseen. The Auditors (who viewed the November 2023 version) could see evidence of risk identification and appropriate control measures. These sensibly included a range of key corporate / infrastructure and conduct based risks, including the then senior leadership vacancies and recent changes.[6] The register included several areas linked to safeguarding with appropriate safeguarding control measures.

11.13 Safeguarding *per se*, also featured as a risk owned by the Chapter Safeguarding Lead and managed by the DST. Key control measures included but were not limited to, safer recruitment, safeguarding practices and policies and links with the LADO and local authority. A relevant entry in the register highlighted the annual review of the SLA with the DST.

11.14 When reviewing the minutes of the May 2023 Chapter meeting, Auditors noted that the COO and Archdeacon had raised issues related to the availability of safeguarding resources via the SLA. The COO acknowledging that, *"…it offered good provision for case work but less for training and support, which had not helped managers understand developmental issues whilst shaping the*

6 The three key leadership roles that were vacant have all be refreshed with new appointments in the last year.

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Cathedral's own approach." The Audit recognise this as good governance involving focused and professional curiosity and challenge concerning key strategic issues. The Audit has formed the view that the Cathedral's approach to safeguarding could be further strengthened by the provision of a dedicated resource.

Recommendation C1: The Cathedral should have a more defined Cathedral Safeguarding Advisor (CSA) resource supporting its own arrangements, providing greater insights, and building close relationships with statistical cathedral neighbours. Whilst a dedicated resource, the role would maintain – a close link with DST and be supervised by the DSA / DSO.

11.15 See also **Recommendation D2 and D3.**

11.16 The Archdeacon sits as Vice Chair on the DSAP, which currently has a role in the strategic oversight of the Cathedral. Whilst it makes sense to have an insight into the work of the Cathedral (and vice versa) the DSAP's primary focus is on the work of the DBF. When engaging some DSAP members, it was clear that the Cathedral was a secondary function and not subject, in the opinion of the Audit to the same level of insight as the Diocese. This could mean there is a risk of a reduced level of scrutiny, reflection, and challenge and thereby less reassurance.

11.17 The Audit has seen evidence of a fledgeling Safeguarding Working Group in the Cathedral. It reports to the Archdeacon of Gloucester (as Chapter lead for people and safeguarding) and as the Archdeacon explained its naming convention reflects its role in the delivery of day-to-day functions. Its purpose is to ensure that safeguarding initiatives are joined across Cathedral teams, training is effective and to review operational delivery. That said, the operational aspect links directly to strategic oversight, rather than simple day to day management. In the opinion of the Audit the Cathedral must be viewed and scrutinised through a more strategic lens. This includes but is not limited to consideration of its historic and structural context, its level of engagement with worshipers, schools, tourists / visitors and the hosting of high-profile events, all of which generate

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a footfall of hundreds of thousands of people per year. The Working Group may have the potential given the role of the Archdeacon to morph into such a body. That said, independent oversight is crucial.

11.18 The Audit has seen good practice in other Cathedrals that are supported by an Independent Advisory Group, chaired by an independent person (similar to the DSAP) and operating to terms of reference that ensure insight and scrutiny of the Cathedral in respect of its safeguarding responsibilities. Such an approach, providing detailed feedback to Chapter would enhance the Trustees' ability to challenge presentations and reports from safeguarding staff when seeking greater levels of reassurance during scrutiny sessions.

Recommendation C2:

- **a)** The Cathedral should develop a strategic scrutiny body (or restructure the current Working Group) to ensure greater clarity on oversight of its own safeguarding arrangements.
- **b)** This function should be independently chaired, comprising key roles within the Cathedral and Diocese / DSAP engagement to ensure line of sight and sharing of learning.

Chorister Safeguarding

11.19 The Audit examined various aspects of chorister safeguarding, including direct engagement with choristers, their parents and the individual staff responsible for them from both the Cathedral and the Cathedral school. The audit also observed 'chorister tea', the journey from the school to the Cathedral, the chorister robing area, rehearsals, and an Evensong service.

11.20 The Audit observed a sense of organisation, cohesion, and proactiveness in the team responsible for safeguarding choristers. The Canon Precentor exhibited strong leadership, effectively

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managing arrangements, and maintaining a positive rapport with both choristers and staff which is particularly impressive given his short time in post.

11.21 Recognising the substantial size and responsibility associated with the typical 'chorister tutor' role, the chorister safeguarding team opted to distribute the responsibilities among various staff members. The Audit views this decision as sensible, not only for managing workload but also for broadening the pool of available adults for chorister support. This approach enhances the likelihood of choristers forming appropriate connections with at least one staff member. The positive effects of this decision were evident in the attitudes of staff, choristers, and parents. The conductor for the girl choristers, who shoulders some of these responsibilities, demonstrated a positive and authoritative presence during rehearsals, employing positive reinforcement that resonated well with the children.

11.22 The Cathedral employs a chorister chaperone and a volunteer registered chaperone who also exemplified good safeguarding practice during the Audit. For example, a chaperone stays for the duration of rehearsals to attend to any chorister who may take ill or need support during the service. Additionally, the Audit observed that when a tourist approached the gates of the stage to take a photo, the chaperone was able to quickly intervene to ensure they did not take an image of the children, offering instead to take the photo for them without the choristers visible.

11.23 Communication between the school, the parents and the Cathedral staff is strong. Termly parent representative groups consist of the head boy and girl chorister parents, the school, the chorister safeguarding team, and the DSA, to discuss matters arising and scheduling for choristers. A dedicated inbox for all chorister staff is available for parents to use should they need a quick response. The Audit recognises that this approach is good practice.

11.24 The Chorister and Chorister Parent Handbook highlights the importance of 'maintaining a sensible balance for choristers.' This focuses on the choristers maintaining positive attitudes and is

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supported by various examples from the school, Cathedral safeguarding staff, and parents.

11.25 All choristers engaged by the Audit conveyed a positive perception of their role, with many describing it as 'busy but fun'. They expressed a resounding ‘yes’ when asked if they felt safe in the Cathedral and all were quick and confident in their ability to articulate who they would go to if they had concerns. The Head Chorister, who joined in 2018, highlighted her amazing experience, making new friends, and learning about music.

11.26 The Audit included discussions with a few current and former parents, all of whom conveyed a thoroughly positive experience as chorister parents. One parent described their children joining Gloucester Cathedral as choristers as "*the best thing we ever did*."

11.27 Parents were given multiple opportunities to share their feedback on Cathedral safeguarding with the Audit, however, few chose to engage. As a standalone measure, this is inconclusive, but the strong and effective safeguarding arrangements observed by the Audit, coupled with the overwhelmingly positive experiences of those who did engage provide good reassurance.

11.28 Both choristers and staff raised no concerns about the physical safety of choristers, and it is worthy of note that specific chorister only toilets are used whilst in the Cathedral.

11.29 Given the number of choristers has doubled since the admission of girl choristers in 2021, the song room (used for robing) is no longer suitable for the increased usage. Additionally, the song room's layout, featuring steep stone steps and congestion from schoolbags and other items, poses safety concerns. Staff vigilantly remind choristers to be cautious; nevertheless, there is an evident risk that requires attention.

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Recommendation C3: Locate a more suitably sized space for the volume of choristers entering and using the song room and robing area to ensure that potential accidents and risk is significantly reduced.

11.30 A SCIE recommendation was previously made around whether people other than parents, can (with appropriate notice) pick choristers up. This recommendation was fully met by the Cathedral. In addition, the Audit observed good practice carried out by chorister chaperones during the chorister pick up, that involved signing each chorister out to their respective parents.

11.31 Safeguarding is addressed in the Chorister and Chorister Parents Handbook. Specific policies related to the safeguarding of choirs are cited, supported by an information sheet that is also accessible on the Cathedral's 'Visiting Choirs' webpage. Despite a safeguarding tab linking to the Diocese website on the Cathedral's site, the visibility of the safeguarding handbook and CofE policy remains unclear in both locations. See **Recommendation C12**.

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12 Prevention

12.1 The Cathedral has implemented a robust set of preventative measures as part of its safeguarding arrangements. These include an emphasis on safer recruitment, the establishment of codes of conduct, mechanisms for raising awareness and engaging stakeholders, as well as ensuring measures are in place for both the workforce and visitors. Collectively, these demonstrate the Cathedral's ongoing commitment to prioritising the well-being and safety of its staff, volunteers and visitors.

12.2 Recruitment processes are aligned with legislation, relevant policies, and guidance from the CofE. Those in identified roles undergo appropriate training on safer recruitment and have support readily available. Materials are also provided that include helpful guidelines on the required level of training for specific positions and a flowchart outlining the safer recruitment process for volunteers. The Audit noted that there are some individuals yet to complete safer recruitment training.

Recommendation C4: The Cathedral should ensure that all relevant staff have completed safer recruitment training within the next three months.

12.3 Available guidance for volunteers covers processes such as applications, interviews, training, shadowing, role induction, DBS checks and reference gathering. All positions now have an associated role profile. This is good practice. The Audit considers that the recruitment of volunteers could be further strengthened via clear messaging at each stage of the process.

Recommendation C5: The Cathedral should ensure that its commitment to safeguarding and requirements, such as the need for confidential declarations, are embedded (where relevant) in all job adverts, application forms and job descriptions

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12.4 The Cathedral has an up-to-date safeguarding handbook for staff and volunteers, which is current and signposts to relevant policies. The Audit found that some references and hyperlinks require updating.

Recommendation C6: The Cathedral should review all policies and handbooks to reference up-to-date House of Bishop guidance and policy and replace any broken hyperlinks.

12.5 Of those who participated in the Audit's surveys, most respondents stated that they had seen improvements in the overall safeguarding arrangements at the Cathedral. Progress has been supported by both senior leaders and safeguarding leads, with awareness raising attracting an ongoing focus. A range of methods are used in this regard, such as signage in the Cathedral, details within service sheets, 'Safeguarding Sunday' sermons and the inclusion of safeguarding contact details on the inner side of volunteer lanyards. One volunteer explained in a Cathedral survey that they would feel confident to know who to contact with a safeguarding concern because it's *"in my lanyard*". This is good practice.

12.6 Awareness raising needs to be an ongoing process. This is underlined by the Audit's survey results which indicated some respondents were unaware of key safeguarding messages.

Recommendation C7: Establish within a policy the practice of printing the Safeguarding Contact Information within the inner side of lanyards for both Cathedral staff and volunteers.

Recommendation C8: Develop a toolkit of awareness raising materials tailored to meet the unique context of the Cathedral. Assets could include, email signature blocks, posters for displaying within the Cathedral, social media graphics, banners or promotional graphics for use within wider communications channels (e.g. via the main Cathedral newsletter).

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12.7 The Audit identified good preventative practice with safeguarding being routinely considered in the planning and briefings for events such as the Three Choirs Festival and Light Eternal, and during activities such as the Breakfast Club. Furthermore, strong lines of communication are established with Cathedral volunteers via a bespoke newsletter.

Recommendation C9: To ensure a joined-up approach, coordinate the planning and issuing of the DBF safeguarding communications (e.g. monthly newsletter) with staff at the Cathedral responsible for communicating with staff and volunteers.

12.8 The Cathedral maintains a highly active and engaged presence on social media platforms. Featuring a variety of posts which offer a well-rounded portrayal of the Cathedral as a worship, cultural, historical, and community hub while also addressing matters related to safeguarding and social justice.

12.9 The Cathedral's website also presents a strong, modern theme that loads quickly, performs well with search engine optimisation (SEO) and is mobile-responsive. It is positive that the 'safeguarding' section is prominently featured within the navigation and is easily accessible. There are areas of the safeguarding webpage that could be strengthened and the Audit makes recommendations to this effect.

Recommendation C10: The Cathedral should provide visitors to the safeguarding webpage the ability to subscribe to the DBF's monthly safeguarding newsletter.

Recommendation C11: The Cathedral should identify specific resources from the DBF Safeguarding webpages and other relevant resources and provide clearer and direct CTAs on Cathedral safeguarding webpage to such material.

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The Cathedral should re-design the safeguarding webpage to align with hierarchy principles - information being organised in order of importance to the user. The section on how to report a safeguarding concern should take primacy followed by a re-ordering of other sections on the basis of those that are most frequently accessed.

Recommendation C12: The Cathedral should provide a user-friendly way for visitors to access the Safeguarding Handbook and CofE Safeguarding Policy on its website. The Handbook and policy should sit under the Safeguarding tab, within a separate button detailing their intended use.

12.10 As part of its overall prevention agenda, there is evidence that the Cathedral seeks to capture the voices of key stakeholders. Opportunities to hear from the large number of volunteers via a survey are currently in progress and an Education Officer has recently been appointed.

12.11 The Cathedral has defined policies covering lone working. Lone working can arise in a number of ways. Not least, through the provision of individual tours of the Crypt. The Crypt is isolated, underground and dark and the decision as to whether to facilitate such tours are often left to the volunteer. The national guidance on Safer Environment and Activities emphasises the importance of avoiding lone working situations and to this end, the Audit makes the following recommendation.

Recommendation C13: Volunteer guides should not conduct Crypt tours for less than two visitors. This measure is required to avoid situations where a volunteer and an individual may find themselves isolated in secluded areas. The Volunteer Handbook should be amended as appropriate.

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12.12 Given lessons learnt in other cathedrals linked to sudden deaths, suicide and attempted suicide, the Cathedral should carry out a structural survey to identify risks and develop safer by design mitigations. For example, the Gallery of the Cathedral provides an easy opportunity for an individual to enact suicidal behaviours.

Recommendation C14: The COO should have a structural survey carried out to identify risks and thereafter develop safer by design mitigations to prevent vulnerable people from coming to harm.

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13 Recognising, Assessing and Managing Risk

13.1 The Cathedral encounters a diverse range of challenges, posing unique demands on its staff and volunteers. These range from managing large scale public events, to providing support for vulnerable individuals, addressing anti-social behaviour and handling allegations of misconduct. From an individual perspective, risks can stem from those associated with the Cathedral, the broader church community, or those attending services or visiting the premises.

13.2 The Audit observed a whole system approach to safeguarding at the Cathedral aimed at identifying, managing and mitigating risk. This framework encompasses relevant policies, information sharing agreements, and efforts to raise awareness. It allows for easy access to guidance on emergency situations (such as disturbances or demonstrations) and ensures ongoing training.

13.3 A collaborative approach to practice is strengthened through close working relationships with the DBF, the DST and external partners. For example, the Cathedral's Dean is involved in the wider community and chairs the Gloucester City Centre Commission, the Chapter commissioned the visit of the Knife Angel and there is ongoing contact with other bodies such as the Faith Alliance for violence reduction. Overall, the Cathedral's arrangements enhance the opportunities to detect risk, facilitate joint decision-making, and enable the swift implementation of a safeguarding response when required.

13.4 In respect of individual cases, there is support from the DST secured through the Cathedral's SLA with the DBF. The effectiveness of the DST and the audit's recommendations are set out in Part 1 of this report. They have equal relevance to the context of safeguarding at the Cathedral.

13.5 In terms of demand, the Audit was informed that over the last three years there have been 12 safeguarding cases involving the Cathedral. At the time of the Audit there were no open cases,

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although several low-level concerns had been dealt with through advice, guidance and signposting.

13.6 Whilst no firm conclusions can be drawn about the volume of this activity, it is relevant to note two findings from the Audit's survey with the Cathedral's workforce. Only half of the respondents said they had confidence in the Cathedral's processes for reporting safeguarding concerns, with a third not knowing where to find safeguarding policies. In this respect, whilst there is undoubtedly a need to better understand these perceptions, it is reasonable to suggest a correlation could exist. A lack of confidence in reporting and / or understanding could be accounting for the low numbers.

Recommendation C15: In partnership with the DST, the Cathedral should take proactive steps to engage with its staff and volunteers to better understand their perceptions and any other barriers to reporting concerns. This should be accompanied by further awareness raising about the responsibilities of staff and volunteers and the availability of support from the DST and key safeguarding roles in the Cathedral.

13.7 The Audit engaged with the Cathedral operations team during the site visit who demonstrated they were confident and knew how to escalate safeguarding concerns. The team have a wealth of professional experience including backgrounds in the military and working with those with special needs. Their familiarity of safeguarding policies and procedures was good.

13.8 Risk assessments conducted by the Cathedral are led by the DST, adhere to national guidance and prioritise the safety of victims, potential victims, and vulnerable individuals. With regards to those circumstances where safeguarding agreements are required, the Audit saw evidence of effective practice. Whilst there are no safeguarding agreements currently in place at the Cathedral, the Dean was instrumental in establishing two previous agreements and served as the signatory. The Audit also saw appropriate consideration to short-term arrangements for visiting personnel where there are known concerns. This included an agreement outlining prohibitions

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and expectations regarding behaviours for a convicted offender who was visiting as part of a choir. The safeguarding agreement was implemented to cover his attendance in the Cathedral. Again, the full narrative relating to risk assessments and safeguarding agreements as set out in Part 1 is relevant to the Cathedral's arrangements.

13.9 The Cathedral is a registered charity with a legal requirement to submit serious incidents to the Charity Commission. Whilst they have not yet (in their judgement) had to make any reports, it was clear that the duties and process were well understood and accepted. The COO provided Auditors with an overview of the criteria and process that would be applied, including (if necessary) an extraordinary meeting to consider and ratify a decision on whether an incident was classified and administered as an SIR.

13.10 Personal information about safeguarding cases is held by the DST on MyConcern and is compliant with data protection legislation and the General Data Protection Regulations (GDPR). Designated Cathedral staff receive GDPR training. Survey findings showed most of Cathedral staff were aware of the Cathedral's privacy notice in respect of data protection. The SLA in place across the DBF and Cathedral sets out clear parameters governing the legal and best practice requirements for information sharing. Both bodies are signed up to relevant agreements issued by the CofE.

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14 Victims and Survivors

14.1 Opportunities to engage with victims and survivors in the context of the Cathedral is more difficult than for the DBF, insofar as the Cathedral relies on the SLA with the DST to manage operational safeguarding issues, including disclosures (see Victims and Survivors in Part One).

14.2 That said, the Cathedral has hosted specific community focused events that have sought to engage with victims / survivors. One such example involved an art-based project working with young people who had suffered abuse, designed to give them a voice in a safe space.

14.3 The Cathedral also actively participated in the 16 days of activism, lighting up the Cathedral in purple to highlight gender-based violence. Over the 16 days, staff and volunteers worked with and supported others to highlight a range of harms on issues including domestic abuse, coercive control, and stalking. They also signposted to organisations such as Women's Aid and the National Stalking Helpline.

14.4 Whilst it is difficult to measure impact from one off events, the Audit acknowledges that the purpose of such engagement with clergy, staff, volunteers, visitors, and worshipers is to create opportunities to reflect, engage and share. The Audit is aware that this event resulted in increased awareness and received positive feedback. This is acknowledged as good practice.

14.5 The Cathedral has also invested in training for those most likely to encounter victims and survivors. These roles include welcomers, vergers, tour volunteers, staff and clergy. The Cathedral also benefits from the signposting, advice and information for victim and survivors available via the Diocesan website (see Victims and Survivors section in Part One).

14.6 During their day-to-day work, the clergy, staff and volunteers at the Cathedral come into contact with a diverse range of people. Some will be tourists, others will include organised groups, school

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children, local people and worshipers. Some of those who attend will be simply passing time, and a few may be mischievous or people who are troubled, some of whom will seek help and support, whilst others may represent a risk to themselves and others.

14.7 During the site visit, Auditors went into the Cathedral on several occasions and observed interactions between staff, volunteers and visitors. On two occasions, young people (of school age) entered and engaged in some anti-social behaviour. The response was tolerant and measured and it was clear that this was not an unusual occurrence. The staff spoken to on these days were extremely courteous and confident in the support that was on hand from the operations team.

14.8 The DST and the Cathedral's workforce are acutely aware of the complex issues and challenges faced by many of the vulnerable people who visit their premises and who utilise their outstanding Breakfast Club. The concerns range from issues related to mental ill-health and self-neglect (including poor hygiene, lack of warm clothing and food), to their vulnerabilities leading to exploitation by others, as well as suicidal ideation and the potential for aggressive or confrontational behaviour. This level of complexity requires specific training and appropriate support for those involved in direct engagement. The training provision is addressed elsewhere in this report.

14.9 An Auditor visited and participated in the Breakfast Club. It was well run and greatly appreciated by those who used the service. Service users talked about the fact that they felt treated with respect and dignity, the importance of the facility to them and their families and a few acknowledged that sometimes, other users can represent a risk to themselves and others. Those who volunteer and support the club are calm, courteous and have clearly built a good rapport with regulars. The Canon Chancellor is keenly aware of the importance of this facility and the need to ensure appropriate measures to keep everyone safe. The Audit saw evidence of a detailed and considered risk assessment. This reflected upon the fact that levels of need have almost doubled

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in the last few years, concerns about the safety of users and staff and the need for contingency support from the operational team. This resulted in appropriate changes to practice, including but not limited to days, timings and a strengthened partnership with Gloucester City Mission. This represents good practice.

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15 Learning, Supervision and Support

15.1 Staff and volunteers at the Cathedral have access to induction, a defined training programme and other events that help to promote their safeguarding knowledge, skills and experience. These learning opportunities mirror those available to other church officers and are supported by the Cathedral's SLA with the DBF and the work of the DSA for Training and Learning. Additional initiatives, unique to the context of the Cathedral, are also in place.

15.2 Working in partnership with key staff, the DSA helps coordinate and deliver the Cathedral's strategic and operational objectives in this area. Participants experience a mix of online and face to face courses, with the NST's programme being supplemented by locally defined events and awareness raising. The showcasing of the Knife Angel in early 2023 and more recently, the Anti-Violence Bee, are two examples of where the Cathedral has taken different approaches to promote reflection and learning, not only with its workforce, but with the wider community as well.

15.3 Two Cathedral volunteers have been trained by the DSA and form part of the local 'pool' of trainers. This is good practice and provides for dedicated support to the Cathedral's workforce. That said, the volunteers themselves recognise that sustainability is an issue and that without their commitment, it would be unlikely this provision would be in place.

Recommendation C16: The Chapter should engage with the DBF to explore potential options for making the volunteer training roles in the Cathedral more sustainable. This could for example, consider formal 'buddying' options with other volunteer trainers.

15.4 Opportunities to learn are appreciated by staff and volunteers and there is evidence of good feedback on the courses delivered. Most at the Cathedral had seen improvements in safeguarding training, awareness and culture. Furthermore, the significant majority were confident in managing a disclosure and knowing what to do if they were worried about someone's behaviour. Effective training will undoubtedly have played its part in this progress.

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15.5 Induction happens for most staff and volunteers and most believed this covered what they needed to know about safeguarding. Examples of good practice were shared with the Audit such as induction for the yearly appointed organ scholar who meets the DST on their first day before being introduced to any choirs they may be playing for.

15.6 Not everyone, however, expressed confidence in this area. Whilst recognising the focus on induction is likely to have improved over recent years, nearly a third of respondents to the Audit's Cathedral workforce survey indicated they had never been given one. A further 11% couldn't recall. In this sense, there is merit in the Chapter seeking further reassurance that induction arrangements are sufficient.

Recommendation C17: The Chapter should review its induction arrangements and ensure that all staff and volunteers systematically have access to a defined programme that includes a clear focus on safeguarding.

Recommendation C18: 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 three months. This retrospective induction session should be mandatory regardless of a person's length of service.

15.7 Systems are in place to track safeguarding training for the Cathedral's staff and volunteers, and these demonstrate good levels of compliance. However, as with the arrangements led by the DST, these are largely manual processes and there is no dedicated Learning Management System in place to support the collation and oversight of training data. Following a period of drift, the Cathedral recently undertook significant work to update the records and there is a commitment to ensure these are robustly maintained going forward.

15.8 That said, within the Cathedral's Annual Report, DSAP minutes and the training data seen by the

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Audit, there was no evidence of disaggregated data for the Cathedral being presented or discussed. The Audit understands that systems are changing nationally, and this may provide an opportunity for improved oversight in the future. However, line of sight on this data should be established beforehand.

Recommendation C19: The reporting of safeguarding training data to DSAP, the Chapter or any other relevant forum should be disaggregated to allow for oversight on the Cathedral's performance. This training data should be reflected in the Cathedral's annual report.

15.9 In terms of training evaluation, beyond the leadership sessions, processes primarily focus on the quality of courses as opposed to any longer-term testing of impact. This reflects the position across the Diocese and leaves a gap in understanding about whether training is directly influencing practice.

Recommendation C20: Collaborating with the DBF, the Cathedral should support the implementation of an enhanced training evaluation process to test the impact of training on its workforce. Regardless of this being managed by the Cathedral or via the SLA with the DBF, random cohorts of staff and volunteers (and their managers) should be approached three months after attending training to identify specific ways in which they have used what they learnt and to provide examples of how this has made people safer and the Cathedral a safer place.

15.10 In terms of the type and availability of training, additional courses implemented by the DSA, such as Mental Health First Aid and training for the Cathedral's Breakfast Club are examples of responding to need and good practice. There are also positive examples of supporting those with limited IT fluency through the issuing of guidance on how to access online training and helping individuals on a 1:1 basis.

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15.11 Outside of the national training and the locally developed initiatives, there are few, if any, structured learning opportunities. Whilst this might not be necessary for all roles at the Cathedral, building expertise is sensible and likely to make arrangements safer. The Audit's recommendation for the DBF to engage with the Gloucester Safeguarding Children Partnership (GSCP) and the Gloucester Safeguarding Adults Board (GSAB) has relevance in this context.

Recommendation C21: Should the DBF join the training membership schemes for the GSCP and / or the GSAB, the Cathedral should seek to secure proportionate access for its workforce via an amended SLA.

15.12 The Audit also believes there should be a concentrated focus on both 'theme specific' and 'role specific' training at the Cathedral. Firstly, there should be opportunities for staff and volunteers to develop a much more detailed understanding about the nature of sex offenders. Whilst noting the inclusion of this topic within NST training, detailed learning about predators and the nature of offending is both a relevant and contemporary issue for cathedrals. Secondly, digital safeguarding was highlighted as an issue where there were potential knowledge deficits. Thirdly, as part of the Audit's recommendations for the DBF to review its training needs analysis, this should also encompass the Cathedral and seek to develop 'nuanced' training targeted at particular roles.

15.13 For example, over the course of 2023, the Cathedral's Breakfast Club saw an increase in numbers attending as well as an increase in the complexity of safeguarding issues, such as those involving mental health and crime. On engaging with the Breakfast Club volunteers, they agreed that training focused on de-escalation to help them recognise and resolve challenging situations would be of benefit. The Audit agrees.

Recommendation C22: The Cathedral should develop or commission specific training for Breakfast Club volunteers on de-escalation.

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Recommendation C23: The Cathedral should ensure its SLA with the DBF allows for its staff and volunteers to access specific training that is focused on sex offenders and digital safeguarding. The Audit recognises that overarching responsibility for training in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Cathedral with the opportunity to apply interim mitigation measures.

15.14 A range of systems are in place for the Cathedral's clergy to help them cope with the challenges of their role and potential trauma. In the main, these mirror the broader arrangements in the Diocese. Alongside organisational support (such as HR and occupational health), the Bishop(s), Archdeacon and local ministry structures are available for pastoral, practical and spiritual assistance. Continued Ministerial Development is embedded and there is access to a Diocesan professional counselling service and specialist therapeutic support if required. Furthermore, when an allegation is made against a member of the clergy, in line with national policy, they will be helped by a trained 'Link Person' or 'Support Person'. Support from the DST can also be provided when clergy are working as part of a 'Response Group' (and where space is created to reflect with others) or through the DST facilitating 1:1 sessions to discuss / debrief a particular case. For clergy against whom a complaint is made, national church prescribed processes are in place that facilitate access to support. These arrangements are similarly in place for non-clergy staff. This is good practice. See also Part One, Learning, Supervision and Support, paragraph 8.18.

15.15 There are currently no ordinands or curates at the Cathedral. Should it be requested that an ordinand or curate be on a short-term placement at the Cathedral as part of their discernment journey (ordinand) or their training (curate) this is managed by the senior clergy. The Audit was told that the Cathedral and DSA would ensure some contextual awareness on safeguarding is given at the outset.

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15.16 Ministerial Development Reviews (MDRs) of Cathedral clergy routinely take place to promote reflection, learning and improvement That said, an enhanced focus on safeguarding within this process is needed. Whilst no MDRs were made available to the Audit, discussions about their content suggests they could better explore what is working well from a safeguarding perspective, the outcomes being achieved, and future areas for growth and development. The recommendation made for the DBF covering MDRs has equal relevance to the Cathedral and is set out below.

Recommendation C24: There should be a structured focus on safeguarding practice within the MDR process. In collaboration with the DST, arrangements should be revised to ensure that discussions cover a review of safeguarding (in line with the national safeguarding standards) and that these are formally recorded within MDRs.

15.17 There is good collaboration between the Cathedral and DST, supported by a defined SLA and evidence of a culture of working together. Support for those in cathedral safeguarding roles is available from the DST, the COO or other senior staff. There is also access to an independent employee assistance provider.

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Conclusion

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16 Conclusion

16.1 This round of Audits follows the SCIE and PCR2 processes that began in the Diocese in 2016 and in the Cathedral in 2019. It is fair to say that progress has been made in all areas since that time. Whilst there are elements of practice that could be reinforced (and these are highlighted within the recommendations), the DBF and the Cathedral have evidenced their capabilities in delivering good safeguarding practice. These include, but are not limited to, their communications and awareness raising activity, some of their work in the Youth Connect Team, the DST and its approach to thresholds, the provision of support to those involved in safeguarding incidents and the Cathedral's exemplary approach to safeguarding choristers.

16.2 This level of achievement has been made possible by leadership at all levels, from the volunteers meeting, greeting, and supporting people in church-based places and spaces, not least the impressive Breakfast Club, to the PSOs and clergy who are ever present in the frontline of their parishes.

16.3 They are supported by a Bishop and Dean who lead by example and a senior leadership team, that whilst many are relatively new in post, have a firm grasp on what needs to be done, and the courage to stop what doesn't or shouldn't.

16.4 During the site visit the Audit team saw committed people, intent on doing the right thing and being prepared to do more than their fair share to get it done.

16.5 Moving forward and to maintain a positive trajectory they will need to address capacity. If they can and do, they will reduce the likelihood of a lack of resource undermining their ability to manage extractions or critical incidents and be able to build on their considerable strengths whilst developing a strategic capability that will support transition in the future.

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Appendices

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17 Appendix 1 – Gloucester DBF Recommendations

Recommendation D1:

c) Prior to visitations to Deaneries and the parishes, relevant Safeguarding Dashboards should be considered, and advice taken for the DST about any safeguarding specific issues, trends or general themes that should be addressed. This should include recognition of progress and good work done, as well as prompts and encouragement about issues that need to be addressed.

d) Updates on the safeguarding themes should be circulated via visitation news sheets.

Recommendation D2: The DBF should consider options to appoint a Director of Safeguarding. This strategic role, if agreed, should cover the Diocese (parishes) and Cathedral providing the capacity to proactively promote safeguarding and support the operational safeguarding team, as well as strategic leadership for implementing national standards and driving coordinated improvement across both the Diocese and Cathedral.

Recommendation D3: Additional resource should be invested in the DST. This should complement the recommendation regarding a Director of Safeguarding and is additional to a dedicated resource for the Cathedral.

Recommendation D4: The DSAP should, consider how it could widen its membership to include a more diverse range of individuals, reflective of the wider community within which it serves.

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Recommendation D5:

a) The DBF should seek to engage/re-engage in local safeguarding partnership arrangements.

b) The DSAP Chair should also reach out (one to one) to engage key statutory leads and other relevant potential partners by routinely visiting them for short, focused meetings.

c) DSAP should continue to comprise key roles from the Diocese that have a responsibility for local arrangements – those that have responsibility and can report on local issues and be independently challenged and scrutinised by the Chair.

Recommendation D6: The DBF should review and update all relevant policies and handbooks to reference the most recent House of Bishops guidance.

Recommendation D7: The DBF should ensure that its commitment to safeguarding is embedded in all job adverts, application forms and job descriptions.

Recommendation D8: The DBF should develop a single guidance document that sets out the codes of conduct applicable to the various roles in place across the Diocese.

Recommendation D9: A needs analysis should be developed to enhance their understanding of the contemporary needs of the young people they engage and support. This should be subject to regular review to ensure contemporary insights and the outcome(s) made available to, amongst others, the DST, DSAP and Chapter.

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Recommendation D10: Re-design the safeguarding webpage to align with hierarchy principles; information being organised in order of importance to users. A section on how to report a safeguarding concern should take primacy followed by a re-ordering of other sections that are most frequently accessed. The page should also include a mechanism for visitors to subscribe to the monthly safeguarding newsletter.

Recommendation D11: The DST should set-up an auto-reply message for any communication sent to safeguarding@glosdioc.org.uk. This message should be used to provide signposting to support for urgent and non-urgent concerns for both adult and child safeguarding matters.

Recommendation D12: The DBF should review its Risk Register, consider setting safeguarding as section in its own right and populate the section with the specific safeguarding risks it judges to require ongoing oversight.

Recommendation D13: Safety Plans should always include requirements to report when a respondent unexpectedly finds themselves in a position that would breach the non-enforceable Safeguarding Agreement / Safety Plan.

Recommendation D14: Where a conflict of interest exists or is perceived to exist, an appropriate other person should be appointed to chair the Response Group.

Recommendation D15: The DBF should raise awareness with PCCs regarding Charity Commission guidelines as to what constitutes a serious incident.

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Recommendation D16: A central register containing all SIR submissions across the Diocese should be maintained to allow for the quick retrieval of SIRs and the ability to monitor patterns and trends at a local level.

Recommendation D17: Due to the transition to a new safeguarding system, short term administrative capacity should be made available to help update records, assist with case closures and allow the DST to focus on new and ongoing safeguarding concerns.

Recommendation D18: Referred cases resulting in no further action 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 D19: The DBF should consider creating a video explainer that sets out their position on support to and for victims and survivors.

Recommendation D20: The DBF should consider how it could proactively enhance its ability to encourage victims to engage with them. This could include the use of victim / survivor specific signposting in appropriate spaces and places where the material can be accessed and read.

Recommendation D21: The DBF should explore how the commitment, resourcing and arrangements for volunteer trainers could be integrated into the emerging strategic plans for deaneries.

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Recommendation D22: The DBF should review its training needs analysis process to ensure this adequately covers the full range of roles in place across the diocese. The analysis should be used to identify where additional 'role specific' training might be of benefit.

Recommendation D23: Theme specific training sessions focused on the topics of sex offenders / predators and digital safeguarding should be introduced into the training programme and accessible to relevant church officers in the DBF, Cathedral and parishes. The Audit recognises that overarching responsibility for training in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the DBF with the opportunity to apply interim mitigation measures.

Recommendation D24: 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.

Recommendation D25: The Director of People and Safeguarding will ensure that all training records are up to date.

Recommendation D26: The DBF should engage in discussions with the Gloucester Safeguarding Children Partnership (GSCP) and the Gloucester Safeguarding Adults Board to explore options for joining any associated training membership schemes.

Recommendation D27: There should be a structured focus on safeguarding practice within the MDR process. In collaboration with the DST, arrangements should be revised to ensure that discussions cover a review of safeguarding (in line with the national safeguarding standards) and that these are formally recorded within MDRs.

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Recommendation D28: All new clergy should receive a formal, face to face induction session with a member of the DST.

Recommendation D29: 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 D30: The DST should consider circulating a summary of safeguarding drop in discussions to the PSO cohort.

Recommendation D31: The DBF should review what else could be done to help support PSOs, with a focus on increasing access to face-to-face peer support, mentoring and supportive supervision.

Recommendation D32: The DBF should review the ways in which it recognises the contribution of PSOs. Consideration should also be given to sponsoring an annual PSO conference to highlight the good work undertaken, expose PSOs to external speakers providing an insight on survivor's experiences and deliver scenario based contextualised training.

Recommendation D33: The DBF should review the advertising of digital / online training to ensure privacy and settings are configured in line with good digital safeguarding practice.

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18 Appendix 2 – Gloucester Cathedral Recommendations

Recommendation C1: The Cathedral should have a more defined Cathedral Safeguarding Advisor (CSA) resource supporting its own arrangements, providing greater insights, and building close relationships with statistical cathedral neighbours. Whilst a dedicated resource, the role would maintain – a close link with DST and be supervised by the DSA / DSO.

Recommendation C2:

a) The Cathedral should develop a strategic scrutiny body (or restructure the current Working Group) to ensure greater clarity on oversight of its own safeguarding arrangements.

b) This function should be independently chaired, comprising key roles within the Cathedral and Diocese / DSAP engagement to ensure line of sight and sharing of learning.

Recommendation C3: Locate a more suitably sized space for the volume of choristers entering and using the song room and robing area to ensure that potential accidents and risk is significantly reduced.

Recommendation C4: The Cathedral should ensure that all relevant staff have completed safer recruitment training within the next three months.

Recommendation C5: The Cathedral should ensure that its commitment to safeguarding and requirements, such as the need for confidential declarations, are embedded (where relevant) in all job adverts, application forms and job descriptions.

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Recommendation C6: The Cathedral should review all policies and handbooks to reference up-to-date House of Bishop guidance and policy and replace any broken hyperlinks.

Recommendation C7: Establish within a policy the practice of printing the Safeguarding Contact Information within the inner side of lanyards for both Cathedral staff and volunteers.

Recommendation C8: Develop a toolkit of awareness raising materials tailored to meet the unique context of the Cathedral. Assets could include, email signature blocks, posters for displaying within the Cathedral, social media graphics, banners or promotional graphics for use within wider communications channels (e.g. via the main Cathedral newsletter).

Recommendation C9: To ensure a joined-up approach, coordinate the planning and issuing of the DBF safeguarding communications (e.g. monthly newsletter) with staff at the Cathedral responsible for communicating with staff and volunteers.

Recommendation C10: The Cathedral should provide visitors to the safeguarding webpage the ability to subscribe to the DBF's monthly safeguarding newsletter.

Recommendation C11: The Cathedral should identify specific resources from the DBF Safeguarding webpages and other relevant resources and provide clearer and direct CTAs on Cathedral safeguarding webpage to such material. The Cathedral should re-design the safeguarding webpage to align with hierarchy principles - information being organised in order of importance to the user. The section on how to report a safeguarding concern should take primacy followed by a re-ordering of other sections on the basis of those that are most frequently accessed.

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Recommendation C12: The Cathedral should provide a user-friendly way for visitors to access the Safeguarding Handbook and CofE Safeguarding Policy on its website. The Handbook and policy should sit under the Safeguarding tab, within a separate button detailing their intended use.

Recommendation C13: Volunteer guides should not conduct Crypt tours for less than two visitors. This measure is required to avoid situations where a volunteer and an individual may find themselves isolated in secluded areas. The Volunteer Handbook should be amended as appropriate.

Recommendation C14: The COO should have a structural survey carried out to identify risks and thereafter develop safer by design mitigations to prevent vulnerable people from coming to harm.

Recommendation C15: In partnership with the DST, the Cathedral should take proactive steps to engage with its staff and volunteers to better understand their perceptions and any other barriers to reporting concerns. This should be accompanied by further awareness raising about the responsibilities of staff and volunteers and the availability of support from the DST and key safeguarding roles in the Cathedral.

Recommendation C16: The Chapter should engage with the DBF to explore potential options for making the volunteer training roles in the Cathedral more sustainable. This could for example, consider formal 'buddying' options with other volunteer trainers.

Recommendation C17: The Chapter should review its induction arrangements and ensure that all staff and volunteers systematically have access to a defined programme that includes a clear focus on safeguarding.

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Recommendation C18: 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 three months. This retrospective induction session should be mandatory regardless of a person's length of service.

Recommendation C19: The reporting of safeguarding training data to DSAP, the Chapter or any other relevant forum should be disaggregated to allow for oversight on the Cathedral's performance. This training data should be reflected in the Cathedral's annual report.

Recommendation C20: Collaborating with the DBF, the Cathedral should support the implementation of an enhanced training evaluation process to test the impact of training on its workforce. Regardless of this being managed by the Cathedral or via the SLA with the DBF, random cohorts of staff and volunteers (and their managers) should be approached three months after attending training to identify specific ways in which they have used what they learnt and to provide examples of how this has made people safer and the Cathedral a safer place.

Recommendation C21: Should the DBF join the training membership schemes for the GSCP and / or the GSAB, the Cathedral should seek to secure proportionate access for its workforce via an amended SLA.

Recommendation C22: The Cathedral should develop or commission specific training for Breakfast Club volunteers on de-escalation.

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Recommendation C23: The Cathedral should ensure its SLA with the DBF allows for its staff and volunteers to access specific training that is focused on sex offenders and digital safeguarding. The Audit recognises that overarching responsibility for training in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Cathedral with the opportunity to apply interim mitigation measures.

Recommendation C24: There should be a structured focus on safeguarding practice within the MDR process. In collaboration with the DST, arrangements should be revised to ensure that discussions cover a review of safeguarding (in line with the national safeguarding standards) and that these are formally recorded within MDRs.

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19 Appendix 3 – Glossary of Abbreviations

CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
GDPR	General Data Protection Regulations
GSAB	Gloucester Safeguarding Adults Board
GSCP	Gloucester Safeguarding Children Partnership
LADO	Local Authority Designated Officer
LSCP	Local Safeguarding Children Partnership
MDR	Ministerial Development Review
MHFA	Mental Health First Aid
MOSOVO	Management of Sexual or Violent Offenders
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
SCIE	The Social Care Institute for Excellence
SEO	Search Engine Optimisation
SIR	Serious Incident Report
SLA	Service Level Agreement
SoC	Subject of Concern

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