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SAFEGUARDING GROUP

# Independent Safeguarding Audit of Worcester Diocesan Board of Finance and Worcester Cathedral

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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). Conducted by the INEQE Safeguarding Group and working to a consistent framework, the audits test the sufficiency of safeguarding arrangements within CofE dioceses, having a particular focus on Diocese Boards of Finance (DBFs) and Cathedrals. They take account of the CofE's new National Safeguarding Standards that provide the structure for this report.[1]

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

- Over 390 documents being collated and analysed prior to the Audit's fieldwork.
- A range of interviews taking place with Church officers (staff and volunteers), external partners, victims, survivors and other stakeholders.
- 551 anonymous survey responses, which gathered input from key communities connected to the Church. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the DBF, the Cathedral and parishes.
- Five focus groups
- A confidential contact form accessible via a dedicated webpage.
- In total, the Audit undertook 41 separate engagement sessions reaching 96 people.

[1] https://www.churchofengland.org/safeguarding/national-safeguarding-standards


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

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


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# Part One - Worcester Diocesan Board of Finance



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# 2 Context

2.1 The Diocese of Worcester extends from the urban north of the region to the agricultural south, mainly encompassing the local authority areas of Dudley and Worcestershire. Some of its parishes are also located in Gloucestershire, Sandwell and Wolverhampton. Serving a population of nearly 1.7 million people, the geographic footprint of the diocese is characterised by areas of both affluence and deprivation. Spanning 670 square miles, there are 168 parishes in total and the diocese is home to 274 places of worship. At the time of writing, the DBF is investing in the renewal of churches to ensure each major area of population has at least one large and sustainable church by 2030.

2.2 The Diocese of Worcester comprises two Archdeaconries (Worcester and Dudley) which are further divided into six deaneries. Each deanery has an Area Dean and Lay Chair who are jointly responsible for pastoral care in parishes. Almost half of the worshipping community is over the age of 70 and only 12% are under 17. Despite this predominantly older population, the diocese maintains an active role with children and young people. This can be seen through the education delivered to the 22,000 children in local church schools and the DBF's priority to increase the number of paid youth and family workers.

2.3 The average weekly worshipping attendance stands at 7630.2 and 1074.8 for adults and children respectively. Sunday attendance averages 6966.3 as reported in the Diocese's Statistics of Mission 2022.


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# 3 Progress

3.1 Overall, the SCIE safeguarding audit and PCR2 made 43 recommendations / considerations for Worcester DBF. These ranged from issues including supervision, capacity, quality assurance mechanisms within the Diocesan Safeguarding Advisory Panel (DSAP), and the recording of events. Most recommendations have been met, whilst a small number have been integrated into other workstreams and some remain reliant upon national developments.

3.2 The SCIE audit was published in December 2016 and resulted in 18 considerations, all of which were accepted. It identified no '*major gaps'* in the DBF's safeguarding arrangements. The current Diocesan Safeguarding Advisor (DSA), who has been in post since 2015, was present for the SCIE audit and took ownership of the accompanying action plan. At the time, decisions in relation to the implementation of actions were overseen by the DSAP and Operational Safeguarding Group (OSG).

3.3 The Audit is satisfied that the majority of the SCIE considerations have been met.

3.4 The PCR2 was published on 14th October 2020. The 25 recommendations were collated into a Red-Amber-Green (RAG) rated action plan. This was last updated in March 2024. The Audit has seen effective oversight and monitoring by DSAP, including feedback on progress to the Bishop's Council through annual safeguarding reporting. Some PCR2 recommendations were subsumed into the DBF'S Objective Action Plan alongside their Safeguarding Strategy (2023-2026).

3.5 Beyond SCIE and the PCR2 processes, the DBF also undertook a Lessons Learned Review (LLR) in March 2023. Conducted by the current DSAP chair, this focused on the


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interface between pastoral issues and potential safeguarding concerns. It also considered how senior clergy could work more effectively with support from the Diocesan Safeguarding Team (DST).

3.6 Nine recommendations arose from this Learning Lessons Review and whilst the DST has taken positive steps, work remains ongoing. As an example of relevant progress made, the Audit saw evidence of the DBF developing its practice arrangements in response to incidents of conflict, including bullying and harassment. The DBF considered its current provision alongside what other dioceses offer (not limited to those within the CofE). This is evidence of a good and thoughtful response.


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# 4 Culture, Leadership and Capacity

4.1 The Audit saw and heard credible evidence that a safeguarding culture is becoming embedded within the DBF and across the diocese's parishes. An analysis of interviews, focus groups and feedback from surveys, found the most frequently used terminology to describe culture within the diocese was largely positive. People used phrases such as 'welcoming', 'supportive' and 'respectful'. It was clear from survey responses that the overwhelming majority of the DBF's workforce and those working and worshipping within parishes, felt safe in their respective environments. Nearly all knew who their safeguarding leads were and across the diocese, there was almost unanimous agreement with the statement that, '*it is everyone's responsibility to report safeguarding concerns.'*

4.2 Whilst this is a positive foundation to build upon, it is important that the diocese maintains momentum. Building on the work it has done on cultural audits in training evaluations, (mentioned later in the report) it should routinely seek feedback on culture and actively seek out areas for further improvement, independent of training and with key leaders, staff and volunteers across the DBF and parishes.

**Recommendation D1:** The DBF should engage in a range of activities that facilitate insight regarding culture. These should include, but not be limited to the following:

a) Seeking views on culture, including areas of perceived strength and areas for improvement through the use of anonymised surveys.
b) Workshops focused on specific themes (e.g. issues arising from LLRs or other feedback).

4.3 The DBF has been proactive and engages in events focused on mental health awareness, managing and reducing conflict (in which it has led critical work) and was the first diocese to pilot the new *Responding to Bullying and Harassment* training. It has appropriate


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policies in place, providing good practical advice to managers via the DBF's '*Getting it Right*' - line management guidance, the *Code of Conduct* and the local approach to fostering a safe and healthy culture. Furthermore, the DST is involved in several key internal meetings where it can inform, challenge and influence others. A good example of this can be seen in the DST's participation and input into deliverance team meetings.

4.4 The Audit also saw examples of the DBF being committed to internal and external collaboration. These included key staff working with different groups to deliver contextually relevant safeguarding support. For example, the DST provides advice and support to local Bell Ringers and those working in Towers. It also provides bespoke support for a range of community-based initiatives, such as the *Churches Held in Local Leadership* (CHILL). This approach helps to maintain churches by encouraging engagement and reducing bureaucracy. Whilst the aim is to simplify support, the Audit was reassured that this is done at the same time as maintaining appropriate and proportionate employment, leadership and governance structures, as well as effective safeguarding support.

4.5 Another example relates to the DST's engagement with *Top Church*, a renewal resourcing Church located in the centre of Dudley, which the DST has actively designed and delivered bespoke training for. This has taken account of the environment within which they operate, the needs of vulnerable adults and how best volunteering opportunities can be supported. This is good practice.

4.6 The overall accountability for safeguarding is both understood and unambiguously accepted by the Bishop of Worcester. He is reflective, engaged at a senior leadership level and adopts a strategic approach to his safeguarding role and responsibilities.

4.7 Day to day oversight for safeguarding has, however, been delegated to the Bishop of Dudley. Given the Bishop of Worcester's pending retirement, this supports succession


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planning and can be seen as a sensible and practical approach, particularly given the Bishop of Dudley has now been appointed as the Acting Bishop of Worcester following the Diocesan Bishop's retirement. That said, the Audit does not agree with mirroring this arrangement going forward.

4.8 A Suffragan Bishop (in this case the Bishop of Dudley) operating with delegated authority for safeguarding is not unique and there is some merit in the division of responsibility regarding disciplinary matters, should there be a safeguarding Clergy Discipline Measure (CDM). However, if the responsibility is not carefully framed and limited, it could also be seen to distance the Diocesan Bishop from this critical area of leadership. The Audit therefore takes the view that moving forward, the overall responsibility and accountability for safeguarding should not be delegated in the way that it currently is but retained directly by the Acting Bishop of Worcester and articulated as such within local governance.

4.9 This would not prevent the delegation of some tasks to others. For example, Archdeacons and any future Suffragan Bishop. Such delegated tasks might include representing the Diocesan Bishop at DSAP and other events and sub-committees such as the OSG. However, the delegation of safeguarding related tasks should be limited in such a way as to ensure there is no ambiguity about the Diocesan Bishops commitment to safeguarding. For example, they should have frequent and direct engagement with the DSA/DSO, be briefed on key issues and directly involved in the support and development of safeguarding initiatives and relevant strategic decisions. Clergy leadership in this vital area must remain with and be seen to be exercised by the Diocesan Bishop.

4.10 This approach plays to the Bishop of Dudley's considerable experience, lessens the risk of confusion and will also ensure continuity. It is also likely to further embed a safeguarding first philosophy across his area of influence.


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| **Recommendation D2:** The Acting Bishop of Worcester and then the future Bishop of Worcester should retain direct responsibility and ultimate accountability for safeguarding. |
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4.11 Those in key leadership roles have a firm focus on safeguarding and can explain how what they do relates to it. They demonstrated to the Audit an understanding of escalation and pathways for advice and support. This was particularly evident with the highly motivated and engaged Diocesan Secretary, who in the opinion of the Audit, should take on the line management of the DSA.

| **Recommendation D3:** The Diocesan Secretary should line manage the DSA. |
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4.12 The Archdeacons have a good understanding of safeguarding practice and are actively engaged. That said, the Audit identified potential to enhance their roles in this regard. This could be done by developing a safeguarding component to their visitation framework (beyond their Articles of Enquiry) and seeking out more frequent and routine opportunities to promote good safeguarding policy and practice.

| **Recommendation D4:** The Bishop of Worcester, DSA and Archdeacons should reflect on how visitations and / or inspections can become even more safeguarding focused. This reflection should include how a consistent focus on key safeguarding themes (relevant to the places they visit) are captured in a framework. Furthermore, briefing and debriefing opportunities with the DST should be formalised and safeguarding visits should be adopted that go beyond annual swearing in ceremonies. |
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4.13 The DBF's governance arrangements reflect the expectations of the CofE and relevant external regulatory requirements, such as those issued by the Charity Commission. It operates a range of strategic and operational meetings that facilitate effective oversight and direction. Notwithstanding the benefits of routinely reviewing membership via a skills,


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diversity and inclusion lens, and the recommendation set out later in this report regarding the DSA's attendance at the Bishop of Worcester's Staff Meetings (BSM), the current meetings have appropriate representation with regards to seniority and expertise.

4.14 The Bishops' Council meets three times a year. Safeguarding is currently only considered at one of these meetings. This is a potential weakness. That said, the Audit welcomes the commitment of the current Bishop of Worcester to ensure that going forward this becomes a standing agenda item at all meetings. This is a positive move and on the basis of this commitment, the Audit makes no recommendations.

4.15 The Bishop of Worcester's staff meeting is frequent and routine. This is a critical meeting which has influence and oversight of activity across the DBF and diocese as a whole. The DSA is invited when it is thought appropriate. This approach creates vulnerabilities, as it assumes that those without a safeguarding background will know when safeguarding is either a direct or indirect issue. In the opinion of the Audit, the DSA / Diocesan Safeguarding Officer (DSO) should be a member of this meeting by right rather than by invitation.

**Recommendation D5:** The DSA should be appointed as a member of the Bishop of Worcester's Staff Meetings and attend all of its meetings.

4.16 Comprehensive minutes for the Bishop of Worcester's Staff Meetings are not currently recorded and whilst actions and updates are captured, the Audit takes the view that this is insufficient.

**Recommendation D6**: Formal minutes including persons present, matters discussed and actions agreed must be properly recorded and retained.


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4.17 The Diocesan Safeguarding Advisory Panel is active and engaged and well led by a chair with credible and relevant experience. There is good internal representation and support from key statutory partners. An examination of records evidenced good oversight and appropriate levels of challenge by the DSAP. This included approval and monitoring of the Safeguarding Strategy and Operational Plan 2023-26, effective tracking of key data related to DBS checks, training delivery, risk assessments, dashboard activity and reports on safeguarding compliance in parishes. There was also evidence of the key role they played in the Regional Pilot and responding to LLRs. It is worthy of note that the DSAP Chair carried out a key and influential LLR that has led to substantial reflection and positive change.

4.18 One of the strengths of the DSAP is its delivery of strategic oversight alongside its insight into operational delivery. This is achieved via the Diocesan Operational Safeguarding Group, which is Chaired by the Bishop of Dudley. This group receives operational reports from the DSA, Cathedral Safeguarding Lead (CSL) and Assistant DSA (ADSA) on (amongst other issues) case work, risk assessments and DBS renewals for clergy and those with Permission to Officiate (PTO). This is good practice, as is their approach to lapsed DBS and training compliance for clergy and those with PTO. In such instances, matters are appropriately escalated to the current Bishop of Dudley. The Audit saw evidence of influential and authoritative practice in this regard.

4.19 A key strength within the DSAP is its ability to reflect on how its own functions can be strengthened. The Audit welcomed that the group recognised some areas in which collaboration could be improved and the need to ensure better engagement of survivors with the work of the DSAP. The Audit concurs and given the DSAP's plans for further action, no recommendation is made in this regard.


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4.20 The Audit has seen how the DSAP operates an effective level of scrutiny. This is facilitated by the commitment from key leaders and the DSAP Chair. The DSAPs desire to continually improve reflects good practice and will ensure they go from strength to strength. However, in keeping with national guidelines, the DSAP operates as advisory on the basis of its influence, rather than delivering independent scrutiny on the basis of its independent authority. This is a national issue that the Audit is addressing with the National Safeguarding Team.

4.21 Clergy Files (Blue Files) are efficiently managed within the current framework by the highly effective Bishop's Chaplain. Incoming and outgoing files are examined and reviewed by a member of the DST as well as by the Bishop's Chaplain. This is good practice.

4.22 The DST is well led by a highly effective DSA and benefits from the range of expertise each team member brings. This includes safeguarding experience in health, policing (including public protection duties, child abuse investigation and online child sexual exploitation), education, family support and the third sector. They work well within the confines of their current capacity across the DBF, parishes and their role supporting the Cathedral.

4.23 Capacity is a challenge, and the Audit saw and heard evidence that the team work beyond their agreed hours to ensure they are delivering supportive and timely responses. This is commendable but not sustainable.

4.24 The Audit also recognises that increased demand (due to unexpected events and indeed diversions like the Audit itself) have an impact on the team's operational bandwidth. Furthermore, the DST has no dedicated trainer, which consistently creates additional pressures.


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4.25 The DBF, in conjunction with the Cathedral, must review their safeguarding capacity and in doing so should consider opportunities to reinforce and consolidate resources. This can be done by creating an overarching Safeguarding Directorate. This approach would create one safeguarding team with responsibility for providing support across the geographic footprint of the diocese. This would include the DBF, parishes and the Cathedral. It would reinforce the level of operational independence that the DST requires and enhance opportunities for professional supervision without undermining the line management and needs of each part of the diocese / Cathedral. To this end, the Audit makes the following recommendation.

| **Recommendation D7**: Leaders in the DBF and Cathedral should scope the opportunity to consolidate safeguarding resources within a single Safeguarding Directorate for the diocese. This would involve the creation of a Director of Safeguarding role. This role would provide strategic oversight, advice and safeguarding support across the DBF, parish support and the Cathedral. They would be a member of the senior leadership team and assume the authority vested in a DSO. |
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| **Recommendation D8**: The present safeguarding resource should also be reinforced with the appointment of an additional Assistant Diocesan Safeguarding Advisor (ADSA) with a portfolio for training, and a Cathedral Safeguarding Advisor (CSA). The CSA, whilst located in and line managed on a day-to-day basis within the Cathedral, should be professionally supervised by the Director of Safeguarding (or the DSO if Recommendation D7 is not accepted). |
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# 5 Prevention

5.1 Safer recruitment is a clear priority in the diocese and the DBF has implemented robust safer recruitment processes. These are routinely monitored by the DBF and are consistent with legislation and the House of Bishop's guidance, *Safer Recruitment and People Management*. Strengths seen by the Audit range from public statements outlining the DBF's commitment to safeguarding, reference gathering, role specific declaration forms and robust vetting checks.

5.2 The DBF's recently developed policy on the recruitment of ex-offenders is another good example of the positive improvements in this area of safeguarding. Reassurance is also evident in the fact that relevant staff have completed the CofE online Safer Recruitment training module (as per the 2021 training framework).

5.3 To support those involved in recruitment, the DBF hosts relevant guidance within its online resource library ('*Quick Guide to DBS checks*'). Whilst positive, the Audit believes this guidance could be enhanced by creating a defined '*eligibility matrix'*. This matrix would cover the range of roles working across the diocese, setting out the type of check required and the relevant training needed for those in different posts.

**Recommendation D9**: The DBF should develop guidance and an eligibility matrix that defines the type of DBS check and the level of training required for specific roles in the diocese. This should cover the range of posts in place in the DBF, the Cathedral and parishes.

5.4 There are clear arrangements in place to identify and assess DBS returns that include relevant information on previous convictions, cautions or disclosable soft intelligence. This is good practice.



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5.5 The Audit saw evidence of DBF public communication regarding recruitment. This material clearly sets out the expectations and vetting requirements for those involved in safeguarding. This is good practice as it can act as an effective deterrent for unsuitable candidates. The DBF's commitment to safeguarding is outlined in prominent places on the diocese's website, including the 'Home' and 'Vacancies' pages. Adverts and application packs reviewed by the Audit also included transparent messaging about the importance of safeguarding.

5.6 At parish level, appointments are overseen by the local Parochial Church Council (PCC), with the DBF providing a range of support to ensure recruitment in this context is safe and secure. Beyond that described above, briefings for Parish Safeguarding Officers (PSOs) have been issued on administering DBS checks with supporting material available via the Diocesan website.

5.7 Additional training for the administration of DBS checks is also provided by the 'DBS, Safeguarding and HR Processes Coordinator'. This is good practice and helps key staff familiarise themselves with both the process and the functionality of the system. It is completed by all new PSO's and parish administrators / clergy (where required), with ongoing support being available from the coordinator.

5.8 The Audit heard from PSOs about the positive impact that the Parish Dashboard has on their practice, with one commenting, "the *Dashboard has improved everything*."

5.9 Linked to the prevention agenda, activity undertaken by the DST demonstrates its recognition in the value of being visible, present and connected with others across the diocese. At a senior level, the DST provide briefings and updates to Bishop's Council, Diocesan Synod and the Bishop's Staff meeting, as well as reporting on key safeguarding


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developments in diocesan 'all staff briefings' as appropriate. At deanery level, DST members attend Deanery Chapter meetings and Deanery Synod. Within such activity, the Audit saw innovative approaches being used, such as a short, informal video introducing the DST and explaining their role. This is good practice.

5.10 Further activity takes place across the diocese which fosters meaningful conversations, allowing opportunities for staff to develop and share good practice. Such activity has included the DSA and ADSA presenting to Churchwardens about their roles and that of the DST and facilitating PSO network meetings. Other PSO-led initiatives have also proved to be creative including the development of a parish-held safeguarding quiz and activity associated with 'Safeguarding Sunday'.

5.11 There are a range of opportunities for staff to develop, share good practice and learn from others beyond the diocese. These include the regional and national networks that have been established and are attended by the Diocesan Secretary, Diocesan Communications Officers, the DST, the DSAP Independent Chair and the Bishops. The DSA also attends the Worcestershire Safeguarding Adults Network meetings and the Bishop of Dudley is a member of the Dudley Health and Wellbeing Board and an Aspiration Ambassador for Dudley's Healthier Safe Communities.

5.12 The Audit recognises that effective communication about safeguarding is key, with people requiring information at different stages, in different formats and in different locations depending upon their requirements. In this respect, the DBF is active in promoting and raising awareness about safeguarding and the different types of harm that people can be exposed to. It deploys both traditional and digital communication methods, with previous topics having focused upon financial fraud, modern day slavery and church related abuse. As an example of traditional approaches to communication, there is widespread use of


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posters and the DBF has introduced printed, wallet sized 'Z' cards. These are made available to all parishes with the cards signposting to diocesan and statutory safeguarding contacts. This is good practice.

5.13 The DBF makes good use of digital communications in the form of newsletters, online news articles, social media feeds and video conferencing to facilitate regular PSO meetings. The Audit saw an innovative approach to providing administrative support and assistance (of a non-confidential / non-sensitive nature) to PSOs via a dedicated email inbox managed and overseen by experienced PSOs.

5.14 The Diocese of Worcester website is central to communication within the diocese. 'Safeguarding' is a sub-section within the website and the associated pages are coherent and well presented. The website's theme is clean, mobile-responsive and easy to navigate through a primary and secondary menu. Webpages have clearly been designed with the user's needs at the forefront, providing a wide variety of material and information. This ranges from signposting (including external agencies), access to training, safer recruitment guidance, survivor care and a recently developed Safeguarding Policies and Parish Resources library. This is good practice.

5.15 In respect of the resource library for parishes, there was a collaborative approach in its design, with the experiences and views of users steering the development of this useful asset. Indeed, one PSO told the Audit that the resource library "*has been a massive, positive transformation in the last 12 months.*"

5.16 As with all good communication, this needs to be a two-way process. Actively seeking and responding to the views of children, young people and vulnerable adults is a key component of effective prevention planning and practice. The Audit saw evidence of the DBF facilitating spaces to hear the views of children and young people and seeking their


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input, such as through engaging them in the recruitment process for children's and youth workers. The Audit is aware that the DBF has previously hosted a Children’s and Youth Council and supports the DBF in its intention to develop further initiatives to cultivate youth participation.

5.17 During the site visit, Auditors engaged with a range of young people and staff from a local youth group. The group leader, who also serves as the Chaplain at a nearby school, has played a significant role in attracting children to the youth group through her interactions at the school. Many of these children presented with additional needs and challenges, which were managed appropriately during the visit. Staff have undergone safeguarding training and DBS checks.

| **Recommendation D10:** The DBF should consider new models for youth participation in consultation with its growing network for those employed as Children and Youth Workers. |
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5.18 Strong relationships between the staff and children, as well as among the children themselves, were evident. The smaller group size has been beneficial, allowing these children to thrive in an environment where inclusivity and acceptance are clearly celebrated. The young people expressed that they felt safe within the group and knew which adults to approach if they needed help. The Auditors noted the presence of child-friendly posters around the venue, and positively, the young people engaged by the Audit Team were able to recall both the locations and the content of these posters.

5.19 The Curate described the relationship with local schools as 'symbiotic', and discussions with key staff revealed a preference for maintaining the current group size to preserve this supportive environment.

5.20 In respect of hearing the voices and learning from the experiences of victims / survivors of abuse, see the Victims and Survivors section of this report.


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5.21 In terms of preventing harm to staff and volunteers, the DBF has a Lone Working Policy and a lone working risk assessment in place. Equivalent material is available to parishes. Section 11.1 of the Parish Safeguarding Handbook outlines a 'code of safer working practice', which is easily accessible through the diocese's website and has been issued by the DST to parishes as a stand-alone document.

5.22 The DBF recognises the need to raise awareness about safety as it relates to the 'structural environment' of the Church, involving its buildings and surroundings. PCCs are directed to the 'Parish Safeguarding Handbook' and 'Safe Environment' documents which offer guidance and support about managing risk in this context.

5.23 The Audit also saw evidence of safeguarding being considered in a broader sense within the physical spaces being occupied. For example, an article on the Diocesan website 'Taking great Church photos', highlights the importance of seeking parental consent when publishing images of children was highlighted.


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# 6 Recognising, Assessing and Managing Risk

6.1 The DBF has in place a range of mechanisms that support the recognition, assessment, and management of risk across the diocese. These include the appointment of a skilled and diverse DST, the adoption of the national case management system and the implementation of safeguarding policies, training programmes, recruitment procedures and awareness initiatives. Clear and established reporting pathways exist and overall, the DBF's arrangements increase the likelihood of risk being identified and there being effective and timely interventions.

6.2 The DBF maintains an operational and regulatory risk register, with the most recent updates being in 2023 and 2024 respectively. They cover key corporate issues, are structured coherently and include relevant issues that cover the broad range of the DBF's functions. Whilst It is clear annual reviews take place, the Audit believe this process could be strengthened; firstly, by recording the next review dates on registers and secondly by implementing a process whereby register owners assess cross organisational risk on a quarterly basis.

6.3 Of relevance to safeguarding, both highlight risks relating to the recruitment and retention of volunteer roles in parishes, including PSOs. Concerns in this context were raised directly with the Audit and whilst challenges remain, it is positive that leaders are sighted on this risk and have recognised the need for ongoing focus and improvement.

6.4 The Audit also noted that the regulatory risk register identifies the inherent uncertainty surrounding the future landscape of safeguarding provision, particularly in light of the Independent Inquiry into Child Sexual Abuse (IICSA), the Wilkinson and Jay reports. The consideration of wider contextual issues is good practice.


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6.5 In the Audit's opinion, there is an opportunity to further strengthen existing processes by developing a stand-alone safeguarding risk register. This would help to facilitate a more acute focus on safeguarding and allow the DBF to articulate and mitigate risk as it correlates to the national safeguarding standards.

| **Recommendation D11:** The DBF should include the review dates on risk registers. Risks should be reviewed on a quarterly basis by register owners to assess cross organisational risk particularly in the event of significant changes to workplace processes. |
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| **Recommendation D12**: The DBF should develop a standalone safeguarding risk register to facilitate a comprehensive analysis of safeguarding matters. Risks should be identified and defined against the National Safeguarding Standards. |
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6.6 As part of the DST's approach to triaging concerns, the DSA sensibly applies a 'low threshold' to encourage reporting. Evidence of this is reflected on the MyConcern Case Management System (CMS). This has helped the team to build relationships with those in safeguarding roles, and promote behaviours where concerns are more likely than not to be escalated to the DST. The receipt and screening of lower-level concerns ensures the DST has oversight on cases where the risk may not be properly understood by the reporting person.

6.7 This process is further strengthened by the availability of a specific safeguarding referral form, covering key points such as the timescale of events, who has been notified and the reason behind the concern. It provides a specific email address for return and emphasises confidentiality. This is good practice.

6.8 The DST makes good use of the risk grading function on MyConcern. Cases are allocated a risk level of 'high', 'medium' or 'low'. This could be strengthened by detailed recording of


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the rationale for the risk grading and prioritisation of cases, alongside there being clear timescales for actions and the review of these.

**Recommendation D13:** As part of the triage process, the DSA should record the rationale for risk grading and the prioritisation of cases, alongside specifying timescales for action and any review of progress.

6.9 The Diocese of Worcester was the first diocese to work with the national project team to manually onboard their own data under a revised system. This was designed to speed up migrating dioceses to the national case management system. This work commenced in January 2024 and was completed in June 2024. It is appropriate to acknowledge that this added to the workload of the team.

6.10 The Audit recognises the challenges with MyConcern, both in terms of the national system itself and the application of its functionality. For example, (as highlighted in Audit reports for other Church Bodies) some of the system's terminology is outdated and user requirements could be enhanced to meet the specific needs of the CofE safeguarding arrangements.

6.11 There are some local frustrations that the system is 'slow' but the Audit saw good evidence that it is being used effectively. Members of the DST attend national user meetings to provide input and receive regular updates. This serves as a channel for raising problems and proposing ideas for change.

6.12 At the time of the Audit, there were 73 open cases recorded on MyConcern. Each case had been assigned a risk level, with 50 graded as 'low' risk, 22 as 'medium' and 1 as 'high.' 57 cases had been filed and closed on the system.


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6.13 Of the open cases, 55 were not allocated to a named individual on the *Concerns Dashboard*, but to an 'owning group', namely the DST. The absence of an identified worker on this dashboard has the potential to confuse accountability and responsibility for case management. Whilst entries in the chronology section appeared to indicate a case owner, the dashboard homepage should reflect this. This will also allow for the more effective monitoring of workloads allocated to DST members.

**Recommendation D14:** The MyConcern CMS dashboard should reflect a specific case owner for each open case as opposed the generic 'owning group'.

6.14 With regards to the core processes engaged by the DST, the Audit saw evidence of good practice. This included a multi-agency approach with statutory agencies, the convening of safeguarding case management groups (formerly referred to as Core Groups), strategy meetings, risk assessments, support for persons of concern and consideration of wider issues such as the impact of safeguarding incidents on the worshipping congregation.

6.15 However, as previously set out, practices could be further strengthened with improved recording on MyConcern demonstrating management oversight. A small number of cases seen by the Audit did not reflect the level of detail that would be expected. Notwithstanding the fact that the Audit recognises the level of demand and other pressures (including the Audit itself) on the DST, case recording is critically important and must be prioritised.

**Recommendation D15:** Supervision entries should be recorded by the DSA on MyConcern, They should follow a consistent format and be uploaded on at least a monthly basis. This format should ensure the DSA can clearly record the rationale for any decisions they have taken on a case, including case closure.


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**Recommendation D16:** The DSA should be afforded time to complete extra training on the use of the MyConcern national case management system.

6.16 Outcomes of cases brought to the attention of the DST typically involve one or more of the following:

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 Clergy Disciplinary Measures (CDM)
e) Initiation of the Safeguarding Case Management and Early Intervention Action Group procedures.

6.17 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.

6.18 The DST has significant offender management experience within its team and works closely with relevant statutory agencies. At the time of the Audit, there were 21 respondents categorised as having active safety plans on MyConcern. The Audit saw good use of these plans in managing risk. This included a multi-agency approach, the setting of explicit prohibitions / expectations and regular reviews which were documented and signed by relevant parties.

6.19 Safety plans adhered to the national template issued by the CofE, although the Audit noted here (as it had in previous Audits) the limitations of this in not taking account of respondents attending other churches or church establishments. The Audit will raise this with the NST.


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6.20 As examples, the Audit saw good use of a safety plan for an individual who had not committed a criminal offence but had been subject to a disciplinary process in a previous employment.

6.21 The Audit also saw one safety plan that did not direct the respondent to refuse or inform the Incumbent of any invitations from parish members to attend their homes where children may be present. The accompanying risk assessment in this case appropriately identified that the respondent may form relationships within Church that would bring them into contact with children, but the above scenario did not transfer to prohibitions on the safety plan. The Audit will also raise this issue with the NST for consideration in the CofE guidance and template.

6.22 The Audit was advised that reviews of safety plans with respondents have taken place over a phone call. Whilst recognising the ease of this method, the Audit believe it diminishes the seriousness of the process and reduces the ability for an in-depth assessment of the existing arrangements. The Audit discussed this with the DST who acknowledged that reviews should be completed during a face-to-face meeting with relevant attendees.

| **Recommendation D17:** The review process for respondents on safety plans should be completed in person with the relevant personnel in attendance. |
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6.23 The DST facilitated a meeting for the Audit with an incumbent from a local parish and a respondent who is subject to a safety plan. This was welcomed by both parties and allowed the Audit to explore the safety plan process in more depth. The respondent voiced their understanding of the reason for the monitoring arrangements and expressed their appreciation of the support being provided. The Incumbent was very clear about their role


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in escalating safeguarding concerns or queries to the DST, and whilst there was clearly a good professional relationship with the respondent, both acknowledged relevant risks and expressed confidence in the process.

6.24 The Audit was also made aware that a respondent to a safety plan had requested a character reference from their incumbent to apply for a job. Following consultation with the DST this was declined. The Audit consider the escalation of this matter to the DST as good practice.

6.25 Whilst the Audit recognises that training related to offender management is a national issue, more effective training should immediately be made available to those who work directly with respondents (again, this has been highlighted in previous Audit reports). This is particularly relevant for those working with sex offenders, who in the experience of the Audit, tend to manipulate, minimise, self-justify and blame others for their behaviour. Further information can be found in the Learning, Supervision and Support section of this report.

6.26 Safeguarding Case Management Groups (SCMG) are routinely chaired by Archdeacons. On occasions, the Bishop of Dudley has chaired these meeting, specifically in cases involving members of the clergy. The DSA no longer chairs these meetings and considering their role in the supervision of case management, the Audit acknowledges this as a sensible arrangement. Whilst comments to the Audit indicated there can sometimes be difficulties in convening a SCMG due to diary demands, the Audit was reassured of swift action in cases of an urgent nature.

6.27 In one case, the Audit saw evidence of authoritative decision making, resulting in the investigation and timely suspension of a person of concern. The group actively considered the support needs of all parties, identified the need for a prompt referral to the Local


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Authority Designated Officer (LADO) and kept detailed records. There was also evidence in a safeguarding case management meeting of a decision resulting in an independent and external safeguarding risk assessment about a member of clergy and their suitability to officiate. This is considered good practice.

6.28 There is a Service Level Agreement (SLA) for safeguarding services between the DBF and the Dean and Chapter of Worcester Cathedral. The agreement clearly articulates safeguarding arrangements stipulating that *'on safeguarding matters the Dean and Chapter of Worcester Cathedral are obliged to take the advice of the DSA.'* The SLA has not been formally updated as the Cathedral are waiting to appoint a new Cathedral Safeguarding Officer (CSO), but sensibly, arrangements regarding support from the DST remain in place (note Recommendation D8, that the Audit has recommended that this role be a CSA professionally line managed by the DSA / DSO).

6.29 The DBF has a number of national information sharing agreements (ISAs). These include the national data sharing agreement with the police, an ISA between the CofE and Church of Wales and a local ISA between the Probation Service and 3 nominated parishes as part of the Welcome Project. There are currently no ISAs in place with local authorities.

6.30 The Audit was advised that on occasion there can be challenges with receiving timely information from statutory agencies due to data protection legislation, and therefore they maximise the use of their professional contacts to speed up processes. The DST demonstrated their awareness of the existing SLAs.

6.31 A national initiative, the *Welcome Project*, was piloted by the DST, the Diocesan Criminal Affairs Group and three parishes. The project is designed to enable the participants to work with HM Prison and Probation in supporting offenders (whose offences may not reach the threshold of requiring a safeguarding response to attending Church). An information


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sharing agreement is in place and whilst it has yet to be utilised as much as the DST would like, this is considered good practice.

**Recommendation D18:** The DBF should engage the Local Safeguarding Children Partnerships and Safeguarding Adult Boards to explore the possibility of developing either a partnership ISA and or bi-lateral ISAs with relevant agencies with whom it is regularly engaged.

6.32 The DBF is a registered charity with a statutory requirement to submit Safeguarding Serious Incident Reports (SIRs) to the Charity Commission. The potential for a breach of charity law features in the regulatory risk register and the Audit was advised that the DBF follows the House of Bishop's national guidance. One case was provided to the Audit which had met the threshold for a Safeguarding SIR.

6.33 The DBF has a defined escalation process in place to manage differences of opinion about safeguarding concerns and has recently implemented an 'Early Intervention Group' (EIG) process to discuss cases where it is unclear whether a referral requires a safeguarding response or not. These groups were a key recommendation from an LLR. The EIG is designed to be light touch and responsive. These groups consist of one or more senior clergy, someone from HR and a member of the DST.

6.34 There are six weekly supervision sessions for the DSA with the NST regional lead. The '4x4x4' supervision model provides a structured framework for the DSA. The Audit was informed that its success relies on a good rapport and commitment between and from all parties involved.

6.35 The DSA elected to give the regional lead full access to MyConcern to allow for the dip sampling of cases. This demonstrates transparency and is considered by the Audit as good practice. That said, there are limitations in that the NST lead cannot make entries on the system and the effectiveness of this approach has not been tested. The discussions


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around case management tend to focus on the more complex cases taken by the DSA. There is therefore no oversight or scrutiny regarding lower-level cases to quality assure decision making and relevant actions. That said, the Bishop of Dudley has a 4-6 weekly line management supervision with the DSA and is briefed on cases that are closed which provides additional scrutiny.

6.36 Supervision notes from the meeting with the NST Regional Lead are kept by the DSA. The DSA recognises the sharing of any learning from these sessions would strengthen the supervision process with the ADSAs, but capacity remains an issue. The Audit have been advised that supervision records are now placed in case records on the MyConcern system which will allow access to users.

**Recommendation D19:** Learning points identified through supervision sessions between the DSA and NST regional lead should be recorded under the lessons learned tab on the MyConcern system to allow ease of access to information.

**Recommendation D20:** Referred cases resulting in no further action / and or provision of advice and guidance should be included as part of the supervision discussions between the DSA and the NST regional lead. This issue has been raised by the Audit with the NST.

6.37 Supervision for the DST is linked to personal development portfolios that enable reflection and forward planning. This is good practice.

6.38 The DSA provides line management and support to members of the Safeguarding Team through regular monthly meetings, fortnightly case catch up sessions, and frequent check-in conversations. The implementation of a more structured system would strengthen this approach.


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**Recommendation D21**: The DSA should implement formal / individual supervision sessions with the ADSAs to enhance in-depth discussions about cases and adopt a consistency of approach for management oversight. The recording of such sessions and any related case actions should be uploaded to MyConcern.

6.39 The storage of personal information held by the DST on MyConcern is compliant with data protection legislation and the UK General Data Protection Regulations (GDPR). A breach of GDPR is listed as a corporate risk on the regulatory risk register. The Audit was told this forms part of the induction process for all staff who must sign a GDPR contract, acknowledging they have read the Data Privacy notice and the data protection arrangements in the DBF employee handbook. Current arrangements extend to secure practices that involve the use of password protection, Microsoft SharePoint and a CofE Worcester email address. The Audit consider this good practice. Findings from the Audit's survey indicate that the overwhelming majority of the DBF's workforce and the majority of those in parishes are aware of the diocese's privacy policy in respect of data protection.


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# 7 Victims and Survivors

7.1 For many victims and survivors, living with the abuse they have suffered can be deeply traumatic. Few may disclose abuse at the time it takes place, perhaps (in child abuse cases) because they did not know that what was happening was wrong, they had no-one to turn to, they were ashamed or simply afraid about the consequences of speaking out.[2] Disclosing abuse can feel overwhelming, unfamiliar, and incredibly challenging.[3] It is in this context that Church bodies must create and maintain healthy cultures to ensure that victims and survivors will be heard, taken seriously and that help, and protection will be effective.

7.2 The Audit gathered feedback from victims and survivors in the diocese through an anonymous online survey. Results and findings were largely mixed, pointing to the range of individual experiences. That said, it is positive that most respondents were in agreement they would 'encourage a friend to report abuse if it happened to them' and also that they 'would report a safeguarding issue if it happened again.'

7.3 The DBF follows the House of Bishop's '*Responding Well to Victims and Survivors of Abuse*' policy. Feedback from victims and survivors supports that there was a high level of awareness of the CofE's safeguarding policies and procedures before they reported their abuse.

7.4 From a leadership perspective, there is a clear recognition of the importance of prioritising a good and immediate response to victims and survivors. To help do this effectively, the DBF is currently developing a Survivor Strategy that is scheduled for completion by the

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


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end of 2024. Whilst this has been subject to a delay (and the DBF acknowledge it has not progressed at the pace intended), the initiative itself is positive and the Audit supports its implementation.

**Recommendation D22**: The DBF's Survivor Strategy should;

- Set out the diocese's strategic aims and key priorities in respect of victims and survivors.
- Include collaboration and consultation with victims and survivors (see Recommendation D23).
- Be developed in conjunction with the Cathedral and take account of its particular circumstances.

7.5 The DST is cognisant of the need to engage, listen and critically learn from victims and survivors. Minutes and associated papers from a recent Operational Safeguarding Group meeting evidence the steps taken by the DST to hear, learn and amplify the voices of victims and survivors. An anonymised summary of a case provided opportunities to reflect and learn from the experience of a survivor of non-recent church-related abuse.

7.6 Accruing a range of mutual benefits, working partnerships with groups who have experienced Church-based abuse could help to further extend the DBF's aspirations. Objectives of such groups could include defined co-production and consultation on materials and support provided to survivors, alongside insight into areas of learning, development, training and overall improvement activity.

**Recommendation D23**: The DBF should scope and plan how to formalise engagement, consultation and collaboration with victims and survivors. Such engagement should be meaningful, trauma-informed and in accordance with '*Responding Well to Victims and Survivors of Abuse.*'


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7.7 There is evidence of a relational and person-centred approach by the DST when engaging with victims and survivors. Practice in this respect was described by one victim / survivor as 'trauma-informed', with others commenting on the support, compassion, and sensitive manner in which they were engaged by the DST.

*"I felt listened to, safe and supported"* - Victim / Survivor

*"I was given the fullest possible support. I was never made to feel this was not their [DST's] responsibility"* - Victim / Survivor

7.8 The arrangements in place across the diocese provide a range of support to victims and survivors of church-related abuse and the Audit saw evidence of excellent practice. In one case, the Audit saw the support offered to a victim / survivor of non-recent abuse. This individual spoke highly of the DST and expressed how the DSA "*came across as professional and deeply caring…I got the impression she was independent [from the Church]."* They had received support from statutory agencies, the two national CofE initiatives - Safe Spaces and the Interim Support Scheme, as well as funding for specialist therapeutic support. Whilst a personal apology from the Bishop of Worcester was offered and space was provided for the individual to reflect on this, they decided it wouldn't be appropriate to receive an apology from someone (the Bishop) who ultimately was not connected to the (non-recent) abuse which occurred. That said, the individual elaborated that this was notwithstanding all the work they did with the DSA and the ADSA, which was much more positive than receiving an apology.

7.9 The Diocese of Worcester's website contains a range of signposting material and advice. This includes key contact details, access to the Diocesan *Authorised Listening (AL)* Service, reporting routes, further resources and contact details for support organisations. Whilst there is positive practice in this respect, the Audit believes this webpage could be strengthened and makes the following recommendation in this respect.


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**Recommendation D24**: The DBF should review and update as necessary the '[Survivor Care and Support'] webpage. This should consider:

- What are the needs of those visiting the page.
- Content hierarchy – what is the most critical information and ensuring that it is arranged accordingly.
- Is all relevant material and information available (e.g. the provision of hyperlinks to '*Responding Well to Victims and Survivors of Abuse*')

This should include collaboration and consultation with victims and survivors.

7.10 The Audit is aware of the various harms people can suffer, including that of spiritual abuse.[4] While this is a complex area and knowledge across the Church continues to develop, the Audit saw a small number of examples (both recent and non-recent) where faith-based approaches of 'forgiveness' and 'repentance' appeared to be misguided and failed to consider potential risk.

7.11 One such application of 'forgiveness' demonstrated the misconception of a parishioner that 'forgiveness' meant 'restoration', where everything goes back to the way it was before (without the need to manage or mitigate potential risk). Such examples typify the challenges faced by safeguarding professionals who operate in an environment where the context is driven by faith, the belief in redemption and the desire to forgive. Indeed, the DBF has undertaken activity to develop knowledge and more deeply understand spiritual abuse across the diocese and this is addressed further in the Learning, Supervision and Support section of this report.

7.12 The DBF reported that there are no specific challenges in accessing local support services.

[4] https://www.churchofengland.org/safeguarding/safeguarding-e-manual/safeguarding-children-young-people-and-vulnerable-adults/42


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# 8 Learning, Supervision and Support

8.1 The DBF appropriately prioritises safeguarding training and is committed to the provision of learning opportunities that positively impact upon the workforce across the diocese. Supported by a defined strategy, the training programme in place is aligned to the national framework and efforts continue to ensure robust compliance. This strategy includes a focus on training needs, the local plan and the mechanisms for evaluation and review. The strategy also includes a risk register setting out the key issues that could potentially inhibit work in this area.

8.2 Feedback to the Audit on the general administration, quality and delivery of safeguarding training has been generally positive, with impact being seen in the high confidence levels expressed by many in the Audit's surveys. That said, there are a range of ongoing pressures, legacy problems from previous poor record keeping and areas for potential improvement.

8.3 For example, whilst the DSA, ADSAs and the Programme Lead for Children, Young People and Families manage delivery between them, the Audit believes a single training role in the DST is likely to accrue benefits. Such a role could help with consistency and the underpinning leadership in this area of work. There is also likely to be a greater degree of flexibility, with scope for the post holder to develop more local opportunities to learn (beyond the NST programme) and to broaden capacity for deeper evaluations. Such arrangements have been seen by the Audit to operate successfully in other DBFs.

8.4 As outlined in the Victims / Survivors section of this report, the DBF have provided additional learning opportunities for Spiritual Directors to develop their knowledge, skills and responsibilities to act in relation to spiritual abuse. While this is good practice, the Audit believes that this approach could be further strengthened.


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**Recommendation D25**: The DBF should:

a. Include and facilitate the exploration of the themes of 'forgiveness' and 'repentance' within the spiritual abuse training.

b. Offering the Spiritual abuse training more widely in the diocese to include clergy and Church Officers.

8.5 With regards to training delivery, most sessions are made accessible online and whilst many people are supportive of this approach, some participants were noted as continuing to struggle with online training. The Audit was told by some staff and volunteers about the improved effectiveness of face-to-face training when it allows for more interaction through participant engagement and trainer input.

8.6 Some positive steps have been taken by the DBF in response to these issues, such as using PSOs to help deliver face-to-face training and leadership sessions. However, these arrangements are ad-hoc, with capacity remaining a barrier to a more structured approach. An additional ADSA role with a dedicated training portfolio is likely to bring added value. This would help to address capacity, facilitate more early help and frontline engagement via direct delivery of training. It would also provide a more coherent approach to supporting the volunteer pool of PSO trainers. See Recommendation D8.

8.7 The DBF operates an evaluation process to assess the training impact on practice, outcomes and behaviour. As part of this process and evidencing good practice, trainers have been collecting participant responses to a '*culture audit'* completed at the beginning of the leadership course. It is positive that the DSA intends to have some participants retake the culture audit a year later to assess changes in responses and that trainers have modified the feedback questionnaire to combine course feedback with evidence of impact.


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8.8 These changes were submitted to the National Safeguarding Learning and Development Manager to ensure they adhered to the core elements of the national training pathway. Not only were the changes accepted, but the manager also requested to add the way the culture audit had been set out and the case study to the training portal as exemplar resources for other DBFs. Results from the culture audit are used to identify focus areas for training and provide feedback to senior leaders about participants' perspectives.

8.9 This finding is interesting when compared to the Audit's workforce surveys, which recorded that most respondents reflected high confidence levels in the safeguarding culture at the diocese, their ability to raise concerns (without there being a fear of reprisals) and for the DBF and parishes, that they believe that leaders listen carefully. This might illustrate an improving picture in some regards, although there are obvious barriers for some of the workforce. Whilst noting capacity pressures are hindering evaluation and follow up of the culture audit, it is important that this maintains a strong profile and that the DBF seeks to further develop its understanding of what more it can do to improve trust and confidence. See Recommendation D1.

8.10 With regards to training evaluation more generally, there is no coordinated overview of the other courses being delivered across the diocese. This leaves a gap in the DBF's local understanding about whether training (whoever delivers it) is directly influencing practice and making people safer. As a potential solution, the workforce (including volunteers and their managers) should be approached three months after training has taken place to establish how the training has influenced their practice and to capture evidence of the impact that it has made.

| **Recommendation D26:** The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers about how training has helped their practice. As part of this process questions about unmet training needs should be asked. |
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8.11 Oversight of training is an area of scrutiny and features as a topic at Bishop's Council, DSAP and the Operational Safeguarding Group. Within these forums, training data is considered, as are issues impacting upon compliance and resourcing. Current information shows an increase in uptake with online training, although challenges continue to exist in some parishes, with ongoing encouragement attempting to facilitate improved compliance. Whilst this is recognised by the DBF, the Audit recommends further scrutiny is applied in this context.

**Recommendation D27**: The DBF should identify whether there are any particular members of the workforce including volunteers with poor training compliance. Depending on the outcome, bespoke strategies should be developed to encourage and improve attendance. The DBF should consider engaging their NST Regional Lead to establish whether good practice in this regard has been developed elsewhere.

8.12 There are a range of resources in place across the diocese to assist members of the clergy. Feedback to the Audit via surveys and interviews demonstrated that they feel well supported. This manifests in briefings on wellbeing by the Archdeacons, access to counselling, and other policies such as compassionate leave.

8.13 Ministerial Development Reviews (MDRs) also support the clergy by helping them to reflect, learn and improve. Locally, these are led 'in-house', take place routinely and identify areas for growth and development. The focus on safeguarding as part of this process is an area for the DBF to consider further. For example, in some dioceses previously audited, the MDR preparation framework includes questions covering training requirements and how clergy members are contributing to a good safeguarding culture, a focus on victims and survivors and how they ensure people feel able to challenge.


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8.14 Whilst positive, MDRs could go further and be more explicitly aligned with the national safeguarding standards. Improving the preparation documentation and the facilitators evaluation form in this way could help concentrate reflection about what is working well, the outcomes being achieved and future areas for growth and development across all aspects of the standards.

**Recommendation D28**: In consultation with the DST, the MDR process should be reviewed, and amendments made for safeguarding prompts / questions and recording within the preparation and the evaluation forms to fully align with the national safeguarding standards.

8.15 The DBF has an established induction process that includes safeguarding, delivered through pre-read materials and targeted one-to-one meetings with key role holders. Parishes are responsible for their own appointments and induction is mandatory before church officers engage with children, young people, and adults at risk across the diocese.

8.16 DBF staff are expected to complete safeguarding training relevant to their roles by the second week of their appointment. Training for the DBF also covers key systems such as the Contact Management System (CMS), Microsoft Teams, Safer Recruitment (if needed), unconscious bias, Modern Slavery, and Cyber Security.

8.17 In response to the Audit's parish workforce survey, just over one third of staff and volunteers confirmed they had received an induction on starting in their role. Some will have been in post for many years, and weaker arrangements at the time of them joining the Church are likely to be affecting this result (or confusion as to what constitutes induction or training). Regardless, the DBF should seek to further promote its expectations in this respect to ensure there are clear induction processes for all new staff and volunteers within parishes.


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**Recommendation D29:** The DBF should promote awareness across all Parochial Church Councils (PCC) about the importance of induction events for new staff and volunteers.

8.18 There is both in-house and external routes available to the DST that allows for accessible advice and support. For example, the DST uses established contacts with the NST, local authorities, police and probation services, and there is an appetite for maintaining relationships in this context.

8.19 There is also an enthusiasm for learning within the DST itself, with the team attending a range of Continuing Professional Development (CPD) opportunities, including those offered by the NST. The DSA actively participates in network meetings run by the Worcestershire Safeguarding Adults Board (WSAB) and has previously engaged with the Worcestershire Safeguarding Children's Board (WSCB), presenting on the Church's efforts against Modern Slavery.

8.20 However, the WSCB meetings ceased on the implementation of new safeguarding children partnership arrangements, and the LADO had to withdraw from DSAP meetings. From a safeguarding children perspective, there are likely to be benefits in seeking to re-establish more formal engagement with key partnership forums.

**Recommendation D30:** The DBF should engage in discussions with relevant safeguarding children partnerships about the potential for Church Officers to be formally engaged in their arrangements (as relevant members of key groups / sub-groups).

8.21 As identified in other audits (and supported to a degree via the DBF's own culture audit), given the DSTs workload and its routine exposure to trauma, psychological support should


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be more defined within the DST's support systems. By this, the Audit believes that routine access to such support should be an expectation as opposed to 'available on request'.

| **Recommendation D31:** 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. |
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# Part Two - Worcester Cathedral


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# 9 Context

9.1 The Cathedral Church of Christ and Blessed Mary the Virgin of Worcester, has a rich history dating back to the 6th or 7th centuries (although the current building was not consecrated until the 11th Century). With roots in the Monastic Foundation and following Benedictine Rule, the Cathedral became a significant place of pilgrimage during the Middle Ages. It was from this Monastic tradition that the first dean and canons were appointed, ensuring continuity in theology and everyday cathedral life.

9.2 Worcester Cathedral is located centrally and overlooks the banks of the River Severn. The Cathedral's commitment to environmental sustainability has been rewarded with a Silver Eco-Church award and it is currently in the process of applying for the Gold.

9.3 The City of Worcester has a population of approximately 104,000 residents, with many attractions, an abundance of green spaces and the University of Worcester. There were 181,655 visitors to the Cathedral last year, with a weekly average of nearly three and a half thousand. Those engaging in worship (through Sunday service) average 227 a week, with the midweek figure standing at 217 attendees. These numbers encompass both regular and more transient visitors.

9.4 At the time of the Audit, the Cathedral was recognised as being in a period of significant change. There have been substantial personnel changes, leading to a loss of many long serving members of staff holding vital institutional knowledge. This has created a significant impact on safeguarding in terms of capacity and some confusion about roles and responsibilities. The Cathedral is currently in the process of recruiting a new Cathedral Safeguarding Officer (CSO) and improving its systems and processes. Support from the DST is ongoing and of benefit.


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# 10 Progress

10.1 The Independent Social Care Institute for Excellence (SCIE) safeguarding audit of the Cathedral was published in March 2021 and resulted in **28** recommendations. In terms of the Past Cases Review 2 (PCR2) process, whilst opting to be involved in the Diocesan review, there were no specific recommendations arising for the Cathedral. Since 2015, there have also been three LLRs commissioned in relation to the Cathedral.

10.2 All **28** SCIE recommendations were accepted by the Cathedral and an action plan was developed to define and track improvements. This first version was last updated in March 2023. The Audit saw evidence that demonstrated effective oversight at Chapter, Cathedral Safeguarding Committee (CSC) meetings and in reports to DSAP. The format of the initial action plan was recently updated, and a new Safeguarding Action Log has been implemented. This is RAG rated, comprehensive, covers all considerations, references well to sections of the report and includes improvement and impact of actions taken.

10.3 The log highlights that all recommendations have either been met or integrated into other workstreams. The only recommendation marked as unmet involves the arrangements and oversight of the Junior Church. The Junior Church is not currently functioning, and it has been agreed to revisit this action once the new Dean is in post.

10.4 The LLRs undertaken by the Cathedral did not result in any formal action plans. That said, the DSA feels that progress is being made at the Cathedral in light of the identified learning, such as that relating to information sharing and case management.

10.5 Whilst there is evidence of progress in many areas, staff turnover, two serious cases and a lack of resource has hindered the overall pace of developments. That said, the


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forthcoming appointment of a CSO / CSA, and the good working relationships with the DBF, provides reassurance that leaders at the Cathedral can take the steps that need to be taken.


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# 11 Culture, Leadership and Capacity

11.1 The Cathedral has experienced significant turnover in staff over the last few years. Information seen by the Audit indicates that 60% of staff have been in post for less than five years, 30% for less than two and 20% have yet to complete a full year. Recognising this flux within its workforce, leaders at the Cathedral have prioritised the development of staff relationships by creating opportunities for them to meet with each other more regularly. This has included informal ad-hoc discussions at all staff meetings in which individuals and groups are encouraged to constructively engage and inform the building of a positive culture.

11.2 That said, stubborn challenges remain with regards to how the Cathedral is perceived by some. Whilst the Audit saw and heard evidence of a collaborative and supportive culture between senior leaders and the management team, and indeed surveys reflected many positives, a number of respondents across the workforce and worshipping community highlighted that they believe that there is still work to be done. Indeed, when asked if they thought a safeguarding culture was now embedded, just over half of the Cathedral's workforce and fewer from the worshipping community (who responded to the survey) believed that it was.

11.3 However, most people felt safe amongst their colleagues and within their worshipping communities and there was almost unanimous agreement to the statement; '*it is everyone's responsibility to report safeguarding* . This is positive.

11.4 Four children and young people surveys were completed and three respondents provided feedback of a negative nature across all questions. This included them reporting not feeling safe, not being able to talk to a trusted adult if they felt uncomfortable, worried or upset


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and not feeling listened to. Each of the three negative responses came from the same IP address and in the Audit's opinion, reflected adult terminology. However, several young people could have completed the survey together using the same device or from the same location, so the concerns should be taken seriously. They should also be used to inform the Cathedral's focus on children and young people going forward.

11.5 Critically, this activity needs to reinforce, and where necessary strengthen, the trust and confidence held by young people in the Cathedral's broader safeguarding arrangements. It will be important to continue to raise awareness and signpost the safeguarding leads to whom people can turn if they have any concerns. Whilst many of those who engaged with the Audit said they could identify safeguarding leads, some could not. That said, it is worth noting that the current Safeguarding Lead only took up their role in March 2024.

| **Recommendation C1:** The Cathedral must engage in meaningful and evidence-based approaches to establish the culture within its staff, volunteer and worshipping communities. In doing so, it should seek feedback that reflects what their stakeholders think could or has made a difference. Such an approach can involve snapshot and deep dive surveys, internal focus groups and the use of third-party professional facilitators. Detailed reports on the outcomes of such work should be shared with Chapter and the DSAP to help develop action plans that drive improvement. |
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11.6 An Auditor visited the Cathedral in the lead up to the Audit. The visit was informal and unannounced. Those who engaged with the Auditor as part of this visit did so voluntarily. The staff and volunteers who were engaged were friendly, informative and during conversation they provided detailed and reassuring answers about their approach to safeguarding. They did not know they were speaking with an Auditor and their conduct was exemplary. They reflected good practice.


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11.7 Whilst evident that there is work underway to build relationships and embed safeguarding in practice, the Cathedral's journey of improvement is ongoing. That said, there is a level of optimism and the distributed leadership across the Cathedral will play a key role in driving a positive safeguarding culture. The new Dean has a clear understanding of the tasks ahead and is committed to working with senior leaders, staff, volunteers and the worshipping community to deliver change.

11.8 There is good evidence of a collaborative approach at the Cathedral. The Chief Operating Officer (COO) regularly attends both DSAP and the diocese's Operational Group for Safeguarding (OGS), whilst Cathedral representatives engage on safeguarding frequently and routinely with King's School. Furthermore, the Dean (in his previous role) has worked on developing guidelines for managing the homeless and has pushed to make Safeguarding Sunday an '*ingrained gift*' in the Cathedrals approach rather than a tick box activity.

11.9 Accountability for safeguarding is understood and unambiguously accepted by the Dean. In this context, the Audit heard and saw evidence of appropriate and authoritative practice. Furthermore, minutes of Chapter and CSC meetings clearly evidence that in his previous role, the Dean was an active and thoughtful participant who developed a deep understanding of safeguarding in practice.

11.10 Overall, those in key roles understand the scale of the task ahead and in interviews demonstrated an appetite to listen to the Cathedral's staff, volunteers, worshippers and visitors. Each was able to explain how their role relates to safeguarding and when questioned, they could explain and signpost the pathways for advice and support. This level of knowledge and commitment was particularly evident with the highly motivated and engaged Cathedral COO.


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11.11 The Canon Precentor has a firm focus on safeguarding and collaborates with others in the Cathedral to ensure safeguarding is an area of focus and attention for Vergers, the Music Department and others.

11.12 The Cathedral Chapter Safeguarding Lead occupies a significant strategic safeguarding role and has been in the unenviable position of having to blend strategic oversight with operational delivery alongside the management of some complex and challenging legacy cases. This is not a sustainable position and the Audit welcomes the fact that the Cathedral is making progress with the recruitment of a CSO / CSA.

11.13 Strategic leadership is a critical component when it comes to safeguarding and the Audit has made a recommendation regarding the creation of a safeguarding directorate (see recommendation D7). This would be led by a Director of Safeguarding. This role would hold the authority of a DSO and support governance bodies in the Diocese and Cathedral. The Director of Safeguarding role would oversee safeguarding activity in the Cathedral, the DBF, and by inference provide oversight and support to the parishes.

11.14 Safeguarding staff would be amalgamated within this directorate to provide a greater level of operational independence and to facilitate more frequent and routine professional supervision. This approach would consolidate safeguarding staff, no matter where they were deployed, and provide a greater level of resilience to deal with unforeseen extractions and unexpected demands.

11.15 If the recommendation to adopt the above model is not accepted, the professional safeguarding lead in the Cathedral, the Cathedral Safeguarding Advisor (CSA) should be directly professionally supervised by the DSO.


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**Recommendation C2:** The proposed professional safeguarding lead for the Cathedral should be part of a consolidated Diocese Safeguarding Team, deployed in the Cathedral but professionally supervised by the DSO or Director of Safeguarding.

11.16 The Cathedral operates a range of appropriate governance and oversight meetings. These reflect the expectations of the CofE and relevant requirements, such as those issued by the Charity Commission.

11.17 Chapter membership includes a number of executive and non-executive members. Two thirds of the non-exec members must be lay persons. This creates an opportunity for Chapter (when reviewing its membership) to carry out skills, diversity and inclusion audits. This will help to ensure informed scrutiny by engaging senior individuals with safeguarding experience and will ensure Chapter is subject to appropriate challenge from those who represent the community within which it sits.

11.18 Minutes from Chapter meetings evidence an appropriate and meaningful focus on a range of safeguarding issues, including case management systems, safeguarding related policies and discussion on how oversight can be improved. This has led to improvements such as a recommendation to create an operational safeguarding group to compliment the work of the Chapter Safeguarding Committee (CSC). The Audit believes the Chapter's safeguarding focus could be further strengthened by adopting a thematic approach to key safeguarding issues, national standards and Charity Commission requirements.


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**Recommendation C3:** The Chapter should review and revise its annual safeguarding oversight to ensure that it applies a thematic approach to Chapter meetings. For example, considering safer recruitment at one meeting, training and evaluation at the next, followed by a deep dive of a recent complex case or a LLR at another.

The final meeting of every year should include a report from the CSC covering how progress is being made against the national standards and a briefing on Serious Incident Reports and near misses for the reporting period. This will help to ensure a thorough understanding of key issues and evidence compliance with Charity Commission reporting expectations.

11.19 The CSC is led by a highly credible chair and whilst in the early stages of development, it has the potential to provide critical strategic oversight and informed advice to Chapter. It currently has wide-ranging responsibilities set out in its Terms of Reference (ToR), which straddle operational and strategic issues. Given the commitment to create a Cathedral Operational Group (COG), a proposition the Audit supports, it would make sense to revisit the ToRs for the CSC and divide the focus of each group to ensure they complement rather than compete and confuse.

**Recommendation C4:** Upon creation of a Cathedral Operational Group (COG), the ToRs of the CSC should be reviewed and reconstructed. This should be done to ensure that strategic and operational issues are allocated to the appropriate body. For example, the CSC should act as the critical friend to the Dean and Chapter, providing assurance that safeguarding practice is fit for purpose, whilst the COG should provide insight, oversight and reassurance about day-to-day operational safeguarding activity to the CSC.


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**Recommendation C5:** The CSC should review the use of risk registers to ensure:

a) They apply focus against safeguarding risks relevant to the Cathedral. In doing so they should consider the division and relationship between strategic and operational risks and how to focus on issues likely to impact on the stability, health and wellbeing of the workforce. For example, the cost of living, capacity pressures, transferred trauma and the implications of the Jay report.

b) As part of this work, respective forums should review how their use of risk registers align with their ToRs and feed into the overarching responsibilities of each group and committee under Chapter.

c) Develop a specific operational and strategic Safeguarding Risk Register.

**Recommendation C6:** The Cathedral Chapter, Safeguarding Committee and Operational Group should:

a) Each carry out a skills, inclusion and diversity audit. In doing so, they should consider how they might better represent the community within which they sit.

b) Dependent on the composition of existing membership, consider whether more individuals with credible external adult and children's safeguarding expertise can be engaged.

11.20 The capacity to meet safeguarding needs within the Cathedral has been stretched for some time and is not solely related to the absence of an appointed CSA. The Audit also noted that capacity impacts the Director of Welcome, Learning and Engagement who oversees a cohort of 120 volunteers. Recognising these pressures, safeguarding has been largely reliant on the goodwill of a small number of people, the work ethic of the CSL and a stretched DST. This is commendable practice from those involved, but not sustainable.

11.21 The Audit acknowledges that this is an interim position whilst posts are being filled and therefore makes no additional recommendation in this regard, beyond recognising that stresses across the system are having a cumulative impact.


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11.22 In the Audit's opinion, the situation is now critical and the Cathedral's commitment to recruit to vacancies as soon as possible is welcomed. That said, it is important that appointments (particularly the CSA) fit within the overarching safeguarding structure moving forward. The post-holder recruited should have the right skills and abilities and if possible, experience that compliments that which already exists in the wider DST. Creating a consolidated Safeguarding Team that harnesses the range of available expertise will be in the interest of everyone across the diocese.

**Chorister Safeguarding**

11.23 The Audit acknowledges previous and recent challenges within the Music Department at the Cathedral and recognises the impact these issues have had on all those involved.

11.24 The Audit found that the Cathedral have effective safeguarding measures for its choristers, demonstrating good practice in several areas. This conclusion was drawn from the Audit site visit, documentation received and through discussions with choristers, parents, staff King's School Worcester, and individual Cathedral staff.

11.25 Through engagement with choristers and parents from the boys', girls', voluntary, and youth choirs, it is clear that current choristers hold their time at the Cathedral in high regard. They consistently reported feeling safe and supported by the dedicated staff around them.

**Risk and Prevention**

11.26 Risk is managed proportionately within this department. Robust procedures are in place to monitor attendance by both Cathedral and school staff and the use of chorister-only toilets and the chaperoning to and from these facilities during services exemplifies good practice.

11.27 Additionally, all choristers demonstrated an awareness of not using public toilets or engaging directly with the public. However, since staff occasionally use these toilets when


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choristers are not present, nearly all staff acknowledged the need for clearer signage indicating appropriate times of use.

11.28 There is an opportunity to enhance safeguarding by including signposting to trusted adults or other safeguarding related topics within the toilets themselves. This space is frequently visited by choristers, and a reminder of whom they can approach for help should be reinforced here.

| **Recommendation C7**: The Cathedral should establish a rota or other signposting indicating appropriate times that adults may use the Song School toilets. |
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| **Recommendation C8:** The Cathedral should implement safeguarding signposting within the dedicated toilets for choristers. |
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**Chorister Safeguarding Policy**

11.29 The Chorister Safeguarding Policy and related policies are notable strengths within the Music Department at Worcester Cathedral. Of particular significance is the reference to the IICSA recommendation for Cathedrals who link with choir schools to ensure there is no ambiguity in safeguarding responsibilities between the two entities. The Audit views this understanding as clear and well-implemented at Worcester.

11.30 A level of reassurance is further provided by addressing the rehabilitation of offenders within the policy, outlining how this will be managed in order to prioritise the safety of choristers and all young people. This is good practice.

11.31 However, some aspects of the Chorister Safeguarding Policy are outdated, and the Audit notes the absence of a current review date. Policies could be strengthened by ensuring they are up to date and regularly reviewed, providing confidence and assurance to readers.


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| **Recommendation C9**: The Cathedral should ensure that the Chorister Safeguarding Policy includes an up-to-date review date, indicating when the next review will occur. All outdated messaging and dates should be removed or noted within the version table on the cover. |
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**Ratios and Supervision**

11.32 With a small team of staff and many choirs to manage, lone working can occur. However, choristers and staff reported that appropriate staff ratios are maintained at all times. It is reassuring that the Cathedral's Lone Working Policy is robust and detailed, including points to mitigate risk and a chorister-specific lone working context is included within the Chorister Safeguarding Policy.

11.33 The Audit finds the use of small windows in wooden doors to be an innovative approach to merging safeguarding with history and heritage. This provides a line of sight into each room without detracting from the Cathedral's original architecture. However, this measure only provides a snapshot in time, whereas CCTV could offer an added layer of security.

| **Recommendation C10:** The Cathedral should explore and consider the possibilities of installing CCTV within the Song School. |
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11.34 In discussions about trips and events, appropriate supervision and ratios were highlighted again. Choristers indicated that they do not receive the contact numbers of staff during trips, as they are never alone and thus do not need them. It is positive that choristers feel safe and appropriately supervised however this measure alone is not sufficient should a child get lost, go missing, or intentionally leave a group. Safety could be enhanced through the use of lanyards with a dedicated music department contact number, should a child go missing. The Audit have been made aware that a 'Lost Child Policy' is in operation within the Cathedral, however were not sighted in this at the time of the Audit, nor is such a policy available on the Cathedral's website. As a result, the following recommendation is made.


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**Recommendation C11:** The Cathedral should ensure their Missing Child Policy is available for staff and parents via their website and ensure that this includes procedures for sharing contact numbers with children and young people during trips and events. It should also apply while moving to, from, and within the Cathedral.

**Bullying and Reporting Concerns**

11.35 In response to a previous case concerning bullying reported by a former chorister, there has been a consequential impact on the music department. Prior to this case, the department's system and response for addressing such issues was not robust. This was highlighted in the SCIE audit undertaken in 2021, which recognised the need to better understand concerns about bullying in choirs. However, the Audit is now satisfied that significant steps have been implemented to not only address the specific case but also to enhance staff awareness and responsiveness to bullying.

11.36 The Audit heard good examples of concerns being addressed both sensitively and swiftly. Choristers expressed that they feel at ease knowing that bullying is now managed in an appropriate, timely, and sensitive manner. This is reinforced in the Chorister Safeguarding Policy, Chorister Bullying and Behaviour Policy and Chorister Handbook, all of which outline expected and appropriate behaviours as well as the steps to take if any chorister or chorister parent has behaviour concerns.

11.37 Responsiveness to reported concerns extends beyond bullying. A chorister chaperone also shared an instance where they raised a concern that was handled quickly and effectively. The chaperone was worried about members of the public taking photos of the choristers. In response, preventative measures were implemented, such as signposting that makes it clear visitors must refrain from photographing the choristers.


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# 12 Prevention

12.1 Safer recruitment policies and practices are a vital part of creating safer environments, discouraging unsuitable individuals from joining an organisation and preventing harm. The Cathedral has a range of measures in place to ensure the safer recruitment of individuals to various roles. Such measures include reference gathering, confidential declarations for eligible roles, the Cathedral's safeguarding commitment being specified in application packs, and criminal record checks for certain roles.

12.2 The Audit acknowledges that significant efforts have recently been undertaken to ensure accurate and up to date recruitment records for staff and volunteers. In addition, a new HR system is currently being explored which could potentially bring enhancements and benefits to such practice. Whilst the Audit recognises and supports the Cathedral's efforts and objectives, there is further work to do in this regard.

**Recommendation C12**: Within the next three months, the Cathedral should ensure that all recruitment records are consolidated into one central database with no gaps in data.

**Recommendation C13**: The Cathedral should ensure that all relevant staff and volunteers have up to date DBS checks.

12.3 The Audit is of the opinion that the Cathedral would also benefit from improved clarity about what level of DBS check and training is required for each of its roles.

**Recommendation C14**: The Cathedral should develop a guidance document to indicate the level of training and DBS that particular roles are likely to require. This could be completed in conjunction with the DBF, should Recommendation D9 be accepted.


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12.4 The Audit notes that those in identified roles are required to undergo appropriate training on safer recruitment. Current records reviewed by the Audit indicated that not all individuals in such positions have the appropriate and up to date training.

| **Recommendation C15**: The Cathedral should ensure that all relevant staff have completed safer recruitment training within the next three months. |
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12.5 In order to develop effective preventive measures, it is important that 'safeguarding' is an active subject-matter across the Cathedral and that it is routinely discussed and seen as an area for continuous improvement. Positively, the Audit saw evidence of safeguarding being discussed during Chapter, all staff meetings, operational conversations, induction sessions and volunteer learning events. Indeed, at a recent all staff meeting, the Audit saw good practice with the use of anonymised scenarios to facilitate discussion, reflection and learning. Opportunities to engage the Cathedral's worshipping community are also adopted, through such initiatives as 'Safeguarding Sunday'. This is good practice.

12.6 Arrangements are in place at the Cathedral to facilitate the sharing of good practice and learning from others. The SLA between the Cathedral and the DBF allows for sharing of good practice and learning. This was seen in practice via the DSA sitting on the Cathedral Safeguarding Committee, and the COO attending the DSAP. The Audit saw evidence of records reflecting positive sharing of learning through the DSA's report to the Cathedral Safeguarding Group. Informal networks are also present and through platforms such as WhatsApp, provide a vehicle for staff and volunteers to learn from others and share good practice.

12.7 Amplifying and raising awareness about abuse can equip people to better recognise and respond. In this respect, the Audit saw evidence of safeguarding being promoted prominently throughout the Cathedral via innovative and novel approaches. These


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included posters, weekly news (pew sheets and online) and certain exhibitions, events, courses and sermons. Whilst the Cathedral has raised awareness on a range of issues (e.g. child abuse, sexual abuse, abuse of power and domestic violence), it's collaborative '[County Lines' project]() with the Clewer Initiative is particularly commendable. Led by the Learning Team at the Cathedral, this initiative involved the Mother's Union, Worcester Community Rail partnership, and local schools. Using the arts, it aimed to engage young people about the risk of being groomed and abused through the form of exploitation known as 'County Lines'. A film was produced and a one-day schools event brought together 150 children and young people at the Cathedral.

12.8 The Audit noted strengths with the prominence of access to and contents of safeguarding information on a dedicated webpage on the Cathedral's website. Relevant materials include the Safeguarding Policy, signposting to support services, and details on how to report a concern.

12.9 Over half of staff, volunteers and those people worshipping at the Cathedral told the Audit (via surveys) that they had seen "*improvements with raising the levels of awareness around safeguarding*". Whilst the Audit saw some limited references to safeguarding in the Cathedral's digital communication, this is an area which could be strengthened via the introduction of a staff and volunteer newsletter. A newsletter can be a strong mechanism for conveying safeguarding information, keeping the workforce informed, engaged and aligned with the organisation's goals and culture.

| **Recommendation C16**: The Cathedral should establish an email newsletter issued to staff, volunteers and other interested parties, which should include reference to safeguarding and related subject matter. |
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12.10 Actively seeking and acting on the views of children, young people and vulnerable adults is a key component to effective prevention planning. Whilst there are arguably less opportunities for the Cathedral to gather such feedback, the Audit did see the use of a creative initiative. The 'In Their Shoes' project helps to hear and amplify the voices of those who have suffered gender-based violence. This is good practice.

| **Recommendation C17**: The Cathedral should consider and establish models for how it captures the voices and experiences of children, vulnerable adults and survivors. See also Recommendation D9 and Recommendation D23. |
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12.11 Arrangements are in place to manage safeguarding risks that are associated with the layout of the Cathedral building and its broader working environment. This can be seen in the risk assessments relating to access to the Tower, the availability of a Lone Working Policy and the guidance on maintaining boundaries included in the Volunteer Handbook.


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# 13 Recognising, Assessing and Managing Risk

13.1 The Cathedral attracts hundreds of thousands of visitors annually and has around 500 worshippers who attend regularly. The Cathedral's diverse team of staff and volunteers are involved in various activities including guided tours, hosting visitors, supporting vulnerable individuals, handling disruptive behaviour and protests and overseeing the daily operations of religious services.

13.2 The approach towards safeguarding is integrated into the Cathedral's policies, guidance, training, and recruitment. Combined with communications and initiatives such as 'Safeguarding Sunday', mechanisms are in place to raise awareness and ensure safeguarding remains a priority. It is positive that findings from the Audit's survey with the Cathedral workforce showed that most respondents acknowledged the role they played in safeguarding and that it was everyone's responsibility to report concerns.

13.3 The Cathedral's risk register covers key corporate issues including safeguarding and was recently updated in March 2024, with the next review date set for September 2024. The Audit's recommendations for the DBF risk register are set out in Part One of this report and have equal relevance to the context of safeguarding at the Cathedral.

13.4 The Audit believe specific safeguarding risks as they pertain to the Cathedral should form part of the recommended standalone DBF risk register as outlined in Part One of this report. This will allow for maximum oversight.


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**Recommendation C18**: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral mirroring the safeguarding risk register recommended for the DBF as outlined in Part One of this report. The existing SLA which facilitates support from the DST to the Cathedral should incorporate an expectation that specific safeguarding risks that pertain to the Cathedral including measures to manage and mitigate such risks, should be recorded in the Cathedral's safeguarding risk register.

13.5 The current safeguarding processes facilitate the effective triage of referrals within the Cathedral. The current Cathedral Safeguarding Lead (CSL) assesses reports to determine if they are a safeguarding concern, a pastoral issue or a security risk. Concerns are logged on MyConcern and checked by the ADSA. If cases do not meet the safeguarding threshold they are marked as 'matters of note' and reassigned to the CSL. In the absence of a permanent CSO / CSA, the Audit consider this good practice. This process is strengthened further whereby the Senior Executive Team (SET) review the CSL's decisions.

13.6 The Cathedral has an SLA with the DBF and the Audit saw evidence of a strong working relationship regarding case management but were made aware that a number of ongoing challenges remain. For example, there have been significant staffing changes over the last 3 years and in 2023, concerns were recorded at an OSG and at a Safeguarding Committee Meeting about the additional safeguarding support required at the Cathedral.

13.7 The SLA has yet to be formally updated (due January 2024) and in the absence of an appointed CSA / CSO, a contingency plan is in place whereby the DBF (via the DST) is providing additional support, overseeing all case work, and ensuring regular contact with the CSL. The Audit is aware that a recruitment process is in place to appoint the new CSA / CSO but recognises the impact of the current arrangements on those in already demanding roles.


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**Recommendation C19:** The Cathedral should prioritise the review of the SLA between the DBF and Cathedral to ensure it reflects any new safeguarding arrangements.

13.8 Additional information sharing arrangements extend to organisations conducting group visits the Cathedral, such as school trips or arranged tours. Expectations are outlined in the Cathedral's booking application, with organisations being required to provide their safeguarding policy. If they do not have one, organisations must agree to follow the Cathedral's policy. This is considered good practice.

13.9 There was evidence of strong external partnerships, including statutory participation in safety plans and involvement in multi-agency projects such as the County Lines project and the Maggs Day Centre for homeless people. Although capacity remains a challenge, the Cathedral's arrangements enhance the opportunities to detect risks, support collaborative decision making, and enable the swift implementation of safeguarding responses when required.

13.10 Case activity, at the time of the Audit, showed eight open concerns. Six were of a low level and had been dealt with through advice, guidance and support. There were two safeguarding concerns at the Cathedral which had been closed and filed. The Audit was advised that not all filed cases have been migrated to MyConcern.

13.11 It is relevant to note the findings from the Audit's survey involving the Cathedral staff and volunteers. Whilst many respondents indicated they understood how to escalate a safeguarding concern and knew who to report it to, less than half had confidence in the escalation process.


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**Recommendation C20:** The Cathedral should work in partnership with the DST to engage staff and volunteers in building confidence in the safeguarding escalation process and to understand any barriers to swift and effective reporting.

13.12 As part of a dip sample of individual cases, the Audit saw an example of good practice by the DSA as part of a safeguarding matter involving a member of the Cathedral's workforce. In this case, a Core Group was convened with agenda items taking into consideration a range of issues including the welfare of the respondent, potential victims / survivors, and communication plans for those who may have been affected. The broader effectiveness of case management by the DST is set out in Part One of this report. It has equal relevance to the context of safeguarding at the Cathedral.

13.13 There have been two Core Groups involving the Cathedral convened in the past year. The Audit saw evidence of good practice, including detailed record keeping, investigative and follow up enquiries, effective communication with an external diocese, clear guidance from the DSA, and consideration of support for relevant parties. Additionally, there was evidence of good practice through the application of swift and effective HR processes.

13.14 Safety plan risk assessments conducted by the Cathedral (in collaboration with the DST) adhere to national guidance and prioritise the safety of victims, potential victims and vulnerable individuals. The welfare of the respondent is also considered. The effectiveness of the management of these is set out in Part One of this report.

13.15 The Cathedral has recently become a registered charity (March 2024). The Audit was advised that leaders are aware of the House of Bishop's guidance regarding the statutory requirement to report serious incidents to the Charity Commission. At the time of the Audit there have been no submissions.


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13.16 The Cathedral's Data Protection Policy specifies its legal responsibility to demonstrate compliance with UK data protection legislation and GDPR. The use of MyConcern for handling personal information related to safeguarding cases aligns with these requirements. Various documents, including the privacy notice for employees, workers and contractors, as well as the SLA between the DBF and Cathedral, provide guidance on data protection legislation. Clergy, staff and volunteers receive training on data protection, information sharing and how to identify a Data Subject Request. This is good practice.

13.17 That said, notwithstanding the sustained efforts to ensure compliance with data protection requirements, the Audit was made aware there may be cases where volunteers are using personal emails for sharing information. Responses to the Audit's survey (from the Cathedral's workforce) indicated that just over half of respondents were aware of the privacy notice in respect of data protection.

| **Recommendation C21:** Volunteers should be provided with a Cathedral email address for the purpose of communicating with others and sharing information. |
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| **Recommendation C22:** The Cathedral should continue to raise awareness with the workforce regarding the privacy notice in respect of data protection. |
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# 14 Victims and Survivors

14.1 The Cathedral follows the House of Bishops' guidance set out in '*Responding Well to Victims and Survivors of Abuse.*' Whilst there is no proactive engagement with victims and survivors, the Cathedral appropriately raises awareness to emphasise the importance of safeguarding, the routes of disclosure and the process to be followed if someone reports abuse. This helps to maintain an ongoing focus on safeguarding, and by default, a focus on victims and survivors. Signage for 'Promoting a Safer Church' is displayed throughout communal areas across the Cathedral building along with other support services.

14.2 As part of the existing SLA between the Cathedral and DBF, the Audit saw evidence of the sharing of good practice in respect of strengthening the voice of victims and survivors and hearing their experiences. Minutes and associated papers from a recent Cathedral Safeguarding Group meeting demonstrate the steps taken by the DST to hear, learn and amplify the voice of victims and survivors. In addition, an anonymised summary of a case also provided opportunities to reflect and learn from the experience of a survivor of non-recent church-related abuse.

14.3 Worcester Cathedral report that they have a good relationship with local support services and statutory agencies.


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# 15 Learning, Supervision and Support

15.1 Leaders at the Cathedral understand and accept the importance of safeguarding training. They have recognised there are areas for improvement and efforts to strengthen the Cathedral's arrangements are continuing.

15.2 From a strategic perspective, in line with the existing SLA, the Diocese Safeguarding Learning Strategy 2024 has applicability to the Cathedral's workforce. This includes a focus on training needs, the local plan and the mechanisms for evaluation and review. The strategy also includes a risk register setting out the key issues that could potentially inhibit work in this area. This is positive.

15.3 Training events mirror those available for other Church officers across the diocese. In this respect, much of the detail set out in Part One of this report is of equal relevance. Safeguarding training aligns to the national programme and whilst sessions are usually 'attended' online, informal face-to-face sessions have been delivered at the Cathedral.

15.4 Notably, there has been a focus on Autism Awareness and there are efforts underway to deliver training that is more context specific. These initiatives showcase good practice. Recommendations for the DBF to implement more context specific training on sex offenders and digital safeguarding are seen as relevant to the Cathedral's activity as well.

15.5 The Audit found that the historical absence of maintaining accurate training records in the Cathedral has inhibited oversight of compliance. Indeed, the Audit ascertained that a significant number of key staff have either no training record or that training is outstanding. This apparent lack of grip is likely to account for some of the feedback the Audit received. For example, a notable proportion of respondents to the Cathedral's workforce survey


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either ‘didn’t know’, ‘disagreed’ or ‘strongly disagreed’ that there have been improvements with safeguarding training provision. However, since the initiation of the Audit, improvement actions have been taken. The CSL has established a more robust system for documenting and tracking attendance and whilst challenges persist and work is in progress (in the main due to capacity issues), this is positive.

| **Recommendation C23**: The Cathedral should seek to embed and ensure the ongoing maintenance of training records for all its staff and volunteers.<br><br>Any capacity issues identified as hindering this should be addressed swiftly by the Cathedral’s leadership team. |
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| **Recommendation C24:** The Cathedral should ensure all staff and volunteers have completed their required training within a period of no later than three months from the publication of this report. |
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15.6 There is no specific evaluation process for safeguarding training at the Cathedral and as such, no defined way of measuring the impact of training on practice, outcomes, and the behaviour of staff and volunteers.

15.7 As part the core training evaluation process managed via the DST, and the recommendations set out in Part One for improving this process, a distinct focus on the Cathedral should be included. Any future evaluations of training courses should be designed to allow for the disaggregation of data relating to the Cathedral.


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**Recommendation C25**: In collaboration with the DBF, the Cathedral should support the implementation of an enhanced training evaluation process to test the impact of training on its own 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. This could be aligned with the DBF's approach to 'culture audits' as part of the follow-up to training.

15.8 As detailed in Part One of this report, members of the Cathedral's clergy have access to counselling services through the DBF to support their wellbeing and effectiveness in their roles.

15.9 MDRs also routinely take place within the Diocese, and identify areas for growth and development. The recommendation for strengthening the safeguarding focus of MDRs has relevance for Cathedral clergy.

15.10 New staff and volunteers at the Cathedral are supported through an induction process that includes safeguarding. Whilst many confirmed the existence of this induction, the process is due to undergo a review this year as prioritised by the new CSA / CSO. It remains good practice for any individual working directly with children, young people, or vulnerable adults to complete both safeguarding training and a comprehensive induction before starting their duties.

15.11 The Cathedral maintains a productive relationship with the DST, which facilitates some access to external agencies that broaden opportunities for learning and improvement


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(beyond training). Whilst positive, relevant Cathedral staff with a safeguarding function should also be seeking out such opportunities for themselves. This could, for example, involve reaching out to local safeguarding partnerships / Boards (Children and Adults) and requesting membership on multi-agency safeguarding forums or groups.

**Recommendation C26:** Cathedral staff with a core safeguarding function should seek to engage with local multi-agency safeguarding forums or groups (independent to the DBF).

15.12 The Audit found a lack of adequate support and CPD arrangements for those engaged in safeguarding work in the Cathedral. However, there is some awareness that this is something that needs to be developed. The new CSA / CSO is due to have professional supervision, although the details have yet to be arranged. The Audit makes a recommendation for what this should include.

**Recommendation C27:** The details of the professional supervision for the new CSA / CSO should be promptly finalised and communicated. This supervision should incorporate oversight of casework, regular feedback and be used to identify opportunities for continual learning and adaptation. In the view of the Audit, this supervision should be provided by the DSO / Director of Safeguarding.


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# Conclusion



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# 16 Conclusion

16.1 The Audit found that the DBF and Cathedral have made good progress since the SCIE audit and PCR2 process. A range of improvement activity has resulted in more effective practice and the creation of safer environments. This positive trajectory provides a platform upon which the Acting Bishop of Worcester, the new Dean and in due course the next Bishop of Worcester, can build.

16.2 The DBF has laid a solid foundation for a safeguarding culture that prioritises the well-being of individuals and fosters a safer environment for everyone involved in the diocese. They have proactively developed safeguarding policies and improved practice, collaborate well with internal and external stakeholders and have led on a number of innovative safeguarding projects. Critically, they seek out opportunities to listen to their workforce and volunteers and have developed a safeguarding strategy and action plan that sets out a commitment to continuously improve. Indeed, good practice is highlighted throughout the report, not least in the trauma informed support offered to victims and survivors.

16.3 While challenges regarding capacity remain, the DBF's proactive approach and willingness to learn and adapt demonstrate its dedication to creating a safer and supportive environment for all.

16.4 Whilst it is clear that the safeguarding culture across the DBF and parishes has considerably strengthened, the Audit is aware that the Cathedral still faces some challenges in this regard. That said, Worcester Cathedral has demonstrated a dedication to safeguarding, with notable strengths in policy development, risk management, and partnerships with external organisations. Chorister safeguarding is a particular strength and the Audit saw evidence of robust policies and procedures, and heard positive feedback


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from choristers and their parents. Beyond some legacy issues regarding culture in the Cathedral, the other stubborn challenges that remain primarily related to capacity constraints, not helped by recent staff turnover.

16.5 The DBF and Cathedral are well served by a professionally blended DST, a highly effective DSA and Cathedral Safeguarding Lead. From the Audit's perspective, professional safeguarding capacity is a significant issue. In the opinion of the Audit and notwithstanding the excellent work being done, this has increased pressure on a few people with core safeguarding responsibilities resulting in each having to do more. This is simply not sustainable and represents a risk. The Audit therefore welcomes the commitment from the DBF and Cathedral leadership to build on the good work already done by further strengthening their safeguarding provision.


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# Appendices


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# 17 Appendix 1 – DBF Recommendations

**Recommendation D1:** The DBF should engage in a range of activities that facilitate insight regarding culture. These should include, but not be limited to the following:

a. Seeking views on culture, including areas of perceived strength and areas for improvement through the use of anonymised surveys.
b. Workshops focused on specific themes (e.g. issues arising from LLRs or other feedback).

**Recommendation D2:** The Acting Bishop of Worcester and then the future Bishop of Worcester should retain direct responsibility and ultimate accountability for safeguarding.

**Recommendation D3:** The Diocesan Secretary should line manage the DSA.

**Recommendation D4:** The Bishop of Worcester, DSA and Archdeacons should reflect on how visitations and / or inspections can become even more safeguarding focused. This reflection should include how a consistent focus on key safeguarding themes (relevant to the places they visit) are captured in a framework. Furthermore, briefing and debriefing opportunities with the DST should be formalised and safeguarding visits should be adopted that go beyond annual swearing in ceremonies.

**Recommendation D5:** The DSA should be appointed as a member of the Bishop of Worcester's Staff Meetings and attend all of its meetings.

**Recommendation D6**: Formal minutes including persons present, matters discussed and actions agreed must be properly recorded and retained.


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| **Recommendation D7**: Leaders in the DBF and Cathedral should scope the opportunity to consolidate safeguarding resources within a single Safeguarding Directorate for the diocese. This would involve the creation of a Director of Safeguarding role. This role would provide strategic oversight, advice and safeguarding support across the DBF, parish support and the Cathedral. They would be a member of the senior leadership team and assume the authority vested in a DSO. |
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| **Recommendation D8**: The present safeguarding resource should also be reinforced with the appointment of an additional Assistant Diocesan Safeguarding Advisor (ADSA) with a portfolio for training, and a Cathedral Safeguarding Advisor (CSA). The CSA, whilst located in and line managed on a day-to-day basis within the Cathedral, should be professionally supervised by the Director of Safeguarding (or the DSO if Recommendation D7 is not accepted). |
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| **Recommendation D9**: The DBF should develop guidance and an eligibility matrix that defines the type of DBS check and the level of training required for specific roles in the diocese. This should cover the range of posts in place in the DBF, the Cathedral and parishes. |
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| **Recommendation D10:** The DBF should consider new models for youth participation in consultation with its growing network for those employed as Children and Youth Workers. |
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| **Recommendation D11:** The DBF should include the review dates on risk registers. Risks should be reviewed on a quarterly basis by register owners to assess cross organisational risk particularly in the event of significant changes to workplace processes. |
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| **Recommendation D12**: The DBF should develop a standalone safeguarding risk register to facilitate a comprehensive analysis of safeguarding matters. Risks should be identified and defined against the National Safeguarding Standards. |
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| **Recommendation D13:** As part of the triage process, the DSA should record the rationale for risk grading and the prioritisation of cases, alongside specifying timescales for action and any review of progress. |
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| **Recommendation D14:** The MyConcern CMS dashboard should reflect a specific case owner for each open case as opposed the generic 'owning group'. |
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| **Recommendation D15:** Supervision entries should be recorded by the DSA on MyConcern, They should follow a consistent format and be uploaded on at least a monthly basis. This format should ensure the DSA can clearly record the rationale for any decisions they have taken on a case, including case closure. |
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| **Recommendation D16:** The DSA should be afforded time to complete extra training on the use of the MyConcern national case management system |
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| **Recommendation D17:** The review process for respondents on safety plans should be completed in person with the relevant personnel in attendance. |
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| **Recommendation D18:** The DBF should engage the Local Safeguarding Children Partnerships and Safeguarding Adult Boards to explore the possibility of developing either a partnership ISA and or bi-lateral ISAs with relevant agencies with whom it is regularly engaged. |
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| **Recommendation D19:** Learning points identified through supervision sessions between the DSA and NST regional lead should be recorded under the lessons learned tab on the MyConcern system to allow ease of access to information. |
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| **Recommendation D20:** Referred cases resulting in no further action / and or provision of advice and guidance should be included as part of the supervision discussions between the DSA and the NST regional lead. This issue has been raised by the Audit with the NST. |
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**Recommendation D21**: The DSA should implement formal / individual supervision sessions with the ADSAs to enhance in-depth discussions about cases and adopt a consistency of approach for management oversight. The recording of such sessions and any related case actions should be uploaded to MyConcern.

**Recommendation D22**: The DBF's Survivor Strategy should;

- Set out the diocese's strategic aims and key priorities in respect of victims and survivors.
- Include collaboration and consultation with victims and survivors (see Recommendation D23).
- Be developed in conjunction with the Cathedral and take account of its particular circumstances.

**Recommendation D23**: The DBF should scope and plan how to formalise engagement, consultation and collaboration with victims and survivors. Such engagement should be meaningful, trauma-informed and in accordance with '*Responding Well to Victims and Survivors of Abuse.*'

**Recommendation D24**: The DBF should review and update as necessary the 'Survivor Care and Support' webpage. This should consider:

- What are the needs of those visiting the page.
- Content hierarchy – what is the most critical information and ensuring that it is arranged accordingly.
- Is all relevant material and information available (e.g. the provision of hyperlinks to '*Responding Well to Victims and Survivors of Abuse*')


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**Recommendation D25:** The DBF should:

A. Include and facilitate the exploration of the themes of 'forgiveness' and 'repentance' within the spiritual abuse training.

B. Offering the Spiritual abuse training more widely in the diocese to include clergy and Church Officers.

**Recommendation D26:** The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers about how training has helped their practice. As part of this process questions about unmet training needs should be asked.

**Recommendation D27**: The DBF should identify whether there are any particular members of the workforce including volunteers with poor training compliance. Depending on the outcome, bespoke strategies should be developed to encourage and improve attendance. The DBF should consider engaging their NST Regional Lead to establish whether good practice in this regard has been developed elsewhere.

**Recommendation D28**: In consultation with the DST, the MDR process should be reviewed, and amendments made for safeguarding prompts / questions and recording within the preparation and the evaluation forms to fully align with the national safeguarding standards.

**Recommendation D29:** The DBF should promote awareness across all Parochial Church Councils (PCC) about the importance of induction events for new staff and volunteers.

**Recommendation D30:** The DBF should engage in discussions with relevant safeguarding children partnerships about the potential for Church Officers to be formally engaged in their arrangements (as relevant members of key groups / sub-groups).


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**Recommendation D31:** 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.


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# 18 Appendix 2 – Cathedral Recommendations

**Recommendation C1:** The Cathedral must engage in meaningful and evidence-based approaches to establish the culture within its staff, volunteer and worshipping communities. In doing so, it should seek feedback that reflects what their stakeholders think could or has made a difference. Such an approach can involve snapshot and deep dive surveys, internal focus groups and the use of third-party professional facilitators. Detailed reports on the outcomes of such work should be shared with Chapter and the DSAP to help develop action plans that drive improvement.

**Recommendation C2:** The proposed professional safeguarding lead for the Cathedral should be part of a consolidated Diocese Safeguarding Team, deployed in the Cathedral but professionally supervised by the DSO or Director of Safeguarding.

**Recommendation C3:** The Chapter should review and revise its annual safeguarding oversight to ensure that it applies a thematic approach to Chapter meetings. For example, considering safer recruitment at one meeting, training and evaluation at the next, followed by a deep dive of a recent complex case or a LLR at another. The final meeting of every year should include a report from the CSC covering how progress is being made against the national standards and a briefing on Serious Incident Reports and near misses for the reporting period. This will help to ensure a thorough understanding of key issues and evidence compliance with Charity Commission reporting expectations.


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| **Recommendation C4:** Upon creation of a Cathedral Operational Group (COG), the ToRs of the CSC should be reviewed and reconstructed. This should be done to ensure that strategic and operational issues are allocated to the appropriate body. For example, the CSC should act as the critical friend to the Dean and Chapter, providing assurance that safeguarding practice is fit for purpose, whilst the COG should provide insight, oversight and reassurance about day-to-day operational safeguarding activity to the CSC. |
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**Recommendation C5:** The CSC should review the use of risk registers to ensure:

a. They apply focus against safeguarding risks relevant to the Cathedral. In doing so they should consider the division and relationship between strategic and operational risks and how to focus on issues likely to impact on the stability, health and wellbeing of the workforce. For example, the cost of living, capacity pressures, transferred trauma and the implications of the Jay report.
b. As part of this work, respective forums should review how their use of risk registers align with their ToRs and feed into the overarching responsibilities of each group and committee under Chapter.
c. Develop a specific operational and strategic Safeguarding Risk Register.


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| **Recommendation C6:** The Cathedral Chapter, Safeguarding Committee and Operational Group should:<br>a. Each carry out a skills, inclusion and diversity audit. In doing so, they should consider how they might better represent the community within which they sit.<br>b. Dependent on the composition of existing membership, consider whether more individuals with credible external adult and children's safeguarding expertise can be engaged. |
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| **Recommendation C7**: The Cathedral should establish a rota or other signposting indicating appropriate times that adults may use the Song School toilets. |
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| **Recommendation C8:** The Cathedral should implement safeguarding signposting within the dedicated toilets for choristers. |
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| **Recommendation C9**: The Cathedral should ensure that the Chorister Safeguarding Policy includes an up-to-date review date, indicating when the next review will occur. All outdated messaging and dates should be removed or noted within the version table on the cover. |
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| **Recommendation C10:** The Cathedral should explore and consider the possibilities of installing CCTV within the Song School. |
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| **Recommendation C11:** The Cathedral should ensure their Missing Child Policy is available for staff and parents via their website and ensure that this includes procedures for sharing contact numbers with children and young people during trips and events. It should also apply while moving to, from, and within the Cathedral. |
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**Recommendation C12**: Within the next three months, the Cathedral should ensure that all recruitment records are consolidated into one central database with no gaps in data.

**Recommendation C13**: The Cathedral should ensure that all relevant staff and volunteers have up to date DBS checks.

**Recommendation C14**: The Cathedral should develop a guidance document to indicate the level of training and DBS that particular roles are likely to require. This could be completed in conjunction with the DBF, should Recommendation D9 be accepted.

**Recommendation C15**: The Cathedral should ensure that all relevant staff have completed safer recruitment training within the next three months.

**Recommendation C16**: The Cathedral should establish an email newsletter issued to staff, volunteers and other interested parties, which should include reference to safeguarding and related subject matter.

**Recommendation C17**: The Cathedral should consider and establish models for how it captures the voices and experiences of children, vulnerable adults and survivors. See also Recommendation D9 and Recommendation D23.

**Recommendation C18**: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral mirroring the safeguarding risk register recommended for the DBF as outlined in Part One of this report. The existing SLA which facilitates support from the DST to the Cathedral should incorporate an expectation that specific safeguarding risks that pertain to the Cathedral including measures to manage and mitigate such risks, should be recorded in the Cathedral's safeguarding risk register.


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**Recommendation C19:** The Cathedral should prioritise the review of the SLA between the DBF and Cathedral to ensure it reflects any new safeguarding arrangements.

**Recommendation C20:** The Cathedral should work in partnership with the DST to engage staff and volunteers in building confidence in the safeguarding escalation process and to understand any barriers to swift and effective reporting.

**Recommendation C21:** Volunteers should be provided with a Cathedral email address for the purpose of communicating with others and sharing information.

**Recommendation C22:** The Cathedral should continue to raise awareness with the workforce regarding the privacy notice in respect of data protection.

**Recommendation C23**: The Cathedral should seek to embed and ensure the ongoing maintenance of training records for all its staff and volunteers. Any capacity issues identified as hindering this should be addressed swiftly by the Cathedral's leadership team.

**Recommendation C24:** The Cathedral should ensure all staff and volunteers have completed their required training within a period of no later than three months from the publication of this report.


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**Recommendation C25**: In collaboration with the DBF, the Cathedral should support the implementation of an enhanced training evaluation process to test the impact of training on its own 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. This could be aligned with the DBF's approach to 'culture audits' as part of the follow-up to training.

**Recommendation C26:** Cathedral staff with a core safeguarding function should seek to engage with local multi-agency safeguarding forums or groups (independent to the DBF).

**Recommendation C27:** The details of the professional supervision for the new CSA / CSO should be promptly finalised and communicated. This supervision should incorporate oversight of casework, regular feedback and be used to identify opportunities for continual learning and adaptation. In the view of the Audit, this supervision should be provided by the DSO / Director of Safeguarding.


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# 19 Appendix 3 – Glossary of Abbreviations

| | |
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| ADSA | Assistant Diocesan Safeguarding Adviser |
| AL | Authorised Listening |
| BAM | Bishops' and Archdeacons Meeting |
| BSM | Bishop's Staff Meeting |
| CDM | Clergy Discipline Measure |
| CHILL | Churches Held in Local Leadership |
| CMS | Case Management System |
| CofE | Church of England |
| COG | Cathedral Operational Group |
| COO | Chief Operating Officer |
| CPD | Continuing Professional Development |
| CSA | Cathedral Safeguarding Advisor |
| CSC | Cathedral Safeguarding Committee |
| CSL | Cathedral Safeguarding Lead |
| CSO | Cathedral Safeguarding Officer |
| 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 |
| EAP | Employee and Clergy Assistance Programme |
| EIAG | Early Intervention Assessment Group |
| GDPR | General Data Protection Regulations |
| HR | Human Resources |
| IICSA | The Independent Inquiry into Child Sexual Abuse |


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|---|---|
| ISA | Information Sharing Agreement |
| LADO | Local Authority Designated Officer |
| LLR | Learning Lessons Reviews |
| MDR | Ministerial Development Review |
| NST | National Safeguarding Team |
| OGS | Operational Group for Safeguarding |
| OSG | Operational Safeguarding Group |
| PCC | Parochial Church Council |
| PCR2 | Past Cases Review 2 |
| PSO | Parish Safeguarding Officer |
| PTO | Permission to Officiate |
| RAG | Red-Amber-Green |
| SCIE | The Social Care Institute for Excellence |
| SCMG | Safeguarding Case Management Groups |
| SET | Senior Executive Team |
| SIR | Serious Incident Report |
| SLA | Service Level Agreement |
| SPOC | Single Point of Contact |
| TOR | Terms of Reference |
| WSAB | Worcestershire Safeguarding Adults Board |
| WSCB | Worcestershire Safeguarding Children's Board |


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