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SAFEGUARDING GROUP

Independent Safeguarding Audit of Exeter Diocesan Board of Finance and Exeter 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). Led 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, other relevant material, as well as evidence from surveys, focus groups, direct correspondence and interviews. For Exeter DBF and Exeter Cathedral, this involved the following:

- Over 500 documents being collated and analysed prior to the audit's fieldwork.
- A range of interviews being undertaken with Church officers (staff and volunteers), external partners, victims, survivors and other stakeholders.
- 438 anonymous survey responses being received, which gathered input from key communities connected to the Church. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the DBF, the Cathedral and parishes.
- Eight focus groups.
- A confidential contact form being made available via a dedicated webpage.
- In total, the Audit undertook 55 separate engagement sessions reaching 123 people.

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

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

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

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Part One - Exeter Diocesan Board of Finance

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2 Context

2.1 Situated in the southwest, Exeter Diocese is virtually coterminous with the county of Devon. From bustling market towns and cities to coastal cliffs and beaches, Exeter Diocese is an urban and rural Diocese, encompassing local authority areas of Devon, Torbay and Plymouth. 2,575 square miles, it comprises four archdeaconries, and 21 deaneries. There is a notably high number of benefices within Exeter Diocese, consisting of 489 parishes and 601 places of worship.

2.2 Devon's population is older than the national average, one reason being that it is a popular retirement destination. Despite this older population, the Diocese is home to four universities: Exeter, Plymouth, Plymouth Marjon and Arts University Plymouth. The universities coupled with the internationally renowned Meteorological Office in Exeter are key to driving change and economic success. Despite a large service and manufacturing industry, deprivation is an issue. More rural areas of the county of Devon suffer from poor connectivity. Some of the most deprived areas within Exeter Diocese are located within Plymouth and Torbay. Hidden deprivation is also a stark reality.

2.3 The latest Census data reports a population of approximately 1,214,000 within the Exeter Diocese area. According to statistics provided by the national church statistics team, average all age weekly attendance of those attending worship in their Diocese stands at 17,900. With the Diocese also being a popular tourist destination, this brings holiday visitors to parish churches.

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3 Progress

3.1 Overall, the SCIE audit and PCR2 process made 41 considerations / recommendations for Exeter DBF. These covered a range of issues such as the diversification of the safeguarding team, supervision, policies and processes, quality assurance mechanisms and record keeping.

3.2 The SCIE audit was published in January 2018 and of the 24 'considerations' it made, all were accepted by the DBF. At the time, decisions in relation to the implementation of actions were overseen by the Diocesan Safeguarding Advisory Panel (DSAP), formerly the Diocesan Safeguarding Management Group (DSMG). The action plan created in response to SCIE was seen through to completion under the remit of the former DSA in post. It included the areas of improvement identified at the end of the SCIE report, although it did not cover all 24 considerations suggested by SCIE. That said, the Audit is satisfied that areas not covered in the action plan have been properly progressed.

3.3 The PCR2 was published in September 2021 and made 17 recommendations for improvement. 14 of these had a local focus and three covered national issues. The local recommendations were collated into a RAG rated action plan, which was last updated in 2024. It was reported that all PCR2 recommendations had been met and the evidence obtained by this Audit demonstrated this to be the case. That said, ongoing reassurance that progress is being sustained is an area that should attract ongoing scrutiny via the DSAP.

3.4 The DBF provided the Audit with many examples of good safeguarding practice, such as how the lessons learned through reviews are positively impacting on casework, and how staff have challenged decisions where they have believed more robust action should have

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been taken. The DBF has also introduced local procedures that go beyond national guidance, for example, prohibiting sex offenders from representing the church (including taking part in the choir, organ playing and bell-ringing) and ensuring that all DBF staff undergo Disclosure and Barring Service (DBS) checks.

3.5 Whilst the DBF has undoubtedly made good progress on their improvement journey, some processes require routine attention, such as processing DBS checks, widening DSAP membership and case management activity.

3.6 These issues are addressed within the body of this report.

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4 Culture, Leadership and Capacity

Culture

4.1 The DBF continues to focus on how culture can be strengthened across the Diocese, and it has made good progress in this context. This was reflected in the Audit's independent surveys, one-to-one interviews and feedback from focus group discussions. For many of those engaged, the way they described the prevailing culture was both credible and reassuring. Most felt that a safeguarding culture is now firmly embedded, and they were confident about raising concerns without fear of reprisals. Significantly, these findings were largely mirrored in the feedback from those working, volunteering and worshipping in parishes.

4.2 As part of its ongoing activity to develop and sustain a positive culture, alongside its commitment to continuous improvement, the DBF has introduced a range of well-structured initiatives. These are helping to formalise, reinforce and strengthen its approach. Such initiatives include the Diocesan Wellbeing Panel, a forum that facilitates collaboration and coordination between DBF employees and clergy to enhance wellbeing; the adoption of *Growth Values* (shared expectations that positively influence internal and external behaviour) and the development of the DSAP Culture Sub-group, informally referred to as 'Culture Club'. Launched in part as a response to national guidance, the Culture Club seeks to improve safeguarding awareness and drive improvement in areas such as accountability, training, community engagement, and communication.

4.3 The DBF's Whistleblowing Policy, displayed on the Diocesan website, includes a dedicated section that prompts consideration of whether safeguarding might be relevant to any raised concern. This helps to promote good practice and ensure that concerns are properly evaluated within the context of safeguarding protocols.

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4.4 Notwithstanding the noted strengths, not everyone felt as positive, and it was clear to the Audit that more could be done to enhance the safeguarding culture across the Diocese. Some of the issues repeatedly raised with the Audit included the following: the need to effectively differentiate between safeguarding and conduct issues; to address the frustrations of Parish Safeguarding Representatives (PSRs) due to a perceived lack of understanding amongst PCC (Parochial Church Council) members; to tackle negative perceptions of safeguarding measures; and to prevent the loss of local knowledge when PSRs leave their roles.

4.5 That said, the Diocesan Safeguarding Advisory Panel (DSAP) is fully sighted on these challenges and is currently working to address them. To support DSAP's activity, the Audit makes the following recommendations.

Recommendation D1: The DBF should regularly create opportunities to elicit feedback regarding its culture, including its approach to inclusion, awareness of unconscious bias and whether people feel safe in the various spaces and places within and across the Diocese. In doing so, it should:

a) Use a range of tactics such as surveys, focus groups and third-party facilitators.
b) Encourage feedback from all stakeholders (but also target specific groups when appropriate).
c) Focus on specific themes, such as those highlighted in this report.
d) Ensure anonymity and confidentiality
e) Analyse all information received and share feedback.

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Recommendation D2: The DBF should develop and promote guidance and training resources that help relevant staff and volunteers differentiate between safeguarding and conduct concerns. This material should include practical examples and case studies to illustrate the distinction.

Recommendation D3: The DBF should design and deliver joint training for PSRs and their PCCs.

a) This should be face-to-face and seek to promote a common understanding of safeguarding principles, responsibilities and roles.

b) It should include contextual and role specific case studies and scenarios that highlight and reinforce the importance of the PSR role.

c) As part of this approach establish systems to capture and share the knowledge and experience (including a skills audit) of PSRs, ensuring an understanding of the range of direct and indirect experience PSRs have is captured, so that there is continuity and a process to value and prevent knowledge loss when individuals leave their roles.

4.6 The Audit saw and heard evidence of good collaboration and a healthy culture between the DST and various organisations, both internally and externally. This included partnering with other DBFs, parishes, and their respective leadership teams to address concerns, implement preventative measures, and integrate safeguarding into day-to-day engagement as well as managing cases and low-level concerns. Further evaluation of the DST is set out below.

Leadership

4.7 The overall accountability for safeguarding is understood and unambiguously accepted by the Acting Bishop of Exeter. The Audit heard evidence of their authoritative safeguarding

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practice, and this was corroborated in the files and other material that the Audit examined. The previous Diocesan Bishop had moved the DST into the Bishop's Office, and it was clear that this has facilitated ease of access to and a close working relationship with the DSA.

4.8 The Audit is reassured that the role of the Suffragan Bishop (who has delegated responsibility for a range of safeguarding issues) does not dilute, but in fact complements the Diocesan Bishop's line of sight. It ensures that a meaningful leadership focus can be applied and that the Diocesan Bishop is kept informed of relevant or escalating issues.

4.9 This approach plays to the Suffragan Bishop's considerable practice experience and strengths in the field of safeguarding (with young people in hard-to-reach spaces and places). Going forward, the role has the potential to provide continuity and capture corporate memory. Through the ongoing and close collaboration with the DST, it will help to further embed a safeguarding first philosophy across the Diocese.

4.10 Those in key roles have a firm focus on safeguarding, have committed to and participated in appropriate training, and are able to explain how their work relates to it. This was particularly evident with the highly motivated Diocesan Secretary. Their life experience and work in a range of safeguarding related positions have ensured a deep understanding of the issues within faith-based environments. When engaged by the Audit, the Diocesan Secretary was able to highlight several contemporary strategic challenges, along with potential opportunities to capitalise on regional assistance and support regarding training and mutual assistance. These issues will feature in the Audit's annual report.

4.11 The DBF has a Director of People Services and Safeguarding. They are a core member of the Bishop's Staff Team, the Bishop's Strategy Group, the Diocesan Wellbeing Group and the Senior Management Team. This individual has significant HR experience,

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developed over a number of years across a diverse range of organisations and is undoubtedly an asset to the DBF. That said, they have no statutory safeguarding background or operational safeguarding experience and would therefore be unable to provide the insight, identification of safeguarding risks and challenge expected of a suitability qualified Director of Safeguarding / DSA. Furthermore, the current naming convention could create a false sense of security that safeguarding issues will be identified or covered in such forums.

Recommendation D4: The DBF should amend the naming convention for the Director of People Services and Safeguarding to more accurately reflect the role.

4.12 The archdeacons have key safeguarding roles, including leadership, pastoral support, and promoting training. However, they face capacity challenges (as do others). They provide a structured level of support to Core Groups, which are well-chaired by the highly effective Bishop's Chaplain and incorporate a safeguarding element into their work during Visitations.

Recommendation D5: Time and capacity permitting, the DST / DSA should work with the archdeacons to establish how they could develop the safeguarding elements of their role. For example, this could include reinforcing the use and dip-sampling of dashboards, further embedding safeguarding prompts within their general work, and considering how they could configure a safeguarding PSR network based on deaneries.

Governance

4.13 The DBF operates a range of appropriate governance and oversight meetings. These reflect the expectations of the CofE and other requirements, such as those issued by the Charity Commission. That said, the focus of safeguarding within some of these groups could be better articulated to further strengthen the DBF's arrangements. The Audit makes the following recommendations in this regard.

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Recommendation D6: The Bishop's Council, Bishop's Staff Meetings, and DSAP should implement the following:

a) **Skills, Inclusion, and Diversity Audits:** Conduct audits to assess the skills, inclusion, and diversity of their membership and attendance. This will help ensure these bodies are appropriately representative and can effectively address safeguarding concerns from various perspectives.
b) **Thematic Approach to Safeguarding Oversight:** Adopt a thematic approach to safeguarding oversight and preparation for Charity Commission reporting. This should involve coordinating a focus on the National Safeguarding Standards at each meeting, with a specific emphasis on either operational or strategic compliance, depending on the level of governance. For example, a three-year programme could focus on different elements of the standards at each meeting. This structured approach will ensure comprehensive coverage of key safeguarding areas.
c) **Review of Risk Registers:** Regularly review and update risk registers based on the Audit's outcomes and the key strategic issues that may impact the workforce's stability, health, and wellbeing.

4.14 The Bishop's Council and Bishop's Staff Meeting are frequent and routine, and the DSA is invited when it is thought appropriate. This meeting is key and notwithstanding the fact that some of those around the table will have a good understanding of safeguarding in the context of the Church, no one will possess the experience or nuanced understanding of a safeguarding professional. Such professionals are much more likely to see the indirect safeguarding issues when a broad range of initiatives or strategies are being discussed. In the opinion of the Audit, the DSA should be a member of this forum by right rather than by invitation. The Audit welcomes the fact that this is subject to current consideration by the Acting Bishop of Exeter and makes the following recommendation in this regard.

Recommendation D7: The DSA should attend Bishop's Council and staff meetings by right rather than invitation.

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DSAP

4.15 The DSAP is active, engaged and led by a chair with credible and relevant statutory experience. The Chair is thoroughly committed to driving improvements in safeguarding and has established positive relationships with the DST, DSA, and senior DBF and Cathedral leaders.

4.16 Whilst there is good internal representation, DSAP membership should be expanded, and consistent attendance by members should be encouraged. The Audit was made aware of the efforts that DSAP has made to engage statutory partners; a persistent challenge seen in other areas. However, statutory partners are stretched and securing the attendance of appropriate individuals with the necessary experience and authority at meetings outside of the statutory framework will continue to be difficult. To address this, the Audit makes the following recommendation.

Recommendation D8: To improve communication and collaboration with statutory safeguarding partners, the DSAP Chair (or a designated representative) should hold brief, focused one-to-one meetings with key statutory leads two or three times per year. This will allow for valuable information exchange on safeguarding trends, legislation, and best practices, which can then be shared with the full DSAP to enhance their understanding and effectiveness.

4.17 A review of the DSAP minutes demonstrates that meetings have considered a range of relevant issues. These include, but are not limited to, capacity and resourcing, balancing high caseloads within a small team, and the division of operational and strategic oversight. Other areas of focus have included culture and negative perceptions, training and development (including the need to shift from a deficit model to a strengths-based approach), and 'light-touch scrutiny' that avoids excessive bureaucracy.

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4.18 Additionally, the DSAP has considered the roles of the Chair and Regional Lead in attending case management meetings. These are appropriate areas of focus, which could be further enhanced by adopting a more intrusive framework that seeks higher levels of reassurance. This could be achieved by going beyond simply noting what was reported and, instead, actively seeking further information. Improving data collection, analysis, and internal auditing of key themes would strengthen the DSAP's insight, the veracity of the reassurance offered, and its overall impact.

Recommendation D9: The DSAP should reconfigure its framework with a longitudinal programme that reflects a structured and themed approach to scrutiny. This should focus on:

a) The application of the National Safeguarding Standards.
b) The division of operational and strategic oversight (a position already under consideration within the DBF).
c) The management and oversight of action plans.
d) The commissioning of internal audits.
e) Evidence of impact.
f) Alignment of operational and strategic risk registers (with DSAP Business).

4.19 Feedback from DSAP attendees indicated that, on occasion, some panel members could exert their authority in a way perceived to inhibit open discussion. While acknowledging that authoritative guidance from senior leaders is sometimes necessary, the independent chair's role in fostering a balanced environment that encourages professional curiosity, and challenge is crucial and must be respected by all. To this end, it is for the Independent Chair to open, manage and close discussions.

4.20 The status of DSAPs is a national matter and will be addressed as part of the Audit's feedback to the NST. This will include the Audit's view that independent chairs of DSAPs

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should be appropriately and uniformly remunerated across the CofE. Locally, the Audit believes the DSAP would be further strengthened through ensuring a consistent training offer exists for its members.

Recommendation D10: To further professionalise and develop the overall performance of the DSAP the DBF should provide role-specific and locally contextualised training for its members.

4.21 The DSAP Chair recognises that they have work to do to ensure the authentic voice of victims and survivors is heard. When engaged by the Audit, they acknowledged the challenges and reinforced their commitment to establishing a mechanism to achieve this.

4.22 Whilst welcoming the fact that plans are in place to explore how this can be done, including the potential for regional survivor engagement, the Audit believes this work needs to be expedited. It recommends that the DSAP broaden its outreach to expand opportunities to listen to victims and survivors.

Recommendation D11: The DSAP should expedite its work to establish regional victim and survivor networks. It should also map the opportunities available to reach out to other existing groups to request opportunities to engage in listening events.

Clergy Files (Blue Files)

4.23 Blue Files are efficiently managed within the current framework by an excellent Bishop's Chaplain and their team. Incoming files are examined and reviewed by both the DSA and Bishop's Chaplain. This is good practice.

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4.24 Critically, the Audit's review of these files evidenced a high degree of professional curiosity and exemplary authoritative practice by the Diocesan Bishop and supporting staff. For example, one incoming file reviewed by the Bishop's Chaplain and DSA was found not to have been updated with any documents over an eight-year period. Another unconnected file drew significant concerns about the veracity of a Clergy Current Status Letter (CCSL) sent from a different area. These concerns were escalated appropriately and are now subject to ongoing enquiries.

DST and Capacity

4.25 The DST are an experienced, blended team and an asset to the Diocese as a whole. They are exceptionally well led by a DSA/DSO with significant operational and strategic level experience.

4.26 The team benefit from multi-disciplinary experience. Team members have complementary skills developed through their respective professional backgrounds and work well within the limits of current capacity across the DBF, the Cathedral and parishes.

4.27 There is also significant evidence of effective collaborative working with external agencies and statutory authorities not least the relevant LADOs, who expressed a high level of confidence in the team. This sentiment of confidence was further echoed in interviews with personnel across the Diocese.

4.28 That said, the DST was described as 'operating on the edge of sustainability'. The Audit concurs with this assessment. Regardless of the team's undeniable strengths, it does not have the capacity to meet the ambition of the church to grow, nor in the opinion of the Audit, an ability to manage long-term extraction or diversion of resources. This is evident in several areas not least the fact that all too frequently, the DST work beyond their agreed hours to ensure supportive and timely responses.

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4.29 Many of the individuals who rely upon the DST commented that you '*could get them in an emergency*' but it was harder to engage with the team on non-urgent issues. Worryingly, some people said they knew the pressure they were under and therefore didn't want to bother them.

4.30 It was clear to the Audit that senior leaders are aware of these pressures and whilst they wish to support and reinforce the DST, they are limited by current budgetary constraints. The Audit was told that investing more resource in the DST would mean reducing resource elsewhere. This places everyone in an unenviable position and will attract analysis, comment and a recommendation in the Audit's annual report.

4.31 That said, the Audit believes that the DBF cannot afford to fail to invest in its DST and makes the following recommendations regarding addressing the immediate risks.

Recommendation D12: Leaders in the DBF and the 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 to provide strategic oversight, advice, and safeguarding support across the DBF, parishes, and the Cathedral. The individual in this role would be a member of the senior leadership team and assume the authority vested in a Diocesan Safeguarding Officer (DSO). *A paper will be published expanding on the rationale for this role shortly.*

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Recommendation D13: The present safeguarding resource should be reinforced with the appointment of an additional fulltime Assistant Diocesan Safeguarding Advisor (ADSA). The current admin post should focus exclusively on support to the DST and the Dashboard Program and be released from other HR tasks that are currently undertaken (e.g. DBS checks).

Training (in most cases) could continue to be outsourced. A cost benefit analysis should be carried out to establish and verify the advantages of this model versus the appointment of a dedicated trainer (see Recommendation D28).

A Cathedral Safeguarding Advisor (CSA) should be appointed as part of the DST. Whilst the CSA would be located in and line-managed day-to-day within the Cathedral, they would be part of the DST and receive professional supervision from the Director of Safeguarding (or the DSA if the recommendation for a Director of Safeguarding is not accepted).

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5 Prevention

5.1 Safer recruitment is a priority in the DBF and the arrangements in place for this aspect of safeguarding are secure. Local practice evidences many strengths, with processes being aligned to legislation and relevant guidance issued by the CofE.

5.2 The House of Bishop's policy on *Safer Recruitment and People Management* (SRPM) is followed, and supporting good practice, the Audit saw evidence of the DBF using checklists, standard operating procedures, role descriptions and asking safeguarding related questions during interviews. Positively, it also saw evidence of practice going beyond that outlined within the CofE policy. One such example was the recently introduced policy requiring all DBF staff (whose role does not qualify for an Enhanced DBS check) to have a Basic check. This approach has been extended to all PCC members, including Churchwardens. Where parish volunteers are not eligible for an Enhanced DBS check, but occupy roles of responsibility, the DBF advises that a Basic check is recommended. This is good practice.

5.3 The records reviewed by the Audit showed that all DBF staff have an up-to-date DBS check recorded within the last three years. There are defined procedures in place to manage instances where information is disclosed through the recruitment process or where a 'blemish' is returned on a DBS check.

5.4 At parish level, PCCs are encouraged to use the Thirtyone:eight '*Online Eligibility guide*'[2] to clarify what level of DBS check is required for specific roles. Where there is uncertainty, either the DST or Thirtyone:eight can be approached for clarification and advice. The DBF has also produced a detailed guide called '*Processing DBS Checks in our parish and FAQs*

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[2] https://thirtyoneeight.org/dashboard/eligibility-guide/

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2023'[3] which outlines the adopted eligibility criteria.

5.5 As another example of good safeguarding practice, whilst the DBF has a standard policy in relation to the recruitment of ex-offenders, it has introduced additional arrangements to enhance the mitigation of risk in this context. These involve restrictions being placed on anyone with a conviction for a sexual offence from holding a representational role such as bell-ringing, leading or taking part in choirs or playing the organ.

Recommendation D14: The DBF should amend the Parish Recruitment of Ex-Offenders Policy (Template) available on the website[4] to reflect the exclusions on holding representational roles.

5.6 At parish level, there is a recognition by the DBF of the demands placed on Parish Safeguarding Representatives (PSRs) and a range of tools and guidance have been developed to help parishes effectively deliver their safeguarding functions. As examples, Parish Safeguarding Dashboards have been adopted and the DBF has invested in Safeguarding Hubs that are available for all parishes. DBS Workshops, PSR induction sessions and online safer recruitment training provide additional layers of support.

5.7 The Audit heard from PSRs and clergy about the positive impact of the Parish Safeguarding Dashboard on their practice.

"I love the Parish Safeguarding Dashboard" Parish Clergy

"I find the parish dashboard absolutely invaluable, and I wouldn't be without it." PSR

5.8 The DST leads by example and is routinely involved with external agencies, dealing with individual cases and promoting safeguarding awareness in the context of the church. For

[3] https://exeter.anglican.org/wp-content/uploads/2023/06/Processing-DBS-Checks-in-our-Parish-and-FAQs-June-2023.pdf
[4] https://exeter.anglican.org/parish-toolkit-for-safeguarding/recruitment-of-ex-offenders-sample-parish-policy-3/

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example, the DST has been involved in *Allegation Management Meetings* chaired by the Local Authority Designated Officer (LADO) for children's cases, and the Duty Manager for People in Positions of Trust (PIPOT) in adult cases. It has also been engaged in other statutory meetings, (such as Child in Need meetings) and meets regularly with Management of Sexual or Violent Offenders (MOSOVO) officers in the police and the probation services. With a focus on Prevent issues and monitoring community tensions, the DST represents the DBF on the Counter Terrorism Independent Advisory Group (CTIAG). Internally, safeguarding is a discussion topic during DBF staff meetings, Synod, and department-specific meetings, such those involving the Deliverance Ministry Team.

5.9 To help meet their needs, build relationships and develop awareness, the DST engages in direct, in-person meetings with PCCs throughout the Diocese. Whilst undoubtedly beneficial, efforts have been somewhat constrained by capacity within the team. That said, the Audit fully supports the intention of the DST to expand these activities where possible.

Recommendation D15: The DBF should facilitate regular face to face sessions and/or networking events for PSRs to learn and share good practice.

Recommendation D16: The DBF should consider facilitating an annual PSR networking event where they are able to come together and hear from leading safeguarding professionals on new and emerging themes as they relate to their role.

5.10 The Audit recognises that effective communication about safeguarding is key, with people needing information at different stages, in different formats and in different locations. In this respect, the DBF is active in promoting and raising awareness about safeguarding and the different types of harm that people can suffer. One notable example seen by the Audit

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involved a recent online news article about church-related email scams[5] and associated coverage on BBC Radio Devon. Further safeguarding-specific campaigns have included the sharing of a video promoting the use of the Parish Safeguarding Dashboard, Safeguarding Sunday and Domestic Violence Awareness training.

5.11 Using a variety of awareness-raising methods is essential for ensuring effective communication and reaching a broad audience. In this respect, the DBF has adopted digital and social media channels, mainstream media, first hand video testimonials, and both general and specialist newsletters. With opportunities to attend communications and engagement training, church officers at parish level have also been supported in this regard. This is good practice.

5.12 The DBF's website[6] serves as a central communication hub which performs well with search engine optimisation (SEO). 'Safeguarding' is easily located through the primary menu and the associated sub-section is well-organised, comprehensive and reflects a focus on the user's needs. This includes signposting to external bodies, support on safer recruitment, access to safeguarding policies and guidance and a thorough 'Parish Toolkit for Safeguarding' webpage.

5.13 The DBF recognises the importance of good communication and its correlation with cultivating a positive safeguarding culture. In this context, the Audit supports the DBF's plans to increase its use of storytelling and victim / survivor testimony through the medium of video.

[5] https://exeter.anglican.org/devon-churches-scam-emails-warning/
[6] https://exeter.anglican.org/resources/safeguarding/

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Recommendation D17: The DBF should consider and develop a communication plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of the followers, adopting different techniques specific to the platform and utilisation of relevant awareness days, campaign and events to amplify the message.

5.14 As with all good communication, this needs to be a two-way process and actively engaging children, young people and vulnerable adults is an important part of successful prevention planning and implementation. The Audit saw evidence of the DBF supporting and promoting a culture of actively listening to people, hearing their views and responding as appropriate. This is good practice. With regards to hearing the specific voices of victims / survivors of abuse and how the DBF learns from their experiences, see the Victims and Survivors' section of this report.

5.15 Reflecting a thorough approach to its prevention activity, the Audit saw evidence of template risk assessments that are completed for a range of Church activities. These included pastoral and home visits (lone working), blemished DBS checks, standard risk assessments, Safety Plans (Attendance Agreements) and domestic abuse risk assessments (the DASH risk assessment tool). Further parish level risk assessment templates are available on the DBF website.

5.16 In terms of lone working, guidance is in place within the DBF staff handbook. This provides practical guidance tailored to employees. For others within the Diocese, guidance is provided through a range of material such as the Clergy Field Guide, Code of Safer Working Practice and the Parish Safeguarding Handbook.

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5.17 The Audit also saw evidence of safeguarding being considered in a broader sense within the physical spaces being occupied. One such example is how the DST supports and advises parishes where there are risks posed by the misuse of church outbuildings.

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6 Recognising, Assessing and Managing Risk

6.1 The safeguarding arrangements in place across the Diocese help to ensure the recognition, assessment and management of risk. They include a dedicated and highly experienced DST, alongside safeguarding policies, procedures, recruitment practices, and training. A defined Service Level Agreement (SLA) ensures appropriate support is available to the Cathedral, primarily from the DSA. Well-defined reporting pathways and communication channels for concerns increase the likelihood of early risk detection, collaborative decision making, and timely interventions.

6.2 The DBF maintains a risk register that comprehensively addresses a wide range of corporate issues, with risks clearly documented and mitigating factors noted. The register was last reviewed in May 2023 and undergoes a formal review annually. However, the risk register only briefly mentions safeguarding and opportunities exist for the DBF to enhance this process by creating a dedicated safeguarding risk register. This would allow for a more focused approach to safeguarding and enable the DBF to better articulate and mitigate risks in line with the National Safeguarding Standards. The Audit believes that the DBF's approach to risk management would be strengthened by considering broader societal issues, such as the Jay report, the cost of living crisis, and the exponential rise in mental health issues.

Recommendation D18: 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 (see also Recommendation D5).

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Recommendation D19: The DBF should ensure its approach to risk management and its relevant risk registers take account of the impact of wider societal issues.

6.3 The DST has set clear criteria for triaging safeguarding cases. These criteria determine the appropriate pathways for cases brought to its attention. Outcomes typically involve one or more of the following:

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

6.4 The DST sensibly sets a 'low threshold' and reporting to the team is encouraged through training, induction and regular communication across the Diocese. This allows for a good line of sight on issues where risks might not be properly understood by the reporting person. It also ensures that the DST is an effective touch point for those seeking support.

6.5 The DST described a large proportion of its workload as being 'subthreshold' in terms of safeguarding, with many enquiries being resolved through advice, guidance and signposting. Positively, the teams approach in this context enables them to foster relationships, build trust and create an environment where concerns are more likely to be escalated. Indeed, interviews across the Diocese indicated there was a high degree of confidence in how the DST operates.

6.6 To help decide which cases require action by the DST, the team applies thresholds that are linked to specific criteria, although the process remains sufficiently flexible for each case to be judged on its own merits. For example, whilst the Care Act 2014 definition of

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an 'adult at risk' is used to determine allocation, cases falling outside of this description are also engaged by the DST. In this sense, thresholds are very much determined based on presenting circumstances and a sensible approach is taken to what the DST gets involved with. For those cases not meeting the definition of an 'adult at risk, the DST will respond where domestic, sexual and psychological abuse are features. For other cases, these are signposted for support and / or can be passed to the Archdeacon for a response.

6.7 In one case seen by the Audit, a situation involving a vulnerable adult was not taken on by the team due to the statutory Care Act definition not being met. Notwithstanding the fact that appropriate referrals to the police and offers of pastoral support were made, the individual involved was disappointed that no further action was taken by the DST.

6.8 Beyond the importance of how victims and survivors might perceive such decisions, there is the potential for the messaging about the DST's low threshold being diluted. Put simply, if people don't believe the Church will want to be involved in their case, this may act as a barrier to them contacting the DST.

6.9 Furthermore, given the DBF's status as a charity, the focus on the Care Act definition might be incongruent with the expectations set out by the Charity Commission for England and Wales. The Commission applies a much more flexible definition of safeguarding and sets an expectation on 'trustees' to '*take reasonable steps to protect from harm people who come into contact with the charity*'. The protection from such harm does not uniquely correlate with the Care Act definition. By default, there is a risk that any stringent use of the Care Act 2014 to determine 'eligibility' might place the DBF in conflict with the Charity Commission's statutory guidance. This will be the subject of consideration in the Audit's Annual Report.

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Recommendation D20: When determining the allocation / ownership of safeguarding cases within the DST, decisions should continue to be made on a case-by-case basis. Professional judgement should be used to allow for the inclusion of adult cases that fall outside the statutory definition of adults at risk.

6.10 The DST records details of relevant cases on an electronic database and maintain an enquiries folder for other matters. Whilst the team make good use of this system, it presents some challenges. Information can be easily deleted by mistake or overwritten and, retrieving specific details can be cumbersome. However, the team is preparing to transition to the national MyConcern case management system in October 2024 which should help mitigate some of these issues.

6.11 At the time of the Audit, there were 89 open cases to the DST. Within these cases, a robust approach to safeguarding was seen by the Audit, with evidence of effective responses to both routine and emergency contacts. This included collaboration with other dioceses and statutory agencies, the convening of safeguarding case management groups, conducting risk assessments and providing support to those involved.

6.12 There was also evidence of the DST proactively considering the potential of future risk. For instance, in one case, an alert from another Diocese prompted swift action regarding a person of concern in the local area. Police and Probation Services were quickly contacted, and a local deterrence plan (including safety advice) was provided to parishes.

6.13 The Audit also saw persistent evidence of professional curiosity, challenging conversations, effective and authoritative decision-making and appropriate caution regarding actions which could negatively have impacted live police investigations. The Audit is confident the persistent approach of the DST towards its safeguarding functions contributes to making people safer across the Diocese.

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

6.15 For instance, the Audit found evidence of the effective use of Safety Plans to manage risks posed by convicted offenders and others who present a risk within the Cathedral or local parish settings. At the time of the Audit, 34 active Safety Plans were in place. These are regularly reviewed by the DST, in collaboration with the parish priest and relevant statutory agencies. Each plan includes specific prohibitions and is subject to documented, in-person reviews, which the Audit believes enhances the rigour and seriousness of the process. This is good practice.

6.16 The number of plans in place does not fully capture the extensive time invested in the safety planning with persons of concern (PoC). A notable example of good practice was seen by the Audit, where restrictions prohibited a PoC from using certain toilets (as these were in an unsupervised area of the Church). This is recognised by the Audit as good practice.

6.17 The Audit met with an incumbent and respondent to a Safety Plan. The incumbent was very clear of the requirement to consult with the DST regarding any proposed changes to Safety Plan arrangements. It was evident that there was a good professional relationship between the two parties. The respondent demonstrated knowledge of the conditions of the plan, and the associated risks were transparent and acknowledged. The incumbent also referred to the use of scenario-based discussions during the review process to develop clarity and comprehension of the plan.

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6.18 The DST has experience in managing sex offenders and it is encouraging that further training is planned. The Audit recommends enhanced training for those who work directly with this cohort of offenders (beyond the DST). The provision of bespoke localised training is addressed in more detail in Learning, Supervision and Support section of the report (see Recommendation D29).

6.19 The Audit saw convincing evidence of the effective use of Safeguarding Case Management Groups (SCMGs) in managing complex cases involving church officers. The current arrangements reflect good practice, with meetings being routinely chaired by the Bishop's Chaplain and attended by the Registrar. The meeting follows a structured agenda which promotes effective collaboration, scrutiny and information gathering. Diarised slots for archdeacons every week facilitate attendance by the right people when required. This is good practice.

6.20 A media release, following the conviction of an offender who had been subject to SCMG discussions, demonstrated openness and transparency, and offered support to anyone impacted by the case. This was seen by the Audit as an example of good practice.

6.21 The Audit also saw examples of good record keeping, a victim / survivor centric approach to decision making and proactivity in information sharing with the police. Minutes of SCMGs evidenced a consistency of approach, challenging and difficult conversations and robust decision making.

6.22 That said, the Audit noted concerns regarding the increase in referred cases to the SCMG and what was described as being a 'cumbersome and administratively heavy' process for what should be business as usual for the DST. There is a risk that the effectiveness of SCMGs will be diminished if these are not delivered in line with national guidance.

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Recommendation D21: SCMGs should continue to be convened in line with the House of Bishops' policy and practice guidance, whilst maintaining a degree of flexibility for higher end complex cases.

6.23 The DBF has an annually reviewed Service Level Agreement (SLA) with Exeter Cathedral. The agreement articulates clear safeguarding arrangements, stipulating that the DST will provide support to the Cathedral in terms of the delivery of core safeguarding activity. Whilst these arrangements seem to work well, this adds additional work demand for the DST.

6.24 The DBF, as a registered charity, is required to submit Safeguarding Serious Incident Reports (SIRs) to the Charity Commission. The Audit was informed that there is adherence to the House of Bishop's national guidance on this issue. The DBF has submitted five SIRs, and the Audit was advised that all cases had been shared with the National Safeguarding Team (NST).

6.25 The challenges of handling safeguarding issues can lead to differences of opinions among decision makers. The DBF has wisely addressed this by establishing a clear escalation process within their Diocesan Safeguarding policy, which is readily accessible on their website. Furthermore, this process is reinforced by a broad range of guidance and supporting documentation, including a Whistleblowing policy, a Safeguarding Complaints policy and a comprehensive flowchart to help navigate complex scenarios.

6.26 The DSA receives formal casework supervision from the NST's regional safeguarding lead on a six-weekly basis, there is routine informal contact, and the regional lead often works from the DST's office. This provides a good level of support for the DSA and the wider team. Quality assurance of practice is regular and takes place via the dip sampling of cases. This is good practice.

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6.27 The Audit saw evidence of structured supervision sessions which largely address complex cases and wider strategic issues. They also consider the wellbeing of the DSA, community impact considerations and communication strategies. Discussions are well documented with the date of the next supervision session recorded. The oversight of casework could be enhanced by dip-sampling including lower-level cases and those that have resulted in no further action. As per previous Audit reports, this will be raised with the NST.

Recommendation D22: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DSA and NST. This will also be raised by the Audit with the NST.

6.28 The DSA provides line management and support to members of the team through monthly case management meetings. The Regional Manager and DSAP Chair occasionally attend. There are also six-monthly performance development reviews with the team.

6.29 The supervision currently provided to the ADSAs is effective, but cases discussed and actions arising from these discussions are not reflected in the chronology of events on case records. Doing so would strengthen oversight, sharpen the audit trail and provide better information should cases need to be covered during periods of absence.

6.30 The DST should also ensure it routinely records the rationale for decisions when cases are closed.

Recommendation D23: Where cases are discussed during supervision, the recording of the discussion and the actions agreed / decisions made, should be included on individual case records. These should follow a consistent format and be uploaded as soon as practicable after the supervision session has taken place.

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Recommendation D24: For cases resulting in no further action by the DST, case records should always reflect the rationale for the decision being made.

6.31 Measures are in place to ensure that personal information is stored and shared in ways which are compliant with the Data Protection Act 2018 relevant regulations, including GDPR. These include storing data in a diocesan database, with access being limited to employees, and the use of work credentials to gain access. Additional security protocols include keeping files in secure cabinets, locked rooms, granting specific permissions for access and regularly reviewing privacy notices to reflect any changes in data processing. Security is further enhanced by training clergy, staff and volunteers on data protection, information sharing and how to identify data subject requests. Data protection is also a prominent feature on the DBF risk register.

6.32 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 Victims and survivors of abuse often endure profound trauma as a result of their experiences. Many may not report the abuse at the time it takes place, perhaps due to a lack of awareness, isolation, shame, or fear of reprisal.[7] Disclosing abuse can be a daunting and unfamiliar process, fraught with challenges. [8] In light of this, Church bodies must cultivate and maintain supportive environments where victims and survivors feel heard, taken seriously, and reassured they will receive effective help and protection.

7.2 The Audit collected valuable feedback from victims and survivors within the Diocese through an anonymous online survey. The survey results revealed a diverse range of individual experiences, highlighting both positive and negative aspects. To further enrich the quantitative data from the survey, the Audit conducted one-to-one discussions with individual victims and survivors. These in-depth conversations provided essential context and nuanced perspectives, with participants helping the Audit to develop a more comprehensive understanding of the issues.

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

[7] No one noticed, no one heard, NSPCC 2013, https://learning.nspcc.org.uk/research-resources/2013/no-one-noticed-no-one-heard
[8] '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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7.4 The Audit did, however, see evidence of the DSAP 'Culture Sub-group' actively working to address this shortfall. While the group is still in its early stages, initiatives are currently underway and the DBF recognises the need for increased collaboration with survivors. The Audit supports this. Authentically engaging with groups that have experienced Church-based abuse can foster mutual benefits and align with the DBF's overall objectives. Such partnerships could involve joint development and consultation on safeguarding materials and the support offered to survivors, as well as valuable insights into areas for learning, growth, training, and improvement.

Recommendation D25: The DBF should scope and develop a formal plan about how it will engage, consult and collaborate with victims and survivors. Any related initiatives should be meaningful, trauma-informed and developed in accordance with '*Responding Well to Victims and Survivors of Abuse.*' See also Recommendation D10.

7.5 The DBF has arrangements in place to support victims and survivors of church-related abuse, and the Audit found good practice in this respect. These measures include a policy outlining the provision of therapeutic support to victims and survivors, the offer of a Bishop's letter of apology or to meet and signposting to Safe Spaces, a free and independent support service for anyone who has been abused by someone in the Church or as a result of their relationship with the Church of England.

7.6 The Diocese of Exeter's website contains a range of signposting material, advice and an outline of the local commitment to supporting victims and survivors of abuse.[9] This includes access to the support service, Safe Spaces, the Independent Listening service from First Light and moMENtum, a support group for male survivors of childhood sexual abuse.

[9] https://exeter.anglican.org/resources/safeguarding/victimsandsurvivors/

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7.7 In one case, the Audit heard directly from a victim / survivor of church-related abuse. This individual demonstrated the resilience and strength of a survivor who, with the right support, managed their trauma and channelled their experiences into positive action and personal growth. This individual commended the DST for its proactive and supportive response. They specifically mentioned the openness, empathy, and empowerment they experienced throughout the process and their engagement with the DSA.

"*[The DSA] has been so considered and thoughtful. He has not overloaded me with information. He has given me the right information at the right time. There's clearly been a sort of phased approach to how he has sent communications through*"

7.8 This individual also commented how the DST is trauma-informed, empowering and effectively prioritises needs. It ensured that the safeguarding process was well-managed, and that practice was undertaken in a way that minimised further harm.

"[The DSA] has been very good at managing that process. From the very first contact that I had…the tone of the email… I couldn't fault it at all"

"I found their [the Safeguarding Team] response very surprising, in a good way"

7.9 In recognition of its commitment to a relational and person-centred approach, the DST has undertaken trauma-informed training. Two members of the DST have also completed specialised training with Sexual Abuse Listening Therapy (SALT), a Christian charity providing counselling and support services to victims of abuse.

7.10 The DBF noted that accessing local support services can be challenging due to the discrepancy between the church's broader definition of safeguarding and the narrower

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criteria used by statutory agencies. As a result, many referrals made by the DST may not meet the statutory threshold for help and protection. Even when they do, the DST highlighted that limited resources can often result in support being largely insufficient. Despite these challenges, the credibility and experience of the DST allows them to effectively communicate with relevant services and advocate strongly on behalf of the individuals with whom the DST is engaged.

7.11 The Audit spoke to an individual (victim / survivor) that still engaged with the Church. The Individual had reflected on some of the improvements that have been made, not least the provision of professional safeguarding support by the DST. However, they retained the firm view that the Church could not be trusted.

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8 Learning, Supervision and Support

8.1 The importance of creating opportunities that positively impact on the knowledge, skills and experience of the workforce is understood and actioned by the DBF. There is, however, no safeguarding training strategy in place to help direct the DBF's focus on this issue. Whilst the overarching programme is consistent with the CofE's Safeguarding Learning and Development Framework, a local strategy (as seen in other areas) is likely to add value.

8.2 For example, a defined strategy would help the DBF to articulate its overall intentions for training, reinforce the key messages within the national framework and set out the processes for identifying training needs, delivery and evaluation. It would also help to emphasise the need for safeguarding to be rooted in all aspects of the Church and provide the DBF with a coherent framework against which progress could be robustly tested.

Recommendation D26: The DBF should create a Diocese-wide training strategy that aligns with the CofE's Safeguarding Learning and Development Framework.

8.3 In terms of delivery, training sessions are facilitated by both the NST and the DST, with specific courses being provided for a range of roles, such as churchwardens, spiritual directors, and PSRs. Training on '*ministry of reconciliation'* and domestic abuse is also included that broadens safeguarding awareness across the Diocese. Beyond the church-led training, staff and volunteers are also encouraged to access relevant courses offered by Local Authorities and safeguarding partnerships / boards, although attendance at any such training is not formally recorded by the DBF.

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8.4 Content wise, safeguarding courses align to the NST modules, although the DBF was noted as having added content to the leadership training. This was due to the national training package no longer referencing Safety Plans.

8.5 Whilst training is made accessible online and many across the Diocese are supportive of this method of delivery, others referred to challenges in this context. For example, whilst online training includes relevant content warnings, there is no signposting to specific avenues of support. For some, they felt this could exacerbate the vulnerability of participants if completing courses at home and / or on their own. The Audit will raise this with the NST.

8.6 That said, arrangements are in place that allow for some staff and volunteers to use a 'pass' on specific courses. This has been introduced to recognise that some content could potentially trigger trauma in those participating based on their own personal experiences. Whilst this is a sensible position to adopt, for those affected, bespoke arrangements need to be developed to ensure some level of training can be delivered.

Recommendation D27: For those who are unable to complete certain safeguarding training due to the potential of trauma arising from their own personal experiences, local arrangements should be developed by the DBF to ensure access to training remains available for this cohort. This could be achieved through 1:1 or small group sessions being delivered face-to-face by the DST.

8.7 The evaluation of training is somewhat limited to monitoring compliance via the national safeguarding training portal and the use of local spreadsheets. In the Audit's opinion, a more detailed process that assesses the impact of training on practice, outcomes and behaviours is likely to accrue significant benefits for the DBF. Indeed, the existing arrangements leave a gap in the DBF's understanding of whether training is directly influencing practice and making people safer.

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8.8 The DBF acknowledges the need for a more structured approach in this area and the Audit recognises the argument that there is a role for the NST on this issue. That said, notwithstanding the limited resources in the DBF, a very simple mechanism could be introduced that begins to collate evidence in this context.

Recommendation D28: 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. Random cohorts of staff and volunteers (and their managers) should be approached three months after attending training (via email / short survey) to reflect on the ways they have used what they learnt and to provide examples of how this has helped their practice.

8.9 Data seen by the Audit identified significant engagement in training across all levels in the Diocese. There is a good system of sending reminders that ensures clergy, LLMs, and other roles stay up to date with their safeguarding training requirements. Where needed, prompts to clergy include a letter from the Bishop, although positively performance remains strong. Leadership and Senior Leadership Pathways have a compliance rate of 97% for licensed clergy and 99% for licensed lay ministers. Whilst the DBF has made good progress in this respect, it is important to highlight that for a small percentage of staff and volunteers, their training is out of date. The Audit recognises that efforts by the DBF are underway to address this.

8.10 Overall, the DBF continues to ensure that safeguarding learning is prioritised, and it is delivering a good range of opportunities across the Diocese. That said, as seen in other dioceses, a dedicated training role would support the DBF to attain a much higher degree of performance. Whilst acknowledging the resource requirements, the recruitment of a dedicated trainer would significantly help the DST to meet existing demand and expand its ability to deliver a range of bespoke training. The Audit believes this is an area worth

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considering in the context of a cost-benefit analysis measured against the current outsourced provision.

Recommendation D29: The DBF should consider the recruitment of a dedicated safeguarding trainer. This should be done in the context of a cost-benefit analysis measured against the current outsourced provision.

8.11 Indeed, bespoke training (that is both role and subject specific) is likely to help improve the overall safeguarding arrangements across the Diocese. For example, a concentrated focus on training about the behaviour of sex offenders, de-escalation, exploitation and digital safeguarding are all seen by the Audit as being pertinent to particular settings and personnel. There is a strong argument that these (and other) topics should feature as part of an enhanced training offer that is delivered locally, although the completion of a training needs analysis would be required to properly inform what is needed by whom in this context.

Recommendation D30: The DBF should complete a training needs analysis covering the training needs of the DBF, Cathedral and those within parishes to identify what contextual themes would be relevant for local delivery.

8.12 Staff in safeguarding roles are provided with a comprehensive induction programme designed to equip them with the necessary confidence and knowledge for their role. This induction is completed prior to any direct engagement with children, young people, and vulnerable adults. It is regularly reviewed, updated, and quality assured. The Operations Director collaborates closely with the DSA to ensure that safeguarding is appropriately covered, that mandatory online training is completed, and that new staff members meet the DST and receive a presentation from them.

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8.13 The DBF prioritises staff wellbeing through a range of initiatives and structured policies. A Wellbeing Strategy, approved in January 2024, supports a healthy work-life balance for employees and is complemented by a Hybrid Working Policy that allows flexibility between home and office working. Regular feedback is encouraged through informal conversations with managers, annual reviews, and an annual pulse survey. In addition, a Wellbeing Calendar sets out a range of initiatives throughout the year, including activities for National Walking Month and Mental Health Awareness Week. Mental health is a particular focus, with all staff having participated in Mental Health Awareness training and access to anonymous counselling services through the Churches Ministerial Counselling Service (CMCS).

8.14 Staff maintain strong connections with other safeguarding professionals. The DST is composed of a former police officer and experienced social workers with backgrounds in children's services and adult social care. Regular interaction with external agencies is a hallmark of the team's work. From an operational perspective, they frequently meet with the LADO and PIPOT on cases involving Church Officers.

8.15 Through links with local police, the DST has also provided critical information that has resulted in the arrest of offenders and locating missing individuals. Although third-sector providers are no longer invited to Local Safeguarding Panels, the DST remains actively involved in groups such as the Counter Terrorism Independent Advisory Group (CTIAG), the Devon Trauma Informed Partnership, and the South West Ecumenical Safeguarding Forum. These connections reflect the DBF's commitment to safeguarding, enabling the DST to stay engaged with current safeguarding practices and multi-agency coordination across the region.

8.16 The DBF demonstrates a commitment to the continuous professional development within the DST. The team regularly attends training provided by the NST, which has included

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Trauma-Informed Training, Risk Management Training, Spiritual Abuse Training, and Supervision Models Training. Additionally, the DBF has allocated a dedicated budget for the DST's ongoing professional development, enabling them to access specialised external courses. Notably, the DSA and ADSAs are undertaking training in the management of sex offenders and complex cases. This is good practice.

8.17 There are comprehensive supervision arrangements in place for the DST that follow national best practice models. The DSA is line managed by the DBF's Director of People and Safeguarding who does not have a statutory safeguarding background. Professional supervision is provided by the NST's regional safeguarding lead every six weeks. This arrangement, piloted during the Pathfinder Project, is now adopted as best practice across the CofE. Outside of this process, there is routine and frequent contact between the DSA and the regional lead that involves case discussions and quality assurance activity.

8.18 As part of this professionally defined relationship, the regional lead has no decision-making authority nor any involvement in the escalation or complaints process. The Audit found that whilst this can create occasional confusion with the line management structure, these issues are currently being addressed through the national Pathfinder Project.

8.19 Assistant DSAs and the wider team are managed and supervised by the DSA. Whilst these arrangements were seen to work well, the direct involvement of Assistant DSAs in practice suggests that they too, would benefit from the NST's support.

Recommendation D31: The DBF and NST should explore the potential for Assistant DSAs being included in some / all of the professional supervision sessions facilitated by the NST's regional lead.

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8.20 The DBF demonstrates good practice in its provision of support to meet the emotional and psychological needs of the clergy. This includes an offer of pastoral support from managers and senior clergy, complemented by access to the Churches Ministerial Counselling Service (CMCS), which includes up to 12 free counselling sessions with trauma specialist counsellors (with an option for further sessions based on need). Recognising the specific demands of safeguarding, the Clergy Support Trust can also be accessed for additional, tailored assistance. Moreover, all employees and ministers (excluding PTO ministers) benefit from membership with *Health Assured*, an Individual and Employee Assistance Program that offers access to counselling, advice, and signposting for further support. These services are highlighted during the induction process and through resources such as the Employee Handbook and wellbeing calendars. In higher-profile cases, the Engagement and Communications Team provides dedicated support to clergy, helping them navigate the complexities of public scrutiny.

8.21 For those in key safeguarding roles, such as those working in the DST, the Audit believes support should be mandated to help with workforce resilience and retention.

Recommendation D32: Members of the DST involved in casework (and other relevant roles as determined by the DBF and Cathedral) should receive mandatory independent counselling to mitigate the impact of their exposure to traumatic events.

8.22 Ministerial Development Reviews (MDRs) take place routinely and follow a structured process to identify areas of growth and development. They include safeguarding as a key theme. The responsibility for undertaking MDRs alternates between the Suffragan Bishop, Archdeacon, or an external reviewer. MDR documentation includes review forms and resources available to clergy and their families, and the results of MDRs are shared with the Bishop of Exeter's office. Safeguarding is specifically included in the preparatory

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materials, and clergy are encouraged to explore areas for growth and development in this context. Overall, whilst MDRs have experienced some delays post-COVID, there remains an ongoing commitment to this process.

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9 Conclusion

9.1 The Exeter Diocesan Board of Finance (DBF) has developed a robust foundation for safeguarding. They have established a comprehensive set of safeguarding policies, procedures and risk management strategies. Alongside this their commitment to building and maintaining a better culture is typified by their approach to creating and supporting initiatives such as the Diocesan Wellbeing Panel and the Culture Club. All of which underpin their efforts to foster a positive, supportive and safer environment for all.

9.2 This has been driven by strong leadership and a commitment to safeguarding across the Diocese. This is particularly evident in their dedicated Diocesan Safeguarding Team (DST). This small team is well led and comprises of skilled professionals who are held in high regard by the internal and external stakeholders with whom they collaborate.

9.3 Moving forward, the DBF can mitigate the risks they face and further enhance their approach by prioritising the recommendations outlined in this report. While the recommendations cover a diverse range of issues, addressing capacity constraints within the DST is paramount. By tackling this critical issue, the DBF will reduce risk and create the necessary bandwidth to effectively implement other key recommendations. These recommendations include reconfiguring the composition and enhancing the effectiveness of their oversight bodies, as well as strengthening their capacity to engage with, listen to, and respond effectively to survivors.

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Part Two - Exeter Cathedral

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10 Context

10.1 Exeter Cathedral, also more formally known as the Cathedral of St. Peter, has a rich history dating back to the 11th century. Situated in the heart of Devon, the Cathedral was originally built on the site of a Roman army camp, and rebuilding work in the 13th Century resulted in its renowned Gothic architecture.

10.2 With an estimated population of approximately 134,579 residents, Exeter is a vibrant city, boasting a diverse demographic. The city has a robust economy, and significant avenues of economic growth include the University of Exeter, Royal Devon and Exeter Hospital. This combined with the city's rich cultural attributes, institutions and festivals have created a popular tourist destination.

10.3 Exeter Cathedral regularly hosts services, concerts and community events. It serves as a hub for spiritual life within the community. Exeter Cathedral Choir plays a pivotal role in services and events hosted by the Cathedral, with the Cathedral being regarded as a *'centre of music excellence in the southwest'*. Up until recently, choristers boarded within Exeter Cathedral School, but this arrangement ceased in September 2024. The Cathedral brings in a substantial number of visitors, estimated at around 156,075 annually, who come to attend worship services, events, seek sanctuary, or simply explore its historic beauty.

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11 Progress

11.1 The Social Care Institute for Excellence (SCIE) safeguarding audit of Exeter Cathedral was published in April 2019 and resulted in 46 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. The Cathedral also commissioned an external consultant to identify what was required for the Cathedral to be compliant with the National Safeguarding Standards. Considerations / recommendations arising from all reviews have since been subsumed into the Cathedral's Safer Church Action Plan.

11.2 A range of improvement activity was triggered in response to the SCIE audit and of the original 46 recommendations, 28 have been completed, with the remaining 18 linked to ongoing developments. These will be subject to an impact assessment six months after full implementation. Examples of good safeguarding practice includes improved reporting pathways, conflict resolution training for volunteers and the designation of both male and female whistleblowing officers.

11.3 The independent review undertaken by David Ley in June 2023 was recommended by the Cathedral's Safeguarding Management Committee (SMC) in preparation for a full safeguarding review. The Dean authorised this to focus on two of the five standards: Culture, Leadership and Capacity and Prevention. The Ley Review resulted in 22 'considerations' for the Cathedral, one of which covered the need to review incomplete SCIE actions. At the time of Audit, 11 considerations from this review have been marked as complete, and 11 remained in progress. The Audit saw evidence that demonstrated oversight of progress at SMC meetings.

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11.4 Whilst the Cathedral has made good progress on its improvement journey, they recognise that some areas require ongoing attention. For example, safer recruitment and victim and survivor support, both of which are incorporated in the Safer Church Action Plan.

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12 Culture, Leadership and Capacity

Culture

12.1 The 2016 visitation of the Cathedral was prompted by a range of factors, including, but not limited, to safeguarding. It resulted in significant change at the time, and saw the retirement of the then Dean, changes to personnel and the refocusing of governance structures. The Audit found that its impact continues to resonate in the Cathedral today.

12.2 Both the Cathedral's workforce and worshipping community have mixed views on the safeguarding culture. While most in both groups feel positive about the culture and are confident, they can raise concerns, a significant minority report negative experiences and perceptions. This suggests that whilst progress has been made, the Cathedral still needs to work on creating a consistently positive and inclusive environment for everyone.

12.3 That said, given resourcing and other ongoing challenges, the Audit acknowledges that the direction of travel is positive, that leadership is alive to the issues, and they are taking steps to address and monitor progress. They have reflected on the findings of their own surveys, restructured and refreshed its Chapter and sub-committees, and are holding inclusive *Town Hall* meetings. The most recent Town Hall focused on building a positive safeguarding culture, emphasising awareness, responsibility, and support, and included a practical exercise to reinforce key concepts. Good practice includes the provision of lanyards and prompt cards that focus on safeguarding and signposting for pathways to help and support.

12.4 Despite best efforts, some low-level challenges persist. For example, whilst most volunteers acknowledged the improvements being made, a small number continue to feel frustrated about the timeliness of communication and managing expectations. The Audit found that these issues relate to capacity i.e. one person being placed in the unenviable

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position of covering multiple vacancies rather than any intentional disregard of this group. Furthermore, whilst the volunteer cohort continues to be held in high regard, the expectation placed upon a key individual (who covers multiple roles) to respond instantaneously to all requests is unrealistic.

12.5 As part of its ongoing commitment to improving culture, the Cathedral is working with the DSAP Culture Sub-group, informally referred to as 'Culture Club'. Developed in collaboration with the DSAP, it focuses on communication, training, and leadership engagement. It aims to positively impact culture through various means, including raising awareness and empathy through storytelling and ensuring that safeguarding is integrated into governance meetings. The initiative is a positive step and acknowledged by the Audit as good practice.

12.6 The Audit also saw evidence of the Cathedral's outreach and engagement initiatives, launched as part of its attempts to open up to a wider audience. This includes the work undertaken to provide dementia training for staff, the '*Wednesday Kitche*n', partnering with local organisations to support rough sleepers, and the implementation of post-incident meetings that allow staff to reflect on their responses, express concerns, and identify areas for improvement.

Leadership

12.7 The overall accountability for safeguarding is understood and unambiguously accepted by the Dean. He has experience of introducing safeguarding into other church settings, a clear understanding of the challenges facing Exeter and the opportunities upon which to build.

12.8 Those in key leadership roles have a firm focus on safeguarding and are able to explain how what they do relates to it. The Chief Operating Officer (COO), Canon Precentor and

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Chapter Safeguarding Lead were all able to explain policy, practice and the pathways for advice and support.

12.9 Despite facing significant pressure and a heavy workload (due to multiple vacant positions), the Cathedral COO remains dedicated to safeguarding. When engaged by the Audit, they emphasised the importance of fostering a positive culture, improving complaint handling, avoiding personalisation and addressing issues fairly and transparently. The Audit concurs with the need for a more structured and transparent managerial approach to resolving complaints. To this end the Audit makes the following recommendation.

Recommendation C1: The Cathedral should review its complaints process and ensure there is a clear and structured procedure that prioritises fairness, transparency, and a non-personalised approach. This review of procedures should include:

a) **Clear Reporting Channels:** Well-defined and accessible reporting channels for individuals to raise concerns or complaints.

b) **Timely Acknowledgement and Investigation:** Prompt acknowledgement of complaints and a clear timeframe for investigation.

c) **Impartial Investigation:** An impartial investigation process that avoids personalisation and focuses on facts and evidence.

d) **Confidentiality:** Appropriate confidentiality measures to protect all parties involved.

e) **Outcome Communication:** Clear communication of the investigation's outcome to all parties involved.

f) **Support and Resolution:** Access to support and guidance for both complainants and respondents throughout the process, with a focus on achieving fair and appropriate resolutions.

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12.10 The Canon Precentor was clear and unambiguous about their safeguarding responsibilities and the Audit saw and heard evidence regarding their collaboration with and oversight of others in the Cathedral. This included their work with Virgers and those in the Music Department.

12.11 The Chapter Safeguarding Lead (CSL) has significant and relevant experience. They occupy an important strategic safeguarding role, and the new appointment is viewed as positive by the Audit. The post holder is currently in the unenviable position of operating in the absence of a dedicated professional safeguarding resource and therefore is reliant upon safeguarding support via the Service Level Agreement (SLA) with the DBF. This is currently inadequate. This statement is not and should not be read as a criticism of the SLA, or the abilities within the DST, it is simply a reflection on the limits of what can be done with a small, stretched team.

12.12 The Audit welcomes the fact that the most senior leadership in the Cathedral recognises the need to invest in a dedicated professional safeguarding resource and makes the following recommendation.

Recommendation C2: A Cathedral Safeguarding Advisor (CSA) should be appointed as part of the DST.

a) Whilst the CSA would be located and line-managed day-to-day within the Cathedral, they should be part of the DST and receive professional supervision from the DSA / DSO or the Director of Safeguarding (if **Recommendation D11** is accepted). This addresses the creation of an overarching Director of Safeguarding Role – (*A paper will be published expanding on the rationale for this role shortly*).

b) The appointment and supervision of the CSA should be incorporated into the internal review of the existing SLA.

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Governance

12.13 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. New trustees and the appointment of a new Chair (the CSL) to the Cathedral Safeguarding Management Committee have further strengthened its arrangements.

12.14 A review of Chapter's minutes covering 2023 to 2024 evidences the significant progress the Cathedral has made over this time. There is now a much more proactive approach to safeguarding, alongside a focus on continuous improvement and collaboration with the Diocese. However, to sustain this trajectory, the Cathedral must address capacity challenges, ensure that training is both comprehensive and accessible and continue to reinforce a positive safeguarding culture throughout its community.

Recommendation C3: The Chapter should ensure that it is in a position to reassure itself (from a governance perspective) that the following issues are being appropriately addressed within and across the Cathedral.

a) Capacity challenges.

b) The provision of enhanced and accessible safeguarding training.

c) Evidence of a continued commitment to and improvement regarding the safeguarding culture.

12.15 The Chapter is complemented by an improving Safeguarding Management Committee (SMC). SMC minutes from February to June 2024 similarly demonstrate a proactive and collaborative approach to strengthening safeguarding. They evidence recommendations / actions being addressed, effective collaboration with the DBF, the implementation of safeguarding measures, a focus on specific areas of concern, and engagement with national developments. The CSL agreed that a separation of strategic oversight and

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operational activity could be enhanced by being separated out and to this end, the Audit makes the following recommendation.

Recommendation C4: To optimise safeguarding efforts and ensure a clear division of focus, the Cathedral should form a dedicated Cathedral Safeguarding Operations Subgroup to complement the work of the Chapter and the SMC. This subgroup should:

a) Focus on operational issues: Address day-to-day safeguarding matters, such as reviewing cases, monitoring compliance, and ensuring policies are implemented effectively.

b) Meet frequently: Hold regular meetings to maintain oversight and address operational concerns promptly.

c) Mirror the DSAP approach: Adopt a similar approach to the DSAP in terms of operational oversight and scrutiny, ensuring consistency and alignment with diocesan practices.

Recommendation C5: The SMC should shift its focus to strategic safeguarding matters like policy development and risk management. This means meeting less often to allow for in-depth discussions on these strategic issues. The SMC should also adopt a thematic approach to reviewing safeguarding standards, ensuring all key areas are covered comprehensively. Finally, it should maintain oversight by addressing critical issues and escalations from the safeguarding operational subgroup.

Recommendation C6: All oversight and governance bodies should adopt:

- A skills, inclusion and diversity audit (in line with the **Recommendation D5** made for the DSAP).
- A thematic approach to oversight and preparation for Charity Commission reporting.
- A review of risk registers on the basis of the outcomes of the Audit and key strategic areas which may impact on the stability, health and wellbeing of the workforce.

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- Ensure that risk registers relating to Chapter, SMC and any operations sub-groups are appropriately aligned at the relevant level.

Chorister Safeguarding

12.16 Exeter Cathedral, in collaboration with Exeter Cathedral School (ECS), oversees the safeguarding and pastoral care of its choristers. Whilst a range of policies and dedicated staff exist across both institutions, recent concerns from parents, staff, and choristers themselves have prompted positive changes in the Cathedral's safeguarding arrangements.

Parent and Chorister Perspectives

12.17 Interviews and surveys conducted with choristers and their parents highlighted mixed perspectives on the Cathedral's safeguarding approach. The Director of Music (DoM) and Canon Precentor were often praised for being an '*immense support*' to the children, with further good practice demonstrated through the termly drop-in sessions provided for parents. However, there was notable concern regarding communication.

Communication

12.18 The Audit observed that whilst communication has shown signs of improvement, it has not always been as effective as needed. A key issue is the use of the dedicated Chorister Phone. There were inconsistencies amongst staff and parents regarding how this should be used, with problems identified such as missing chargers and sometimes a lack of (or delayed) response to parent messages. These issues naturally prompt parents to seek alternative communication channels or lead to a breakdown in communication. Ensuring that staff are trained in maintaining and using the Chorister Phone is essential to keeping this line of communication reliable and effective.

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Recommendation C7: Exeter Cathedral should ensure that the dedicated Chorister Phone is utilised as out lined in the Information for Chorister Parents handbook.

12.19 The recent change to the Chorister Tutor role now being jointly employed by Exeter Cathedral School (ECS) and the Cathedral is welcomed by many. However, although this change has only recently taken place, communication explaining this to parents had not occurred at the time of the Audit, leaving some uncertain about the role's scope and expected benefits. Many of the concerns raised by parents may be alleviated by this change. Ensuring clearer communication about this role is vital to fostering trust and transparency between parents and Cathedral staff.

Recommendation C8: The Cathedral should formally communicate the details of the Chorister Tutor to parents and carers as soon as practicable, explaining the role, its governance and expected functions.

12.20 The Audit found a lack of clarity amongst chaperones, choristers, and chorister parents regarding the role of the chaperone. Where ambiguity exists, good safeguarding practice does not. Without clear delegation, behaviour management has defaulted to the DoM, creating confusion about who is responsible for addressing behavioural issues. This has left staff, including chaperones, feeling they lack the authority to intervene effectively, which impacts upon the overall welfare of the choristers. Greater recognition of the chaperone's role by senior music staff would enhance their authority and influence. Simple steps such as introducing the chaperones at the start of each session, reiterating their role to the children, and ensuring that parents are made aware of who they are, are key to giving this role the significance it deserves. To address this issue, the following recommendation is made.

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Recommendation C9: The Cathedral should consider how the role of the chaperone is strengthened to provide a clearer understanding of responsibilities, particularly regarding behaviour management. This should include the provision of behaviour management training, ideally delivered by the school, to ensure a consistent approach to both Cathedral and school policies.

12.21 Effective information sharing is a key responsibility for chaperones, particularly in ensuring that relevant details are passed to the right individuals at the right time. The Audit found a lack of clarity about the use of a 'record book' for detailing 'low-level' issues involving choristers. Whilst some staff referred to a physical book, others mentioned a digital record. The Audit heard that there is a shift towards making this an online document to improve the speed of communication and to ensure that records can be accessed by the school. The Audit supports this transition and encourages the Cathedral to make all relevant staff aware of this change moving forward.

Physical Safety and Prevention

12.22 The physical safety of choristers is a priority for the Cathedral, and several measures have been implemented to ensure risk is identified and mitigated effectively. For example, choristers are chaperoned to and from ECS to the Song School, with a dedicated toilet provided for their use during rehearsals and services to minimise contact with the public.

12.23 The Audit also heard of good practice in relation to the management of trips and tours, where a 1:8 adult-to-child ratio is maintained. Additionally, the introduction of CCTV systems in 2023 in the Boys' and Girls' Song Schools and the Organ Loft is a positive step forward. However, the Cathedral's CCTV policy currently lacks specific safeguarding references, which should be addressed to align with best practice.

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Recommendation C10: The CCTV policy should specifically reference safeguarding in relation to the protection of children, young people and vulnerable adults.

12.24 The Audit observed drive and commitment to improving the safeguarding provision for choristers by Cathedral and School staff. The catalyst for changes to the Chorister Tutor's role stemmed from identified gaps in the consistency of chaperoning, particularly during morning rehearsals. The reliance on volunteer chaperones led to inconsistencies in supervision, leaving some sessions under-supervised. The new procedures, alongside the updated Chorister Tutor role, are expected to resolve these concerns and provide improved arrangements and continuity for the choristers.

12.25 The Canon Precentor collaborated with chorister parents to create an *Information for Chorister Parents 2024-25* handbook and a poster outlining steps for choristers to follow if they have concerns. The Audit believes the information provided in the handbook is comprehensive and an invaluable resource for chorister parents. Additionally, it is considered good practice that the handbook has been made available online for parents to facilitate ease of access.

12.26 That said, the Audit identified a lack of child-friendly safeguarding messaging in the Song School.

Recommendation C11: The Cathedral should ensure that child-friendly safeguarding posters are displayed in the Song School and associated toilets, to serve as a clear reminder of whom to approach should they need support or have concerns.

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Safeguarding Policies and Procedures

12.27 Exeter Cathedral has a range of safeguarding policies and procedures in place to ensure choristers are adequately safeguarded. These include biannual safeguarding reports to the Dean and Chapter and weekly safeguarding meetings involving key staff from the school and Cathedral. Additionally, all new adult choir members are required to meet with the school's Designated Safeguarding Lead (DSL), providing an opportunity to discuss safeguarding in relation to the choristers - a practice that reflects good safeguarding culture.

12.28 There is a Memorandum of Understanding between the Cathedral and ECS, which provides the lines of responsibility for choristers at all times. Although a useful document, parents did not appear to be aware of it.

Recommendation C12: The Memorandum of Understanding between the Cathedral and ECS should be made easily accessible to chorister parents, such as by being placed online or in another permanent location.

12.29 The Cathedral also has a Visiting Choir Safeguarding Form and policy, which covers safeguarding requirements for visiting choirs, as well as a Lost Child policy, visible at the security and first aid stations. This is good practice.

Chorister Working Hours and Wellbeing

12.30 Whilst a recommendation for national guidelines on chorister working hours will ultimately be made to the NST, it is important to acknowledge that the concerns leading to this recommendation were raised by multiple cathedrals, including Exeter. Parents at Exeter had mixed views on how the Cathedral managed the demanding schedule, with some expressing concerns over exhaustion and burnout, particularly during busy periods like

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Christmas and Easter. Others felt more positively about the support provided. Although this recommendation extends beyond Exeter's direct control, it remains essential for the Cathedral to consider how it can prioritise chorister wellbeing, whilst at the same time maintaining their high standards of performance and the important role that they play in the traditions of the CofE.

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13 Prevention

13.1 Exeter Cathedral has a good system in place to support safer recruitment and various policies and procedures that define practice expectations. As an example, a range of checks are undertaken to ensure the suitability of applicants such as references, DBS checks and confidential declaration forms for eligible roles. There is also relevant messaging on the Cathedral's website, job descriptions reference the Cathedral's commitment to safeguarding, relevant questions are asked at interview and there is training for those involved in the recruitment process. All these measures help to create an environment that deters those who might be unsuitable or pose a risk to the young and vulnerable from working in the Cathedral.

13.2 That said, there is currently no single, centrally held record for personnel information for staff and volunteers. This creates a risk in terms of maintaining proper oversight of the workforce, the status of individuals and key information relating to their recruitment, selection and employment. The Audit is aware that the Cathedral is planning to introduce a new system to streamline the management and oversight of such records. The Audit supports this.

Recommendation C13: Action should be undertaken to reassure the Cathedral that all eligible staff and volunteer's roles that requiring DBS checks are updated within the three-year cycle.

13.3 The Cathedral has adopted the DBF's policy whereby individuals with convictions for sexual offences are not able to hold representational roles such as bell-ringing, leading or taking part in choirs or playing the organ. This is good practice.

13.4 Safeguarding is routinely discussed at the Cathedral through both formal and informal meetings, forums and individual discussions. The Safeguarding Management Committee

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(SMC) and Chapter meetings include routine discussions about safeguarding, with the SMC regularly reporting to Chapter. Indeed, the Audit saw evidence of appropriate consideration of safeguarding across numerous committee meetings, including the Cathedral Community Committee and the HR Committee.

13.5 Regular staff and Townhall meetings with volunteers include safeguarding as part of their agenda, often using quizzes and scenarios to enhance awareness and deepen understanding. The Audit recognises this approach as good practice. That said, not all of those within the workforce agreed and the Audit gathered feedback from a minority who believed that improvements were required.

Recommendation C14: To ensure that communication methods and content are meeting the needs of the workforce, the Cathedral should introduce more formal methods to capture feedback on this issue, identify areas for improvement and tailor safeguarding discussions as appropriate.

13.6 Opportunities to engage the congregation in discussions about safeguarding are distinct and unique. The Audit saw evidence of such matters being discussed during the Cathedral Community Committee and at events such as 'Safeguarding Sunday'.

13.7 In its efforts to raise awareness, the Cathedral uses a range of tools to promote and disseminate information to its key stakeholders. Such tools include a safeguarding handbook, posters, newsletters, lanyards, pew news leaflets, monthly magazine and social media channels. Whilst unrelated to safeguarding, the Audit observed positive reach and engagement through its social media and believes there are opportunities to enhance these channels as a mechanism to connect, inform and share important safeguarding information.

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Recommendation C15: The Cathedral should develop a communication plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of followers, adopting different techniques specific to the platform in use and utilisation of relevant awareness days, campaigns and events to amplify the message.

13.8 The Audit recognise the efforts the Cathedral has undertaken to consolidate key safeguarding information within a Safeguarding Handbook for Staff and Volunteers. Steps have been taken to provide this through a range of resources (digitally and through a printed document). Notwithstanding these efforts and an iterative process based on feedback, some of those in the workforce with whom the Audit engaged believed that further improvements could be made, including clarity on the reporting pathways. The Audit agrees and makes the following recommendations in this regard.

Recommendation C16: An editorial group should be established to review and adapt as necessary the safeguarding handbook and associated policies. Membership of the group should include the DSA / DSO and the Chapter Safeguarding Lead. This editorial group should seek the feedback and input of key stakeholders, including but not limited to volunteers and staff.

13.9 The safeguarding webpage[10] on the Cathedral's website provides a central and valuable resource which is user-friendly, well organised, accessible, and up to date. The mechanism to report a safeguarding concern is prominent, with relevant contacts and associated guidance provided. Whilst the webpage is positive overall, some minor improvements could help further strengthen it.

[10] https://www.exeter-cathedral.org.uk/about-us/safeguarding/

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Recommendation C17: The Cathedral should prominently feature direct links and clear signposting to relevant support services on its safeguarding webpage.

13.10 The Cathedral undertakes a range of activities to raise awareness about the different types of abuse and specific themes linked to the safeguarding agenda. Such themes have included contemporary issues such as domestic abuse, mental health and modern slavery. That said, notwithstanding the efforts undertaken, the Audit is of the opinion that awareness raising specific to the needs of the Cathedral's community could be improved.

Recommendation C18: Using its knowledge about the unique safeguarding issues facing the Cathedral, a plan for awareness raising should be implemented that is tailored to those who work, volunteer or worship at the Cathedral.

13.11 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 opportunities for the Cathedral to gather such feedback, these can be ad-hoc and infrequent. In this respect, the Audit believes there is the potential to introduce more defined mechanisms that help to facilitate this happening in a more structured manner.

Recommendation C19: The Cathedral should review the arrangements it has in place to capture the voices and experiences of children, vulnerable adults and victims and survivors. It should develop a defined 'engagement' plan that ensures stakeholders are identified, spoken to frequently, and that their views are routinely reported to Chapter and relevant committees. The plan should also include arrangements for how such voices influence contemporary practice and new initiatives.

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13.12 Exeter Cathedral adopts a multifaceted approach to risk management, encompassing various areas and activities. For example, the Cathedral has implemented a range of risk assessments to address different aspects of its functions and settings. These include assessments specifically designed for the Cathedral floor, market events, general office procedures, tower tours, kitchen operations, and home visits. The Cathedral also utilises risk assessments for CCTV usage and personal situations such as pastoral visits and lone working. Independent risk assessments for clergy members are undertaken when necessary. Overall, there is evidence of good practice in this context.

13.13 The Cathedral primarily outlines its approach to lone working through the Lone Working Policy which is included in the Staff Handbook. The use of Personal Risk Assessments provides a further resource for those individuals wanting to evaluate risk and implement mitigations associated with specific situations. The arrangements in place are seen by the Audit as being supportive and reflect good practice.

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14 Recognising, Assessing and Managing Risk

14.1 The Cathedral plays a pivotal role in Exeter, both as a place of worship and as a venue for cultural and community engagement. Its diverse array of activities ranges from regular religious services to world-class music performances and family-friendly events. Its complex functions are supported by a team of dedicated staff and volunteers who maintain a clear focus on ensuring the Cathedral is as safe and secure as possible. When considering that the number of annual visitors is in the region of 156,075 per year, the challenges in this context are plain to see. Whether hosting guided tours, supporting vulnerable individuals and managing risk or escalating safeguarding matters, the Cathedral's workforce (in its broadest sense) work hard to make people safer.

14.2 The recognition, assessment and management of risk at the Cathedral is supported by comprehensive policies, guidance, training, and recruitment procedures. The Safeguarding Handbook for Staff and Volunteers 2024 is published on the Cathedral's website and contains some relevant guidance including a practical flow chart regarding the escalation of safeguarding concerns. Whilst the Audit views this as positive, the Handbook requires revision (See Recommendation C16).

14.3 The Cathedral actively promotes a supportive environment where being curious and seeking advice about safeguarding is encouraged. It has adopted and published key messaging to ensure the profile of safeguarding remains high. That said, survey results indicated that whilst the majority of the Cathedral's workforce understand their role in respect of safeguarding, just over half indicated that they have confidence in the process of escalating safeguarding concerns.

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Recommendation C20: The Cathedral should collaborate with the DST to enhance confidence in the safeguarding escalation process and address any barriers to reporting.

14.4 Chapter's strategic risk register was recently updated in July 2024 and effectively addresses key corporate risks, including a dedicated section on safeguarding concerns. Risks are clearly documented, and mitigating factors noted. The Audit considers the separate safeguarding section of the risk register as good practice. Safeguarding (or actions relating to safeguarding) are also referenced in other sections of the register. The Audit believes that it could be further strengthened by considering broader societal issues. Examples of these are set out in Part One of this report and have equal relevance to the context of safeguarding at the Cathedral.

14.5 It will be important to align risk registers with the specific focus applicable to the governance body responsible for them, e.g. Chapter, SMC and any operational sub-group (see Recommendation C6).

14.6 There are dedicated safeguarding staff at the Cathedral with the appointment of a Designated Safeguarding Lead who oversees safeguarding matters and reports to Chapter. Case management is led by the DSA who also performs the role of the CSA.

14.7 The Audit was advised that there have been six safeguarding incidents, twelve contacts for advice and one referral to the Mental Health Team over the last three years. At the time of the Audit, the Cathedral reported that it had only one open case.

14.8 The Cathedral benefits from safeguarding arrangements outlined in the Service Level Agreement (SLA) with the DBF. This was last updated in November 2023. The DBF (via the DST) provides support, oversees all case work, and ensures regular contact with the

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DSL. The Audit saw evidence of a strong working relationship between the DST and the Cathedral regarding case management but recognises the impact of the current arrangements on those in already demanding roles. Whilst the current arrangements of the DSA also acting as the CSA are functional, capacity constraints mean the team are essentially reactive, spending about 90% of their time on case management. The capacity of the DST, the SLA and its relationship with the Cathedral is discussed in Part One of this report.

14.9 Despite these challenges the Audit noted good practice whereby the Cathedral supports staff and volunteers involved in safeguarding incidents through debriefing and reflective practice. The Audit consider this to be both an important and an effective approach.

14.10 The Cathedral conducts risk assessments for many areas of its business, including the Wednesday Kitchen, pastoral home visits and roof and tower tours. Control measures focus on security and safety in its broadest sense and can include virger staff patrolling buildings and grounds and training for staff in preventing violence in the workplace. This is considered good practice.

14.11 For organisations using or hiring the Cathedral, there is clear guidance, which includes a specific safeguarding section. There is signposting to the Cathedral's safeguarding policy and procedures and details of key contacts. Arrangements could be strengthened by requesting visiting organisations to submit their own safeguarding policies for the Cathedral to review and approve. If they do not have one, organisations should agree to follow the Cathedral's policy. This would allow the Cathedral to identify any conflicts in expected behaviours. Equally, requesting a signature indicating that those in charge of visiting parties have read the Cathedral safeguarding policy and agree compliance would provide additional reassurance and a clear audit trail.

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14.12 The Cathedral maintains strong external partnerships and commissions and contracts other organisations and individuals who might engage or come into contact with children, young people or vulnerable adults. The Audit was informed that such appointments would be 'mainly office based' which is a location separate to the Cathedral. Furthermore, responses to the Audit stated that if work contractors are involved, they would be supervised by the Clerk of Works and there would be no direct contact with the young and potentially vulnerable whilst on site.

Recommendation C21: Visiting, contracted or commissioned organisations should be required to submit their safeguarding policy to allow the Cathedral to assess any conflict with its own safeguarding requirements. A signature should be supplied indicating that those in charge of visiting parties have read and agree with the Cathedral safeguarding policy for the term of their visit.

14.13 During the Audit, there was one Safety Plan in place for the Cathedral which had been recently reviewed by the DST. The findings regarding Safety Plans are addressed in Part One of this report and apply equally to the Cathedral.

14.14 The Audit was advised that no Safeguarding Case Management Group (SCMG) meetings had been initiated at the Cathedral in the last year. The broader effectiveness of case management by the DST and the convening of SCMGs is set out in Part One of this report.

14.15 The Cathedral has a defined escalation process to help manage any differences of opinion about safeguarding concerns. The Audit was told that differences are dealt with by the Safeguarding Chapter Lead and the DSA / CSA and that they would initially be addressed in the Safeguarding Management Committee. If there is no agreement, the matter can be escalated to the Dean and the Bishop of Exeter. Alternatively, the matter can be escalated to the Chair of the DSAP. The DSA has the authority to escalate matters to the NST. These arrangements reflect good practice.

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14.16 The Cathedral has recently become a registered charity (February 2024). The Audit was advised it will adhere to the House of Bishops' guidance regarding its statutory requirement to report Safeguarding Serious Incident Reports to the Charity Commission. At the time of the Audit there had been no submissions.

14.17 The Cathedral's Data Protection Policy is contained within its employee handbook and specifies the legal responsibility to demonstrate compliance with UK data protection legislation and GDPR. The Cathedral's risk register sensibly refers to data protection requirements. To ensure compliance, several protective measures are in place including password protection, restricted access to information, and physical arrangements where information is stored in locked cabinets and drawers.

14.18 The Audit was advised that should the Cathedral engage third parties to process personal data on its behalf, such parties are under a duty of confidentiality and are obliged to implement appropriate technical and organisational measures to ensure the security of data. Clergy, staff and volunteers receive training on Data Protection, information sharing and how to identify a Data Subject Request.

14.19 Notwithstanding the sustained efforts to ensure compliance in this area, responses to the Audit's survey (from the Cathedral's workforce) indicated that work is required to raise further awareness about the Cathedral's data protection privacy notice. Around one fifth of the survey respondents were unaware of it.

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

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15 Victims and Survivors

15.1 The Cathedral follows the House of Bishops' guidance set out in '*Responding Well to Victims and Survivors of Abuse.*' Whilst there is no proactive engagement with victims and survivors, the Cathedral appropriately raises awareness to emphasise the importance of safeguarding, the routes for 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 in communal areas in the Cathedral building.

15.2 The absence of any defined engagement by the Cathedral with victims and survivors is, in the Audit's view, a deficit in their safeguarding arrangements. Whilst acknowledging that any such activity in this space needs to be proportionate and supported by adequate and appropriate resources, the likely low number of victims / survivors that have a direct connection with the Cathedral should not on its own be prohibitive.

15.3 In this respect, building on the related recommendation for victim / survivor engagement set out in Part One of this report, the Cathedral should seek to extend its SLA with the DBF and be included as part of the DBF's plan.

Recommendation C23: The Cathedral should partner with the DSAP as it develops an initiative to create opportunities for the Church to listen to, engage with and respond to victims and survivors (see also Recommendation D10).

Recommendation C24: The Cathedral should seek to extend its SLA with the DBF and be included in the proposed plan that will cover how victims and survivors are engaged, consulted and collaborated with by the DBF.

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16 Learning, Supervision and Support

16.1 The importance of developing the safeguarding knowledge, skills and experience of the workforce is recognised by Cathedral leaders. There is a defined induction process, access to training and a range of other events that help to strengthen practice. Opportunities to learn are appreciated, there is good participation and overall, progress is positive.

16.2 The SLA between the Cathedral and DBF, alongside the Employee Handbook, also helps with learning by facilitating access to additional resources, support and oversight from the highly capable DST. The handbook itself details the Cathedral's commitment to training, and helpfully sets out the specific training requirements for various job roles.

16.3 The DSA maintains their own CPD through attending national events and relevant training delivered by local authorities, children / adult partnerships and charities. This ensures their skills remain up to date and that practical knowledge is maintained about contemporary safeguarding issues. In the event that the Cathedral appoints a CSA, the approach to CPD should be mirrored.

16.4 As with the DBF, the Cathedral uses the CofE's Safeguarding Learning and Development Framework to guide its strategic response to training. Whilst this is relevant, a more locally develop strategy is required to sharpen focus within this area.

Recommendation C25: The Cathedral should engage with the DBF and ensure its specific arrangements are included as part of the development of the Diocesan wide training strategy as recommended in Part One of the report (see Recommendation D25).

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16.5 In terms of the Cathedral's approach to monitoring training data and evaluation, the narrative set out for the DBF in Part One of this report is equally relevant. Whilst arrangements need strengthening, the Audit did see evidence of how the Cathedral had reviewed staff files to gain additional reassurance about training compliance. This was good practice given the limitations created by the existing systems.

Recommendation C26: The Cathedral should engage the DBF to ensure a consistent approach to training evaluation (as recommended for the DBF) is similarly implemented. This should seek to capture evidence from staff, volunteers and their managers about how training has helped their practice. Random cohorts of staff and volunteers (and their managers) should be approached three months after attending training (via email / short survey) to reflect on the ways they have used what they learnt and to provide examples of how this has helped their practice.

16.6 The Cathedral adopts a blended approach to training, with participants having access to both in-person and online sessions. This 'typical' training is complemented by a range of awareness raising initiatives, such as incorporating safeguarding discussions into various forums. The Audit saw evidence of a solicitor's presentation on reporting serious incidents to the Charity Commission and sessions involving the DSA at a Townhall meeting where the topic of disclosures was discussed. Both were comprehensive and provided valuable learning for participants.

16.7 For those whose vulnerability might be exacerbated by participating in certain training, the details set out in Part One of this report have equal relevance to the Cathedral. The ability for some to use a 'pass' is recognised as a sensible approach, although any developed arrangements as recommended for the DBF should ensure inclusion of the Cathedral's workforce.

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Recommendation C27: For those who are unable to complete certain safeguarding training due to the potential of trauma arising from their own personal experiences, arrangements developed by the DBF that ensure access to training for this cohort should include a specific focus on the Cathedral's workforce.

16.8 Workforce survey results from Cathedral respondents indicated that most had seen improvements in safeguarding training. That said approximately one third disagreed or gave a neutral response. Despite these findings, a significant majority knew how to manage a disclosure and understood what to do if they were worried about someone's behaviour. This is positive and provides a degree of confidence in the knowledge, skills and experience of the Cathedral's workforce.

16.9 How the Cathedral's workforce could be further developed through the delivery of 'contextually relevant training' is covered in part one of this report.

Recommendation C28: The Cathedral should engage the DBF on producing a training needs analysis with its workforce to identify what contextual themes would be relevant for an enhanced training programme.

16.10 The Audit saw investment in the induction process for new members of staff. The programme starts on the first day, involves pre-read material, targeted 1:1 meetings, and in-person sessions with safeguarding firmly on the agenda. Survey findings indicated that most of the Cathedral's workforce had been given an induction, with the majority confirming it included what they needed to know about safeguarding. Whilst encouraging, almost one third stated they had never gone through the process or couldn't recall having done so.

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Recommendation: **C29** The Cathedral should seek reassurance that the arrangements for induction are sufficiently robust and that all new starters are being engaged.

Recommendation C30: All those working at the Cathedral who were not given an induction at the commencement of their role should be required to undertake one within the next three months. This retrospective induction session should be mandatory regardless of a person's length of service.

16.11 The Audit noted there is no defined training evaluation process to measure the long-term impact of training and its influence on practice. This is addressed in Part One of the report and has equal relevance to the Cathedral.

Recommendation C31: The Cathedral should engage with the DBF to support the implementation of a formal training evaluation process.

16.12 Ministerial Development Reviews (MDRs) support clergy members to reflect on their ministry and promote development and growth. Safeguarding is embedded into the process and Audit findings for the Cathedral align with those set out for the DBF under Part One of the report.

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17 Conclusion

17.1 This Audit highlights a Cathedral undergoing positive change in its safeguarding journey. The Leadership Team is clearly committed, and substantial improvements are evident in areas like reporting, training, and risk management. Proactive measures such as the Town Hall meetings and readily available safeguarding information contribute to a growing culture of awareness.

17.2 However, the journey towards a fully robust safeguarding environment is not complete. A key priority is addressing the disconnect between leadership's positive view and the negative experiences reported by a minority of staff and volunteers. This requires open dialogue and a demonstrable commitment to addressing the concerns raised.

17.3 Capacity issues must also be acknowledged and tackled, as they impede the Cathedral's ability to respond swiftly and effectively to safeguarding matters. Clear communication is crucial as is the ability to maintain centralised records and ensure relevant and appropriate DBS checks are carried out.

17.4 By addressing the recommendations within this report, particularly those related to professional safeguarding support, capacity building, cultural development, and victim / survivor outreach and support, the Cathedral could significantly accelerate its activity, sustain progress and further improve its overall safeguarding arrangements.

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Appendices

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18 Appendix 1 – DBF Recommendations

Recommendation D1: The DBF should regularly create opportunities to elicit feedback regarding its culture, including its approach to inclusion, awareness of unconscious bias and whether people feel safe in the various spaces and places within and across the Diocese. In doing so, it should:

a) Use a range of tactics such as surveys, focus groups and third-party facilitators.
b) Encourage feedback from all stakeholders (but also target specific groups when appropriate).
c) Focus on specific themes, such as those highlighted in this report.
d) Ensure anonymity and confidentiality
e) Analyse all information received and share feedback.

Recommendation D2: The DBF should develop and promote guidance and training resources that help relevant staff and volunteers differentiate between safeguarding and conduct concerns. This material should include practical examples and case studies to illustrate the distinction.

Recommendation D3: The DBF should design and deliver joint training for PSRs and their PCCs.

a) This should be face-to-face and seek to promote a common understanding of safeguarding principles, responsibilities and roles.
b) It should include contextual and role specific case studies and scenarios that highlight and reinforce the importance of the PSR role.

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c) As part of this approach establish systems to capture and share the knowledge and experience (including a skills audit) of PSRs, ensuring an understanding of the range of direct and indirect experience PSRs have is captured, so that there is continuity and a process to value and prevent knowledge loss when individuals leave their roles.

Recommendation D4: The DBF should amend the naming convention for the Director of People Services and Safeguarding to more accurately reflect the role.

Recommendation D5: Time and capacity permitting, the DST / DSA should work with the archdeacons to establish how they could develop the safeguarding elements of their role. For example, this could include reinforcing the use and dip-sampling of dashboards, further embedding safeguarding prompts within their general work, and considering how they could configure a safeguarding PSR network based on deaneries.

Recommendation D6: The Bishop's Council, Bishop's Staff Meetings, and DSAP should implement the following:

d) **Skills, Inclusion, and Diversity Audits:** Conduct audits to assess the skills, inclusion, and diversity of their membership and attendance. This will help ensure these bodies are appropriately representative and can effectively address safeguarding concerns from various perspectives.

e) **Thematic Approach to Safeguarding Oversight:** Adopt a thematic approach to safeguarding oversight and preparation for Charity Commission reporting. This should involve coordinating a focus on the National Safeguarding Standards at each meeting, with a specific emphasis on either operational or strategic compliance, depending on the level of governance. For example, a three-year programme could focus on

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different elements of the standards at each meeting. This structured approach will ensure comprehensive coverage of key safeguarding areas.

f) **Review of Risk Registers:** Regularly review and update risk registers based on the Audit's outcomes and the key strategic issues that may impact the workforce's stability, health, and wellbeing.

Recommendation D7: The DSA should attend Bishop's Council and staff meetings by right rather than invitation.

Recommendation D8: To improve communication and collaboration with statutory safeguarding partners, the DSAP Chair (or a designated representative) should hold brief, focused one-to-one meetings with key statutory leads two or three times per year. This will allow for valuable information exchange on safeguarding trends, legislation, and best practices, which can then be shared with the full DSAP to enhance their understanding and effectiveness.

Recommendation D9: The DSAP should reconfigure its framework with a longitudinal programme that reflects a structured and themed approach to scrutiny. This should focus on:

a) The application of the National Safeguarding Standards.
b) The division of operational and strategic oversight (a position already under consideration within the DBF).
c) The management and oversight of action plans.
d) The commissioning of internal audits.
e) Evidence of impact.
f) Alignment of operational and strategic risk registers (with DSAP Business).

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Recommendation D10: To further professionalise and develop the overall performance of the DSAP the DBF should provide role-specific and locally contextualised training for its members.

Recommendation D11: The DSAP should expedite its work to establish regional victim and survivor networks. It should also map the opportunities available to reach out to other existing groups to request opportunities to engage in listening events.

Recommendation D12: Leaders in the DBF and the 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 to provide strategic oversight, advice, and safeguarding support across the DBF, parishes, and the Cathedral. The individual in this role would be a member of the senior leadership team and assume the authority vested in a Diocesan Safeguarding Officer (DSO). *A paper will be published expanding on the rationale for this role shortly.*

Recommendation D13: The present safeguarding resource should be reinforced with the appointment of an additional fulltime Assistant Diocesan Safeguarding Advisor (ADSA). The current admin post should focus exclusively on support to the DST and the Dashboard Program and be released from other HR tasks that are currently undertaken (e.g. DBS checks).

Training (in most cases) could continue to be outsourced. A cost benefit analysis should be carried out to establish and verify the advantages of this model versus the appointment of a dedicated trainer (see Recommendation D28).

A Cathedral Safeguarding Advisor (CSA) should be appointed as part of the DST. Whilst the CSA would be located in and line-managed day-to-day within the Cathedral, they would be part of the DST and receive professional supervision from the Director of Safeguarding (or the DSA if the recommendation for a Director of Safeguarding is not accepted).

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Recommendation D14: The DBF should amend the Parish Recruitment of Ex-Offenders Policy (Template) available on the website[11] to reflect the exclusions on holding representational roles.

Recommendation D15: The DBF should facilitate regular face to face sessions and/or networking events for PSRs to learn and share good practice.

Recommendation D16: The DBF should consider facilitating an annual PSR networking event where they are able to come together and hear from leading safeguarding professionals on new and emerging themes as they relate to their role.

Recommendation D17: The DBF should consider and develop a communication plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of the followers, adopting different techniques specific to the platform and utilisation of relevant awareness days, campaign and events to amplify the message.

Recommendation D18: 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 (see also Recommendation D5).

Recommendation D19: The DBF should ensure its approach to risk management and its relevant risk registers take account of the impact of wider societal issues.

[11] https://exeter.anglican.org/parish-toolkit-for-safeguarding/recruitment-of-ex-offenders-sample-parish-policy-3/

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Recommendation D20: When determining the allocation / ownership of safeguarding cases within the DST, decisions should continue to be made on a case-by-case basis. Professional judgement should be used to allow for the inclusion of adult cases that fall outside the statutory definition of adults at risk.

Recommendation D21: SCMGs should continue to be convened in line with the House of Bishops' policy and practice guidance, whilst maintaining a degree of flexibility for higher end complex cases.

Recommendation D22: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DSA and NST. This will also be raised by the Audit with the NST.

Recommendation D23: Where cases are discussed during supervision, the recording of the discussion and the actions agreed / decisions made, should be included on individual case records. These should follow a consistent format and be uploaded as soon as practicable after the supervision session has taken place.

Recommendation D24: For cases resulting in no further action by the DST, case records should always reflect the rationale for the decision being made.

Recommendation D25: The DBF should scope and develop a formal plan about how it will engage, consult and collaborate with victims and survivors. Any related initiatives should be meaningful, trauma-informed and developed in accordance with '*Responding Well to Victims and Survivors of Abuse.*' See also Recommendation D10.

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Recommendation D26: The DBF should create a Diocese-wide training strategy that aligns with the CofE's Safeguarding Learning and Development Framework.

Recommendation D27: For those who are unable to complete certain safeguarding training due to the potential of trauma arising from their own personal experiences, local arrangements should be developed by the DBF to ensure access to training remains available for this cohort. This could be achieved through 1:1 or small group sessions being delivered face-to-face by the DST.

Recommendation D28: 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. Random cohorts of staff and volunteers (and their managers) should be approached three months after attending training (via email / short survey) to reflect on the ways they have used what they learnt and to provide examples of how this has helped their practice.

Recommendation D29: The DBF should consider the recruitment of a dedicated safeguarding trainer. This should be done in the context of a cost-benefit analysis measured against the current outsourced provision.

Recommendation D30: The DBF should complete a training needs analysis covering the training needs of the DBF, Cathedral and those within parishes to identify what contextual themes would be relevant for local delivery.

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Recommendation D31: The DBF and NST should explore the potential for Assistant DSAs being included in some / all of the professional supervision sessions facilitated by the NST's regional lead.

Recommendation D32: Members of the DST involved in casework (and other relevant roles as determined by the DBF and Cathedral) should receive mandatory independent counselling to mitigate the impact of their exposure to traumatic events.

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19 Appendix 2 – Cathedral Recommendations

Recommendation C1: The Cathedral should review its complaints process and ensure there is a clear and structured procedure that prioritises fairness, transparency, and a non-personalised approach. This review of procedures should include:

a) **Clear Reporting Channels:** Well-defined and accessible reporting channels for individuals to raise concerns or complaints.
b) **Timely Acknowledgement and Investigation:** Prompt acknowledgement of complaints and a clear timeframe for investigation.
c) **Impartial Investigation:** An impartial investigation process that avoids personalisation and focuses on facts and evidence.
d) **Confidentiality:** Appropriate confidentiality measures to protect all parties involved.
e) **Outcome Communication:** Clear communication of the investigation's outcome to all parties involved.
f) **Support and Resolution:** Access to support and guidance for both complainants and respondents throughout the process, with a focus on achieving fair and appropriate resolutions.

Recommendation C2: A Cathedral Safeguarding Advisor (CSA) should be appointed as part of the DST.

a) Whilst the CSA would be located and line-managed day-to-day within the Cathedral, they should be part of the DST and receive professional supervision from the DSA / DSO or the Director of Safeguarding (if **Recommendation D11** is accepted). This addresses the creation of an overarching Director of Safeguarding Role – (*A paper will be published expanding on the rationale for this role shortly*).
b) The appointment and supervision of the CSA should be incorporated into the internal review of the existing SLA.

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Recommendation C3: The Chapter should ensure that it is in a position to reassure itself (from a governance perspective) that the following issues are being appropriately addressed within and across the Cathedral.

a) Capacity challenges.
b) The provision of enhanced and accessible safeguarding training.
c) Evidence of a continued commitment to and improvement regarding the safeguarding culture.

Recommendation C4: To optimise safeguarding efforts and ensure a clear division of focus, the Cathedral should form a dedicated Cathedral Safeguarding Operations Subgroup to complement the work of the Chapter and the SMC. This subgroup should:

a) Focus on operational issues: Address day-to-day safeguarding matters, such as reviewing cases, monitoring compliance, and ensuring policies are implemented effectively.
b) Meet frequently: Hold regular meetings to maintain oversight and address operational concerns promptly.
c) Mirror the DSAP approach: Adopt a similar approach to the DSAP in terms of operational oversight and scrutiny, ensuring consistency and alignment with diocesan practices.

Recommendation C5: The SMC should shift its focus to strategic safeguarding matters like policy development and risk management. This means meeting less often to allow for in-depth discussions on these strategic issues. The SMC should also adopt a thematic approach to reviewing safeguarding standards, ensuring all key areas are covered comprehensively. Finally, it should maintain oversight by addressing critical issues and escalations from the safeguarding operational subgroup.

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Recommendation C6: All oversight and governance bodies should adopt:

a) A skills, inclusion and diversity audit (in line with the **Recommendation D5** made for the DSAP).
b) A thematic approach to oversight and preparation for Charity Commission reporting.
c) A review of risk registers on the basis of the outcomes of the Audit and key strategic areas which may impact on the stability, health and wellbeing of the workforce.
d) Ensure that risk registers relating to Chapter, SMC and any operations sub-groups are appropriately aligned at the relevant level.

Recommendation C7: Exeter Cathedral should ensure that the dedicated Chorister Phone is utilised as out lined in the Information for Chorister Parents handbook.

Recommendation C8: The Cathedral should formally communicate the details of the Chorister Tutor to parents and carers as soon as practicable, explaining the role, its governance and expected functions.

Recommendation C9: The Cathedral should consider how the role of the chaperone is strengthened to provide a clearer understanding of responsibilities, particularly regarding behaviour management. This should include the provision of behaviour management training, ideally delivered by the school, to ensure a consistent approach to both Cathedral and school policies.

Recommendation C10: The CCTV policy should specifically reference safeguarding in relation to the protection of children, young people and vulnerable adults.

Recommendation C11: The Cathedral should ensure that child-friendly safeguarding posters are displayed in the Song School and associated toilets, to serve as a clear reminder of whom to approach should they need support or have concerns.

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Recommendation C12: The Memorandum of Understanding between the Cathedral and ECS should be made easily accessible to chorister parents, such as by being placed online or in another permanent location.

Recommendation C13: Action should be undertaken to reassure the Cathedral that all eligible staff and volunteer's roles that requiring DBS checks are updated within the three-year cycle.

Recommendation C14: To ensure that communication methods and content are meeting the needs of the workforce, the Cathedral should introduce more formal methods to capture feedback on this issue, identify areas for improvement and tailor safeguarding discussions as appropriate.

Recommendation C15: The Cathedral should develop a communication plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of followers, adopting different techniques specific to the platform in use and utilisation of relevant awareness days, campaigns and events to amplify the message.

Recommendation C16: An editorial group should be established to review and adapt as necessary the safeguarding handbook and associated policies. Membership of the group should include the DSA / DSO and the Chapter Safeguarding Lead. This editorial group should seek the feedback and input of key stakeholders, including but not limited to volunteers and staff.

Recommendation C17: The Cathedral should prominently feature direct links and clear signposting to relevant support services on its safeguarding webpage.

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Recommendation C18: Using its knowledge about the unique safeguarding issues facing the Cathedral, a plan for awareness raising should be implemented that is tailored to those who work, volunteer or worship at the Cathedral.

Recommendation C19: The Cathedral should review the arrangements it has in place to capture the voices and experiences of children, vulnerable adults and victims and survivors. It should develop a defined 'engagement' plan that ensures stakeholders are identified, spoken to frequently, and that their views are routinely reported to Chapter and relevant committees. The plan should also include arrangements for how such voices influence contemporary practice and new initiatives.

Recommendation C20: The Cathedral should collaborate with the DST to enhance confidence in the safeguarding escalation process and address any barriers to reporting.

Recommendation C21: Visiting, contracted or commissioned organisations should be required to submit their safeguarding policy to allow the Cathedral to assess any conflict with its own safeguarding requirements. A signature should be supplied indicating that those in charge of visiting parties have read and agree with the Cathedral safeguarding policy for the term of their visit.

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

Recommendation C23: The Cathedral should partner with the DSAP as it develops an initiative to create opportunities for the Church to listen to, engage with and respond to victims and survivors (see also Recommendation D10).

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Recommendation C24: The Cathedral should seek to extend its SLA with the DBF and be included in the proposed plan that will cover how victims and survivors are engaged, consulted and collaborated with by the DBF.

Recommendation C25: The Cathedral should engage with the DBF and ensure its specific arrangements are included as part of the development of the Diocesan wide training strategy as recommended in Part One of the report (see Recommendation D25).

Recommendation C26: The Cathedral should engage the DBF to ensure a consistent approach to training evaluation (as recommended for the DBF) is similarly implemented. This should seek to capture evidence from staff, volunteers and their managers about how training has helped their practice. Random cohorts of staff and volunteers (and their managers) should be approached three months after attending training (via email / short survey) to reflect on the ways they have used what they learnt and to provide examples of how this has helped their practice.

Recommendation C27: For those who are unable to complete certain safeguarding training due to the potential of trauma arising from their own personal experiences, arrangements developed by the DBF that ensure access to training for this cohort should include a specific focus on the Cathedral's workforce.

Recommendation C28: The Cathedral should engage the DBF on producing a training needs analysis with its workforce to identify what contextual themes would be relevant for an enhanced training programme.

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Recommendation: **C29** The Cathedral should seek reassurance that the arrangements for induction are sufficiently robust and that all new starters are being engaged.

Recommendation C30: All those working at the Cathedral who were not given an induction at the commencement of their role should be required to undertake one within the next three months. This retrospective induction session should be mandatory regardless of a person's length of service.

Recommendation C31: The Cathedral should engage with the DBF to support the implementation of a formal training evaluation process.

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20 Appendix 3 – Glossary of Abbreviations

ADSA	Assistant Diocesan Safeguarding Adviser
AL	Authorised Listening
BAM	Bishops' and Archdeacons Meeting
BSM	Bishop's Staff Meeting
CCSL	Clergy Current Status Letter
CCTV	Closed-circuit TV
CDM	Clergy Disciplinary Measures
CDM	Clergy Discipline Measure
CHILL	Churches Held in Local Leadership
CMCS	Churches Ministerial Counselling Service
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	Chapter Safeguarding Lead
CSO	Cathedral Safeguarding Officer
CTIAG	Counter Terrorism Independent Advisory Group
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DoM	Director of Music
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
DSL	Designated Safeguarding Lead
DSMG	Diocesan Safeguarding Management Group

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DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
EAP	Employee and Clergy Assistance Programme
ECS	Exeter Cathedral School
EIAG	Early Intervention Assessment Group
GDPR	General Data Protection Regulation
HR	Human Resources
IICSA	The Independent Inquiry into Child Sexual Abuse
ISA	Information Sharing Agreement
LADO	Local Authority Designated Officer
LLR	Learning Lessons Reviews
MDR	Ministerial Development Review
MOSOVO	Management of Sexual or Violent Offenders
NST	National Safeguarding Team
OGS	Operational Group for Safeguarding
OSG	Operational Safeguarding Group
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PIPOT	People in Positions of Trust
PoC	Persons of concern
PSR	Parish Safeguarding Representative
PTO	Permission to Officiate
RAG	Red-Amber-Green
SALT	Sexual Abuse Listening Therapy
SCIE	The Social Care Institute for Excellence
SCMG	Safeguarding Case Management Groups
SEO	Search Engine Optimisation
SET	Senior Executive Team

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SIR	Serious Incident Report
SLA	Service Level Agreement
SMC	Safeguarding Management Committee
SPOC	Single Point of Contact
SRPM	Safer Recruitment and People Management

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