

**Independent Safeguarding Audit of  
London Diocesan Fund and St Paul's  
Cathedral**

**2025**

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# Introduction

# 1 Introduction

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

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 the London Diocesan Fund (LDF) and St Paul's Cathedral, this involved the following:

- Over 330 documents being collated and analysed prior to the Audit's fieldwork.
- A range of interviews being held with Church officers (staff and volunteers), external partners, victims, survivors and other stakeholders.
- 2390 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 LDF, the Cathedral and parishes.
- Nine focus groups
- A confidential contact form being made available via a dedicated webpage.
- In total, the Audit undertook 70 separate engagement sessions reaching 154 people.

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<sup>1</sup> [https://www.churchofengland.org/sites/default/files/2023-10/national-safeguarding-standards-and-quality-assurance-framework\\_sep23.pdf](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, the London Diocesan Fund and Part Two, St Paul's Cathedral. This has been done to ensure that each audited body is able to focus on their own strengths and areas for identified improvement.
- 1.4 The report has been reviewed for factual accuracy by both the LDF and the Cathedral.

# Part One - London Diocesan Fund

## 2 Context

- 2.1 It is noteworthy that London Diocese is the largest diocese by population within the Church of England, licensed ministry and number of worshippers. It serves a population of 4,246,000, which surpasses other major dioceses such as Southwark and Leeds. This is further contextualised by the fact that the five Episcopal Areas within the Diocese are individually as large as many smaller to average dioceses.
- 2.2 Geographically, the Diocese covers a considerable area of 277 square miles, stretching across Greater London north of the Thames and encompassing a wide range of boroughs from the west to the east and north. This vast area includes a mix of prominent central boroughs and a broader suburban expanse. The Diocese operates a five Episcopal Area Scheme where ministry deployment and oversight is delegated to an Area suffragan bishop, and a Diocesan Safeguarding Advisor (DSA) is appointed per area. London Diocese encompasses 403 parishes and is home to 462 centres of worship and currently counts 87,000 as its worshipping community.
- 2.3 The Diocese serves a diverse, urban and suburban set of communities spanning eighteen local authorities. Its central location, encompassing the Cities of London and Westminster, underscores its national significance as a hub for economic activity, tourism, and recreation.
- 2.4 Demographic data provided by the LDF to the Audit, highlights the Diocese's remarkable diversity. A significant 46% of the population was born outside the UK, and 69% are from UKME/GMH<sup>2</sup> backgrounds, starkly contrasting with national averages. This diversity is

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<sup>2</sup> The Church of England has adopted the terms UKME (UK Minority Ethnic) and GMH (Global Majority Heritage) as part of its strategic commitment to racial justice. These terms aim to facilitate representation across governance and diversity networks.

also reflected in religious affiliation, with only 24% of residents identifying as having no religion, and a substantial 31% adhering to non-Christian faiths. The population is notably younger, with a median age of 35, largely due to a high concentration of young adults.

2.5 Economically, the Diocese presents a picture of contrasts. While average earnings are high, this is mitigated by a high cost of living and a population that is often time-poor. Furthermore, there are significant areas of deprivation, with the Stepney Area specifically noted as being comparable to one of the most deprived dioceses in the country.

### 3 Progress

- 3.1 The Social Care Institute for Excellence (SCIE) Safeguarding Audit and PCR2 made 42 'considerations' / recommendations for the LDF. These covered a range of issues which included capacity, training, updating of policies and record keeping.
- 3.2 Published in June 2016, the SCIE Audit resulted in 15 'considerations' all of which were accepted and consolidated into an initial action plan. The Diocesan Safeguarding Officer (DSO) currently in post reviewed the relevance of these recommendations and took forward relevant actions into the Diocesan Safeguarding Team's (DST's) 'Programme of Work'. This programme is coordinated and managed by the Safer Churches Programme Manager.
- 3.3 The Diocese's PCR2, published in November 2021, resulted in 27 recommendations for the Diocese itself. An initial action plan was developed in response with actions assigned to various owners. Again, relevant actions were subsequently migrated over to the LDF's consolidated Programme of Work.
- 3.4 Since 2015, a range of internal learning activity has taken place. The Audit was sighted on five cases which resulted in learning activity, either inherited by the current DSO or having commenced based on their own professional judgement. Good practice to be taken forward was identified alongside scrutiny to improve practice where it is needed.
- 3.5 Following the 2021 inquest into Fr Alan Griffin's death, the Diocese published an independent Lessons Learnt Review (LLR) in June 2022, which resulted in 17 recommendations. To address these recommendations, a task and finish group, led by the

Bishop of Stepney, the Church's lead bishop for safeguarding, was formed to execute a dedicated action plan. This process involved a review of past practices and the implementation of local improvements and embedding of national policy into practice. Each recommendation has been included on this action plan. While action has been taken against these recommendations, a small number of ongoing areas of work remain, some of which are now embedded within the Diocese's Safer Churches Programme of Work. That said, the Audit cautions against complacency. The learning derived from this LLR should be consistently under review to ensure lessons remain current and considered.

- 3.6 The 'Programme of Work' was created in 2022; it is a dynamic document which was rewritten to be structured on the National Safeguarding Standards. Progress is overseen through regular meetings between the DSO, Safer Church Programme Manager and Casework Manager. This also feeds into other meetings, including the Diocesan Safeguarding Advisory Panel (DSAP), the Joint Operations Team and the Audit and Risk Committee.

## 4 Culture, Leadership and Capacity

### Culture and Safeguarding

- 4.1 Audit surveys across the LDF workforce, the parish workforce, and the wider worshipping community reveal a robust and positive trend in safeguarding. An overwhelming majority across all three groups report significant improvements in arrangements and agree that the importance of safeguarding is now better recognised.
- 4.2 This view is largely supported by evidence from focus groups and one-to-one Audit discussions with clergy, staff, volunteers, and worshippers. Participants noted that leadership at all levels increasingly treats safeguarding as core theology rather than mere risk management. This distributed leadership model has attracted positive feedback, with numerous parishes exhibiting good practice.
- 4.3 Consequently, confidence in the safety of church environments is high. An overwhelming majority of both the parish workforce and the worshipping community report feeling safe, a position mirrored by a significant majority within the LDF. However, this confidence is not universal. Specific groups, particularly those from racially or economically marginalised backgrounds, report that they can still feel minoritised with an incomplete sense of belonging. Additionally, some survivors and victims view the culture as "still behind" or lacking in trauma-informed approaches.
- 4.4 The Audit surveys indicate that a safeguarding culture is becoming established and embedded, a sentiment shared by most of the LDF and parish workforces. This cultural shift is underpinned by a growing sense of security in reporting concerns, with a majority feeling able to raise issues without fear of reprisal.

- 4.5 When asked to describe the church in the audit surveys, all three groups overwhelmingly chose positive descriptors. The LDF workforce prioritised supportive, collaborative, and welcoming, while the parish workforce and worshipping community highlighted 'welcoming', 'inclusive', and 'supportive'.
- 4.6 While this perception is bolstered by teams described as "mission-focused" and "values-led," the day-to-day pressures can have an operational impact. Staff and volunteers, particularly those in safeguarding, or linked clergy roles, report high workloads, 'burnout', and a sense of "doing the bare minimum" due to resource constraints. Furthermore, distinct "silos" and variations in practice persist across the Episcopal areas, creating what was described by some, as a "postcode lottery" regarding safeguarding responses.
- 4.7 Finally, a small number of clergy reported experiencing a hierarchical culture that they feel makes it difficult to challenge leadership. Others, however, view the notable minority of parishes and clergy who receive the extended episcopal oversight of the Bishop of Fulham or Bishop of Ebbsfleet on the grounds of theological conviction related to the ordination of women, or have requested "Additional Pastoral Provision" owing to a difference of views with their Area Bishop in relation to aspects of *Living in Love and Faith*, as having the potential to create misalignment and unhealthy division.
- 4.8 These issues are highlighted later in the report, providing examples of the numbers who have passed resolutions under the House of Bishops' Declaration on the Ministry of Bishops and Priests (2014) within a particular Area. In the opinion of the Audit, these patterns should be scrutinised more closely to ensure their underlying drivers, and their impact on collective culture, are fully understood. A recommendation is made regarding

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this issue in the governance section of this report.

## Leadership

### The Area Scheme and the London Plan

4.9 Leadership within the Diocese of London is unique, defined by the 'Area Scheme' and a complex geography that necessitates a distinct operational framework. Under this Scheme, in common with a small number of larger dioceses, the diocese employs a distributed model, delegating substantial authority to Area Bishops in Willesden, Kensington, Edmonton, and Stepney. These Area Bishops effectively function as leaders of 'mini-dioceses' that rival independent dioceses in scale. In addition, the London Plan defines the provision by which parishes which are unable to receive the ministry of women as priests and bishops receive Extended Episcopal Oversight. Both the Bishop of Fulham, a suffragan without a geographic territory, and the Bishop of Ebbsfleet, an Assistant Bishop, provide episcopal ministry for respectively Traditionalist Catholic and Conservative Evangelical parishes that have passed resolutions. As is the case across the Church of England, a form of unity is maintained through structural concession.

4.10 Although Area Bishops enjoy significant autonomy, the Diocesan Bishop maintains direct oversight of the Two Cities as its Area Bishop and holds ultimate accountability for diocesan-wide discipline and safeguarding. She is clear that authority is delegated, not devolved. This is strictly enforced, with the Diocesan Bishop describing her role as the "Unix", the central operating system where final accountability rests.

### The Diocesan Bishop

4.11 The Diocesan Bishop, who has since become the Archbishop of Canterbury, brings significant safeguarding experience to the role, rooted in a career that spans frontline nursing and national NHS leadership. Her experience during major public inquiries, alongside her senior roles within the Church's national safeguarding structures, provides

a sophisticated foundation for oversight. The Audit found consistent evidence of her effectiveness in strengthening systems, governance, and culture across every level of her service.

- 4.12 In London, the Bishop has successfully led a transition from an under-resourced model to a more robust and balanced, if still stretched, safeguarding operation. This transformation is evidenced by the establishment of a larger team of Area-based advisers, the achievement of near-universal Parish Safeguarding Officer (PSO) coverage, and the implementation of regular episcopal scrutiny of open casework. Her leadership is focused by a mature, data-driven approach; notably, she interprets low referral rates as a risk to be proactively addressed rather than a source of false reassurance, ensuring a culture of constant vigilance.
- 4.13 She is highly regarded for her management of the LDF's distributed model. She leads with a 'safeguarding first' philosophy, evidencing a willingness to initiate "blunt conversations" regarding inappropriate behaviour.
- 4.14 During the drafting of this report, media coverage regarding the Diocesan Bishop revisited past concerns surrounding the tragic death by suicide of a retired priest following unsubstantiated allegations. While outside the specific terms of this Audit, the case was considered as part of the progress update. The Diocesan Bishop acknowledged that the review of concern processes needed improvement. Profoundly affected by the case, she has overseen a deliberate cultural shift: safeguarding core groups are now more functional, processes having been streamlined, and open cases are rigorously scrutinised to prevent delays. She regards these improvements as a vital strength resulting directly from the lessons learned but is not complacent and keen to continue the Church's safeguarding improvement journey.

## Area Bishops

- 4.15 The sheer geographic and demographic scale of the Diocese of London places the Episcopal team under immense strain. Area Bishops oversee vast responsibilities, including safeguarding, appointments, and pastoral care, across complex jurisdictions. However, unlike many diocesan bishops elsewhere, they face severe capacity challenges due to limited administrative and management capacity normally fulfilled by those in ordained roles.
- 4.16 Balancing rigorous procedural demands with essential pastoral work generates significant pressure. Consequently, there is strong evidence for employing dedicated Bishops' chaplains and Assistant Archdeacons to mitigate risk and prevent burnout.
- 4.17 Reinforcing support for Area Bishops is particularly critical now that the Bishop of Stepney has moved to a Diocesan role. As a highly experienced figure who held the dual strategic portfolio of Lead Bishop for Safeguarding and local Area Bishop, their departure has left a significant gap.

## The General Secretary

- 4.18 The General Secretary of the Diocese has extensive experience in faith-based environments and has worked closely with the Diocesan Bishop to drive significant investment in the DST. While the current General Secretary has maintained the team's expanded capacity, it is important to note that the most significant growth, increasing the team from 3.2 Full-Time Equivalent (FTE) to 10.6 FTE, began prior to their appointment. Notwithstanding the critical commentary regarding capacity in this report, it is right to acknowledge that under their leadership, the safeguarding team has expanded to over ten FTEs.

## **The Head of Safeguarding**

- 4.19 The Head of Safeguarding has been a significant asset to the Diocese, having overseen and led the restructuring that built a largely professional DST.
- 4.20 The team is clearly under pressure. Factors such as geographic dispersal, remote working, and mixed levels of experience have had an impact, not least on the consistency of casework and record-keeping, which needs to be strengthened. However, both the Head of Safeguarding and the Case Manager demonstrated a clear awareness of these issues and their impact. Recommendations, if accepted, concerning the need to reinforce the DST, will help to alleviate some of the issues and ongoing processes will address related matters.
- 4.21 At the same time, the Audit identified distinct relational issues within the DST, including professional and personal divisions, and grievances amongst team members. Specific concerns raised by a former member of the DST, which this Audit was unable to substantiate, should be addressed by an independent HR review. This should be driven by clear terms of reference that include the concerns raised.

## **Archdeacons**

- 4.22 Archdeacons demonstrate a robust commitment to safeguarding, applying deep professional experience to navigate risk. Through collaboration with the DST, they leverage local knowledge and networks to heighten awareness and champion professional standards. Their active and constructive participation in Safeguarding Case Management Groups (SCMG) (formerly known as Core Groups) highlights their potential to serve as effective Chairs; however, this role is contingent upon appropriate training and the resolution of the critical capacity constraints detailed later in this report.
- 4.23 Indeed, capacity remains a significant concern. While the Audit acknowledges the

Archdeacons' resilience, the current workload intensity poses a threat to long-term sustainability. Support structures must be reinforced to prevent burnout and ensure mission focus is not compromised. Furthermore, reliance on individual goodwill (working beyond normal hours) must be balanced with formal protocols to ensure systemic consistency.

4.24 The leadership team operates within a complex environment characterised by pronounced theological differences. While the Bishops maintain a clear commitment to racial justice and inclusive leadership, they face the ongoing challenge of maintaining unity and meaningful relationships with clergy who hold differing convictions, particularly regarding the ordination of women or specific tenets of *Living in Love and Faith*. The Audit noted concerns that certain structural provisions, originally designed for specific pastoral purposes, may at times be perceived as being utilised in response to wider leadership or theological disagreements. This complexity is evidenced by the fact that, in one Episcopal Area considered by the Audit, 22 (nearly 20%) of parishes resolved to receive extended episcopal oversight.

4.25 Beyond formal arrangements, the Audit identified that historical structural barriers and cultural norms can inadvertently limit leadership opportunities for women, ethnic minorities, and those from working-class backgrounds. This has led to feedback from individuals with lived experience who have felt isolated or marginalised due to their race, gender, or beliefs. To move toward greater organisational cohesion and move beyond tokenism, the leadership recognises that addressing these perceived or real barriers requires sustained oversight, governance scrutiny, and a proactive shift in organisational culture.

4.26 Central to this work is the understanding that a 'healthy culture' is not merely a secondary

goal, but a fundamental safeguarding imperative. Whether these cultural challenges are real or perceived, they must be addressed to ensure an environment where every individual feels safe, respected, and valued. A healthy culture fosters an atmosphere of openness where concerns can be shared without fear of isolation, and where transparency replaces old patterns of deference. By prioritising a culture of belonging and mutual accountability, the Diocese ensures that safeguarding remains a lived reality rather than just a policy requirement.

## Governance

4.27 Safeguarding has been a stated strategic priority for five years and is increasingly established as a strategic priority within the Diocese's oversight framework, aligning with the regulatory expectations of both the Church and the Charity Commission. This commitment is underpinned by an executive leadership team that demonstrates heightened engagement, genuine openness to external scrutiny, and operational competence through improved risk focus and tracking.

4.28 That said, whilst executive-level meetings are well-attended and regularly consider safeguarding, the Senior Management Group, the Joint Operations Team, and other senior leadership forums do not yet have formal Terms of Reference. The Audit was informed that these documents were being drafted at the time of review. It is essential that safeguarding is embedded within the new Terms of Reference for all such meetings and established as a standing agenda item.

**Recommendation D1:** The Terms of Reference for all senior leadership team meetings should be finalised as a matter of urgency, ensuring that safeguarding is included as a specific, standing agenda item.

4.29 Effective governance oversight is hindered by the structural composition of the LDF Trustee Board. With a membership ranging between 46 and 54, the Board is exceptionally

large, creating an environment where collective responsibility is diffused and meaningful scrutiny is difficult.

4.30 Feedback from a significant and well-informed range of those engaged by the Audit felt that this challenge is exacerbated by internal politicisation, where debate is often skewed towards the concerns of specific theological traditions rather than objective safeguarding considerations. To bridge the gap between the Board and operational reality, the attendance of a Director of Safeguarding should be mandated at all LDF Board meetings (subject to the acceptance of the relevant recommendation). This would ensure that authoritative safeguarding expertise is consistently applied to decision-making.

4.31 Effective safeguarding governance relies on focused scrutiny and clear accountability. However, the current governance structure, where the Bishop's Council is coterminous with the Diocesan Board of Finance, whilst this is similar to many diocese it is particularly relevant in London given its scale. In the opinion of the Audit it has resulted in an unwieldy membership of 46 to 54 individuals. This excessive size dilutes collective trustee responsibility, allows internal politicisation to obscure critical safeguarding risks, and hinders the agility required for effective oversight. To align with charity best practice and ensure safeguarding is prioritised, a distinction must be drawn between broad synodical debate and focused trustee governance.

**Recommendation D2: Governance Restructuring for Safeguarding Oversight**

It is recommended that the Diocese restructures its governance to distinguish between the policy-focused Bishop's Council and a streamlined LDF Board of Directors. To achieve this, the Diocese should:

- a) Create a smaller, more agile Trustee body to discharge the legal and fiduciary duties of the LDF. This group should be reduced to a size conducive to effective decision-making (ideally 12–15 members).

- b) The current Area-based approach to oversight should be reviewed in line with this approach to ensure uniformity of processes and the application of oversight accountability.
- c) Appoint the Director of Safeguarding as an officer in attendance to this smaller Board. This ensures that trustee decisions are grounded in operational reality and that the distinction between the Board's strategic accountability and the Director's operational authority is reinforced and maintained.
- d) Retain the larger Bishop's Council as a forum for broad theological and policy debate, removing the expectation for this wider group to perform detailed executive scrutiny of safeguarding operations.

### **The Diocesan Safeguarding Advisory Panel**

4.32 The Diocesan Safeguarding Advisory Panel (DSAP) benefits from strong independent leadership and deep multi-disciplinary expertise spanning the legal, educational, voluntary, and statutory sectors. The panel has had a data focus for some time and there is an intention to make better use of the data moving to prioritise data-driven insights that can be published as well as engaging with diverse external voices to ensure effective independent challenge.

4.33 Despite these strengths, the scale and complexity of the Area model present challenges in communication and oversight, potentially decoupling the central DSAP from activity across the Episcopal areas. Although the operational autonomy of the 'five mini-dioceses' provides essential local focus, without robust coordination and frequent engagement, these areas risk evolving into isolated, 'tribal' subcultures.

4.34 To address this, the DSAP should support the adoption of Area Safeguarding Advisory Groups and continue to collaborate on quality assurance analysis with the Regional Safeguarding Lead. This will help to test and strengthen policy alignment, particularly regarding case management and record-keeping.

**Recommendation D3:** To guarantee uniform safeguarding standards, Area Safeguarding Advisory Groups (ASAGs) should be introduced in every Episcopal Area. Acting as a feedback loop, these panels will translate central strategy into local delivery, providing a necessary means of assuring good practice. Crucially, membership must be diverse: the Terms of Reference should require the inclusion of clergy, staff, volunteers, youth leaders, congregants, and local partners. Additionally, priority must be placed on securing representation from a relevant victim or survivor advocacy group.

### **Key Responsibilities**

- i. Monitor the local implementation of the unified safeguarding framework to ensure training and reporting mechanisms are consistent with Diocesan standards.
- ii. Act as a feedback loop by identifying local trends, resource gaps, or specific cultural challenges, and reporting these back to central Diocesan leadership.
- iii. Gauge the safeguarding culture within the Area, moving beyond simple compliance data to evaluate trust and ethos.
- iv. Oversee the delivery of uniform annual surveys across each Area, as well as for LDF central clergy and staff, over the next three years. To facilitate benchmarking across the Diocese, these surveys must utilise a standardised set of questions covering:
  - a. Safeguarding culture and its impact.
  - b. Equality, Diversity, and Inclusion (EDI); and
  - c. Perceptions regarding the existence and impact of deference (specifically the approachability and responsiveness of leaders at all levels).
- v. The ASAG will meet quarterly to provide update briefings to the Area Bishop and the central Diocesan Safeguarding Advisory Panel (DSAP).
- vi. The DSAP should continue to produce an annual report and action plan based on these briefings. This report should analyse trends and themes in safeguarding

referral data and local survey outcomes. It aims to highlight variations across the diocese, identify and promote good practice, and outline steps to address any identified barriers.

### **Terms of Reference: Area Safeguarding Advisory Groups (ASAGs)**

The primary objective of the ASAG is to ensure the consistent application of the Diocesan safeguarding strategy within the Episcopal Area. By acting as a vital bridge between the central Diocesan Safeguarding Advisory Panel (DSAP) and local parishes, the Group aims to eliminate regional disparities (the so-called "postcode lottery") and ensure safeguarding is culturally embedded rather than merely compliant. Furthermore, the ASAG serves as a forum for local contextual feedback, ensuring central policy remains practical and effective on the ground.

**Membership Composition** To maintain a holistic perspective that accurately reflects the life of the Area, membership must include a diverse cross-section of local representatives. The panel should be inclusive and comprise:

- a) The Area Archdeacon (as a standing member), supported by a mix of incumbents, curates, and chaplains to represent diverse parish contexts.
- b) Representatives from lay staff, such as parish administrators or operations managers.
- c) Key volunteer voices, specifically Parish Safeguarding Officers (PSOs) and Churchwardens.
- d) The designated lead member for the Area from the central Diocesan Safeguarding Team.
- e) Representatives from children and youth ministry or young adult leadership to champion the voices and perspectives of younger generations
- f) Lay members of the worshipping community without formal roles, providing an independent perspective.
- g) To ensure transparency and wider community engagement, this should include:

- i. *Statutory*: Representatives from local bodies (e.g., Local Authority Designated Officers (LADO), Police, or Social Services).
- ii. *Non-Statutory*: Representatives from relevant local charities, victim advocacy groups, or community support organisations.

#### **Recommendation D4: Scrutiny of Extended Episcopal Oversight**

The LDF should include in its matrix of monitoring categories of parishes and clergy that have sought Extended Episcopal Oversight a process that goes beyond simple numbers to:

- a) Distinguish between theological objections (e.g., *Living in Love and Faith*, ordination of women), EDI matters, and specific grievances regarding an individual Bishop's background, beliefs, conduct or management.
- b) Scrutinise these patterns to ensure ongoing accountability and integration of parishes, whatever their theological conviction.
- c) Mandate the submission of data from Area offices to the LDF, utilising the proposed ASAGs and DSAP for quality assurance and local context.

### **Clergy (Blue) Files**

4.35 The Clergy (Blue) File system is anchored by an effective oversight mechanism and the Diocesan Bishop's reviewing and signing all outgoing Clergy Current Status Letters (CCSL). This demonstrates accountability and ensures critical oversight.

4.36 Operationally, the process is robust, employing comprehensive front sheets, standardised checklists, and strict access logs to maintain transparency and minimise error across both paper and digital formats. Crucially, the system integrates proactive risk management by involving safeguarding officers, to review files and track historic disciplinary (CDM) matters effectively.

- 4.37 Despite these strengths, the reliance on a hybrid filing system and the need for persistent manual follow-up to secure documents before clergy commence present efficiency challenges. To evolve from this solid foundation, the LDF should prioritise full digitisation as soon as new national policy and practice facilitate this approach.
- 4.38 The storage of Clergy files in fireproof cabinets is an issue that has been raised throughout many of the Audits. Given the cost, it seems that LDF's have defaulted to manage the risk until digitisation is complete.

### **Capacity**

- 4.39 The complexity of London is significantly complicated by its geography and the sheer diversity of its multi-cultural and multi-faith-based population. While the safeguarding system appears robust on paper, not least when considering the growth of the safeguarding team from a low base of 3.2 FTE to its current 10.6 FTE, these aggregated numbers provide a false sense of security.
- 4.40 When safeguarding demands are spread across this vast geography, capacity is quickly diluted; weaknesses in experience levels become more apparent, and overall resilience in the face of contingency requirements are reduced. Some of the London Areas, if independent, would rank as the 11th or 12th largest dioceses in England. Even the smaller Areas are comparable to the smallest stand-alone dioceses in the CofE. From a safeguarding perspective, if outside London and a stand-alone diocese, they would have safeguarding arrangements that included a DSO supported by an experientially blended team of safeguarding professionals (most of whom would have a credible statutory background). In London each area has a single safeguarding advisor. This is insufficient and is not sustainable.

- 4.41 The fragility across the professional safeguarding team is mirrored and the risks exacerbated by a lack of capacity among the clergy required to participate in formal safeguarding arrangements. These roles are essential to support, reinforce, and positively drive a safeguarding culture.
- 4.42 Whilst Area Bishops do not carry the formal statutory responsibilities of a Diocesan Bishop, the Audit noted how they operate within a model of distributed leadership. In this framework, they manage areas that not only rival many dioceses in size but also generate significant workloads, which are further impacted by the unique demographics and complex challenges inherent in the capital.
- 4.43 Most Area Bishops operate without a Chaplain, and with only one Archdeacon, whereas in many of the areas the Audit has engaged, multiple archdeacons exist and/or are supported by associate Archdeacons. These deficits force senior clergy to make binary choices, for example, engaging in pastoral work *or* attending to safeguarding support. Furthermore, Area Bishops and Archdeacons lack adequate administrative support further compounding the stark choices they have to make when faced with competing demands.
- 4.44 The National Church should reflect on whether this ‘5-in-1’ model is sustainable in its current form. Without significant structural reform and or reinforcement of the support structures for Area Bishops, the model risks operational failure and could undermine the welfare of its leadership team.

**Recommendation D5:** Archdeacons should be supported by Assistant Archdeacons and have shared administrative support; all Area Bishops require a Chaplain (this will provide crucial support on a range of issues but not least management of the Clergy (Blue) files); the Diocese should consider presenting a business case to the appropriate national body.

## **The Diocesan Safeguarding Team**

- 4.45 The Diocesan Safeguarding Team (DST) functions as the central hub for all safeguarding matters within the diocese. While the structure is designed to encompass strategy, operations, and administration, current operational realities mean the team is working at or beyond full capacity to meet statutory and church requirements.
- 4.46 The Head of Safeguarding holds overall accountability for the department and serves as the accredited Diocesan Safeguarding Officer (DSO). They hold absolute responsibility within the Diocese, independent of the Bishop of London, for the delivery of operational matters relating to the safeguarding of children and vulnerable adults.
- 4.47 Ideally, the Head of Safeguarding's primary function is strategic, focusing on the wider safeguarding culture, representing the diocese at a senior level, and managing relationships with external statutory agencies. However, the role is not removed from operational realities; the Head retains direct oversight of high-risk and complex cases, necessitating a difficult balance between high-level strategic planning and significant operational decision-making.
- 4.48 Despite recent internal challenges that impacted team relationships (addressed earlier in this report), the organisation's safeguarding provision is anchored by an experienced team. Both leadership and the majority of staff possess credible, specialist backgrounds in policing, public protection, and social care. This collective expertise drives a commitment to professional practice, strengthened by an evolving culture of openness, transparency, and a willingness to reflect on lessons learned. However, the team continues to face distinct structural challenges.

- 4.49 The Area DSAs are the primary contact point for parishes, clergy, and volunteers. Their work is largely reactive and demand-led, focusing on triaging referrals, investigating concerns, and managing risk. Currently, the demand for their advice and intervention frequently exceeds available hours, creating a high-pressure environment focused on immediate risk management rather than proactive support.
- 4.50 The Safer Churches Programme Manager role was designed to drive systemic change and manage long-term improvements. However, maintaining the separation between this strategic project work and the immediate demand of the frontline remains a constant challenge given the overall workload.
- 4.51 While recent investments have been made, the scope of the administrative support role is limited. For example, administrative time is consumed by processing Disclosure and Barring Service (DBS) checks for the LDF (notwithstanding that areas manage DBS for their clergy). Consequently, the administrator is unable to provide wider operational support to the Head or the DSAs, creating a functional silo where the resource is utilised almost exclusively for compliance processing.
- 4.52 Given the geography and complexity of London, the team faces critical pressures. In 2024 alone, the team managed a high volume of cases (see Part 1 - Recognising, Assessing and Managing Risk of this report). Beyond these operational volumes, the DST must also navigate a residual legacy of mistrust linked to non-recent safeguarding failures and unclear roles.
- 4.53 While the organisation is developing a supportive environment, prioritising staff resilience

through counselling access and flexible working, the focus must shift from establishing foundations to ensuring long-term sustainability. Current bottlenecks threaten efficiency, and disparities in job titles, pay parity (internally and with external organisations), and progression paths suggest the internal HR structure has not matured to match the needs of staff, posing a significant risk to recruitment and retention.

**Recommendations to Strengthen Practice and Deliver Change:**

4.54 The following recommendations are made to support the transition to a more resilient and effective leadership and governance framework. To support change the LDF should:

**Recommendation D6:** Formally elevate the Head of Safeguarding role to Director level, with a clear job description (Appendix 3) and Board-level representation. This role should have strategic authority and the ability to direct operational safeguarding activity across the Diocese of London. This would include acting as the most senior safeguarding advisor (when escalation required) to other church bodies across the diocese, for example Holy Trinity Brompton (HTB). This will provide an ultimate authoritative safeguarding voice across the geography of the diocese.

Appoint a Deputy Director to provide leadership capacity (and resilience). The operational case manager role may provide a good fit for this link between strategic engagement and operational grip. This role should have a deputy to operate in support and provide contingency.

**Recommendation D7:** DSAs in Episcopal Areas are under-resourced and there is little capacity to ensure support. The following recommendations are made to address this critical issue. The LDF should:

- a) Change the current naming convention to Area Safeguarding Advisors (ASA).
- b) Ensure there are two ASAs within each area, with one designated as the Senior Area Safeguarding Advisor (SASA).

- c) Whilst the appointment to such roles (if the recommendation is accepted) is a matter for the Director/Head of Safeguarding in agreement with the LDF, this should be seen as an opportunity to reset safeguarding support across the LDF. The role for SASA should be a competitive process that enables a strategic approach to building strong blended teams that complement the strengths in the overarching DST.
- d) Opportunities should also be considered to create job share roles as this will further enhance the opportunities to embed teams with a range of complementary experience from credible former statutory safeguarding roles.

**Recommendation D8:** Conduct a review of salary structures to assess and address pay parity with external organisations and progression, ensuring the Diocese can recruit and retain experienced safeguarding professionals.

**Recommendation D9:** Redefine the existing administration role as Safeguarding Support Officer focusing on direct support on matters related to supporting the DST and parishes.

**Recommendation D10:** To ensure continuous culture and professional development the LDF should:

Implement mandatory, regular training for all DST members, delivered in-house by the team (Enhanced In-House Training) to reduce reliance on external providers, supported by a specific budget for specialist needs.

Strengthen systems for reflection, staff welfare, supervision, and resilience checks.

Adopt a strategy of consistent, transparent communication that celebrates success to boost internal morale and enhance public confidence.

## 5 Prevention

- 5.1 One way in which the LDF demonstrates its prioritisation of safeguarding is through its arrangements for safer recruitment. The LDF follows the House of Bishops' Safer Recruitment and People Management guidelines, ensuring processes are aligned to legislation. Local practice is effective, including comprehensive training for recruitment personnel, accessible online resources, risk assessments conducted in respect of DBS checks for LDF staff and expert support for DBS checks through a contracted provider.
- 5.2 The Audit is of the opinion that the current responsibility for DBS administration, held by the DST, would be more appropriately located within the HR team. This should include a clear process for information sharing with the DST, particularly when a DBS check reveals relevant information. This realignment would free up administrative capacity within the DST to offer more proactive outreach and support to parishes.

**Recommendation D11:** The LDF should transfer DBS administration for LDF employees from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

- 5.3 Good safeguarding practice is developed, adopted, and shared across the diocese. In addition to adopting national guidance, the LDF maintains its own bespoke Safeguarding Policy, tailoring best practice to the local context. This policy is subject to continuous review and update; for instance, the LDF has already actioned the removal of certain references to 'Promoting a Safer Church' following national advice that this was no longer appropriate; however, it is recognised that some necessary cross-reference is still required within the documentation. Furthermore, good practice is actively shared and embedded through key mechanisms, including a clear and accessible Whistleblowing Policy and mandatory Safeguarding Induction training for all new PSOs.

- 5.4 The LDF maintains several arrangements with other dioceses and regional groups to ensure the systematic sharing of good practice and to promote mutual learning across different functional areas. Specialist knowledge is shared through groups like the South-east Regional Trainers, which includes eight neighbouring dioceses. Meeting approximately four times a year, their agenda is shaped by national activity, demonstrated by a recent session dedicated to safeguarding issues concerning bell-ringers. Additionally, the DSO belongs to a regional DSO group, which focuses on encouraging the exchange of practical advice and tips on good practice.
- 5.5 Crucially, the LDF also facilitates good practice sharing directly with parishes. This is achieved through various channels, including PSO drop-in sessions, mailings, the Diocesan newsletter, the website, and formal PSO training. A significant element of the drop-in sessions is the direct exchange of practice and learning between parishes, with a common theme being effective methods for encouraging Parochial Church Council (PCC) members to engage with mandatory safeguarding training and DBS checks.
- 5.6 The LDF employs a number of approaches to promote safeguarding, utilising a range of accessible materials and methods suitable for different audiences. These efforts include distributing an informative LDF-produced booklet, available in both physical and digital formats. Furthermore, crucial safeguarding updates and information are shared via the Diocesan newsletter and a dedicated safeguarding newsletter. The LDF also publishes relevant articles on its website and uses timely, special announcements for urgent or specific communications. To ensure internal awareness, safeguarding is a fixed item at regular meetings, including a dedicated slot during LDF staff inductions and the induction for new deacons. Finally, the LDF maintains an accessible safeguarding section on its internal intranet, prominently featuring a straightforward 'Raise a concern' mechanism.

- 5.7 To improve suitability, the Audit specifically noted instances where both the materials and the facilitation of sessions were adapted to meet the needs of individuals with additional requirements. Examples of these adjustments include the provision of large print documents, using materials printed on different colour paper, and providing translation services to ensure materials are accessible in other languages. This is good practice.
- 5.8 The Audit reviewed the LDF Communications Strategy (which is currently in draft form) and its dedicated Safeguarding Communications Plan. The Audit supports the strategy's aims to enhance value by ensuring the DST is highly visible and accessible at all times. It also promotes the consistent delivery of clear, positive messages and the achievement of good safeguarding outcomes. Furthermore, the strategy advocates for the regular review of existing policies and procedures to guarantee they are both accessible and fit for purpose. In respect of the use of social media for disseminating safeguarding information, the LDF stated its preference not to rely heavily on these platforms due to the potential for negative or adverse commentary. While acknowledging these challenges, the Audit maintains that social media remains a strong and effective channel for delivering safeguarding messages and should be appropriately utilised.
- 5.9 The Audit concluded that more needs to be done to deliver clear, positive messages regarding safeguarding. Specifically, it believes that social media and online channels should be used more effectively as a crucial tool for raising awareness of the various kinds of abuse.

**Recommendation D12:** The LDF should adjust its communication plan to include a broader range of safeguarding messages across its digital channels. In order to enhance this engagement, it should:

- a) Tailor content to resonate with the specific interests and preferences of followers on each platform.
- b) Embedding key safeguarding messages throughout its social media channels. This ensures consistent and frequent reinforcement of important information.
- c) Employ diverse communication strategies suited to each platform's unique features and user expectations.
- d) Capitalise on relevant awareness days, campaigns, and events to amplify key messages and expand audience engagement.
- e) Aim to raise awareness of different forms of abuse (such as domestic and spiritual abuse) and address contemporary safeguarding issues (including, but not limited to, modern slavery and county lines).

5.10 The LDF provides consistent, ongoing support for PSOs, who are vital local contacts. They run monthly PSO drop-in sessions, which typically see an average attendance of around 32 officers. While these sessions sometimes focus on a specific topic, they primarily serve as an open forum for PSOs to raise any questions or concerns they may have. Following each meeting, a brief summary of bullet-point notes is distributed and made available on the website for the benefit of those who could not attend.

5.11 This responsive approach was notably demonstrated in November 2024, when the team arranged an extra session following the publication of the Makin Report and the Archbishop of Canterbury's resignation. This provided a necessary space for over 45 PSOs to discuss and prepare for the difficult questions they were facing locally, particularly on Safeguarding Sunday, given the widespread and often polarised public views on the issues at that time. This is good practice.

5.12 Effective prevention planning and implementation must be a two-way process, actively

involving children, young people, and vulnerable adults. The Audit is of the opinion that the LDF could significantly strengthen its efforts to capture the views of children and young people and ensure these voices are fully considered within the prevention initiatives.

**Recommendation D13:** Further to reviewing existing practice, the LDF should consider implementing new and / or extended models for youth participation in consultation with parishes and its existing networks.

- 5.13 In respect of hearing the voices and learning from the experiences of victims / survivors of abuse, see the Victims and Survivors section of this report.
- 5.14 Lone working within the LDF is covered 'The Code of Safer Working Practice'. Specifically, a buddy system has been implemented for staff when they are working alone, alongside a mandatory check-in procedure upon concluding a visit, ensuring that someone is aware of their movements and safe departure. Where practically feasible, the DST prioritises not conducting visits on their own, thereby reducing the need for lone working. The LDF team has also enhanced its collective knowledge and skills by attending Personal Safety & Lone Working training, with the acquired learning subsequently shared across the entire team to ensure consistent application of best practice.
- 5.15 Beyond the LDF's specific code, Parishes maintain their own individual safety protocols and practices, which are further reinforced by broader national Church guidance concerning personal safety. Furthermore, the LDF has taken steps to support this by facilitating comprehensive training on Personal Safety and Lone Working specifically for clergy. This programme covers a range of critical topics, including procedures for Lone and Frontline Working, methods for Identifying and Assessing Risk, best practices for Travelling for Work, and the importance of Setting Boundaries and Reporting incidents. Additionally, the training equips staff with essential skills for Responding to Physical and

Verbal Aggression, employing De-escalation and Defusion Techniques, and providing appropriate Post-Incident Support. This is good practice.

- 5.16 In light of the various activities that take place within churches, and in recognition of the broader risks involved, it is positive that the LDF has issued a range of relevant guidance. This includes resources such as the 'Emotionally Healthy Discipleship Course', a 'Toolkit on Running Safer Food Banks', 'Guidance on Using your church as a film location', and advice concerning 'Rough Sleeping in and around Churches'.

### **Children and Youth Ministry**

- 5.17 The Diocese supports a significant volume of youth and children's activity across parishes, delivered by a mix of paid staff and volunteers. The Audit heard strong evidence of commitment, creativity, and care from those leading this work. Youth workers and volunteers consistently described safeguarding as integral to their ministry. The Audit's survey found a significant majority feel supported by adults within the Church. In addition, the majority agreed or strongly agreed that they know what to do if something makes them feel uncomfortable, upset, or worried in a church context.

- 5.18 Alongside this, the Diocese has articulated a clear strategic ambition around 'Growing Younger', reflecting an intentional commitment to invest in children and young people and to build sustainable ministry capacity for the future.

- 5.19 The Audit recognises that the Children and Youth Team has not been passive in relation to safeguarding oversight. A proactive internal safeguarding review was undertaken, led by the DST. This was described as a "look under the hood" exercise to strengthen practice rather than a response to an incident. It demonstrates openness to scrutiny and a willingness to improve.

5.20 Following that review, the team began significant work to identify and map paid youth workers across parishes. PSOs were contacted directly, with follow up reminders issued where needed. Over 350 parish responses were received, despite there being no formal requirement for parishes to comply. The team is now seeking confirmation of safer recruitment processes, safeguarding training status, levels of experience, and signed codes of conduct for paid workers. These are practical and proportionate steps towards better oversight.

5.21 The Diocese has also recognised the limitations of current systems and is actively exploring the implementation of a CRM to improve visibility and accountability.

5.22 However, at present, diocesan oversight of youth and children's workers still remains fragmented. There is no single, reliable system that enables the LDF to know with confidence who is undertaking youth and children's work across all parishes, whether they have been safely recruited, or whether safeguarding training and practical support are current. This limits assurance and places disproportionate reliance on local parish processes. As a result, the Audit makes the following recommendation.

**Recommendation D14:** The Diocese should continue its project to implement a centralised system, such as a CRM or safeguarding database, for recording all youth and children's workers, paid and voluntary, covering recruitment checks, safeguarding training status, and role descriptions. This should support line of sight and accountability, rather than replace parish responsibility.

5.23 The Audit also identified significant workforce instability, particularly among paid youth workers. High turnover, driven by cost of living pressures and limited career pathways,

was consistently raised in discussions. Whilst this is not unique to London, it creates safeguarding risk, particularly where inexperienced staff are working with limited supervision and variable line management.

- 5.24 There are, however, important mitigating factors. The youth worker apprenticeship programme provides a structured and supported entry route into ministry. Apprentices are employed directly by the LDF rather than by parishes, enabling safer recruitment, clearer oversight, and the ability to intervene or redeploy if a placement is not safe or effective. This offers a stronger safeguarding framework than is often available to parish employed roles and represents developing good practice.
- 5.25 In practice, there is evidence of collaborative working between diocesan safeguarding leadership and larger church networks, with regular inclusion in safeguarding events and supportive working relationships with DSAs. The Children and Youth Team records low level safeguarding concerns on an internal database and routinely shares relevant information with the safeguarding team. This is good practice.
- 5.26 Additional good practice was observed in some parishes where regular termly safeguarding refreshers are delivered to youth volunteers, using scenario based discussions to build practical confidence in responding to disclosures.
- 5.27 Digital safeguarding awareness was also evident. Examples included moderated WhatsApp groups where only leaders can post announcements, and group chats that include at least two adult leaders. In addition, some parishes have appointed Children's Champions who act as visible safeguarding presences within worshipping communities, providing an additional listening point for children and informal oversight.

5.28 Safeguarding training for youth roles is expected in line with national requirements. However, some youth workers and volunteers described national safeguarding training as generic and insufficiently contextualised to the realities of youth work. Particular gaps were identified around mental health, online harms, child on child abuse, and managing complex pastoral disclosures. In some cases, participants expressed concern that training scenarios did not reflect safe or realistic practice.

**Recommendation D15:** The Diocese should develop supplemental, context specific training for youth and children’s leaders, with emphasis on online harms, grooming, mental health, and practical scenarios. These should be co designed with frontline workers and young people.

5.29 During the Audit visit to a youth group in Twickenham, staff were observed actively engaging young people in discussion around complex and sensitive topics, including drugs and alcohol, sex and relationships, and issues of leadership and power. Importantly, these discussions were led by the interests and requests of the young people themselves. This is good practice.

5.30 That said, while informal listening to the voices of children and young people takes place at parish level, the Audit found that there could be improved structured diocesan mechanisms to gather feedback and input from children and young people to inform safeguarding learning, policy, or improvement activity.

**Recommendation D16:** The LDF should establish a diocesan youth reference group on safeguarding, ensuring the perspectives of children and young people directly inform policy, training, and practice. This would strengthen a culture of listening and early intervention.

### **External Programmes, Alpha, and Safeguarding Accountability**

5.31 The Alpha course originated at Holy Trinity Brompton and continues to be delivered there,

giving it an ongoing connection to this church. It is operated by a separate charitable body and is widely used across Church of England parishes. Alpha also has a strong public profile and reputation, both positive and contested, which is readily apparent through open source information.

5.32 Alpha can sit in a more blurred space. While it is a separate organisation, it is always run by hosting churches as part of their mission and ministry, using church volunteers, church leadership oversight, and church communications, while drawing on centrally produced Alpha materials. In these circumstances, Alpha is not an external group hiring a room. It is a church led activity, and safeguarding responsibility therefore rests with the hosting church rather than with Alpha.

5.33 Risk arises where this distinction is not clearly understood. Parishes may assume safeguarding is covered through Alpha's central structures, while Alpha's delivery model assumes appropriate local oversight is already in place. Given the course's ease of reproduction, its reliance on facilitators, and its use of small group discussion, this lack of clarity can increase the risk of inappropriate influence or spiritually harmful practice if boundaries are not well managed.

5.34 Clear diocesan guidance would help parishes understand when activities are genuinely third party provision and when safeguarding responsibility remains with the church.

**Recommendation D17:** The London Diocesan Fund should consider developing and issuing clear guidance for parishes on safeguarding accountability where externally developed programmes and courses are used within church life, including Alpha. This guidance should help parishes distinguish between activities that are genuinely third party provision and those

that form part of the parish's own mission and ministry, setting out expectations for safeguarding oversight, local risk assessment, and clarity of responsibility.

## 6 Recognising, Assessing and Managing Risk

- 6.1 The LDF maintains a consolidated operational and regulatory risk register, with the most current information clearly documented for each individual risk and its potential consequence. This register is logically structured, covers all key corporate issues, and addresses the broad range of the LDF's functions. The most recent review of a safeguarding-related risk took place in July 2025.
- 6.2 However, the current format groups 'HR and Safeguarding' together in a single section. In the Audit's view, there is a significant opportunity to strengthen existing processes by developing a stand-alone safeguarding risk register. This dedicated approach would ensure a more acute focus on safeguarding issues, enabling the LDF to better articulate and mitigate specific risks in alignment with the national safeguarding standards.

**Recommendation D18:** The LDF 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.

- 6.3 The structure currently in place allocates a DSA to each distinct Episcopal Area. This arrangement is specifically designed to enable the DSAs to cultivate strong working relationships and develop a comprehensive knowledge of all the parishes within their designated area. By regularly visiting these parishes, the DSAs become a familiar and accessible figure, ensuring that all staff and volunteers know exactly who to contact immediately when they require safeguarding advice. Despite this focused role, each DSA is also required to dedicate one day a week to an 'on-duty' phone line. This system is under resourced and the pressures and impact of this are covered in the 'Capacity' section of this report.

6.4 Over the past three years, the volume of concerns officially logged as safeguarding incidents has fluctuated. In 2022, there were 394 incidents recorded, a number that decreased the following year to 285 in 2023. However, an increase was noted in 2024, with the figure rising to 713 recorded incidents. So far this year, as of 17th June 2025, 344 incidents have been recorded. In addition to the incidents, 206 contacts were logged specifically for safeguarding advice. These are tracked using the categories defined within the NSCMS. It is important to note that data for this category is currently limited; the LDF did not record figures for advice-related contacts prior to the NSCMS's implementation, making it impossible to provide historical data for calls seeking advice before this period. Finally, of all the concerns brought to the Safeguarding Team over the last 12 months, 72 resulted in a formal referral to statutory authorities. These referrals were directed to the Police, Children's Social Care, and Adult Social Care.

6.5 The management of cases, including triage, allocation, and supervision, within the Safeguarding Team begins when a DSA opens a report on the National Safeguarding Case Management System (NSCMS). The Casework Manager then takes responsibility for assessing the matter and assigning an initial risk threshold. Case allocation is primarily based on geographical areas, with one DSA typically assigned to each region. However, due to fluctuations in demand and capacity across these areas, work is often redistributed among DSAs to ensure manageable workloads. For instance, cases may be allocated to a quieter area, such as Stepney, to provide 'breathing space' for DSAs in busier areas (like Two Cities or Kensington), or to assist in upskilling less operationally experienced staff. Regarding risk thresholds, all requests for simple advice are recorded as low. Any matter requiring an assessment and active risk management (e.g., managing DBS disclosures or establishing safety plans) is graded as medium. All concerns involving church officers are automatically given a high grading. The Casework Manager ensures consistency by grading all reports during the initial triage stage.

- 6.6 While the Audit views the Casework Manager's system of triage, categorisation, and prioritisation as a significant positive mechanism for ensuring uniformity and freeing up operational time, it is acknowledged that the individual performing this crucial function requires additional support to prevent backlogs from occurring during periods of absence. This is covered in Part 1, Culture, Leadership and Capacity section of this report.
- 6.7 A clear process is in place for assuring the quality of safeguarding cases. This includes The DSO/Head of Safeguarding receiving structured safeguarding supervision from the NST's Regional Safeguarding Lead (RSL) for the South East region every six to eight weeks. In addition, The Audit notes that an enhanced programme of casework QA work has been completed as part of a wider ongoing programme of continuous improvement within the Diocese.
- 6.8 The Casework Manager provides monthly supervision for all DSA workloads. Specifically, these monthly sessions cover workload management, work-life balance, any accrued Time Off In Lieu, and Continuing Professional Development (CPD). While case-specific comments from these discussions are immediately logged onto the NSCMS, it's worth noting that formal minutes of the supervision meetings themselves aren't recorded due to current capacity constraints.
- 6.9 The Casework Manager role currently suffers from a vulnerability as there is no internal deputy cover available. Crucially, the lack of a deputy means that any absence by the Casework Manager effectively inhibits core operational functions, such as the triage and allocation of new cases. This exposes the system to risk of delay and backlog.

**Recommendation D19:** A Deputy/Assistant Case Manager should be established to prevent backlogs when the main case manager is on leave.

6.10 The Audit observed a disparity and lack of consistency in the approach to record keeping across the various Diocese's Episcopal Areas. While acknowledging that this variation is likely due to the different skill sets present within the team, the Audit maintained that a uniform standard for recording keeping on case management is nonetheless essential.

**Recommendation D20:** The LDF should strengthen the professionalisation of record keeping within the NSCMS, supported by proper and reflective supervision and quality assurance.

6.11 The LDF has a clearly defined process for the review and ongoing monitoring of Church Safety Plans. These plans are formally reviewed by the DST annually, though high-risk cases or changes in circumstances prompt more frequent reviews. At the time of the Audit, 38 active Safety Plans were in place. The Audit saw good use of these plans in managing risk. They were well-defined, proportionate to the identified risks, and appropriately authorised. Furthermore, the Audit observed records which provided clear evidence of supervision being carried out, accompanied by meaningful and constructive comments from the supervisor.

6.12 The LDF currently adopts the National Risk Assessment Template and associated national guidance. In addition to following this national framework, the LDF has established several specific, localised resources to support staff in their roles. These include a Role Description for a Supporter and a Supporter Confidentiality Agreement. Furthermore, the LDF provides written documentation that clearly outlines the challenging aspects of the support role, alongside video briefings designed to enhance understanding of the risks posed by individuals who sexually harm. Crucially, the recent Audit noted that the viewing of these video briefings is actively encouraged to be conducted in a manner that is both sensitive and supportive for those who are engaging with the material. While recognises these are good practice, the Audit believes that it is critically important that such training takes account of the context and complexities of such tasks within a faith-based environment.

**Recommendation D21:** The LDF should ensure that any training related to risk assessments, safety planning and wider offender management is contextually fit for purpose in a faith-based environment.

- 6.13 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 church or local parish settings. Each plan includes specific prohibitions and 'what is working well', which the Audit believes enhances the rigour and seriousness of the process. This is good practice.
- 6.14 The Audit met with a member of a Reference Group for someone subject to a Safety Plan who clearly demonstrated a thorough knowledge of the process, recognising the severity of the situation and equally, the need to support all involved parties.
- 6.15 The Audit conducted a discussion with an individual 'respondent' who was subject to a Safety Plan due to a conviction related to child sexual abuse. The Respondent accepts and respects the need for the plan, viewing it as essential for his own protection and for the prevention of re-offend. The discussion highlighted the supportive, non-judgmental approach of the church community, which the respondent referred to as his "family".
- 6.16 To ensure effective management and prevent the creation of an excessive number of unmanageable safety plans, the Audit puts forward the following recommendation.

**Recommendation D22:** The LDF should establish a formal policy and criteria for the closure or cessation of Safety Plans. This policy should specify conditions that warrant the plan's conclusion, such as the respondent's relocation or their decision to disengage from church activities.

- 6.17 The LDF demonstrates a structured approach through the regular convening of a formal SCMG. This consistently used structure ensures complex cases are handled with formality, establishing clear accountability and systematic review throughout the process.
- 6.18 A strength lies in the multi-disciplinary expertise represented in the SCMG meetings. Attendees routinely include the Head of Safeguarding (Chair), DSAs, Casework Manager, the Registrar, Archdeacons, and communications/media support. This broad attendance ensures all facets of a case, safeguarding risk, legal implications, pastoral care, communication with those affected, and public messaging are considered during decision-making. Furthermore, the process includes the proactive management of potential conflicts of interest. From a management perspective, the SCMG's minutes consistently demonstrate a systematic focus on risk identification, mitigation, and planning, alongside a clear commitment to continuous improvement and collaborative practice by routinely featuring a dedicated segment on 'lessons learned'.
- 6.19 LDF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. The Audit was informed that no cases had met the threshold for a SIR in the last 12 months, although arrangements are in place to consider potential cases.
- 6.20 The Audit has raised concerns that the current approach to managing differences of

professional opinion regarding safeguarding decisions requires clarity and strengthening. The Diocese presently directs staff to resolve such disagreements using its existing Whistleblowing Policy and Grievance Policy and Procedure. This policy requires employees to initially discuss any employment-related complaint or grievance informally with their line manager, who will consider the specific context of the issue. The Audit concluded that this framework does not provide a sufficiently robust or defined escalation process for serious disagreements about safeguarding actions. In respect of potential conflicts or complexities in safeguarding cases, the DSO has several dedicated avenues for escalation and consultation. These resources include bodies such as the NST RSL, the NST itself, and the DSAP. The DSO can also consult with external safeguarding colleagues, including statutory partners where appropriate, and other diocesan safeguarding teams (provided any information shared is anonymised). Furthermore, at the parish level, any immediate issues or concerns can be escalated directly to the DST. Where differences of opinion arise specifically with external organisations, the DST has the option to refer to that organisation's own dedicated escalation policy.

**Recommendation D23:** The Diocese should implement a defined escalation process that provides a formal structure to managing differences of opinion as they relate to the decisions and actions on safeguarding cases. This process should be applicable to all staff within all jurisdictions covered by the Diocese of London and St Paul's Cathedral.

6.21 The Diocese currently manages its data, including Safeguarding files, through an ongoing migration from a less flexible physical drives/ Virtual Private Network (VPN) storage system to Microsoft SharePoint. This process significantly enhances security, with the Safeguarding storage having been moved in June 2025. The shift enables much safer sharing of information through user-specific links that can be set to be view-only and automatically expire, alongside the application of retention labels. The LDF works to improve data handling at the parish level by explaining good practice, raising awareness,

and requesting the use of parish-specific email addresses, although it is currently unable to provide parishes with *@london.anglican.org* accounts. The Audit findings reinforce the critical requirement for tiered Data Protection Officer (DPO) framework, designating a suitably qualified area-level DPO. Given that the Areas are not separate entities, the framework should ensure the Lead DPO maintains ultimate accountability while the Area Leads provide the localised support. This need is principally driven by two major concerns: the persistently substandard quality of Subject Access Requests (SARs) being submitted, and the absence of secure, official email addresses for both PSOs and clergy, which creates an unacceptable security vulnerability when handling sensitive data.

- 6.22 Findings from the Audit's survey indicate that the overwhelming majority of the LDF's workforce and the majority of those in parishes are aware of the diocese's privacy policy in respect of data protection.
- 6.23 To facilitate information sharing, the LDF currently maintains Information Sharing Agreements (ISAs) with several key organisations. These include the Royal School of Church Music, the National Police Chiefs' Council, the Chapels Royal, and other Dioceses. Furthermore, specific agreements are in place with the Catholic Diocese of Westminster and St Paul's Cathedral, ensuring a clear and coherent framework for the exchange of necessary information.

## 7 Victims and Survivors

- 7.1 The experience of abuse can have a deeply traumatic impact on individuals. Disclosing these experiences can be an incredibly vulnerable process, often accompanied by concerns about navigating systems, the possibility of re-traumatisation, or uncertainty about potential outcomes. To address this, it is crucial that Church bodies establish and maintain a safe and supportive environment. This will help to ensure that victims and survivors feel truly heard, supported, and protected, while also creating opportunities for the Church to learn and grow from their experiences.
- 7.2 In evaluating the LDF's response to this vital safeguarding standard, the Audit gathered feedback from victims and survivors via an anonymous online survey, with a higher response rate than seen in previous audits. The Audit team also conducted one-to-one discussions with victims and survivors to listen to their individual experiences.
- 7.3 The LDF follows the House of Bishops' guidance set out in 'Responding Well to Victims and Survivors of Abuse'. Of those who experienced abuse in the Diocese, awareness of this guidance was under 50%. The Audit highlights this gap, noting that the Diocesan website does not feature a public statement of commitment to this guidance or provide a direct link to the document, suggesting a lack of visible dedication.
- 7.4 Furthermore, it is concerning that a third of Audit survey respondents identified themselves as having never reported their abuse. Reasons cited to the Audit for not reporting their abuse include not being ready, having no confidence in the Church's support systems or leadership, being too young at the time, not being aware that what happened was abuse and one individual cited not being able to access a safeguarding officer. For some, their

abuse occurred as recently as 12 months ago, and others less recently.

7.5 Survey respondents who reported having disclosed their abuse, provided mixed accounts of their disclosure experiences. Positive feedback highlighted some good support from the DST and senior clergy, exemplified by one survivor's recent experience of a DST member prioritising the survivor's needs over institutional interests. However, a significant emerging theme was the Church's perceived protectionist tendency. This concern was echoed by the overwhelming majority of the Audit's survey respondents who believe the Church prioritises its reputation over safeguarding people. Despite examples of positive support, the prevalent negative perceptions and reported systemic issues undermine confidence, creating significant barriers to disclosure, and highlighting the urgent need to rebuild trust in the Diocese's response.

**Recommendation D24:** The LDF should:

- a) Clearly detail the LDF's adherence to national guidance 'Responding Well to Victims and Survivors of Abuse', explicitly outlining its proactive and supportive stance.
- b) Ensure there is a direct link to 'Responding Well to Victims and Survivors of Abuse' guidance on the 'Support for Survivors' webpage.
- c) Embed the NST's 'Responding Well to Victims and Survivors of Abuse' videos onto the 'Support for Survivors' webpage.

7.6 The Audit also believes that the LDF could benefit from listening to a wide range of victim and survivor voices, through hosting Diocese-wide (and beyond) listening events as a broader approach to engagement. These events could offer numerous benefits, such as exploring barriers to disclosure, helping to inform the creation of safeguarding materials and developments, evaluating the effectiveness of current support, and gaining valuable insights.

**Recommendation D25:** The LDF should identify wider opportunities to listen to victims and survivors and those close to them (e.g. family members) utilising existing and established networks. This work should include travelling to neighbouring dioceses which have established survivor forums.

7.7 The Audit has viewed some evidence of follow up by members of the DST, good communication and checking in on victims and survivors following disclosing their abuse. That said, the Audit have also witnessed the negative impact that a lack of consistent follow up care and communication had on a victim / survivor, leaving the individual feeling isolated. To prevent any individual experiencing this negative impact, the Audit recommends that check-ins must be consistent and systematically diarised, ensuring a dedicated and reliable duty of care.

**Recommendation D26:** The LDF should ensure consistent follow-up care and communication with victims / survivors must be systematically diarised to prevent negative impacts.

7.8 The DST emphasises its commitment to a trauma-informed approach, including the careful selection of personnel to engage with victims and survivors. This commitment is supported by an archdeacon's recent dissertation on the archdeacon's role through a "Trauma informed lens."

7.9 The Audit's independent survey found that the majority of survivors who disclosed abuse did not feel the process was sufficiently person-centred or trauma-informed, despite most feeling that safeguarding leads took them seriously. This finding aligns with specific individual feedback; for instance, one person praised a team member as "very responsive over email" and providing "lots of positive support and ideas," yet found their initial meeting to be "not trauma informed" or centred on them. Furthermore, the Audit received concerns

about specific verbal and written communications to victims and survivors being described as lacking a trauma-informed approach. The DST has since reflected on these interactions and recognised that communications could and should have been managed more effectively.

- 7.10 The Audit acknowledges the DST's commitment to adopting a Trauma-Informed approach, which includes undertaking team-wide Trauma Informed Practice training in February 2024 and ongoing supplementary training. While welcoming the additional training, the Audit stresses the importance of ensuring this new knowledge is fully and effectively applied in practice. To this end, the Audit makes the following recommendation:

**Recommendation D27:** To bridge the gap between initial knowledge and long-term application, the LDF should mandate recurring annual Trauma-Informed Practice training to ensure these principles are effectively embedded in practice.

- 7.11 The Audit heard that the LDF allocates a budget for therapeutic support for those who require it. It was heard from one individual that this support was appreciated and was extended to continue to support them. The Interim Support Scheme (ISS) is signposted as an alternative should a victim and survivor require ongoing or targeted support.

- 7.12 A range of reporting mechanisms exist including a reporting form, the diocesan website and Dedicated 'Support for Survivors' webpage and a support leaflet. The webpage is particularly functional as a central hub, consolidating a range of resources including guidance on disclosures, signposting to the NST's Participation Framework, and external support. A downloadable document is linked immediately under these signposts which include a more extensive range of support options. That said, the Audit notes that this document was last updated on 8<sup>th</sup> October 2020 and some links no longer work. In addition, The Truth Project is signposted to as a mechanism for victims and survivors to

share their experiences with the Independent Inquiry into Child Sexual Abuse (IICSA). This project concluded in October 2021 and should be removed in its capacity as a signpost to support.

**Recommendation D28:** The LDF should revise its existing signposts for victims and survivors on the Diocesan website. This should include:

- a) The removal of the Truth Project under 'Making a disclosure'
- b) Reviewing the downloadable document with further support services to ensure it is up to date.

7.13 The Audit acknowledges that apologies have been offered for unsatisfactory experiences, noting that their effectiveness is highest when delivered with a personal and sincere tone that aims for genuine human connection. The powerful positive impact of such an approach is exemplified by an individual's "first class" experience with a London area bishop, whose "humble" apology conveyed a genuine desire to learn, validating the recipient's feelings and promoting trust. This successful case serves as a crucial reference point, demonstrating how a personalised apology can transform a negative perception, although the Audit has also reviewed other written apologies that varied in tone and approach.

**Recommendation D29:** Apologies for unsatisfactory experiences should be delivered with a sincere and personal tone to ensure genuine human connection and maximise their positive impact.

7.14 Of those who completed the Audit's survey who have reported their abuse, just over half believe there is an investment to improve safeguarding practice. The Audit was informed that one of the DSA works nationally with the National team and cascades information locally. The Audit also viewed evidence of presentations given to DSAP. These included

a briefing from the Partnerships Engagement Lead at the NST, as well as a session led by a prominent expert in abuse law, who addressed the group in their capacity as a dedicated advocate for survivors.

7.15 The Diocese has been engaged in a partnership with another diocese to establish a Survivor Reference Group, aiming to embed the perspectives of victims and survivors directly into future enhancements of the LDF's safeguarding arrangements. Although the intent behind this collaborative initiative is highly admirable, the Audit identified that significant complex and challenging issues have emerged during the initial phase of engagement. Consequently, further dedicated work is necessary to properly establish and refine the processes required to ensure this group can function as a truly collaborative and effective body, allowing the partnership to achieve its critical objective of improving the Diocese's response to victims and survivors.

**Recommendation D30:** The Diocese should prioritise refining the processes and structures in place for the Survivor Reference Group.

## 8 Learning, Supervision and Support

### Safeguarding Learning

- 8.1 The Audit found that safeguarding learning across the Diocese of London is largely sustained through a contracted external training model. This has enabled the Diocese to deliver Church of England mandatory safeguarding training at scale within the context of being the largest diocese in the country by population size. The model has ensured the continuity of provision and has supported a strong baseline of compliance. Training delivery is frequent and wide-ranging, with an average of one course per week during term time, supported by a small team of associate trainers. Face-to-face provision is offered periodically to ensure access for those unable to engage online, and combined training days have been introduced to maximise attendance and efficiency.
- 8.2 There is clear evidence of good practice within this approach. Survey data shows broadly positive perceptions of safeguarding learning. A strong majority of diocesan and parish respondents reported that safeguarding arrangements have improved and that safeguarding is taken seriously. Additionally, external trainers adapt national training materials to reflect the London context, including an enhanced focus on forced marriage, female genital mutilation, domestic abuse, and other risks relevant to the Diocese's diverse communities. DSAs routinely attend leadership training alongside trainers, allowing local questions to be addressed and reinforcing consistent messaging across safeguarding and leadership learning. These are positive features of the current model.
- 8.3 However, the Audit found that the current arrangements limit the Diocese's ability to take a more strategic approach to safeguarding learning. Capacity constraints mean there is little scope to design bespoke learning, undertake systematic evaluation of impact, or use learning data to inform the wider safeguarding strategy. Evaluation activity is largely

confined to post-course feedback, which is not yet embedded within a formal framework capable of assessing longer-term impact or identifying trends. This reflects a wider challenge seen in other dioceses, where nationally prescribed content limits local flexibility, but nonetheless highlights an area for development.

**Recommendation D31:** The LDF should undertake a cost-benefit analysis of its current safeguarding training provision, with a view to strengthening strategic oversight of learning. This should include consideration of appointing dedicated diocesan safeguarding trainer(s), responsible for developing a diocesan safeguarding learning strategy informed by needs analysis, overseeing quality assurance, and embedding robust evaluation of training impact.

8.4 The Audit identified weaknesses in training administration and oversight. While training is delivered frequently, systems for recording attendance, tracking compliance, issuing reminders, and following up non-attendance are not yet sufficiently robust. Whilst many staff cited an awareness of this, capacity has limited a solution.

8.5 Administrative support is also required to assist with late cancellations and drop-off on the day of training, particularly for leadership and specialist courses. Where safeguarding training becomes out of date, there is not always clear or consistent action taken to address this.

**Recommendation D32:** The LDF should strengthen its systems for recording and monitoring safeguarding training, including clearer escalation where required training is not completed or has lapsed. This should be proportionate but sufficiently robust to ensure safeguarding competence is maintained for all relevant roles. This should be considered in the cost-benefit analysis undertaken by the LDF.

## Clergy Support

- 8.6 Clergy across the Diocese of London are routinely managing complex safeguarding situations, particularly involving issues of mental health, homelessness, and individuals presenting with acute distress. This was consistently described as an ordinary feature of ministry in many London contexts, especially in parishes serving areas of high deprivation.
- 8.7 Many clergy who engaged with the Audit confirmed that safeguarding training has improved and provides a clearer foundation for recognising risk and understanding statutory expectations. However, the Audit found that training is not consistently matched by structured support once safeguarding concerns arise in practice. There is no routine or formalised framework for safeguarding-focused supervision for clergy, and support is often informal, self-directed, or dependent on individual relationships.
- 8.8 Evidence from clergy discussions highlighted that safeguarding situations can carry significant emotional and psychological impact, particularly where clergy are involved in complaints, allegations, or complex risk management arrangements. Some members of clergy described this work as isolating at times, with limited opportunity for structured reflection or shared responsibility. The LDF identified MDRs as a mechanism for development. Although the Audit recognises that the generic form now includes a question regarding safeguarding, clergy feedback suggested these reviews do not provide a consistent or sufficient forum for safeguarding support.
- 8.9 At the same time, the Audit found clear and consistent evidence of strong support from individual DSAs. Many clergy across different episcopal areas spoke positively about the accessibility, responsiveness, and professionalism of DSAs, particularly in relation to case-specific advice, risk management, and contextual decision-making. This is a significant strength. However, reliance on individual roles cannot fully mitigate the absence of a wider, structured approach to clergy safeguarding support.

**Recommendation D33:** The Diocese should strengthen support for clergy by developing a consistent approach to safeguarding-related supervision and pastoral support, proportionate to role and context, and clearly distinct from disciplinary or performance management processes.

### Supervision and Support of Safeguarding Roles

8.10 The Audit found that safeguarding staff within the LDF benefit from regular professional contact and informal peer support. Safeguarding practice is discussed through routine dialogue and team meetings. However, supervision arrangements are largely informal and not consistently defined or recorded. While support is available, it is not always structured or clearly distinct from operational management, which limits the LDF's ability to evidence reflective safeguarding supervision or practitioner support.

**Recommendation D34:** The Diocese should introduce a proportionate safeguarding supervision model for professional safeguarding staff. This should include scheduled reflective supervision sessions, distinct from operational management meetings, with clear expectations around frequency, purpose, and recording.

8.11 The Audit also found that learning from safeguarding practice is shared through discussion but is not consistently captured at an organisational level. There is limited systematic recording of key learning points or emerging themes, which reduces opportunities to demonstrate organisational learning and to use practice insight to inform wider safeguarding development.

**Recommendation D35:** The Diocese should implement a simple and consistent method for recording learning from safeguarding practice, including key themes, emerging risks, and practice challenges. This learning should be reviewed periodically and used to inform safeguarding strategy, policy review, and training priorities.

8.12 Survey data indicates generally positive perceptions of safeguarding learning, with a strong majority of diocesan and parish respondents agreeing that safeguarding arrangements have improved and that safeguarding is taken seriously. That said, within the LDF workforce, over a quarter of respondents were unsure whether they had received a formal induction, and a significant proportion were uncertain whether safeguarding was included as part of that induction. While this may reflect the passage of time for longer-serving staff, it points to the importance of strengthening consistency and recording around induction processes.

**Recommendation D36:** The Diocese should review and standardise safeguarding content within staff and role-holder induction processes, ensuring that safeguarding responsibilities, reporting pathways, and expectations are clearly communicated and consistently recorded and refreshed where roles or responsibilities change.

8.13 Support for PSOs is a strength. The LDF provides regular opportunities for engagement, advice, and guidance, including accessible forums for discussion and problem-solving. This approach is proportionate to the scale of the Diocese and reflects a clear commitment to supporting volunteers in complex safeguarding roles, however, resource is required to maintain this level of engagement and support across the diocese.

8.14 The Audit also identified an opportunity to strengthen oversight of the appointment of new PSOs. While training and ongoing support are available, there is limited diocesan input at the point of appointment. This creates a risk that individuals may be appointed without sufficient understanding of the role or the complexity of safeguarding responsibilities.

**Recommendation D37:** To sustain effective support for Parish Safeguarding Officers, the Diocese should assess the resources required to maintain regular engagement, advice, and guidance at scale, and ensure that this provision is sufficiently resourced to remain consistent across episcopal areas.

## 9 Conclusion

- 9.1 The Audit has found compelling evidence that the Diocese of London is guided by a dedicated and well-intentioned leadership team. From the Diocesan Bishop and Area Bishops to the General Secretary, the Head of Safeguarding, and into the parishes, there is a genuine commitment to improving safeguarding standards. The Bishop of London, in particular, has demonstrated a clear focus on this area, evidently reflecting on the mishandling of past cases to inform and improve current practice.
- 9.2 This leadership commitment is not merely theoretical; it is mirrored in workforce and parish surveys, where the vast majority of respondents report significant improvements in safeguarding arrangements and a heightened recognition of their importance. However, this does not ignore the fact that cultural challenges regarding theological unity remain, and further work is required to understand the impact of the Diocese's approach to EDI.
- 9.3 Notwithstanding some relational challenges, the Audit observed examples of good practice by members of the DST. These include effective risk management, live safety plans, and the delivery of wide-ranging training on complex issues such as domestic abuse and forced marriage.
- 9.4 However, these positive attributes operate within a unique and highly complex geographical, political, and structural framework. The 'London Model', which effectively incorporates five dioceses into one, creates inherent tensions. While the distributed Area leadership model facilitates local adaptability, it has introduced significant operational friction and a lack of standardisation.
- 9.5 Consequently, the Audit revealed a 'mixed economy' of practice where standards differ

significantly between Areas and parishes. For instance, the absence of a single, reliable system to track youth and children's work leaves the Diocese unable to comprehensively confirm safer recruitment and training status across the board. Moreover, the current governance structure, specifically the exceptionally large LDF Trustee Board, diffuses collective responsibility and hinders meaningful scrutiny.

9.6 Although the DST has expanded from a low base to ten distinct roles, this aggregate figure provides a false sense of security when set against the sheer scale and diversity of London's population. The reality is that the DST and key clergy support roles are operating at or beyond full capacity. The system currently relies heavily on the goodwill of staff and clergy who face excessive workloads. This lack of resource resilience directly impacts the consistency of survivor support. Despite the efforts of many professionals, the experience for survivors remains disparate, with legacy challenges, trust issues, and communication failures still evident.

9.7 The Diocese of London is at a critical juncture. It is well-led and possesses the appropriate safeguarding lens at a strategic level, yet the breadth of the geography and the depth of the workload mean that practice remains inconsistent. The current reliance on an overstretched workforce to bridge the gap between structural complexity and operational necessity is unsustainable. To resolve the fragmentation and risks identified, the Diocese must move beyond goodwill and best intent by committing to substantial investment in its safeguarding arrangements.

# Part Two - St Paul's Cathedral

## 10 Context

- 10.1 St Paul's Cathedral is a world-renowned landmark and a busy working church, famous for its iconic dome that dominates the London skyline. It's considered a symbol of hope, resilience, and creativity. The history of St Paul's as a Christian Cathedral dates back to 604 AD. Preceding this, a Roman temple stood on the same site in the City of London. The current building is the fifth cathedral to be built here. Designed in a Neoclassical English Baroque style, with inspiration from the dome of St Peter's in Rome, this masterpiece by Sir Christopher Wren was constructed between 1675 and 1711.
- 10.2 Today, it serves as a principal church, a vibrant place for worship, prayer, music and learning, as well as serving as a major tourist destination and hub for outreach, heritage, and art. The Cathedral welcomes people from all Christian traditions, other faiths, and those with little to no faith, drawing hundreds of thousands of visitors each year. In addition to its daily services, the Cathedral hosts around 100 special services annually marking important anniversaries and celebrating various charitable organisations and community groups. Extensive educational programmes for both children and adults are facilitated, with activities also arranged for visitors during school holidays.
- 10.3 The Cathedral is situated in the City of London, with a population under 10,000. That said, in 2023 approximately 700,000 workers commuted into the City for work. In 2024, it was recorded that there were 790,000 visitors to St Paul's for that year. While there were an estimated 397,000 worshippers attending the Cathedral in 2024, the Cathedral's regular congregation is quite small, with the vast majority of those attending services doing so on a one-off basis. On average, across the year, the Cathedral receives between 20,000 and 25,000 visitors each week.

10.4 St Paul's Cathedral operates a school for 285 pupils, a preparatory school for boys and girls aged four to 13. It also serves as a residential choir school for the Cathedral's choristers. While most students are day pupils, the choristers must board. The school houses up to 30 boarding boys, and with a new girls' choir commencing in the autumn of 2025, up to 30 girls will also become boarders.

## 11 Progress

- 11.1 The Social Care Institute for Excellence (SCIE) audit of St Paul's Cathedral, published in January 2022, resulted in 27 'considerations'. St Paul's Cathedral was also included in the Diocesan Past Cases Review (PCR2) process, although no specific recommendations were made for the Cathedral. Themes arising from recommendations include volunteer management, training, formalisation of policy, capacity, record keeping, safer recruitment and governance.
- 11.2 The Cathedral accepted all 27 recommendations and has been working on an action plan since. This plan is overseen and owned by the Cathedral's Safeguarding Advisory Group (SAG), which meets quarterly to track progress with reports subsequently fed back to Chapter. Many recommendations were actioned and met, while some actions remain subject to continuous assessment. Notably, two areas remain ongoing, including the review of CCTV coverage, and the finalisation of the Code of Conduct (currently in draft). The Audit heard the Code of Conduct required a considerable amount of time to incorporate stakeholder input. The Audit recognises this; however, urges its immediate prioritisation and completion.
- 11.3 An independent review into the Cathedral's handling of non-recent abuse recently concluded, and its recommendations were submitted to Chapter for approval in May 2025. The review looked at the response by St Paul's Cathedral into disclosures of non-recent abuse and resulted in 11 recommendations. A dedicated SCMG is currently responsible for progressing the implementation of recommendations.

## 12 Culture, Leadership and Capacity

### Culture

- 12.1 Surveys conducted within the Cathedral reveal a generally positive trend in safeguarding, although a clear distinction in perception exists between the workforce and the wider worshipping community. A significant majority of the Cathedral workforce agrees that overall safeguarding arrangements have improved, a sentiment shared by the majority of the worshipping community. However, a significant minority (just under a third) of the latter group remained neutral or undecided, suggesting that while improvements are being realised, the worshipping community may not be as directly aware of specific systemic changes as those operating within the Cathedral's internal structures.
- 12.2 This sense of progress is further evidenced by the fact that an overwhelming majority of both the workforce and the worshipping community report feeling safe within the Cathedral. This shared sense of security is underpinned by a growing belief that a safeguarding culture is becoming successfully embedded across the organisation. Furthermore, both cohorts feel empowered to act should they identify a concern. A significant majority of both staff and worshippers believe they can raise issues regarding conduct without fear of reprisal, indicating a high level of institutional trust and confidence in the established reporting mechanisms.
- 12.3 The alignment between these two groups is perhaps most visible in their descriptions of the Cathedral's broader culture. When asked to characterise the environment, both groups utilised similar positive terminology. The workforce identified the culture as primarily welcoming, supportive, and respectful, while the worshipping community highlighted it as welcoming, inclusive, and respectful. This shared perspective underscores a common experience of a generally positive and open environment, suggesting that the Cathedral's values are being consistently communicated and felt by many across all levels of the

community. That said, like many traditional institutions, the Cathedral faces challenges regarding equality, diversity and inclusion. This can be exacerbated, as one interviewee put it, "...by the whiteness of the place", and the artefacts that adorn its walls.

12.4 Acknowledging what were described as systemic hurdles, many respondents, particularly those in senior leadership roles, recognised the challenge, not least the profound emotional toll placed on leaders with lived experience and the inherent risks of tokenistic representation. In response, they have engaged in a range of initiatives that move from the homiletic to the structural. These actions include leveraging preaching and dedicated programmes to advocate for racial justice, alongside a deeper, critical reflection on the 'symbolic power' of the institution. By questioning existing architecture/artefacts and naming conventions, the leadership is actively reassessing what is being conserved while simultaneously seeking to diversify to better support and empower those on the margins. This approach is welcomed by the Audit, seen as good practice and the Audit encourages a continued push to drive and promote change, via actions as much as words.

12.5 The Audit is clear; safeguarding is about creating an environment in which everyone, regardless of race, gender, or socioeconomic background, feels safe and empowered to speak truth to power. This is why the 'safeguarding culture' national safeguarding standard is rigorously tested. Systemic hurdles are viewed as cultural challenges that directly impact on how safe or included an individual feels. In its simplest sense, safeguarding is about creating spaces where people can live, work, and worship together in a way that allows them to thrive. Recognising that the symbols embedded within the Cathedral's structures and adorning its walls can create a distinct atmospheric tone, the Audit makes the following recommendation:

**Recommendation C1:** The Cathedral should carry out an artefacts and structural survey to identify opportunities to celebrate and promote the diversity of the community it serves.

## Leadership

- 12.6 St Paul's Cathedral is complex and complicated and whilst few places are truly unique, the Audit recognises the iconic nature of the place and the opportunities and challenges in leading it.
- 12.7 The Dean brings extensive safeguarding experience to his role, making him ideally suited to lead the complex 'micro-community' of St Paul's. Crucially, he unreservedly accepts his accountability for safeguarding both within the Cathedral and across its wider influence, with evidence of his leadership in this regard extending well beyond the Cathedral precincts.
- 12.8 He is supported by three Residentiary Canons, the Steward, the Chancellor, and the Precentor. Together, they form a cohesive team with complementary skills. The Audit observed evidence of their ability to reflect, constructively challenging and consistently driving the Cathedral's continuous safeguarding improvement journey. Their work regarding racial justice and inclusion is particularly noteworthy; their 'retain and explain' approach to history and monuments, which actively involves those with lived experience, is a clear example of good practice. It is also worthy of note that the Cathedral's appetite to innovate can be seen in the appointment of a well-qualified and highly motivated lay person as Canon Chancellor. They are without doubt an asset to this team.
- 12.9 The most critical safeguarding function lies with the Canon Steward as the Chapter Safeguarding Lead (CSL). The Canon Steward at St Paul's Cathedral has a considerable and credible background in education and holds a significant safeguarding portfolio, drawing on over a decade of experience across the education, SEND support and ministry sectors. She has been a driving force and positive influence behind a culture shift in the organisation's approach to safety. Her involvement is defined by a relentless push to

weave safeguarding into the very fabric of the institution, ensuring it is no longer a peripheral concern but a permanent fixture on every key agenda, from the high-level deliberations of the Chapter and the Executive Leadership Team (ELT) to the practical discussions of general staff meetings. This represents good practice.

12.10 By helping to establish the Safeguarding Working Group (discussed later in the report), the Canon Steward has enabled a mechanism to ensure rigorous oversight at both operational and strategic levels. Their approach integrates trauma-informed practice with compassionate leadership, ensuring that policy, compliance, and inclusion remain central to the Cathedral's mission and approach to safeguarding and pastoral care. They bring a thoughtful, inclusion and victim-sensitive approach that is open about limitations and actively seeks to build capacity and diversity

12.11 The Dean is further supported by a highly capable COO. Together, they head a senior leadership team committed to maintaining a critical safeguarding lens across all areas of operation. The Audit observed consistent evidence of appropriate challenge and authoritative practice throughout their respective areas of responsibility.

12.12 Furthermore, despite capacity constraints, the Cathedral benefits from the commitment of its highly regarded Cathedral Safeguarding Officer (CSO). With an extensive background in statutory services and active social work registration, the CSO maintains strong working relationships with the DST (via an MOU), internal staff, volunteers, and external partners. Throughout the audit, their ability to provide authoritative, sound, and practical operational advice was consistently evident.

## **Governance**

12.13 The Cathedral operates a range of appropriate governance oversight meetings. These

reflect the expectations of the Church and relevant regulatory requirements, such as those issued by the Charity Commission. St Paul's has successfully embedded safeguarding into core governance, making it a permanent priority for Chapter and the Executive Leadership Team.

12.14 The Chapter is well-balanced and effective, making excellent use of the broad experience provided by both executive and non-executive members. Furthermore, the Senior Non-Executive Member (SNEM) maintains a productive working relationship with the Dean. Together, they balance the requirement for robust oversight with a mature approach to addressing anomalies in the current Cathedrals Measure, such as the Dean chairing his own governance body. For example, the Audit heard evidence of the Dean recusing himself from discussions involving potential conflicts of interest, with the SNEM taking the chair for those specific agenda items. This is good practice and should be formalised.

**Recommendation C2:** The Chapter should adopt a formal procedure whereby the Dean may recuse himself from any agenda item where there is a perceived conflict of interest. Furthermore, as a matter of standard practice, the Dean should withdraw at the conclusion of each meeting to allow the SNEM to chair a 'wash-up' session. This is to enable a 'sense check' to ensure that all members, particularly non-executives, feel their voices have been fully heard.

12.15 Whilst the Chapter has undoubted strengths and a firm focus on safeguarding, supported by several appropriate subgroups and committees, a dedicated safeguarding professional (CSO/DSO) is not currently present at every meeting. This approach could be strengthened, bandwidth permitting, if the CSO attended each Chapter meeting regardless of whether safeguarding is a formal agenda item. Such a move would ensure a professional 'safeguarding lens' is consistently applied to all matters.

**Recommendation C3:** The CSO (or if appointed, the Head of Safeguarding / Director of Safeguarding) should attend all Chapter meetings.

### **Safeguarding Advisory Group (SAG)**

12.16 St Paul's SAG operates through a mature and well-structured governance framework which seamlessly integrates spiritual, operational, and educational expertise. The group is led by a highly experienced Independent Chair, whose extensive background in safeguarding at both operational and strategic levels provides the foundation for its effectiveness. This leadership enables a culture of robust professional curiosity and appropriate challenge, further strengthened by the consistent engagement of senior Cathedral and Diocesan leadership. Such high-level commitment ensures that safeguarding maintains a genuine strategic reach, while the SWG provides essential practical support by monitoring day-to-day compliance.

12.17 The Cathedral's responsible approach to governance is further evidenced by its proactive succession planning. The diligent preparation for the current chair's retirement and the comprehensive induction of their successor represents a sensible strategy that is considered good practice. By distinguishing clearly between immediate operational tasks and long-term strategic objectives, the SAG maintains a disciplined focus on safety.

12.18 This structured approach is reinforced by a healthy institutional culture that prioritises transparency, as demonstrated by an increase in the reporting of concerns and a proactive openness to external scrutiny. By embedding safeguarding into senior inductions and participating in collaborative training with the Diocese of London, the SAG ensures that lessons learned are implemented without delay. These integrated efforts sustain a safe, vigilant, and accountable environment for the entire Cathedral community.

12.19 To further strengthen the SAG, membership should be expanded and diversified, allowing the group to evolve into a more representative and inclusive scrutiny body. Incorporating external voices with specific expertise or lived experience will ensure authentic and credible challenge.

12.20 Furthermore, any expansion should be utilised to bolster governance capacity and build on existing strengths by developing a pipeline of diverse talent. This will, in turn, directly inform and support Chapter-level leadership and strategic decision making. To this end, the Audit makes the following recommendations:

**Recommendation C4:** The SAG should evolve from an internal body into a diverse, externally inclusive scrutiny group. To achieve this:

- a) Actively recruit external members with strategic expertise in victim/survivor advocacy, Equality, Diversity, and Inclusion, and regulatory safeguarding (e.g., social care, policing, or education).
- b) Use SAG membership as a pathway for under-represented groups to engage with and inform Chapter-level governance.

**Recommendation C5:** Refine the structural interface between the SAG and the SWG through updated Terms of Reference (ToR).

- a) The Working Group should manage implementation and action tracking, submitting thematic reports to the SAG for high-level strategic analysis.
- b) To ensure direct communication, the SAG Chair and Cathedral Safeguarding Officer (CSO) should, whenever safeguarding is an agenda item, both attend Chapter meetings. If a Head / Director of Safeguarding is appointed, they should always be present and this would negate the need for the CSO's attendance.

Introduce consistent reporting on concern volumes, triage timeliness, training compliance, and staff caseloads.

**Recommendation C6:** Shift the focus from administrative compliance to measurable outcomes:

- a) Focus on the ‘so what?’ of recommendations. The SAG must oversee the implementation of historic abuse reviews and audits to ensure they result in tangible risk reduction rather than just completed checklists.
- b) Members should receive induction on cathedral-specific risks, including high footfall management, iconic site security, and the unique power dynamics inherent in the National Church.

**Recommendation C7:** Formally monitor staff welfare and burnout levels within SAG meetings to ensure the adequacy of professional supervision and support.

### **Safeguarding Working Group (SWG)**

12.21 The SWG at St Paul’s functions as an operationally focused subgroup. It is chaired by the CSL and populated by appropriate internal representatives, including the CSO. It transforms safeguarding principles and strategic learning into concrete, trackable practice across the Cathedral. Positioned beneath Chapter and the SAG it distils insights from external learning, such as the Makin Review, as well as internal reviews and assurance reports, translating these into detailed action plans that specify necessary changes, designated responsibilities, and clear deadlines. Consequently, its focus remains deliberately practical, ensuring that high-level oversight is converted into measurable frontline improvements. This is good practice.

12.22 The membership of the SWG, whilst effective, is made up of internal representatives. Given the critical link it provides between governance, scrutiny and practice, the group could be further strengthened by increasing its membership. In doing so, particular attention should be paid to opportunities to engage external bodies, and skills, diversity and inclusion opportunities.

12.23 The Audit has considered the role of the Chair. This is currently held by the CSL. In the opinion of the Audit, it is important to distance clergy members and church officers (other than professional safeguarding officers/advisors) from operational safeguarding decisions to address perceptions of conflict of interest. Therefore, it is vital to differentiate between operational direction and governance oversight.

12.24 While the CSL holds a specific accountability function, they are not empowered to make or direct operational safeguarding decisions. That said, the CSL has a significant level of safeguarding experience and has been a 'force for good', successfully embedding safeguarding throughout the Cathedral's governance, leadership, staff, and volunteer groups. Critically, they are clear on the separation of roles and responsibilities.

12.25 To maximise the potential within this group and ensure a clear division of responsibilities within the system, the SWG Terms of Reference (ToRs) should be reviewed and amended. This amendment, amongst other issues, must explicitly state the accountability role and function of the Chair, and the fact that the CSO holds the ultimate authority and final say on all matters relating to operational safeguarding.

**Recommendation C8:** Review and Refresh the SWG Terms of Reference (ToRs)

- a) Amend the ToRs to explicitly distinguish the CSL's accountability function from the CSO's operational mandate. To maintain the principle of distancing clergy members from frontline operational decision-making, any new Chair must be evaluated to ensure their primary professional role aligns with this separation.
- b) Conduct a comprehensive skills, inclusion, and diversity audit. This will facilitate the diversification of the group's membership, ensuring it encompasses a broader range of backgrounds and perspectives to better reflect the community it serves.

c) Utilise this expanded membership to bridge the gap between high-level governance/oversight (Chapter/SAG) and frontline practice. Specifically, the SWG should take a leadership role in:

- Victim and survivor engagement.
- Trauma-informed practice.
- Inclusion initiatives.
- Staff and volunteer health and wellbeing.

### **Capacity - CSO**

12.26 As previously stated, the CSO is a highly skilled professional who maintains her social work registration, bringing extensive expertise in child protection, complex trauma, and adult mental health. This clinical background enables her to manage high-risk casework and non-recent abuse allegations through a resilient, victim-focused lens. Beyond individual casework, she has been the primary architect of a significant cultural shift at the Cathedral, enabling an environment of transparency and 'safer thinking'. Through leadership-level training and collaborative safety planning with the Diocese, she has empowered staff and clergy members to report concerns with confidence.

12.27 However, despite establishing a professionalised infrastructure that balances governance advice, operational oversight and relational advocacy, the breadth of the CSO's current remit is unsustainable. Historically, she has shouldered an extensive administrative and operational burden, encompassing training coordination, compliance, and national liaison. While the recent addition of administrative support has provided some relief, it has also exposed the risks inherent in an over-reliance on a single post-holder.

12.28 The Cathedral's unique footprint, characterised by high footfall, complex event management, and the nuances of its micro-community, presents ongoing challenges.

Critically, there remains a misalignment between operational responsibility and formal governance. Although the CSO carries the primary safeguarding risk, capacity constraints prevent their ability to be in all places at all times, for example their routine representation at Chapter.

12.29 To address these challenges and reinforce existing arrangements, there is a need to strengthen the Cathedral's professional safeguarding presence.

**Recommendation C9:** To ensure the long-term resilience and strategic oversight of the Cathedral's safeguarding functions, the following actions are recommended:

- a) Establish a senior leadership role (Head/Director of Safeguarding) directly accountable to Chapter. This post-holder will lead on all strategic matters, ensuring that safeguarding is integrated into the Cathedral's highest level of governance.
- b) Upon the appointment of the Head/Director of Safeguarding, transition the line management of the CSO and any subsequent professional safeguarding staff to this new role. This moves the reporting line from an administrative arrangement to a professional, peer-led structure.
- c) Recruit an Assistant CSO to alleviate the operational burden on the CSO. This role should specifically focus on the delivery of in-house training and the maintenance of safeguarding standards.
- d) Evaluate the effectiveness of the current administrative support to establish if it meets the needs of the Cathedral Safeguarding Team.
- e) Utilise the increased capacity to ensure the cathedral safeguarding team has a consistent and influential voice at Chapter meetings, bridging the current gap between operational risk and governance insight and oversight.

## **Chorister Safeguarding**

12.30 The chorister programme at St Paul’s Cathedral is distinctive in its scale and profile. Choristers are both members of a world-renowned cathedral choir and boarding pupils at St Paul’s Cathedral School. As a result, safeguarding responsibility operates across the two closely connected environments which requires high levels of coordination between the Cathedral, the Music Department, the School and the boarding provision.

12.31 The Audit found that this complexity is well understood by those working most closely with the choristers. Safeguarding is embedded into the operational life of the Music Department and is treated as integral to decisions about rehearsal, movement around the building, supervision and pastoral care. The Director of Music plays a central coordinating role, working closely with the Head of Boarding, chaperones and safeguarding leads in both settings. Regular meetings and informal day-to-day contact support a shared understanding of individual children’s needs and wellbeing.

12.32 The expansion of the chorister programme, including the introduction of girl choristers and new boarding arrangements, represents a significant development for the Cathedral. The Audit found evidence that safeguarding considerations have been built into this change, though it also increases the importance of ensuring that existing good practice is consistently documented and not overly reliant on individual knowledge.

## **Parent and Chorister Views**

12.33 While no choristers appear to have engaged with the INEQE survey, those who spoke with the audit team during the site visit consistently described feeling safe within the cathedral environment. They were clear that adults are attentive to their safety and wellbeing, and that concerns would be taken seriously. One child expressed this simply by saying, “We know that we’re the priority if something happens”, which is reflective of the Audit findings.

12.34 Choristers also spoke positively about relationships within the choir, with one child describing their favourite aspect of being a chorister as “being part of a family”. This sense of belonging is particularly important within the boarding context and appears to have contributed positively to safeguarding by reducing isolation and encouraging children to speak up.

12.35 Many parents who engaged with the Audit echoed these views. They spoke about strong pastoral oversight, particularly within the boarding house, and about staff noticing when children are unsettled, tired or struggling.

### **Scheduling & Wellbeing**

12.36 The chorister timetable is demanding and requires careful management to avoid fatigue and undue pressure. The Audit found that scheduling decisions are discussed regularly between the Music Department and the School, with active consideration given to children’s academic workload, rest time and emotional wellbeing. Parents recognised the demanding nature of the chorister schedule but were clear that there is active consideration of children’s wellbeing alongside musical expectations.

12.37 There was evidence of flexibility, particularly where individual children were struggling. Adjustments were described as being made informally through professional judgement and close communication with boarding staff. While this approach is currently effective, it relies heavily on experience and relationships rather than on a clearly articulated wellbeing framework.

**Recommendation C10:** The Cathedral should formalise existing good practice around chorister scheduling and wellbeing into a written framework, jointly owned with the School, to ensure consistency, transparency and resilience as the programme continues to develop.

## Chaperoning & Supervision

12.38 The Cathedral employs a dedicated team of chorister chaperones, whose role was created in 2023 following a review of safeguarding arrangements for children. Whilst chaperones work closely with the Music Department, they are line-managed through the Cathedral's safeguarding structure, which reflects a deliberate separation to improve safeguarding oversight. Chaperones described this independence as central to their role, stating that they are present "for the safeguarding of the children", rather than as an extension of the music team. The Audit views this as good practice.

12.39 Chaperones are present for all rehearsals and manage the movement of choristers between the School and the Cathedral. Prior to children arriving, chaperones meet in the choir practice room to confirm attendance, review any information passed on from the School and agree how specific situations will be managed, for example if a child is unwell or anxious. Where children become sick or need to return to the School, this is recorded on a shared system and handed over formally to School staff.

## Other Safety Provisions

12.40 Safeguarding arrangements around the use of toilets and changing areas were explored during the site visit. The Audit found that safeguarding signage, including NSPCC information, is clearly visible in chorister toilet areas. However, safeguarding information is less visible in rehearsal and practice spaces regularly used by choristers. These are key environments in the children's daily experience, and the absence of child-friendly, Cathedral-specific safeguarding messaging reduces opportunities to reinforce messages about speaking up and knowing where to seek help.

**Recommendation C11:** The Cathedral should introduce age-appropriate, Cathedral-specific safeguarding information within rehearsal and practice spaces used by choristers.

12.41 At the time of the Audit, CCTV arrangements across the Cathedral were under active review (see *Prevention section of this report*). Whilst robust policies and controls are in place around access to areas such as the organ loft, the ongoing review provides an opportunity to ensure that CCTV coverage in areas routinely used by choristers is considered explicitly, and documented as part of that process.

**Recommendation C12:** The Cathedral should ensure that the ongoing review of CCTV explicitly considers areas regularly used by choristers, and that decisions regarding coverage and blind spots are clearly documented to provide assurance that arrangements remain proportionate and fit for purpose as the chorister programme continues to develop.

12.42 The Audit found that arrangements for external visits and performances are well planned, with clear risk assessments, appropriate ratios and included practical safeguarding measures, such as providing wristbands with emergency contact details. This is good practice.

12.43 Arrangements for photography involving choristers are managed with care. However, given the Cathedral's prominence as a national and international landmark, managing public photography remains a challenge when choristers are visible in public spaces. The Audit notes that other cathedrals have introduced public announcements, including the use of tannoy systems, to advise visitors when choristers are present and to request that photography is not taken. The use of additional languages to reinforce this is a further proactive measure.

**Recommendation C13:** The Cathedral should consider whether additional, context appropriate measures are needed to manage public photography of choristers, drawing on practice from other cathedrals and ensuring any approach is proportionate and flexible to the Cathedral's context.

### Information Sharing

12.44 Information sharing between the Cathedral and the School is well established and effective. Regular meetings between the Director of Music, the Head of Boarding, chaperones and safeguarding leads support timely sharing of information about individual children. Staff were clear about when information should be shared, with whom, and for what purpose.

### Training

12.45 Levels of training are sensibly set out in the Music Department Safeguarding Procedures. Staff working with choristers receive safeguarding training through both the Cathedral and the School. This dual training model supports consistency in language and expectations across both settings. Staff spoke positively about the quality of training and demonstrated confidence in applying safeguarding principles in practice.

12.46 St Paul's Cathedral staff bring a wide range of professional backgrounds to the chorister programme, including education, safeguarding, pastoral care and governance. However, the Audit found that understanding of neurodiversity and children with SEND varies across roles and is shaped primarily by individual experience rather than by a shared departmental framework. Many chaperones, for example, through their backgrounds in safeguarding and education, demonstrated greater familiarity of inclusive practice. By contrast, some staff described neurodiversity as having limited practical relevance where children are perceived to be able to meet the musical and academic requirements of the role. While this reflects the selective nature of the programme rather than a lack of care

for individual children, it means that inclusive practice is currently underpinned by professional judgement and informal adaptation rather than by a shared understanding of neurodiversity across the team.

12.47 That said, the Audit found no evidence of exclusion or unmet need within the current chorister cohort and found evidence of thoughtful, child-centred adjustments being made in practice where needs have been identified.

12.48 The Cathedral's outreach choir programme demonstrates a thoughtful approach to inclusion, with choirs operating at different levels and children able to engage at a pace that suits them. Safeguarding is embedded into this work, supported by regular team meetings and arriving early to schools to check safeguarding arrangements. The Audit identified an opportunity to draw more deliberately on the expertise already embedded within the Cathedral Education Team and outreach programme to strengthen consistency of understanding and practice within the Music Department. At present, inclusivity for choristers remains more dependent on people than on systems.

**Recommendation C14:** The Cathedral should strengthen training for staff working with choristers by developing a shared understanding of neurodiversity, SEND and inclusive practice within the Music Department, building on existing expertise within the Cathedral Education Team and the Outreach Programme and St Paul's Cathedral School, to ensure confidence and consistency across roles.

## Policies

12.49 The Cathedral has a strong set of safeguarding policies and departmental procedures that apply to the chorister programme, including specific guidance for the Music Department and chaperones. These provide a sound framework.

12.50 The Audit found, however, that some areas of practice that are managed well day to day are not yet fully reflected in written procedures. This includes guidance on staff use of social media in relation to choristers, and formal safeguarding arrangements at key transition points, particularly when boys' voices change. While staff demonstrated awareness of these risks and managed them sensibly, reliance on informal understanding rather than clear policy introduces avoidable risk over time.

**Recommendation C15:** The Cathedral should update relevant safeguarding procedures to explicitly address staff use of social media in relation to choristers and to formalise safeguarding arrangements at key transition points, including voice changes.

## 13 Prevention

- 13.1 Safer recruitment policies and practices play a critical role in creating safer environments, deterring unsuitable individuals from joining an organisation and preventing the abuse of children, young people and vulnerable adults. The Cathedral has a range of measures in place to ensure the safer recruitment of individuals to various roles. Such measures include specific roles completing safer recruitment training, a safeguarding statement used across job advertisements, candidates completing an application form and a confidential declaration, conducting DBS checks (subject to them meeting the set criteria), repeat DBS checks and referencing. On appointment, new candidates must complete Basic Awareness and Foundations safeguarding training. The Cathedral adheres to the House of Bishops' guidance set out in 'Safer Recruitment and People Management'.
- 13.2 In line with Keeping Children Safe in Education 2022 guidance, St Paul's Cathedral has recently implemented a policy for online checks of candidates. These checks constitute a single element of the Cathedral's overall pre-employment process for all roles that involve direct work with children, including those at the Cathedral School.
- 13.3 This new policy adopts a transparent approach, clearly outlining the purpose and rationale for the checks. It specifies precisely who undertakes them, what information is included, and what is considered a concern. Crucially, the policy ensures that candidate consent is sought before any checks are performed. This practice, which has been incorporated into relevant policies and integrated with current procedures, is considered good practice.
- 13.4 Safeguarding is a topic that is regularly and consistently discussed across St Paul's Cathedral at various levels to ensure its centrality to the organisation's operations. It is a standing item on the agenda for every Chapter Meeting and is discussed monthly by the

Executive Leadership Team (ELT). Furthermore, safeguarding expertise is integrated into key governance and operational groups: the Chief Operating Officer (COO), Canon Steward, and Director of Music are all members of the Safeguarding Advisory Group, while the Canon Steward and the COO also sit on the Safeguarding Working Group. Discussion and updates are also embedded in routine staff and volunteer communications. Regular all-staff meetings include a dedicated safeguarding slot, and the CSO frequently attends team meetings. The Cathedral's Friday news is also utilised to share updates or relevant information regarding safeguarding matters. For volunteers, there are specific opportunities for engagement and training: the annual all-volunteers meeting features a safeguarding update, offering attendees a chance to ask questions and discuss the topic further. Similarly, the volunteer Pastoral Duty Team benefits from a yearly 'volunteer day' which incorporates a safeguarding update, refresher training, and discussion. Finally, the Cathedral marks Safeguarding Sunday annually, with the 2024 observance including a sermon and intercessions focusing on a safeguarding theme, ensuring the issue is addressed at a spiritual and public level.

- 13.5 St Paul's Cathedral adheres to the House of Bishops' safeguarding policy, entitled 'Promoting a Safer Church'. Furthermore, the Cathedral has also developed its own safeguarding policy, which is readily accessible on its website. To ensure comprehensive safety, several relevant departments within the Cathedral maintain their own specific safeguarding procedures. These departments include Music, Music Outreach, chorister chaperone, and Learning. Each of these detailed sets of procedures explicitly discusses how to respond to safeguarding concerns and are included as an appendix to the main Cathedral Safeguarding Policy.
- 13.6 The CSO maintains a close working relationship with their counterpart at Westminster Abbey. This relationship involves providing peer support and meeting on a regular basis.

They also act as mutual cover for each other during periods of annual leave or sickness lasting more than three days and attend each other's Safeguarding Advisory Groups or equivalent meetings.

- 13.7 For several years, St Paul's Cathedral and Westminster Abbey, along with the Safeguarding Officer at York Minster, have been instrumental in organising and hosting the annual, two-day Cathedrals Safeguarding Network Conferences. These conferences address different safeguarding issues each year, with topics informed by suggestions and preferences gathered from across the entire network. They provide vital opportunities for networking, sharing updates on good practice, and focusing on learning and development, which includes updates from the NST. The 2026 conference is scheduled to be hosted by the CSO in Oxford.
- 13.8 The Cathedral and Westminster Abbey are currently looking to revive a Pan-London safeguarding network. This proposed network would incorporate not only both institutions but also Southwark Cathedral, Westminster Cathedral, and Methodist Central Hall to ensure broader collaboration across key London sites.
- 13.9 To effectively promote safeguarding to all its diverse audiences, St Paul's Cathedral uses a variety of accessible materials and methods. The Cathedral's website serves as a central, publicly accessible resource, featuring a dedicated safeguarding page. This web page is easy to access through the primary navigation and is mobile responsive which enhances the user's experience. This page displays key documents, including the Cathedral Safeguarding Policy, the Whistleblowing Policy, and the three most recent Safeguarding annual reports from the Independent Safeguarding Chair. Furthermore, it provides transparency by listing the names and contact details for key safeguarding contacts, making it easy for anyone to report concerns.

13.10 For visitors physically on site, contact information is prominently displayed on posters located on the back of the public toilet doors. Worshippers attending services are directly informed via the service sheets, which contain a clear safeguarding statement on the front page. Specific communication channels are employed to reach particular groups. For instance, Childline posters are placed in the chorister toilets, providing a confidential and youth-focused resource directly to the children and young people associated with the Cathedral. Internally, the weekly Friday news is used to disseminate necessary safeguarding updates to all Cathedral employees. Finally, to ensure constant awareness amongst staff, the Church of England's five safeguarding standards are displayed throughout the Chapter House (staff offices) in high-traffic areas, including the toilets, kitchens, and lift, as well as in some of the staff offices within the Cathedral itself.

13.11 The Cathedral currently employs various methods to raise awareness and disseminate information to its key stakeholders, including emails, staff and volunteer briefings, posters, and service sheets. While reviewing communication efforts, the Audit noted the Cathedral's excellent reach and engagement via its social media platforms, albeit in areas unrelated to safeguarding. The Audit believes this presents an opportunity to enhance these digital channels and utilise them more effectively as a powerful mechanism to connect with, inform, and share vital safeguarding information with the wider community.

**Recommendation C16:** 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.

13.12 Actively seeking and acting on the views of children, young people and vulnerable adults is a key component to effective prevention planning. Whilst there are arguably fewer

opportunities for the Cathedral to gather such feedback, the Audit believes there is clear potential to introduce more defined mechanisms.

**Recommendation C17:** The Cathedral should consider and establish models for how it captures the voices and experiences of children and young people in its prevention planning.

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

13.14 Within the Cathedral, various departments are responsible for undertaking risk assessments specific to their activities. This involves different sections of the organisation completing relevant documentation. Examples of these departmental risk assessment templates include those used by the Learning Department, the Virgers and those prepared for specific events such as chorister events and the activities related to the Choral Partnership. These risk assessments are typically reviewed annually unless a major change necessitates a more frequent review.

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

13.16 The Cathedral adheres to the House of Bishops' Safeguarding Policy 'Promoting a Safer Church'. A code of conduct is currently in place for volunteers, while a draft version is pending sign-off for staff. These codes outline appropriate boundaries and the requirement to treat others with dignity, compassion and fairness.

13.17 In respect of bellringing procedures, the Cathedral currently does not have any bellringers who are under the age of 18. However, should a child or young person wish to enter the bell tower, whether to observe a practice, participate in a session, or attend a bellringing

festival, there are established safeguarding procedures which must be followed. These rules strictly state that no one under 18 is allowed to enter the bell tower without a parent or legal guardian present. For bellringing events, specific measures are in place: the group leader must first obtain written consent from the parent or legal guardian for their child to take part. Furthermore, a Designated Safeguarding Lead (DSL) must be appointed for the duration of the event, and they are responsible for formally recording all of these permissions.

13.18 The Audit found that St Paul's Cathedral has strong safeguarding measures in place for school visits. There was a deep commitment demonstrated to create an inclusive environment, which not only meets the educational and curricular needs of visiting students but is also highly conscious of their specific and/or additional needs. This is beyond the standard considerations such as pupil-to-staff ratios, and emergency contact details.

13.19 The facilitation of these school visits genuinely shows the Cathedral's commitment to creating a tailored and inclusive experience. It meets students at their own level, being sensitive to them as individuals and mindful of the content they might engage with. For example, the presence of tombs could be upsetting for a child who has recently experienced a bereavement, and the programme takes such sensitivities into account. Also, the revision of all sessions to be SEN-inclusive, offering resource packs with ear defenders and Makaton posters in the education centre is all seen by the Audit as good practice. Finally, a change in the location for school visit lunches, moving them away from public areas or proximity to toilets, is also welcomed by the Audit as a positive and considerate adjustment.

**Recommendation C18:** The Cathedral should ensure it captures the Designated Safeguarding Lead (DSL) details for all school visits as a mandatory part of the initial booking process.

13.20 It is a positive step that 24/7 security across the Cathedral site has been significantly enhanced by equipping staff with two-way radios. This facilitates rapid and effective communication should any risk be identified. While the Audit acknowledges that a review of the Cathedral's CCTV system is currently underway, it is of the opinion that this process is taking far too long, particularly given that this action was first raised during the SCIE Audit in November 2021. In light of this significant delay, the Audit makes the following recommendation.

**Recommendation C19:** In keeping with aligned recommendations in the Progress and Choristers sections, the Cathedral should expedite the completion of its review of the CCTV system that covers the entire Cathedral grounds. This is required to ensure the security systems are evaluated and updated without further delay, maintaining the safety and security of the premises.

13.21 The Cathedral maintains a strong and effective relationship with the City of London Police, which is considered good practice. The police's prompt response to any concerns and their welcomed patrols within the Cathedral grounds significantly enhance both safety and public reassurance. Their visible presence, as exemplified by the police vehicle noted parked outside during the Audit's site visit, is a key component of this effective partnership.

13.22 The Audit identified an occasional blurring of accountability between Virgers and other members of staff, particularly when dealing with security incidents and delivering pastoral care. This ambiguity is currently resulting in operational challenges and a lack of clarity for the staff involved.

**Recommendation C20:** The Cathedral should immediately establish and communicate clear, written protocols that precisely delineate the roles, responsibilities, and decision-making authority of Virgers and all other relevant staff during both security incidents and the delivery of pastoral care. These new guidelines should be accompanied by mandatory, scenario-based training for all relevant staff to ensure a consistent and effective response, thereby eliminating the current confusion and improving operational efficiency.

13.23 The Audit function was informed of three reported assaults on security staff at the north entrance, which is currently staffed by a single security officer. Considering the volume of foot traffic and the number of individuals presenting with mental health issues, the following recommendation is made.

**Recommendation C21:** Additional security personnel should be deployed at each entrance to enhance safety and incident response capabilities.

## 14 Recognising, Assessing and Managing Risk

- 14.1 The Cathedral maintains a dedicated Safeguarding Risk Register, which is the responsibility of and is overseen by the Safeguarding Advisory Group. This register systematically documents specific safeguarding risks identified at the Cathedral, along with the corresponding mitigation measures put in place to address them. To ensure continued relevance and effectiveness, the register is formally reviewed on a quarterly basis, and this review is a standing agenda item at the Group's meetings. Documents reviewed during the Audit showed that the register was last updated in June 2025. In addition, the risks are categorised according to the five safeguarding standards. This is good practice.
- 14.2 In addition, the Cathedral maintains an Environment Safeguarding Risk Register which falls under the remit of the Head of Security. This document logs potential safeguarding risks arising from the Cathedral's physical environment, alongside the necessary mitigation strategies. It is subject to oversight by the Safeguarding Advisory Group (SAG). It is accessible to all staff on the Cathedral's global drive. Following its recent review, the underlying risk assessment will now be incorporated into the mandatory Safeguarding Basic Awareness training for all personnel.
- 14.3 At St Paul's Cathedral, the high volume of daily visitors necessitates a clear safeguarding protocol. The standard procedure ensures that any safeguarding concerns, which might be observed or reported by a member of staff or volunteers on the Cathedral floor, are immediately escalated. This is typically done by alerting the Virgers, the Chaplain, or another available Clergy member. The aim is to ensure that these concerns are passed swiftly to the most appropriate, readily accessible individual among this group.

- 14.4 The Cathedral adopts a team-based approach to addressing all safeguarding concerns, ensuring that no individual is expected to manage or resolve a situation in isolation. Volunteers and the pastoral duty team are not required to make phone calls to external services, except in an emergency. In non-emergency situations, the Virgers or the clergy member will assume responsibility for the safeguarding incident and take the necessary action. Once the initial incident is resolved, a detailed record must be written and submitted to the dedicated safeguarding inbox.
- 14.5 The Cathedral Safeguarding Officer will then determine and execute any required follow-up, which includes making a referral to statutory services if this was not handled immediately on the floor.
- 14.6 In terms of case management, the Safeguarding Officer generally manages all cases, though a small number involving a vulnerable adult with a primary pastoral need may be managed by the Chaplain. Action is triggered whenever a child or vulnerable adult is identified as being, or possibly, at risk of harm, whether from their own actions, actions of others, or their environment, or if a child is presented as being 'in need'. Staff and volunteers are encouraged to report concerns directly to the Safeguarding Officer, HR, the Chaplain, another clergy member, or the Volunteer Manager. Concerns relating to staff/volunteers are typically managed jointly by HR and the Safeguarding Officer, with the option of referral to the Chaplain for support if desired. To ensure oversight, the Chaplain and Safeguarding Officer review all ongoing cases, usually on a monthly basis, sometimes joined by the CSL (who is the Canon Steward), and cases that do not re-present within three months are formally closed. Further oversight is provided through the Safeguarding Officer's supervision meetings with the Canon Steward, and the Safeguarding Officer and Canon Steward are responsible for bringing any necessary cases to the attention of the Dean. Finally, an HR Officer, the Chaplain, the Volunteer Manager, and the Safeguarding

Officers meet quarterly to review any emerging themes from staff or volunteer reports.

14.7 The Cathedral recorded 230 concerns as safeguarding incidents over the last three years. All concerns relating to safeguarding are immediately considered safeguarding cases; the Cathedral is not generally contacted purely for advice, with the exception of one recent instance involving an asylum seeker.

14.8 Between the third quarter of 2024 and the second quarter of 2025, and including two subsequent cases recorded up to 7th July 2025, 25 cases resulted in a referral to statutory authorities. These referrals were made to a range of agencies including the Police, Mental Health Services, the London Ambulance Service, and Adult Safeguarding teams.

14.9 The Cathedral currently holds 94 open safeguarding cases. Of these, 17 are ongoing insurance claims relating to non-recent abuse. A total of 36 concerns are marked as a priority. Concerns are categorised as a priority if they are ongoing (for example, involving a regular or infrequent visitor) or if they are awaiting an outcome. A review is currently underway to facilitate the closure of a number of outstanding cases, particularly those that originated in the previous system. To ensure that this task is completed within a reasonable timeframe, the Audit makes the following recommendation.

**Recommendation C22:** The Cathedral should commission an external resource (operating to terms of reference set by the CSO) to review, cleanse and archive the data held on the NSCMS and adhere to the 'Guiding Principles' for the NSCMS.

14.10 The Audit observed the CSO's effective and robust communication channels with Westminster Abbey as a significant strength in the Cathedral's safeguarding arrangements.

- 14.11 The primary responsibility for case management at the Cathedral lies with the CSO. The CSO plans to receive reflective supervision from the NST Regional Safeguarding Lead (RSL) once outstanding issues relating to the Memorandum of Understanding (MOU) have been clarified and resolved. In addition to this, the CSO receives valued external clinical supervision, funded by the Cathedral, which specifically focuses on her psychological welfare. Furthermore, the existing MoU between the Diocese of London and St Paul's Cathedral includes provisions for the quality assurance of the Cathedral's casework, which may be provided by the Diocese and/or the RSL as part of the formal supervision arrangements with the NST. In a reciprocal arrangement, the CSO may also offer their professional expertise and unique perspective on cases being managed by the Diocese, as and when required.
- 14.12 The Cathedral does not have any active formal Safety Plans in place. However, it does maintain processes that can be activated should the need for such an agreement arise. During the Audit, evidence was observed of effective collaborative working with the wider diocese. This was specifically noted in a case where an individual on a safety plan was being managed through existing diocesan arrangements. This is good practice.
- 14.13 The Audit was advised there have been no new cases requiring a SCMG at the Cathedral over the past 12 months.
- 14.14 The Cathedral is a registered charity and therefore has a legal requirement to submit SIRs to the Charity Commission. The Cathedral follows the House of Bishops' guidance set out in 'Safeguarding Serious Incident Reporting to the Charity Commission'.
- 14.15 The Audit was informed that one case had met the threshold for a safeguarding SIR in the last 12 months. Although the Audit acknowledged the reasoning given for not notifying the

NST of this SIR, the Audit team is of the opinion that, in the interest of adhering fully to the House of Bishops' Guidance<sup>3</sup>, a copy of the report should be shared with the NST.

**Recommendation C23:** The Cathedral must ensure that all reports concerning safeguarding Serious Incidents are shared with the appropriate bodies, as detailed in the House of Bishops' Guidance. This is specifically to align with the [Safeguarding Serious Incident Reporting to the Charity Commission](#) guidance.

14.16 The Cathedral maintains various agreements to ensure effective and coherent information sharing. For instance, the arrangements for data exchange are formally defined through a standard framework information sharing agreement with the NST and a separate Memorandum of Understanding with the Diocese of London. These two examples illustrate the specific, documented mechanisms put in place to govern how information is shared.

14.17 The Audit was told that the Cathedral has an escalation process for managing disagreements concerning safeguarding matters, this procedure could not be formally substantiated as it was not outlined within the official Safeguarding policy. Despite this, the Audit did confirm escalation pathways between the LDF and Cathedral through the Memorandum of Understanding (MoU) between the two bodies. This MoU establishes clear escalation pathways for handling safeguarding disagreements, specifically mandating that any unresolved dispute between the two parties regarding the appropriate action for a safeguarding concern or allegation must be promptly escalated to the Chair of the Diocesan Safeguarding Advisory Panel (DSAP). Furthermore, the Audit noted that the

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<sup>3</sup> House of Bishops' Guidance states: "Once the Chapter has reported a safeguarding Serious Incident to the Charity Commission, the Chapter must also send a copy of the Serious Incident Report, and a copy of any follow-up reports made to the Charity Commission, to the NST at [rsi.nst@churchofengland.org](mailto:rsi.nst@churchofengland.org); the Diocesan Safeguarding Adviser; the Diocesan Bishop, as the Visitor for the cathedral; and the cathedral's auditors." Section 4, Guidance for Cathedral Chapters, Safeguarding Serious Incident Reporting to the Charity Commission, House of Bishops Guidance, <https://www.churchofengland.org/safeguarding/safeguarding-e-manual/safeguarding-serious-incident-reporting-charity-commission/section-4-guidance-cathedral-chapters>

draft Safer Recruitment Policy grants the Safeguarding Officer the authority to "Escalate any serious concerns or breaches of safer recruitment policy to the appropriate authority."

Given these findings, the Audit makes the following recommendation.

**Recommendation C24:** The Safeguarding Policy should be updated to include details on how safeguarding-related disputes are handled and to outline the escalation procedures.

14.18 St Paul's Cathedral adheres to all relevant UK data protection legislation, including the UK General Data Protection Regulation (UK GDPR), ensuring the secure storage and sharing of personal information. All staff, including clergy and Ministers, receive regular online training on Data Protection principles. While staff training is fully implemented, the inclusion of volunteers in this online training is currently in progress.

14.19 All personal and safeguarding information is shared and stored using systems compliant with data protection standards. Staff use internal encrypted email (via Microsoft) and work-issued mobile phones for sharing sensitive safeguarding information. Crucially, the use of personal email accounts for this purpose is prohibited for all personnel. The Cathedral operates a dedicated Safeguarding Inbox, which has restricted access limited only to authorised personnel.

14.20 For volunteers, who generally do not have access to the Cathedral's electronic system, paper-based safeguarding report forms are provided and utilised. Volunteers are instructed on where to locate blank forms (e.g., the Virgers' Office or security control room) and how to submit them via the Virgers for secure transfer to the CSO, either in person or via the dedicated safeguarding inbox. Finally, the Chaplain and CSO are provided with work-issued mobile phones. These measures collectively ensure that all personal information is processed, shared, and stored in a manner fully compliant with UK GDPR.

## 15 Victims and Survivors

- 15.1 St Paul's Cathedral is firmly committed to following the House of Bishops' guidance as set out in 'Responding Well to Victims and Survivors of Abuse'. A key aspect of this commitment to support victims and survivors involves the collaboration with The Guild of the Companions of St Paul, an association of former choristers, which provides support and a channel of communication to survivors of non-recent abuse. This relationship commenced through the chair of the Guild exercising curiosity into a "missing decade" and making contact. While this joint effort commenced in 2020, its momentum was initially hindered by the pandemic and subsequent lockdowns, but it has since seen improvement and progress.
- 15.2 The Audit reviewed the current Dean's direct engagement, following the positive impact made by his predecessor, which included writing a heartfelt, well-intentioned, and trauma-informed letter to survivors via the Guild. This communication addressed the abuse experienced and broader cultural issues impacting choristers from 1980-89, offering a sincere apology for the profound harm caused. Ongoing support for survivors is provided via several channels: the Guild (acting as a third party), the Cathedral's CSO, and the Dean's personal involvement. To date, the Dean has met with five men, with a sixth meeting pending.
- 15.3 The lasting impact of past safeguarding failures, marked by trauma and pain, necessitates an unwavering focus on victims and survivors. St Paul's Cathedral set funds aside for survivors who made a claim prior to 2007 in acknowledgement that the insurance industry did not offer therapy as standard upon initiation of a claim for child abuse until 2007.

15.4 The Cathedral's priority is to ensure victims and survivors are protected from future harm, given opportunities to heal, and that their authentic voices actively shape the Church's safeguarding arrangements going forward. To effectively oversee and manage the Cathedral's response to historic abuse at the Cathedral School, a SCMG was established. This group ensures that effective support is provided to all involved and that all necessary actions are taken. Significantly, the SCMG includes both the Guild and a survivor among its members. Finally, the Cathedral continues to emphasise healing through various co-planned services centred on reflection, lament, and remembrance. These services serve as platforms to highlight the ongoing work in survivor support and to provide updates on current safeguarding arrangements and policies.

15.5 The Cathedral is committed to learning from victim and survivor engagement by integrating its learning within the wider Diocesan framework. This collaborative model is evidenced by the attendance of the CSO and the Independent Safeguarding Chair at the Diocesan Safeguarding Advisory Panel (DSAP) in June 2025, which focused on victim and survivor engagement planning. Furthermore, the CSO is actively engaged in the Diocese's programme of work aimed at survivor engagement. The Audit believes St Paul's should continue this close working relationship, and should consider in partnership with the LDF, co-hosting listening events at the Cathedral to hear from a wider group of victim and survivor voices.

**Recommendation C25:** St Paul's Cathedral should partner with the LDF to host Diocese-wide listening events, providing an additional platform to hear from a diverse range of voices to inform local safeguarding practice.

15.6 St Paul's annually participates in Safeguarding Sunday. The most recent Safeguarding Sunday at the time of the Audit (2024) featured a sermon delivered by the Bishop of

Huntingdon and acting Bishop of Ely. The sermon addressed the vital need to support victims and survivors, specifically reflecting on the publication of the Smyth (Makin) report and acknowledging the victims and survivors who contributed to it. The Chaplain was also pointed out for anyone needing pastoral support.

15.7 Reporting pathways are established through various mechanisms, including service sheets, posters in public toilets, and the safeguarding page of the Cathedral's website. The Cathedral makes reporting accessible by providing a dedicated safeguarding reporting form. In the case of immediate risk, individuals are advised to call 999. Contact information for the Cathedral's Reception is provided for raising a safeguarding concern during working hours or Thirtyone:eight for reporting concerns outside of those hours.

15.8 Meetings with the Chaplain or CSO are offered to victims and survivors as standard practice. St Paul's Cathedral's website also provides a range of signposts to external support. However, considering that individuals presenting with mental ill health constitute one of the most common safeguarding themes, it would be highly relevant to ensure the website offers appropriate signposting to ongoing mental health support.

**Recommendation C26:** The Cathedral should include signposts to local ongoing mental health supports, such as City of London's 24-hour Mental Health Crisis Helpline.

15.9 What is currently lacking on the Cathedral's website is a dedicated sub-section specifically for victims and survivors of abuse. This would ensure that those in need are confident they have come to the right place. This sub-section should clearly detail the Cathedral's unwavering adherence to national guidance on responding to abuse and utilise the NST's explainer videos.

**Recommendation C27:** The Cathedral should enhance its existing ‘Safeguarding’ webpage by creating a dedicated sub-section for victims and survivors. This new sub-section should:

- a) Clearly detail the Cathedral's adherence to national guidance ‘Responding Well to Victims and Survivors of Abuse’, explicitly outlining its proactive and supportive stance.
- b) Provide a reassuring and welcoming online space where individuals seeking support can immediately feel at ease and be confident that they have found the appropriate resources.
- c) Embed the NST's ‘Responding Well to Victims and Survivors of Abuse’ videos onto the webpage.

## 16 Learning, Supervision and Support

### Safeguarding Learning

- 16.1 The Audit found that safeguarding learning at St Paul's Cathedral has strengthened in recent years. Staff and volunteers reported clear improvements in both the quality and accessibility of safeguarding training, with Church of England mandatory training providing a consistent baseline of understanding across the Cathedral workforce. Senior leaders have engaged directly in safeguarding learning, including attending events such as 'Safeguarding the Safeguarder' to reinforce awareness of staff wellbeing.
- 16.2 A particular strength is the way safeguarding learning is contextualised for the Cathedral environment. In addition to mandatory training, teams receive role-specific safeguarding briefings that reflect the unique safeguarding risks associated with St Paul's, including high visitor footfall, international tourism, responsibilities to educational visits and choristers and frequent contact with adults presenting in mental health crisis. Staff described these contextual discussions as valuable in supporting confident and appropriate safeguarding responses in practice. This is good practice.
- 16.3 Survey data from the Cathedral workforce also supports these findings. A strong majority of respondents reported that safeguarding arrangements have improved and that safeguarding is taken seriously. Levels of confidence in knowing how to raise concerns and access safeguarding advice are high, which is consistent with the Audit's observation of an open and supportive safeguarding culture.
- 16.4 However, survey findings relating to whether the voices of children, young people, and adults are fully heard were more mixed. While progress is evident, this highlights an opportunity to strengthen safeguarding learning by more consistently incorporating lived

experience and feedback into training, supervision, and reflective practice. This is particularly relevant given the Cathedral's extensive engagement with schools, choristers, and adults at risk.

- 16.5 While training attendance is well recorded, evaluation focuses primarily on completion rather than impact. There is limited evidence of systematic evaluation of how safeguarding learning and supervision influence practice, wellbeing, or confidence over time.

**Recommendation C28:** The Cathedral should strengthen its evaluation of safeguarding learning and supervision, moving beyond recording attendance to include proportionate measures of impact. This should include structured opportunities for feedback and reflection, and consideration of how safeguarding learning influences practice, confidence, and wellbeing, particularly for those in roles with regular exposure to safeguarding concerns.

### Clergy Support

- 16.6 Clergy at the Cathedral have access to a range of formal and informal support mechanisms in relation to safeguarding. The Audit heard evidence of clergy working closely with the CSO and Chaplain when safeguarding concerns arise, ensuring that both procedural and pastoral dimensions are addressed. Clergy described safeguarding advice as accessible and proportionate, supporting appropriate decision making in often complex situations.
- 16.7 Pastoral support is a notable strength. The Chaplaincy plays an important role in providing support to clergy and others involved in safeguarding matters, including those raising concerns. This reflects an understanding that safeguarding work can be emotionally demanding and requires care for those undertaking it.
- 16.8 While support is clearly available, the Audit found that arrangements rely heavily on

informal relationships and individual judgement. There is an opportunity to further strengthen consistency by clarifying expectations around safeguarding related support and reflective space for clergy, particularly given the volume and complexity of safeguarding issues encountered in the Cathedral setting.

**Recommendation C29:** The Cathedral should clarify and formalise arrangements for safeguarding related support and reflective space for clergy, ensuring that expectations are clear, consistent, and proportionate. This should include agreed opportunities for reflective discussion on safeguarding matters, recognising the emotional demands of the Cathedral context and supporting clergy wellbeing alongside safe practice.

### **Supervision and Support of Safeguarding Roles**

16.9 The Cathedral benefits from experienced safeguarding professionals who provide authoritative oversight and are well regarded by staff and volunteers. The CSO provides clear operational leadership and maintains effective working relationships with diocesan safeguarding colleagues through established information sharing arrangements. This supports consistency, appropriate escalation, and shared learning.

16.10 Staff and volunteers who raise safeguarding concerns generally report positive experiences of support and follow up. Survey responses and qualitative feedback included multiple examples of timely advice, clear communication, and proportionate action, which reinforces confidence in safeguarding arrangements.

16.11 However, the Audit found that formal reflective supervision is not yet consistently embedded for all safeguarding roles. While safeguarding professionals access appropriate support, other roles with regular exposure to safeguarding concerns, including visitor facing, learning, and pastoral roles, do not all have routine access to structured supervision. Given the emotional demands of the Cathedral environment, this represents

an area for further development.

**Recommendation C30:** The Cathedral should develop and embed proportionate reflective supervision arrangements for roles with regular exposure to safeguarding concerns, including visitor facing, learning, and pastoral roles. This should be appropriate to role and frequency of exposure, and focused on supporting wellbeing, reflective practice, and consistent safeguarding decision making.

## 17 Conclusion

- 17.1 St Paul's Cathedral is a complex, high-profile institution that successfully balances its dual identity as a vibrant place of worship and a global landmark. This Audit finds a cathedral that has made significant strides in maturing its safeguarding culture since the 2022 SCIE review. There is a palpable sense of institutional safety, underpinned by a leadership team that views safeguarding not as a peripheral compliance exercise, but as a core component of its Christian mission.
- 17.2 A primary safeguarding strength across the Cathedral is the collective commitment of its senior leadership and wider governance team. The Dean and members of Chapter exhibit a high degree of safeguarding literacy, which is further strengthened by a transparent approach to institutional self-reflection. The move to embed safeguarding across all governance, oversight, and executive leadership meetings has delivered significant results. Not least ensuring that the promotion of a culture of safety remains a central pillar of the institution's overarching strategic deliberations.
- 17.3 The Audit saw evidence that the Cathedral has begun a journey of advancing its commitment to social responsibility through its work on racial justice. The adoption of a 'retain and explain' policy regarding historical artefacts is noted as an example of good practice. Whilst there is more work to be done, it is fair to say that the leadership is making tangible progress toward creating a more demonstrably inclusive and equitable environment.
- 17.4 Wider oversight structures, particularly the Safeguarding Advisory Group (SAG) and the Safeguarding Working Group (SWG), provide a solid framework for oversight and

operational delivery. They work well in straddling governance, scrutiny, and the practical implementation of outcomes that cascade from one meeting to another. The report makes a number of recommendations that will further enhance and strengthen these arrangements, including skills, diversity, and inclusion audits of membership to ensure an external-facing element.

- 17.5 Operationally, the Cathedral benefits from a highly skilled CSO whose background provides authoritative management of complex cases and non-recent abuse allegations. However, the current breadth of the CSO's remit is unsustainable. To ensure long-term resilience, the Cathedral must move toward a professional, peer-led structure by establishing a senior leadership role (Head of Safeguarding/Director of Safeguarding) and recruiting an Assistant CSO.
- 17.6 Significant progress has been made in prevention, particularly in safer recruitment and the innovative use of online checks for candidates. The partnership with the City of London Police is excellent, providing vital public reassurance. Despite these strengths, the audit notes a critical delay in the review of CCTV systems, an action pending since 2021, which must be expedited to ensure the security of the Cathedral's unique physical environment. Additionally, clarifying the operational boundaries between Virgers and security staff during incidents is essential to eliminate the current ambiguity noted by auditors.
- 17.7 The chorister programme is a distinctive element of the Cathedral's life, and the Audit found that safeguarding is deeply embedded in the Music Department's daily operations. The use of independent chaperones is exemplary. As the programme expands with the introduction of girl choristers, formalising informal wellbeing adjustments into a

written framework and enhancing staff understanding of neurodiversity will ensure that inclusive practice is system-led rather than person-dependent.

17.8 Turning to victims and survivors, the Audit found that the Cathedral has shown genuine compassion and a commitment to restorative practice. The engagement with the Guild of Companions and the inclusion of a survivor in the Case Management Group are significant steps toward healing. To further this work, the Cathedral should enhance its digital presence and access with a dedicated survivor sub-section and by partnering with the Diocese to host wider victim and survivor listening events.

17.9 Ultimately, St Paul's possesses the clear potential to become an exemplar regarding its safeguarding governance framework and operational arrangements. To achieve this, the institution must fully embrace the recommendations provided and prioritise the reinforcement of its professional safeguarding capacity.

# Appendices

## 18 Appendix 1 – LDF Recommendations

**Recommendation D1:** The Terms of Reference for all senior leadership team meetings should be finalised as a matter of urgency, ensuring that safeguarding is included as a specific, standing agenda item.

### **Recommendation D2: Governance Restructuring for Safeguarding Oversight**

It is recommended that the Diocese restructures its governance to distinguish between the policy-focused Bishop's Council and a streamlined LDF Board of Directors. To achieve this, the Diocese should:

- a) Create a smaller, more agile Trustee body to discharge the legal and fiduciary duties of the LDF. This group should be reduced to a size conducive to effective decision-making (ideally 12–15 members).
- b) The current Area-based approach to oversight should be reviewed in line with this approach to ensure uniformity of processes and the application of oversight accountability.
- c) Appoint the Director of Safeguarding as an officer in attendance to this smaller Board. This ensures that trustee decisions are grounded in operational reality and that the distinction between the Board's strategic accountability and the Director's operational authority is reinforced and maintained.
- d) Retain the larger Bishop's Council as a forum for broad theological and policy debate, removing the expectation for this wider group to perform detailed executive scrutiny of safeguarding operations.

**Recommendation D3:** To guarantee uniform safeguarding standards, Area Safeguarding Advisory Groups (ASAGs) should be introduced in every Episcopal Area. Acting as a feedback loop, these panels will translate central strategy into local delivery, providing a necessary

means of assuring good practice. Crucially, membership must be diverse: the Terms of Reference should require the inclusion of clergy, staff, volunteers, youth leaders, congregants, and local partners. Additionally, priority must be placed on securing representation from a relevant victim or survivor advocacy group.

### **Key Responsibilities**

- i. Monitor the local implementation of the unified safeguarding framework to ensure training and reporting mechanisms are consistent with Diocesan standards.
- ii. Act as a feedback loop by identifying local trends, resource gaps, or specific cultural challenges, and reporting these back to central Diocesan leadership.
- iii. Gauge the safeguarding culture within the Area, moving beyond simple compliance data to evaluate trust and ethos.
- iv. Oversee the delivery of uniform annual surveys across each Area, as well as for LDF central clergy and staff, over the next three years. To facilitate benchmarking across the Diocese, these surveys must utilise a standardised set of questions covering:
  - a) Safeguarding culture and its impact.
  - b) Equality, Diversity, and Inclusion (EDI); and
  - c) Perceptions regarding the existence and impact of deference (specifically the approachability and responsiveness of leaders at all levels).
- v. The ASAG will meet quarterly to provide update briefings to the Area Bishop and the central Diocesan Safeguarding Advisory Panel (DSAP).
- vi. The DSAP should continue to produce an annual report and action plan based on these briefings. This report should analyse trends and themes in safeguarding referral data and local survey outcomes. It aims to highlight variations across the diocese, identify and promote good practice, and outline steps to address any identified barriers.

### **Terms of Reference: Area Safeguarding Advisory Groups (ASAGs)**

The primary objective of the ASAG is to ensure the consistent application of the Diocesan safeguarding strategy within the Episcopal Area. By acting as a vital bridge between the central Diocesan Safeguarding Advisory Panel (DSAP) and local parishes, the Group aims to eliminate regional disparities (the so-called "postcode lottery") and ensure safeguarding is culturally embedded rather than merely compliant. Furthermore, the ASAG serves as a forum for local contextual feedback, ensuring central policy remains practical and effective on the ground.

**Membership Composition** To maintain a holistic perspective that accurately reflects the life of the Area, membership must include a diverse cross-section of local representatives. The panel should be inclusive and comprise:

- i. The Area Archdeacon (as a standing member), supported by a mix of incumbents, curates, and chaplains to represent diverse parish contexts.
- ii. Representatives from lay staff, such as parish administrators or operations managers.
- iii. Key volunteer voices, specifically Parish Safeguarding Officers (PSOs) and Churchwardens.
- iv. The designated lead member for the Area from the central Diocesan Safeguarding Team.
- v. Representatives from children and youth ministry or young adult leadership to champion the voices and perspectives of younger generations
- vi. Lay members of the worshipping community without formal roles, providing an independent perspective.
- vii. To ensure transparency and wider community engagement, this should include:
- viii. **Statutory:** Representatives from local bodies (e.g., Local Authority Designated Officers (LADO), Police, or Social Services).

- ix. *Non-Statutory*: Representatives from relevant local charities, victim advocacy groups, or community support organisations.

**Recommendation D4: Scrutiny of Extended Episcopal Oversight**

The LDF should include in its matrix of monitoring categories of parishes and clergy that have sought Extended Episcopal Oversight a process that goes beyond simple numbers to:

- a) Distinguish between theological objections (e.g., *Living in Love and Faith*, ordination of women), EDI matters, and specific grievances regarding an individual Bishop's background, beliefs, conduct or management.
- b) Scrutinise these patterns to ensure ongoing accountability and integration of parishes, whatever their theological conviction.
- c) Mandate the submission of data from Area offices to the LDF, utilising the proposed ASAGs and DSAP for quality assurance and local context.

**Recommendation D5:** Archdeacons should be supported by Assistant Archdeacons and have shared administrative support; all Area Bishops require a Chaplain (this will provide crucial support on a range of issues but not least management of the Clergy (Blue) files); the Diocese should consider presenting a business case to the appropriate national body.

**Recommendation D6:** Formally elevate the Head of Safeguarding role to Director level, with a clear job description (Appendix 3) and Board-level representation. This role should have strategic authority and the ability to direct operational safeguarding activity across the Diocese of London. This would include acting as the most senior safeguarding advisor (when escalation required) to other church bodies across the Dioceses, for example Holy Trinity Brompton (HTB). This will provide an ultimate authoritative safeguarding voice across the geography of the dioceses.

Appoint a Deputy Director to provide leadership capacity (and resilience). The operational case manager role may provide a good fit for this link between strategic engagement and operational grip. This role should have a deputy to operate in support and provide contingency.

**Recommendation D7:** DSAs in Episcopal Areas are under-resourced and there is little capacity to ensure support. The following recommendations are made to address this critical issue. The LDF should:

- a) Change the current naming convention to Area Safeguarding Advisors (ASA).
- b) Ensure there are two ASAs within each area, with one designated as the Senior Area Safeguarding Advisor (SASA).
- c) Whilst the appointment to such roles (if the recommendation is accepted) is a matter for the Director/Head of Safeguarding in agreement with the LDF, this should be seen as an opportunity to reset safeguarding support across the LDF. The role for SASA should be a competitive process that enables a strategic approach to building strong blended teams that complement the strengths in the overarching DST.
- d) Opportunities should also be considered to create job share roles as this will further enhance the opportunities to embed teams with a range of complementary experience from credible former statutory safeguarding roles.

**Recommendation D8:** Conduct a review of salary structures to assess and address pay parity with external organisations and progression, ensuring the Diocese can recruit and retain experienced safeguarding professionals.

**Recommendation D9:** Redefine the existing administration role as Safeguarding Support Officer focusing on direct support on matters related to supporting the DST and parishes.

**Recommendation D10:** To ensure continuous culture and professional development the LDF should:

Implement mandatory, regular training for all DST members, delivered in-house by the team (Enhanced In-House Training) to reduce reliance on external providers, supported by a specific budget for specialist needs.

Strengthen systems for reflection, staff welfare, supervision, and resilience checks.

Adopt a strategy of consistent, transparent communication that celebrates success to boost internal morale and enhance public confidence.

**Recommendation D11:** The LDF should transfer DBS administration for LDF employees from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

**Recommendation D12:** The LDF should adjust its communication plan to include a broader range of safeguarding messages across its digital channels. In order to enhance this engagement, it should:

- a) Tailor content to resonate with the specific interests and preferences of followers on each platform.
- b) Embedding key safeguarding messages throughout its social media channels. This ensures consistent and frequent reinforcement of important information.
- c) Employ diverse communication strategies suited to each platform's unique features and user expectations.
- d) Capitalise on relevant awareness days, campaigns, and events to amplify key messages and expand audience engagement.
- e) Aim to raise awareness of different forms of abuse (such as domestic and spiritual abuse) and address contemporary safeguarding issues (including, but not limited to, modern slavery and county lines).

**Recommendation D13:** Further to reviewing existing practice, the LDF should consider implementing new and / or extended models for youth participation in consultation with parishes and its existing networks.

**Recommendation D14:** The Diocese should continue its project to implement a centralised system, such as a CRM or safeguarding database, for recording all youth and children's workers, paid and voluntary, covering recruitment checks, safeguarding training status, and role descriptions. This should support line of sight and accountability, rather than replace parish responsibility.

**Recommendation D15:** The Diocese should develop supplemental, context specific training for youth and children's leaders, with emphasis on online harms, grooming, mental health, and practical scenarios. These should be co designed with frontline workers and young people.

**Recommendation D16:** The LDF should establish a diocesan youth reference group on safeguarding, ensuring the perspectives of children and young people directly inform policy, training, and practice. This would strengthen a culture of listening and early intervention.

**Recommendation D17:** The London Diocesan Fund should consider developing and issuing clear guidance for parishes on safeguarding accountability where externally developed programmes and courses are used within church life, including Alpha. This guidance should help parishes distinguish between activities that are genuinely third party provision and those that form part of the parish's own mission and ministry, setting out expectations for safeguarding oversight, local risk assessment, and clarity of responsibility.

**Recommendation D18:** The LDF 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.

**Recommendation D19:** A Deputy/Assistant Case Manager should be established to prevent backlogs when the main case manager is on leave.

**Recommendation D20:** The LDF should strengthen the professionalisation of record keeping within the NSCMS, supported by proper and reflective supervision and quality assurance.

**Recommendation D21:** The LDF should ensure that any training related to risk assessments, safety planning and wider offender management is contextually fit for purpose in a faith-based environment.

**Recommendation D22:** The LDF should establish a formal policy and criteria for the closure or cessation of Safety Plans. This policy should specify conditions that warrant the plan's conclusion, such as the respondent's relocation or their decision to disengage from church activities.

**Recommendation D23:** The Diocese should implement a defined escalation process that provides a formal structure to managing differences of opinion as they relate to the decisions and actions on safeguarding cases. This process should be applicable to all staff within all jurisdictions covered by the Diocese of London and St Paul's Cathedral.

**Recommendation D24:** The LDF should:

- a) Clearly detail the LDF's adherence to national guidance 'Responding Well to Victims and Survivors of Abuse', explicitly outlining its proactive and supportive stance.
- b) Ensure there is a direct link to 'Responding Well to Victims and Survivors of Abuse' guidance on the 'Support for Survivors' webpage.
- c) Embed the NST's 'Responding Well to Victims and Survivors of Abuse' videos onto the 'Support for Survivors' webpage.

**Recommendation D25:** The LDF should identify wider opportunities to listen to victims and survivors and those close to them (e.g. family members) utilising existing and established networks. This work should include travelling to neighbouring dioceses which have established survivor forums.

**Recommendation D26:** The LDF should ensure consistent follow-up care and communication with victims / survivors must be systematically diarised to prevent negative impacts.

**Recommendation D27:** To bridge the gap between initial knowledge and long-term application, the LDF should mandate recurring annual Trauma-Informed Practice training to ensure these principles are effectively embedded in practice.

**Recommendation D28:** The LDF should revise its existing signposts for victims and survivors on the Diocesan website. This should include:

- a) The removal of the Truth Project under 'Making a disclosure'
- b) Reviewing the downloadable document with further support services to ensure it is up to date.

**Recommendation D29:** Apologies for unsatisfactory experiences should be delivered with a sincere and personal tone to ensure genuine human connection and maximise their positive impact.

**Recommendation D30:** The Diocese should prioritise refining the processes and structures in place for the Survivor Reference Group.

**Recommendation D31:** The LDF should undertake a cost-benefit analysis of its current safeguarding training provision, with a view to strengthening strategic oversight of learning. This should include consideration of appointing dedicated diocesan safeguarding trainer(s), responsible for developing a diocesan safeguarding learning strategy informed by needs analysis, overseeing quality assurance, and embedding robust evaluation of training impact.

**Recommendation D32:** The LDF should strengthen its systems for recording and monitoring safeguarding training, including clearer escalation where required training is not completed or has lapsed. This should be proportionate but sufficiently robust to ensure safeguarding competence is maintained for all relevant roles. This should be considered in the cost-benefit analysis undertaken by the LDF.

**Recommendation D33:** The Diocese should strengthen support for clergy by developing a consistent approach to safeguarding-related supervision and pastoral support, proportionate to role and context, and clearly distinct from disciplinary or performance management processes.

**Recommendation D34:** The Diocese should introduce a proportionate safeguarding supervision model for professional safeguarding staff. This should include scheduled reflective supervision sessions, distinct from operational management meetings, with clear expectations around frequency, purpose, and recording.

**Recommendation D35:** The Diocese should implement a simple and consistent method for recording learning from safeguarding practice, including key themes, emerging risks, and practice challenges. This learning should be reviewed periodically and used to inform safeguarding strategy, policy review, and training priorities.

**Recommendation D36:** The Diocese should review and standardise safeguarding content within staff and role-holder induction processes, ensuring that safeguarding responsibilities, reporting pathways, and expectations are clearly communicated and consistently recorded and refreshed where roles or responsibilities change.

**Recommendation D37:** To sustain effective support for Parish Safeguarding Officers, the Diocese should assess the resources required to maintain regular engagement, advice, and guidance at scale, and ensure that this provision is sufficiently resourced to remain consistent across episcopal areas.

## 19 Appendix 2 – Cathedral Recommendations

**Recommendation C1:** The Cathedral should carry out an artefacts and structural survey to identify opportunities to celebrate and promote the diversity of the community it serves.

**Recommendation C2:** The Chapter should adopt a formal procedure whereby the Dean may recuse himself from any agenda item where there is a perceived conflict of interest. Furthermore, as a matter of standard practice, the Dean should withdraw at the conclusion of each meeting to allow the SNEM to chair a ‘wash-up’ session. This is to enable a ‘sense check’ to ensure that all members, particularly non-executives, feel their voices have been fully heard.

**Recommendation C3:** The CSO (or if appointed, the Head of Safeguarding / Director of Safeguarding) should attend all Chapter meetings.

**Recommendation C4:** The SAG should evolve from an internal body into a diverse, externally inclusive scrutiny group. To achieve this:

- a) Actively recruit external members with strategic expertise in victim/survivor advocacy, Equality, Diversity, and Inclusion, and regulatory safeguarding (e.g., social care, policing, or education).
- b) Use SAG membership as a pathway for under-represented groups to engage with and inform Chapter-level governance.

**Recommendation C5:** Refine the structural interface between the SAG and the SWG through updated Terms of Reference (ToR).

- a) The Working Group should manage implementation and action tracking, submitting thematic reports to the SAG for high-level strategic analysis.

- b) To ensure direct communication, the SAG Chair and Cathedral Safeguarding Officer (CSO) should, whenever safeguarding is an agenda item, both attend Chapter meetings. If a Head / Director of Safeguarding is appointed, they should always be present and this would negate the need for the CSO's attendance.
- c) Introduce consistent reporting on concern volumes, triage timeliness, training compliance, and staff caseloads.

**Recommendation C6:** Shift the focus from administrative compliance to measurable outcomes:

- a) Focus on the 'so what?' of recommendations. The SAG must oversee the implementation of historic abuse reviews and audits to ensure they result in tangible risk reduction rather than just completed checklists.
- b) Members should receive induction on cathedral-specific risks, including high footfall management, iconic site security, and the unique power dynamics inherent in the National Church.

**Recommendation C7:** Formally monitor staff welfare and burnout levels within SAG meetings to ensure the adequacy of professional supervision and support.

**Recommendation C8:** Review and Refresh the SWG Terms of Reference (ToRs)

- a) Amend the ToRs to explicitly distinguish the CSL's accountability function from the CSO's operational mandate. To maintain the principle of distancing clergy members from frontline operational decision-making, any new Chair must be evaluated to ensure their primary professional role aligns with this separation.
- b) Conduct a comprehensive skills, inclusion, and diversity audit. This will facilitate the diversification of the group's membership, ensuring it encompasses a broader range of backgrounds and perspectives to better reflect the community it serves.

- c) Utilise this expanded membership to bridge the gap between high-level governance/oversight (Chapter/SAG) and frontline practice. Specifically, the SWG should take a leadership role in:
- Victim and survivor engagement.
  - Trauma-informed practice.
  - Inclusion initiatives.
  - Staff and volunteer health and wellbeing.

**Recommendation C9:** To ensure the long-term resilience and strategic oversight of the Cathedral's safeguarding functions, the following actions are recommended:

- a) Establish a senior leadership role (Head/Director of Safeguarding) directly accountable to Chapter. This post-holder will lead on all strategic matters, ensuring that safeguarding is integrated into the Cathedral's highest level of governance.
- b) Upon the appointment of the Head/Director of Safeguarding, transition the line management of the CSO and any subsequent professional safeguarding staff to this new role. This moves the reporting line from an administrative arrangement to a professional, peer-led structure.
- c) Recruit an Assistant CSO to alleviate the operational burden on the CSO. This role should specifically focus on the delivery of in-house training and the maintenance of safeguarding standards.
- d) Evaluate the effectiveness of the current administrative support to establish if it meets the needs of the Cathedral Safeguarding Team.
- e) Utilise the increased capacity to ensure the cathedral safeguarding team has a consistent and influential voice at Chapter meetings, bridging the current gap between operational risk and governance insight and oversight.

**Recommendation C10:** The Cathedral should formalise existing good practice around chorister scheduling and wellbeing into a written framework, jointly owned with the School, to ensure consistency, transparency and resilience as the programme continues to develop.

**Recommendation C11:** The Cathedral should introduce age-appropriate, Cathedral-specific safeguarding information within rehearsal and practice spaces used by choristers.

**Recommendation C12:** The Cathedral should ensure that the ongoing review of CCTV explicitly considers areas regularly used by choristers, and that decisions regarding coverage and blind spots are clearly documented to provide assurance that arrangements remain proportionate and fit for purpose as the chorister programme continues to develop.

**Recommendation C13:** The Cathedral should consider whether additional, context appropriate measures are needed to manage public photography of choristers, drawing on practice from other cathedrals and ensuring any approach is proportionate and flexible to the Cathedral's context.

**Recommendation C14:** The Cathedral should strengthen training for staff working with choristers by developing a shared understanding of neurodiversity, SEND and inclusive practice within the Music Department, building on existing expertise within the Cathedral Education Team and the Outreach Programme and St Paul's Cathedral School, to ensure confidence and consistency across roles.

**Recommendation C15:** The Cathedral should update relevant safeguarding procedures to explicitly address staff use of social media in relation to choristers and to formalise safeguarding arrangements at key transition points, including voice changes.

**Recommendation C16:** 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 C17:** The Cathedral should consider and establish models for how it captures the voices and experiences of children and young people in its prevention planning.

**Recommendation C18:** The Cathedral should ensure it captures the Designated Safeguarding Lead (DSL) details for all school visits as a mandatory part of the initial booking process.

**Recommendation C19:** In keeping with aligned recommendations in the Progress and Choristers sections, the Cathedral should expedite the completion of its review of the CCTV system that covers the entire Cathedral grounds. This is required to ensure the security systems are evaluated and updated without further delay, maintaining the safety and security of the premises.

**Recommendation C20:** The Cathedral should immediately establish and communicate clear, written protocols that precisely delineate the roles, responsibilities, and decision-making authority of Virgers and all other relevant staff during both security incidents and the delivery of pastoral care. These new guidelines should be accompanied by mandatory, scenario-based training for all relevant staff to ensure a consistent and effective response, thereby eliminating the current confusion and improving operational efficiency.

**Recommendation C21:** Additional security personnel should be deployed at each entrance to enhance safety and incident response capabilities.

**Recommendation C22:** The Cathedral should commission an external resource (operating to terms of reference set by the CSO) to review, cleanse and archive the data held on the NSCMS and adhere to the 'Guiding Principles' for the NSCMS.

**Recommendation C23:** The Cathedral must ensure that all reports concerning safeguarding Serious Incidents are shared with the appropriate bodies, as detailed in the House of Bishops' Guidance. This is specifically to align with the [Safeguarding Serious Incident Reporting to the Charity Commission](#) guidance.

**Recommendation C24:** The Safeguarding Policy should be updated to include details on how safeguarding-related disputes are handled and to outline the escalation procedures.

**Recommendation C25:** St Paul's Cathedral should partner with the LDF to host Diocese-wide listening events, providing an additional platform to hear from a diverse range of voices to inform local safeguarding practice.

**Recommendation C26:** The Cathedral should include signposts to local ongoing mental health supports, such as City of London's 24-hour Mental Health Crisis Helpline.

**Recommendation C27:** The Cathedral should enhance its existing 'Safeguarding' webpage by creating a dedicated sub-section for victims and survivors. This new sub-section should:

- a) Clearly detail the Cathedral's adherence to national guidance 'Responding Well to Victims and Survivors of Abuse', explicitly outlining its proactive and supportive stance.
- b) Provide a reassuring and welcoming online space where individuals seeking support can immediately feel at ease and be confident that they have found the appropriate resources.
- c) Embed the NST's 'Responding Well to Victims and Survivors of Abuse' videos onto the webpage.

**Recommendation C28:** The Cathedral should strengthen its evaluation of safeguarding learning and supervision, moving beyond recording attendance to include proportionate measures of impact. This should include structured opportunities for feedback and reflection, and consideration of how safeguarding learning influences practice, confidence, and wellbeing, particularly for those in roles with regular exposure to safeguarding concerns.

**Recommendation C29:** The Cathedral should clarify and formalise arrangements for safeguarding related support and reflective space for clergy, ensuring that expectations are clear, consistent, and proportionate. This should include agreed opportunities for reflective discussion on safeguarding matters, recognising the emotional demands of the Cathedral context and supporting clergy wellbeing alongside safe practice.

**Recommendation C30:** The Cathedral should develop and embed proportionate reflective supervision arrangements for roles with regular exposure to safeguarding concerns, including visitor facing, learning, and pastoral roles. This should be appropriate to role and frequency of exposure, and focused on supporting wellbeing, reflective practice, and consistent safeguarding decision making.

## 20 Appendix 3 – Director of Safeguarding Job Description

### Purpose

To provide senior strategic leadership for safeguarding across the Diocese, ensuring the highest standards of professional practice, culture, and compliance.

The Director will serve as the accredited Diocesan Safeguarding Officer (DSO), holding statutory responsibility for the management of allegations against church officers. While retaining oversight of high-risk cases, the primary focus of this role is to drive systemic change, lead the DST, and represent the Diocese at a Board and statutory partner level.

### Key Responsibilities

#### Strategic Leadership & Culture

Design and implement a long-term safeguarding strategy that moves the Diocese from reactive compliance to a proactive culture of safety and care.

- Act as the senior representative for safeguarding on key governance bodies (e.g., Bishop's Council, Diocesan Synod), providing expert advice to senior clergy and the Bishop of London.
- Lead the "Safer Churches" agenda, enabling an environment of transparency, openness, and reflection across all parishes and cathedral structures.
- Ensure all diocesan policies align with national Church of England guidance and statutory legislation, updating frameworks as necessary.

#### Operational Oversight (DSO Function)

- Fulfil the function of the Diocesan Safeguarding Officer (DSO), maintaining operational independence from the Bishop regarding casework decisions.
- Retain direct oversight and decision-making authority for the most complex, high-profile, or high-risk cases, ensuring robust risk assessments are in place.

- Establish and monitor performance indicators for the DST, ensuring that the triage, investigation, and management of referrals by the operational team meet professional standards.

### **Stakeholder Management & Partnerships**

- Manage high-level relationships with statutory partners, including the Police, Local Authority Designated Officers (LADOs), Probation Services, and the National Safeguarding Team (NST).
- Oversee the establishment and effective running of the new Local Safeguarding Advisory Panels, ensuring they provide effective scrutiny and support.
- Act as the bridge between the safeguarding team and senior clergy, facilitating constructive dialogue and resolving conflicts where necessary.

### **Team Management & Development**

- Provide line management and mentorship to the Deputy Director of Safeguarding, empowering them to lead day-to-day operations.
- Hold budgetary responsibility for the DST, advocating for resources where necessary to ensure capacity meets demand.
- Champion a culture of resilience and well-being, ensuring regular clinical supervision, professional development, and counselling support are accessible to all team members.

### **Person Specification**

#### **Qualifications & Experience**

##### **Essential:**

- Senior professional qualification in Social Work, Safeguarding in Policing, Probation, or a related safeguarding field.
- Extensive experience (5+ years) in a senior safeguarding leadership role, with a proven track record of managing complex risk and strategic decision-making.

- Experience managing a multi-disciplinary team and substantial budgets.

**Desirable:**

- Experience working within a faith-based or voluntary sector context.

**Knowledge & Skills**

- Comprehensive knowledge of statutory legislation (Children Acts, Care Act) and statutory guidance (Working Together to Safeguard Children).
- Ability to translate complex operational challenges into clear strategic plans.
- Exceptional written and verbal communication skills, with the ability to present to Boards and navigate sensitive media enquiries.
- High emotional intelligence and the ability to remain calm and objective under significant pressure.

**Personal Attributes**

- Commitment to the values of the organisation and the welfare of children and vulnerable adults.
- A collaborative leader who values transparency and is willing to address historic failures with honesty.
- Willingness to undergo an Enhanced DBS check.

**Key Working Relationships**

- The Bishop of London, Diocesan Secretary, Archdeacons, Cathedral Dean, Parish Clergy, Safeguarding Support Officer.
- National Safeguarding Team (NST), Police Public Protection Units, Local Authority Children's and Adults' Services, Survivor Support Groups.

## 21 Appendix 4 – Glossary of Abbreviations

ASA	Area Safeguarding Advisor
ASAG	Area Safeguarding Advisory Group
CCSL	Clergy Current Status Letter
CDM	Clergy Discipline Measure
CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
CRM	Customer Relationship Management (system/database)
CSL	Chapter Safeguarding Lead
CSO	Cathedral Safeguarding Officer
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DPO	Data Protection Officer
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
DSL	Designated Safeguarding Lead
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
EDI	Equality, Diversity, and Inclusion
ELT	Executive Leadership Team
FTE	Full-Time Equivalent
GDPR	General Data Protection Regulation
GMH	Global Majority Heritage
HR	Human Resources
HTB	Holy Trinity Brompton
IICSA	Independent Inquiry into Child Sexual Abuse

ISA	Information Sharing Agreement
ISS	Interim Support Scheme
LADO	Local Authority Designated Officer
LDF	London Diocesan Fund
LLR	Lessons Learnt Review
MDR	Ministerial Development Review
MoU	Memorandum of Understanding
NSCMS	National Safeguarding Case Management System
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
RSL	Regional Safeguarding Lead
SAG	Safeguarding Advisory Group
SAR	Subject Access Request
SCIE	Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SEN / SEND	Special Educational Needs (and Disabilities)
SIR	Serious Incident Report
SNEM	Senior Non-Executive Member
SWG	Safeguarding Working Group
ToR	Terms of Reference
UKME	UK Minority Ethnic
VPN	Virtual Private Network



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