

**Independent Safeguarding Audit of
Bristol Diocesan Board of Finance and
Bristol Cathedral**

2024

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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 CofE Dioceses and Cathedrals. They have a particular focus on the CofE's new National Safeguarding Standards that provide the structure for this report.¹

1.2 Audit findings have taken account of the SCIE audits, PCR2 outcomes and other relevant material, as well as evidence from surveys, focus groups, direct correspondence and interviews. For the Bristol Diocesan Board of Finance (DBF) and Bristol Cathedral, this involved the following:

- 302 documents being collated and analysed prior to the Audit's fieldwork.
- A range of interviews with Church Officers (staff and volunteers), external partners, victims and survivors and other stakeholders.
- 377 anonymous survey responses, which gathered input from key communities connected to the Diocese and Cathedral. These were submitted by victims and survivors, children and young people, as well as those worshipping or working within the parishes, the Cathedral and for the DBF.
- Facilitating a focus group with nine choristers, comprising both boys and girls, alongside a separate session involving six chorister parents.
- Holding three additional focus groups engaging with 30 staff and volunteers, including Parish Safeguarding Officers, clergy members, and individuals in diverse roles such

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

as Church Warden, Disability Advisor, Youth Leader, Licensed Lay Minister, and Treasurer.

- A confidential contact form accessible via a dedicated webpage.
- Through a combination of one-to-one discussions, focus groups, online surveys, and confidential contacts, the Audit engaged a total of 457 individuals.

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

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

Part One - Bristol Diocesan Board of Finance

2 Context

- 2.1 The Diocese of Bristol, encompassing Bristol, South Gloucestershire, North Wiltshire, and Swindon, serves a diverse population exceeding one million. Bristol stands out as a major, expanding urban hub, complemented by distinct towns and rural communities, each possessing their own unique identity. The Diocese comprises Churches, parishes, and deaneries with varying congregation sizes and compositions, reflecting the contexts in which they minister. Over 200 Churches host approximately 18,000 worshippers, guided by numerous clergy across seven deaneries.
- 2.2 Around 15,000 children and young people are educated in 72 Church schools, supported by chaplains, serving institutions across the region. In 2022, the Diocese recorded 9,100 regular worshippers actively engaging with the Church through Sunday attendance and other regular activities.
- 2.3 Leadership responsibilities are entrusted to the seven deaneries, with area deans and deanery leadership teams focusing on advancing Diocesan priorities. The Diocese operates under two Archdeaconries, Bristol and Malmesbury, which are covered by two Archdeacons (with additional support from an Associate Archdeacon).

3 Progress

- 3.1 Overall, the independent SCIE and PCR2 audits made 55 local recommendations for Bristol. These ranged from issues such as safer recruitment, training and case management to record keeping, welfare, DBS renewal and raising awareness about safeguarding procedures. The overwhelming majority of recommendations have been met, whilst a small number have been subsumed into other workstreams and a few remain linked and reliant upon policy and practice being delivered at a national level.
- 3.2 The Independent SCIE Audit was completed in February 2017 and resulted in 14 recommendations, all of which were accepted. Progress was initially monitored via an action plan overseen by the Diocesan Safeguarding Steering Group (DSSG). This was later subsumed into the Diocese Safeguarding Improvement Plan, which since 2019 has been scrutinised by the DSSG. Whilst this process was interrupted by COVID19 and then superseded by a range of national developments, the DBF, Diocese Safeguarding Officer (DSO) and DSSG still retain active oversight and have worked closely with this Audit.
- 3.3 Four actions remain ongoing. Those relating to risk assessments and Parish Safeguarding Officers (PSO) training uptake have made progress, and the Audit is confident that under the current leadership, they will be met. The others are linked to whistleblowing and the provision of an authorised listening service. The Audit have been reassured that interim measures are in place for both. Such measures include, for example the Speaking Out (Whistleblowing) Policy and Procedure and the provision of a free and independent support service - ['Safe Spaces'](#), commissioned by the Church of England alongside the Roman Catholic Church in England and Wales.
- 3.4 The PCR2 was published in October 2022. The 41 recommendations from it were embedded into the Diocese Improvement Plan, with oversight led by the DSSG. The Audit

saw evidence of progress, with one clear example involving the inclusion of clergy support within the Diocese's *Transforming [the] Church. Together* strategy.

- 3.5 Beyond SCIE and the PCR2 processes, the DBF has also commissioned Lessons Learned Reviews (LLR). Following an allegation of Church-based abuse that resulted in a finding of misconduct, the associated LLR identified 16 local recommendations all of which were added to the improvement plan. Eleven are met or partially met and five require further consideration.
- 3.6 The independent PCR2 reviewer found – '*good and proactive practice and improvement being made in the Safeguarding Team*'. This Audit concurs, and such improvement is reflected in the approach to managing both Audit and LLR recommendations. The Diocese Safeguarding Officer (DSO) has considerable social work experience across a range of statutory roles. These include managing case reviews and developing focused action plans. He has ensured that recommendations and their actions are mapped, appropriate leads identified, and that progress is recorded.

4 Culture, Leadership and Capacity

- 4.1 Whilst some stubborn challenges remain, most of the feedback received from the Audit's interviews, focus groups and anonymous surveys were positive about changes and the continued commitment towards improvement. The overwhelming majority of responses from those working for the DBF and within parishes highlighted that people felt safe amongst their colleagues and most believed that a safeguarding culture is now embedded throughout their respective Church bodies.
- 4.2 Whilst fewer individuals engaged at the parish community level, those who did reflected similar sentiments. It is worthy of note that the most common descriptions used by them to describe culture were '*inclusive and welcoming*'. Whilst this is positive, it is important that the DBF do not become complacent and to this end the Audit makes the following recommendation.

Recommendation D1: The DBF should carryout bi-annual safeguarding cultural audits. These should be constructed to provide the workforce and worshipping communities with the opportunity to provide feedback on the culture within their Church body.

- 4.3 The Inclusion Group proactively promotes and supports events and initiatives across the year, with input from key advocates including the Disability Advisor, Racial Justice Support Officer and an LGBTQ+ representative. They utilise an *inclusion belonging activity calendar* for the year and adapt activities to be more inclusive of others. For example, January's '*Run Every Day*' theme was changed to '*Move Every Day*' incorporating at-desk / chair exercises. This is good practice.
- 4.4 The DBF's commitment to actively promoting inclusion involves a range of smart initiatives.

These include *Taster* Equity, Diversity and Inclusion (EDI) sessions that encourage discussion about respect and inclusion in the workplace, as well as their focused *Lunch and Learn* meetings. So far, these meetings have provided an introduction to equity, diversity and inclusion and a session on microaggressions. They operate with sensible caveats on confidentiality, providing a safe space for discussion (within safeguarding expectations and principles). It is positive that this important issue is being addressed and that the workforce is encouraged to engage in conversations within safe spaces.

- 4.5 Some staff who spoke to the Audit were very sensitive to these issues and raised questions relating to the potential for a perception of bias related to the imposition of middle-class values and concerns. Others highlighted the potential for unconscious bias and how this might positively or negatively impact on the appetite of individuals to engage with safeguarding issues. The Audit welcomes this insightful and challenging thinking and believes this is an area the DBF should consider by encouraging further reflection.

Recommendation D2: To deal with the positive and negative issues associated with unconscious bias, the DBF should utilise Lunch and Learn Sessions, discussions during supervision and personal development reviews in consultation with the NST (as part of any updates to training).

- 4.6 Beyond creating opportunities for its community to learn and grow, the Audit saw evidence that the DBF was putting its commitment to EDI into practice. This was evident in the way it has broadened and diversified representation across its governance and Safeguarding Team and its approach to raising awareness regarding the legacy of slavery in the city and beyond.
- 4.7 From a safeguarding leadership perspective, there are clear roles and responsibilities as they relate to safeguarding, and the overall accountability of the Bishop is both understood

and unambiguously accepted by them. The Audit observed a firm leadership focus on safeguarding and saw evidence that steps had been taken to reinforce policy and practice and to address Church-based abuse, past and present.

- 4.8 The Bishop leads by example and has led on the work to build a welcoming and inclusive environment. This approach is reflected in the actions and echoed in the shared language used by leaders across the Diocese's footprint.
- 4.9 Those in key roles engaged appropriately and frequently with the DSO and Diocesan Safeguarding Team (DST). They could explain how their functions relate to safeguarding, were clear about pathways for advice and support and could give examples of effective safeguarding practice in the context of their role. For example, the Archdeacon took a strong position on the completion of the Churchwarden's self-declaration prior to being sworn into office. In simple terms, if they do not sign the self-declaration, they cannot be admitted as a Warden. This is recognised as good practice.
- 4.10 The use of visitations (known as Triennial Inspections), in the context of safeguarding assurance also reflects good practice. They are well structured and planned, focused on contextually relevant safeguarding issues and appropriately recorded. The Audit believes this positive approach could be further strengthened by the adoption of consistent timeframes for follow up when remedial action is required.

Recommendation D3: Visitations (known as Triennial Inspections) could be further strengthened by the adoption of consistent timeframes for follow up when remedial action is required, i.e. three-to-six-month periods.

- 4.11 The Audit was impressed by the safeguarding focus of the Mission and Ministry Team. They are involved in the oversight, development, support and vetting of those on their

discernment journey to ordination. The team's approach was found to be reflective, thoughtful and safeguarding focused. When safeguarding concerns could not be resolved during a discernment journey, it was clear from the evidence obtained by the Audit that the team were prepared to defer or reject the candidate. This is good practice.

- 4.12 When questioned regarding reference checks and follow-ups, the Mission and Ministry Team highlighted that the process could be improved (at a national level) regarding the validation process. The Audit agrees.
- 4.13 There is good evidence of effective collaboration between the DST and other internal departments. For example, in supporting safer recruitment, the work carried out by the Bishop's Chaplain and the DSO in reviewing Blue Files (for Clergy joining or leaving the Diocese) has been a strength. Good practice was also evident in the support provided for visitations (known as Triennial Inspections), the mission and ministry teams, engagement with parishes and safety planning.
- 4.14 The DSSG meets quarterly. This in essence reflects the roles and responsibilities of a Diocesan Safeguarding Advisory Panel (DSAP). The DSSG is strengthening and becoming more focused under the current leadership. There is a firm and appropriate focus on safeguarding activity that spans the DBF, parishes and the Cathedral and a renewed focus (and sense of pace) is evident in the minutes and actions from the meetings, not least in the focus on Parish Dashboards and the development of Safeguarding Hubs.
- 4.15 The membership is primarily internal, or parish-based, but also includes representatives from the Cathedral, Trinity College and, on occasion, some statutory agencies. Maintaining frequent and routine participation from statutory agencies is challenging and in the present environment, unlikely to be consistently achieved (especially in a Diocese that straddles multiple Local Authority and Police boundaries). To this end, outreach from the Chair and

members of the DSSG to key statutory partners, with a fixed and focused agenda, is more likely to achieve line of sight and agreement on relevant safeguarding issues.

Recommendation D4: The Chair or other representative of the DSSG should attempt to engage quarterly in outreach to relative statutory partners (Police, health, Children and Adult Social Care or alternatively, the chair of appropriate children or adult’s partnerships). This should be focused with a fixed agenda to discuss current safeguarding trends, themes and patterns.

4.16 The DSSG has recently met with the ‘Equality, Diversity and Inclusion Advisers’ and minutes of that meeting suggest there is a good working relationship. The Audit takes the view that broadening the membership of the DSSG to include representatives from the wider community within which the Diocese sits would be a strength. This could, for example, involve representatives from any local charities who engage with activities, such as support for the homeless and foodbanks. This would potentially enhance local insight, consolidate partnerships and provide diverse external challenge.

Recommendation D5: The Chair of the DSSG should consider broadening the membership of the DSSG to include representatives from the wider community within which the Diocese sits. This could, for example, involve representatives from local charities who engage with activities, such as support for the homeless and foodbanks.

4.17 The DSSG has proven to be a useful forum to help drive change and improvement and this is reflected in its quarterly monitoring of key issues. A good example is the improved trajectory of training compliance over the last three quarters. Furthermore, its approach to learning, by considering the relevance of LLRs from other areas, is positive. The Audit is reassured that moving forward, more can and will be done by the DSSG to enhance and target its scrutiny and support.

4.18 That said, the DSSG could benefit from re-structuring its functions to a defined learning and improvement framework. This framework could help apply a greater emphasis on quality assurance and systematically consider data, the voices of victims / survivors, children and young people, as well as workforce audits, LLRs and any external learning relevant to local themes. This framework would enhance the DSSG's ability to better support the governance roles (Trustees) at the Diocesan Synod and at the Bishops Council.

Recommendation D6: In consultation with the DSO, the DSSG should consider how it could enhance its oversight and scrutiny by adopting a defined learning and improvement framework.

4.19 Whilst an issue for the national Church, the Audit takes the view that formalising the DSSG's role as an authoritative rather than advisory body would reinforce its independence, enhance overall scrutiny and sit comfortably with the DSO model.

Director of Safeguarding

4.20 The Director of People and Safeguarding post is transitioning, and this may provide an opportunity to consider how the focus on safeguarding at a strategic level across the DBF and the Cathedral could be reconfigured.

4.21 An option would be to consider a dedicated Director of Safeguarding. Such a strategic post would form part of the Senior Leadership Team, provide wider strategic support to the DBF, parishes and the Cathedral, and act as a critical friend / professional safeguarding advisor to the Bishop, Dean and those leading safeguarding oversight on governing bodies. This strategic role could provide the capacity to proactively promote safeguarding at all levels, whilst providing additional leadership, supervision and support to the operational Safeguarding Team.

4.22 Critically, such a post would provide the capacity to oversee the implementation of national standards, to drive and coordinate improvement and be the conduit by which a transition to any new system is managed.

Recommendation D7: The DBF should consider the creation of a dedicated Director of Safeguarding role.

Diocesan Safeguarding Team (DST)

4.23 The operational delivery of safeguarding via the DST is universally recognised and appreciated across the DBF, parishes, the Cathedral and College. The team is made up of a capable and blended group of suitably qualified professionals, led by a highly effective DSO and supported by a Director of People, Safeguarding and ED&I.

4.24 The DSO is a registered social worker, who has experience working in children's social care, health and safeguarding children and adult partnerships. Their team has been structured in such a way as to maximise the skills and abilities of its members. There is a former senior police officer with experience of offender management and public protection, a trainer with significant and credible safeguarding expertise, an early-years professional who is adept at working with anxious and vulnerable people and a member of staff who has worked with looked-after children. This multi-agency background is managed to good effect, with cases being assigned on the basis of experience and ability, as well as through the intelligent use of 'in team' mentoring to share and broaden experience.

4.25 The team is relied upon to support key governance, leadership and scrutiny functions, as well as core groups, safety plans and HR / Clergy Disciplinary Measures (CDM) meetings. It provides safeguarding advice, case management and training across the DBF, parishes and, via a Service Level Agreement (SLA), supports the safeguarding arrangements of the Cathedral and Trinity College.

- 4.26 The SLA with Trinity College is known as the Safeguarding Support and Procedure Protocol. This requires the DST to provide support by way of its attendance at staff termly meetings, safeguarding training and the provision of case consultations. The College provides access to its Safeguarding Children and Adults at Risk policy statement (which mentions the role of the DSO) via its website. This was agreed by the College's governing body in December 2014 and revised in 2018 and 2023.
- 4.27 The College is a registered charity and therefore subject to Charity Commission guidelines. Its 2023 annual report to the Charity Commission identified the potential for negative impact arising from controversies in the CofE. This is a reasonable position to take. That said, there is little by way of an overarching baseline assurance for the DBF that the College does not represent a risk to its reputation.
- 4.28 Whilst the College was the subject of a CofE *Periodic External Review* in 2018 / 19 (followed by an update report in January 2021), there is little within these reports to indicate a root and branch assessment of its safeguarding arrangements. The Audit takes the view that it would be reasonable for the DBF to ask the College to commission an independent review in this respect. This could be done in consultation with the DSO and the DSSG. Such a review would provide reassurance to the Diocese and identify strengths and potential areas for improvement.

Recommendation D8: In order to underwrite the SLA and provide assurance for the DBF that baseline safeguarding is fit for purpose, the DBF should request that Trinity College undergo a full independent safeguarding review. The Terms of Reference for which should be agreed with the DSO.

- 4.29 Safeguarding partners engaged by the Audit expressed confidence in the DST regarding its engagement and collaboration with key external agencies, not least the Local Authority Designated Officer (LADO). The DST also proactively completed the safeguarding self-assessment process for local safeguarding partnerships. This is good practice.
- 4.30 The Audit has acknowledged that the DST is universally recognised and appreciated. However, Auditors were also made aware of the frustrations that some people felt when access to the DST / DSO was more difficult. Some within parishes felt that they could rely on the DST for immediate support in a crisis, but that it became more difficult to make contact when dealing with low-level issues. Some also felt that the lack of resource could impact on the information being cascaded via PSOs to Churchwardens, with some of the wardens stating that when any questions were asked, they were directed to the website.
- 4.31 Demand is always difficult to manage and whilst the smart build of the DST enables them to punch well above their weight in numbers, resilience needs to be considered.
- 4.32 To this end, the Audit makes the following recommendation.

Recommendation D9: The current safeguarding staff across the DBF and Cathedral should be consolidated. This consolidation should include the proposed Director of Safeguarding role and the assimilation of the Safeguarding and Pastoral Officer (SPO) within the DST. The SPO would remain a dedicated Cathedral resource but benefit from professional safeguarding supervision. This would enhance the overall experience within the team and provide additional resilience when faced with increased demand or extractions.

- 4.33 This would not prevent an appropriate ‘dotted line’ regarding day-to-day management to the Chief Operating Officer (COO). That said, the current range of responsibilities that have evolved around the SPO’s role also need to be reviewed and consideration given as to whether their span of control is sustainable (this is addressed in Part Two of the Audit Report).
- 4.34 The DSO and members of the DST engaged by the Audit recognised the challenges faced by PSOs at the safeguarding frontline in parishes. Many have other jobs, and all are volunteers. To support them better, the DSO has applied an artificially low threshold. This increases the work of the DST but minimises the risk that a case will be missed. In the context of the current environment, this is good practice.

5 Prevention

- 5.1 There are strong safer recruitment practices within the DBF and across the Diocese. These range from establishing role descriptions and asking appropriate safeguarding questions during interviews to reference gathering and role specific vetting and barring checks.
- 5.2 The DBF was able to provide evidence of the measures it had taken in circumstances where obtaining a reference had proved challenging. This involved prompts made to the referee via the candidate and alternative referees being requested. Further good practice was highlighted through a weekly process that enables the DST to assess DBS checks across the entire Diocese and take action as appropriate. Furthermore, when information about a safeguarding related or violent offence is included in a DBS certificate, a DBS risk assessment is undertaken.

Recommendation D10: The DBF should amend the DBS risk assessment template to state that DBS checks are required every three years to replace their current version which states five years.

- 5.3 The Audit holds the opinion that advertising is an area that could benefit from an improved approach to raising awareness about its commitment to safeguarding. For example, opportunities are being missed by the DBF when they fail to reinforce key messages about requiring a commitment to safeguarding. This is a helpful way of setting out expectations from the beginning of an employment journey.

Recommendation D11: The DBF should ensure that its commitment to safeguarding is embedded in all job adverts, as is the case with application forms and job descriptions.

- 5.4 The DBF oversees and tests the sufficiency of safer recruitment practices within parishes via the Safeguarding Dashboards and the Safeguarding Hubs. As an early adopter of the Parish Dashboard, the Diocese has been able to encourage and drive participation. At the time of writing 80% of parishes are registered as active users. The DBF provides support for the Parish Dashboard through a range of methods. These include introductory videos, online FAQs, one-to-one inductions, PSO forums and other engagements with Parish Officers, for example, during Triennial Inspections. This is good practice.
- 5.5 The Audit acknowledges that understanding and maintaining appropriate boundaries is key for professionals and volunteers. In recognition of these limits, the DBF provides a range of good practice templates for those in parishes working with children, young people and adults.
- 5.6 It is positive that relevant templates include reference to contemporary methods of communication and outline what constitutes inappropriate behaviour on social media. For example, refraining from ‘friending’ young people on social media or taking photos of them at Church events (unless authorised to do so and parent / carer consent has been sought). The DBF provides five template parish policies:
- Parish Safeguarding Policy
 - Parish Domestic Abuse Statement
 - Parish Policy on the Recruitment of Ex-Offenders
 - Parish Policy Statement and Code of Conduct
 - Safeguarding Report for the Annual Parochial Church Meeting (APCM).
- 5.7 The Audit is aware that not all parishes have policies that are easily accessible and believes practice could be strengthened by adopting and publishing such materials on their websites and within their settings.

Recommendation D12: The DBF should identify areas, processes or techniques to raise awareness and encourage parishes to adopt and make accessible the template policies provided by the DBF.

- 5.8 The DBF has a Code of Conduct for staff that is covered by its Dignity at Work Policy. Throughout the Diocese, the DBF promotes a Code of Conduct template for use by all parishes, which can be adapted if necessary. While adopting this policy is optional for parishes, the Audit recognises that encouraging parishes in this way is good practice. Findings from the Audit's Parish and DBF Workforce surveys evidence that the majority of respondents follow the Code of Conduct.
- 5.9 Raising awareness of different types of abuse and promoting appropriate actions is a key component to good safeguarding practice. The DBF has committed to raising awareness for different types of abuse and harm that may occur to children, young people and adults. In order to do this, they utilise a range of communication methods, for example, they have published an [opinion piece](#) in the Church Times on modern slavery and shared articles on gender-based violence via their website. Additionally, safeguarding awareness raising posters are given to parishes upon request.
- 5.10 Other measures utilised in the prevention of abuse include the effective and meaningful discussion of safeguarding related themes throughout the Diocese. The Audit saw examples of this in practice via meetings held with the SLT, Bishop's Staff, Area Deans, Lay Chairs, PSO Forums and Safeguarding Sunday. One example involved a Licensed Lay Minister (LLM) delivering a sermon and reflecting on their own experiences of domestic abuse, the impact it had on both their personal and spiritual life and their experiences of the Church. The influence this had was significant, with one Parochial Church Council (PCC) member who had been reluctant to engage with training later

stating, '*I get it now*'. Other good practice includes arrangements whereby the DSO holds structured one-to-one meetings with all recently appointed incumbents who are newly licensed to the Parish.

- 5.11 It is noteworthy that there are new and emerging networks of PSOs being established throughout the Diocese. This facilitates better connection and support between PSOs who are able to share their experiences and learn from one another. This good practice should be nurtured and further developed.

Recommendation D13: The DBF should facilitate regular networking events for PSOs to learn and share good practice.

- a) The DBF should facilitate an annual PSO networking event where they are able to come together and hear from leading safeguarding professionals on new and emerging themes as they relate to their role.

- 5.12 Strong communication is key to effective prevention across the Diocese. Clear lines of communication help to make sure that everyone engaged with the Church is aware of safeguarding expectations, issues, policies and how to raise concerns and access support. The DBF acknowledges that there is no 'one size fits all' approach for communication and it is flexible to the needs of those they are in contact with. This is highlighted on the Bristol Diocese's [Reporting a Concern](#) webpage, where accessible communication has been provided via the embedding of two British Sign Language videos; one for children and one for adults. This is good practice.

- 5.13 The Audit is aware that the communications team within the DBF is relatively new, and they are currently developing a safeguarding communications strategy which will be implemented across the Diocese.

- 5.14 The DBF has an active online presence on Facebook, Instagram and TikTok. The restructure that the [DBF Safeguarding webpage](#) has recently undergone has had a positive impact on the end-users' experience. There is a logical flow to the navigation and there is a content hierarchy. Users are provided access to various policies, templates, guidance and resources relevant to their role. External signposting is also available. For example, victims and survivors of abuse are directed to a range of organisations who can provide support.
- 5.15 The DST issues a monthly email newsletter to all PSOs, administrators and legal recruiters. This method of communication is preferred by PSOs.
- 5.16 The Audit recognise this as broadly sufficient. However, deeper insights into the impact and engagement of the correspondence could provide useful data and the Audit makes the following recommendation to strengthen this practice.

Recommendation D14: The DBF should adopt the use of an email marketing system for issuing and managing the safeguarding newsletter.

Recommendation D15: The DBF should consider including a mechanism for an audience wider than PSOs, administrators and lead recruiters to subscribe to its monthly safeguarding newsletter via the website.

- 5.17 As with all good communication, this needs to be a two-way process. Actively seeking and responding to the views of children, young people and vulnerable adults is a key component to effective prevention planning. The Audit is aware that practice in this area could also be strengthened and makes the following recommendation.

Recommendation D16: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, vulnerable adults, and survivors within safeguarding prevention planning.

5.18 The DBF has in place a Lone Working Policy which applies to all temporary and permanent team members, volunteers and where appropriate, contractors. The policy outlines that whilst Clergy or Parish Office members are not specifically referenced within its scope, in the absence of a Lone Working Policy in their own Parish, many of the principles will apply to them. It is positive that further work has been undertaken to develop a deeper understanding of this policy and how to apply it in practice via the delivery of Personal Safety Workshops.

5.19 The DBF has introduced a Digital Safeguarding Policy, which describes how it aims to address risks associated with digital engagement. Covering a range of relevant issues, the Audit recognises the development of this policy as good practice. That said, when the Audit explored how it was being operationalised and evaluated, the DBF recognised that there is more work to be done.

Recommendation D17: The DBF should review and take steps to raise awareness and embed the Digital Safeguarding Policy throughout the DBF.

5.20 The Audit assessed preventative measures and risks associated with physical buildings. It is reassuring that within the template policies provided by the DBF, there is guidance on conducting home visits and the behaviour required at these times. For example, leaving bedroom doors open if the person is confined to a bed and only going into rooms when you are invited to do so. Furthermore, it is positive that, on request, the Disability Advisor can offer a disability audit to support parishes within their communities.

6 Recognising, Assessing and Managing Risk

- 6.1 Arrangements are in place that support the recognition, assessment, and management of risk across the Diocese. These include the appointment of an experienced DST, embedding safeguarding guidance and direction through policies, training and awareness raising. Clear and established reporting pathways exist and overall, the structures increase the likelihood of early risk detection, collaborative decision making, assessment and timely interventions.
- 6.2 The DBF risk register covers, as would be expected, key corporate issues. There is appropriate oversight with annual updates, alongside reports to the Diocese Audit and Risk Committee and Bishop's Council. There is a specific safeguarding section with concerns well documented. Whilst the safeguarding element of the risk register is good, it could be sharper, by including other risks that are both relevant and contemporary issues for the Church, such as the cost-of-living crisis and the uncertainty and anxiety that is evident throughout the workforce since the publication of the Jay Report.

Recommendation D18: The DBF risk register should be developed to address contemporary and contextual issues.

- 6.3 Safeguarding concerns are appropriately triaged with the DSO sensibly setting their threshold at a low level to encourage contact. This process is as much about providing advice and guidance as it is about building trust and relationships with those in safeguarding roles. This helps create the conditions where concerns are more likely than not to be escalated to the DST. It allows for a good line of sight on issues where the risk may not be properly understood by the reporting person. This approach is good practice.

6.4 In Autumn 2022, the national case management system MyConcern, was adopted and implemented. Whilst feedback indicates the system is not considered ideal, the DST make good and thoughtful use of it.

6.5 At the time of the Audit, there were 613 open concerns, with 245 filed and 491 showing no case owner. Some of these cases could be closed and archived, although given the wider activity of the DSO and DST, capacity is likely to be a critical issue. In order to avoid unhelpful extraction, the DSO could set terms of reference and utilise a suitably qualified consultant to cleanse the data.

Recommendation D19: The DBF should commission an external resource (operating to terms of reference set by the DSO) to review, cleanse and archive the data held on MyConcern.

6.6 The nature of the cases managed by the DST represent a range of threats, risks and harms. Some involve contemporary concerns whilst others relate to non-recent abuse and / or serious criminal conduct. The recording of the rationale for decision-making (as it relates to cases where specific actions aren't deemed necessary) is an area identified as requiring improvement. As an example, this could include a decision not to examine CCTV recordings even if such recordings were available.

Recommendation D20: Entries on MyConcern should provide a rationale for any 'inaction' on cases, where decisions have been made by the DSO / DST not to take a particular action.

6.7 Of the cases managed by the DST, decisions typically involve one or a combination of four general outcomes:

- a) Onward referrals to statutory authorities.
- b) The management of individuals within the worshipping community.

- c) The provision / signposting to support.
 - d) The initiation of disciplinary processes, such as the Clergy Discipline Measure (CDM).
- 6.8 Risk assessments conducted by the DST are initiated in response to concerns involving church officials, members of the religious community, or individuals from specific high-risk categories seeking participation in Church events or services. These assessments adhere to national directives and prioritise the safety of victims, potential victims, and vulnerable individuals.
- 6.9 For safeguarding agreements, these appropriately set clear prohibitions and actions regarding expected behaviours, consistently record review dates and contain written signatures from relevant stakeholders, including the *respondent*. The agreements are well-defined, proportionate and authorised appropriately. There is evidence of a multi-agency approach, with there being routine information sharing with the Police, Probation service and LADOs. Alongside mitigating the risk derived from an individual, the safety and welfare of those posing the risk is also properly considered. The Audit was informed that the DST provide significant and appropriate levels of support to help parishes monitor those subject to safeguarding agreements.
- 6.10 The Audit was made aware of a shift in approach in recent years with a “*tightening up of process*” and provided with an example of how this impacted an existing agreement. This resulted in a more rigorous approach regarding managing a respondent’s behaviour and despite this being “*painful for them and their family*”, a new agreement was signed. The Audit recognises the ‘safeguarding first’ approach taken by staff in this instance and acknowledges it as good, authoritative practice.

6.11 The number of agreements (15) at the time of the Audit does not reflect the amount of work that is currently being undertaken by the team to set up and continually review these arrangements. Managing safeguarding issues which can arise indirectly from those attending Trinity College, can result in safeguarding agreements, coupled with the longevity of some of these arrangements (being in place for many years), continue to impact the capacity within the DST. This is creating pressures by way of out of hours working and the ability of the DST to manage the demands placed on it.

Recommendation D21: The arrangements with Trinity College regarding the monitoring of safeguarding issues and agreements should be reviewed to alleviate workloads for the DST.

6.12 There is no specific training on offender behaviours, although the Audit was made aware that discussions did take place during the Diocesan Safeguarding Steering Group 2023 (DSSG) to explore the possibility of including a module on sex offender behaviours and risk assessments in the clergy training programme. The importance of this training was highlighted when one member of a focus group explained how an offender, not attached to their Church, had requested to meet with them.

6.13 *“This person that wasn’t allowed to join my Church was an offender and was contacting me and asked for a meeting...he was definitely manipulating me...attempting to manipulate me.”*

6.14 The Audit recommends this training should be implemented and include roles beyond the suggested cohort.

Recommendation D22: Whilst the development of training is a national issue, as an interim measure, the DBF should consider commissioning targeted training specifically on offender behaviours for those engaged with safeguarding agreements, such as Link workers, clergy and PSOs.

6.15 The Audit requested to meet with an individual subject to a safeguarding agreement, but unfortunately, despite concerted efforts from clergy and the DST, this could not be accommodated.

6.16 Although practice guidance regarding Core Groups is available at a national level, not all Core Groups representatives possess complete understanding or clarity regarding their roles or responsibilities. Challenges may also arise in convening the group.

Recommendation D23: The DBF should communicate and reinforce the responsibilities for Core Group members at a local level in line with the CofE House of Bishop's Guidance.

6.17 The DBF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. Support and practice guidance is available at a national level regarding SIR referrals. The Audit was informed that one case had met the threshold for a SIR in the last 12 months. From a dip sample of cases over a three-year period, submissions aligned with national guidance in terms of actual or suspected criminal activity, with evidence of Trustees being informed and reports being shared with the NST. There was further evidence of timely reports, updates to the Charity Commission and a multi-agency approach to concerns.

6.18 Whilst information sharing between the police and the CofE is governed via a national data sharing agreement, during interviews, there was limited knowledge about this or use of it as a guide to practice. For most, they felt that information sharing was primarily based on good relations with the police or other agencies.

Recommendation D24: The DBF team should raise awareness of the National Data Sharing Agreement between the National Police Chiefs' Council and the Church of England within the Diocese and raise the profile with police forces through the NST.

6.19 The Audit was told there is no defined escalation process in place to manage differences of opinion about the decisions and action taken on safeguarding cases. Where such incidents occur, there is access to guidance in the Diocesan Safeguarding Complaints procedure. In the first instance, complaints can be raised with the Director of People and Safeguarding.

Recommendation D25: The DBF should develop and implement a defined escalation processes for dealing with differences of opinion regarding decision making and actions taken on safeguarding cases.

6.20 The newly implemented national MyConcern safeguarding case management system in Bristol covers the DBF and Cathedral. It is a centralised and secure database, allowing for safeguarding concerns to be reported, and recorded. There is also a facility to attach relevant case reports, correspondence and documentation in one place.

6.21 Whilst seen as a positive development, there is room for improvement both in terms of the national system itself and the application of its functionality. For example, some of the

system's terminology is outdated referring to 'historic' concerns and there is no simple mechanism to identify concerns where Core Groups have been convened.

6.22 There are widespread frustrations among users with the system. It was commonly described as “clunky”, and “a case recording system as opposed to a case management system”, with the general consensus being that it lacks the full functionality to meet the needs of the DST. One significant area of concern is the inability to share information across Dioceses regarding individuals of concern. This not only poses a risk due to information not being shared, but also affects time management, as the team resort to phone calls and other manual efforts to gather and disseminate information when necessary. The long-term impact of the adopted system is not yet known but despite these limitations, the DST is making good use of it.

Recommendation D26: The DBF should continue to review the effectiveness of the MyConcern system and engage at a national level to ensure the system meets local needs.

6.23 There is a defined process in place to support the quality assurance of safeguarding cases. This involves supervision meetings with the DSO (every six weeks) chaired by the NST Regional Safeguarding Lead.

6.24 Whilst the NST lead is sighted on cases that the DST are working on, supervision tends to focus on the more significant or complex cases. There is no scrutiny of cases where the DST has directed no further action and / or provided advice and guidance. To further support the DSO and to quality assure practice in the context of accurate decision making and thresholds, the following recommendation is made.

Recommendation D27: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DST and NST. This will also be raised by the Audit with the NST.

6.25 Whilst the arrangements with the NST are broadly positive, internal supervision within the DST could be improved. Current sessions lack formal documentation and agendas. Whilst quality assurance is taking place, the approach is ad-hoc and would benefit from a structured framework. More routine management oversight is likely to help identify any potential practice issues and learning needs for the team.

6.26 There is no daily oversight of the DSO by a suitably qualified manager with safeguarding expertise. This leaves the DSO role exposed. Whilst much of the casework seen was very good, everyone is prone to human error. The proposed Director of Safeguarding role could help address this issue.

Recommendation D28: Based on the Audit's observations, it is recommended that structured supervision processes be implemented locally within the DST.

6.27 The storage of personal information held by the DST on MyConcern is compliant with data protection legislation and the UK General Data Protection Regulations (UK GDPR). Additional security arrangements include secure email systems, locked cabinets and the shredding of confidential documents. Online training is provided for DBF staff, although there is reportedly no equivalent for parish volunteer roles. Some clergy with access at a deanery level or higher are also required to complete this training.

Recommendation D29: Data protection training should be prioritised and completed by clergy, DBF staff and parish volunteers dealing with personal or confidential information.

6.28 The Service Level Protocol in place across the DBF and the Cathedral sets out clear parameters governing the legal and best practice requirements for information sharing.

7 Victims and Survivors

- 7.1 For many victims and survivors, disclosing the abuse they have suffered can be exceptionally challenging. Some will carry their pain in silence, others will come forward, but only when they are ready to do so. The decisions that need to be made in this respect will never be easy, but in the absence of any witnesses, they are ultimately decisions for victims and survivors alone.
- 7.2 In this context, it is essential that all Church bodies create the conditions that build confidence amongst victims and survivors that they will be heard, taken seriously and that help, and protection will be effective. To do this, strong leadership, a healthy culture and robust arrangements for enduring support are key.
- 7.3 Within Bristol, the Bishop has an open and welcoming approach to victims and survivors and the Audit saw evidence of strategic intent translating to good practice. In fact, it was clear that the Bishop has put the needs of victims before what some people class as the needs of the Church. This has helped some victims and survivors in terms of their needs being met, their healing process and their search for justice. Activity is underpinned by the Diocese of Bristol's Survivor Support Strategy 2023. This short, but focused document sets out a range of issues covering engagement and the response to specific cases. Its simplicity is effective in highlighting key priorities.
- 7.4 That said, in line with some of the feedback provided to the Audit from victims and survivors, the DBF recognises that there is more work to be done in this space. For example, whilst individual engagement takes place on a case-by-case basis, there is no formal architecture in place for this to happen more broadly. This could help to create valuable insights for the DBF and enable victims / survivors to have a much clearer role in helping to shape local strategy and services. Whilst some mechanisms exist through which

the views of victims / survivors are captured (such as through reporting to the DSSG by its members), the absence of more structured engagement means that the development of working partnerships with victims / survivors is not being optimised.

7.5 The Audit understands that regional DBFs are exploring how best to pool resources in this area and develop a protocol to improve consistency. In this respect, no specific recommendations are made.

7.6 With regards to reporting abuse, the Audit saw evidence of good compliance with many of the national standards on victims and survivors. Via its analysis of casework, there were examples of effective practice with victims and survivors being '*heard, understood, respected, taken seriously, genuinely cared for, and met with belief*'. Practice reflected the Diocese's strategy, with the DST taking a proactive approach in response to allegations of abuse and ensuring that victims / survivors were supported with care and compassion, signposted to relevant help and provided with the information and assistance they required.

7.7 That said, some of the views expressed to the Audit (as part of the victim / survivor survey) reflected different experiences. Whilst responses were low in number (five), there was significantly less confidence in how their individual cases had been managed. None had felt empowered to report their concerns, none believed they had received effective support, none believed their safety had been prioritised and there were concerns that the reputation of the Church had taken precedence over safeguarding. This feedback, uncomfortable as it is, reinforces the need for the DBF to maintain engagement and person-centred support whenever and wherever possible. It also reflects the need to continually reflect on the sufficiency of practice and the processes in place to quality assure it.

7.8 An Auditor was able to engage with a survivor of Church-based abuse. They highlighted how early in their engagement with the DSO and Bishop they felt believed and that this made a huge difference to them. They were pleased at the steps taken to hold the perpetrator to account and felt reassured that help and support was available to them when and where they needed it.

7.9 They told the Auditor how important it was for them that when the DSO and members of the DST didn't have an answer regarding a question or concern, that they made enquiries and got the answers. Once the formal process had begun, they felt frustrated and anxious when they didn't know what was happening and they reinforced how important it is to be part of the process, to know where the process is and what to expect next. On those occasions when nothing was happening and contact lapsed, they felt isolated and anxious. This reinforces how important it is to maintain frequent and regular contact even when it is a simple update to say there is nothing to report. The emphasis is on the victim and survivor retaining control.

Recommendation D30: When supporting a victim and survivor it is important to set check in points, that once agreed are followed up, even if only to say that there is nothing further to report (the wishes of individuals should be established, and times agreed in advance).

7.10 Other feedback from the victim / survivor highlighted the importance of managing expectations. Their advice was to only promise that which is within your gift and when passing on their complaint, ensure to tell them what is going to happen, what will be shared and with whom and critically, what that might mean by way of others contacting them.

Recommendation D31: When engaging with a victim / survivor manage expectations and provide information about what you are going to do and what that might mean for them.

- 7.11 The victim / survivor also highlighted the importance of the availability of a female safeguarding advisor and the value of being involved in co-production of training.
- 7.12 Notwithstanding some areas that could be improved, the feedback was overwhelmingly positive, and they were glad they had come forward.
- 7.13 In terms of making victims and survivors aware of the routes of disclosure, there is a good range of promotional material and advice on the Diocese of Bristol's website. This includes key contact details, reporting routes, information sharing guidance and contact details for statutory agencies. For staff and volunteers, the DBF has also introduced a credit card sized 'z-card' which covers the key steps to take if harm or abuse is known or suspected. This is simple, yet good and effective practice. The website also sets out the details of services such as 'Safe Spaces' and those focused on sexual assault and domestic violence. Contact information for the DST and a range of external organisations are also available.

Recommendation D32: Once the developments seeking to strengthen victim / survivor engagement have been defined, the Diocese of Bristol website should include information about how victims / survivors can engage with the DBF and contribute to its ongoing developments.

- 7.14 The Audit saw evidence of a strong support network for those affected by safeguarding incidents, whether as a complainant or a respondent. This included the assignment of a 'Link Person' and the provision of pastoral care and / or external support. The Audit also noted good practice with the *Redress Scheme* which is being put in place to provide restitution for victims and survivors, including counselling, emotional wellbeing support, apologies and financial recompense.

8 Learning, Supervision and Support

- 8.1 The importance of having clear arrangements for learning, supervision and support is understood and actioned by the DBF.
- 8.2 The Diocesan Training Strategy sets out a good framework to ensure that all Church Officers are trained in aspects of safeguarding relevant to their role. It properly reflects the need for staff and volunteers to develop the necessary knowledge, attitude and skills to effectively safeguard and protect children, young people and vulnerable adults. It also emphasises the unique nature of the Church environment and the need for safeguarding to be rooted in all aspects of the life and ministry of the Church. This supports the national CofE Safeguarding Learning and Development Framework, 2021 (due for renewal 2024) which states: “...safeguarding needs to move away from something that is in some respects external / imposed upon the Church, to something that flows from within the soul of the Church.”
- 8.3 A dedicated training role within the DST allows for focus and facilitation, with delivery being both face-to-face and via the national e-learning system. There is clarity on the courses available, who should attend the different levels of training and how such opportunities can be accessed.
- 8.4 Most respondents to the Audit’s surveys agreed that they had seen improvements to training across the Diocese. The DST’s contribution in this respect has been significant, enhancing the nationally mandated training with other sessions such as Personal Safety and Mental Health First Aid (MHFA). During 2023, the Disclosure and Barring Service also provided workshops for lead recruiters and in collaboration with the Diocese of Gloucester, bespoke courses for bellringers have been developed. The Audit recognises this as a good practice.

8.5 Whilst reassuring that training is well managed and that the valuable practice of ‘*train the trainer*’ has been adopted, there is space to accrue further benefits. For example, despite training being largely mandated at the national level (and generally focused on virtual delivery), the Audit takes the view that the introduction of more face-to-face training would provide a benefit and be welcomed, not least by those in parishes. That said, gaining evidence of the value and impact of training is key.

8.6 With regards to evaluation, the Audit will be engaging the NST on how it can better support Dioceses in this context, with a particular focus on immediate post-course evaluation. Beyond this, the DBF (supporting its own workforce, the Cathedral and parishes) could approach random cohorts of staff, volunteers and their managers three months after training to identify how they have used what they learnt. This would help build an evidence base of impact. Whilst such an evaluation might be resource intensive and distract members of the current DST from their day-to-day responsibilities, an external consultant with a specific brief could be employed on a short-term contract to deliver a local training evaluation project.

Recommendation D33: The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers, about how training has informed practice and the impact it has had. This could be carried out by an external consultant to avoid extraction or diversion of DST members.

8.7 As part of the evaluation processes, simple questions to participants about possible gaps in training could help to build a picture of what is needed across the Diocese. Other possible mechanisms include targeted surveys and focused discussions with Church Officers in a range of contexts.

Recommendation D34: The DBF should engage with its workforce, develop and implement a specific training needs analysis framework that identifies the range of opportunities available to help identify local learning gaps. Training needs should be considered on an annual basis and used by the DST to design and / or commission local courses to supplement the NST programme.

8.8 As part of its engagement with staff and volunteers and through its review of available evidence, the Audit believes, as previously mentioned in this report, that there is a need for targeted training about sex offenders. Whilst noting the inclusion of this topic within NST training, detailed learning about predators and the nature of offending is both a relevant and current issue for the Church. Furthermore, given the growth in incidents across all of society, where social media and technology are being used to either harm, abuse or facilitate abuse, a greater understanding of safeguarding online is also likely to make people safer. The Audit recognises that overarching responsibility for training in these areas will lie with the NST. However, it would be remiss not to identify these risks and provide the DBF with the opportunity to apply interim mitigation measures.

Recommendation D35: Alongside the recommendation on sex offender training (D20), specific training sessions focused on the topic of digital safeguarding should be introduced into the training programme and made accessible to relevant Church Officers in the DBF, Cathedral and parishes.

8.9 The Audit saw good practice in the development and delivery of training in respect of its style, access, timing and use of trigger warnings. However, some staff and volunteers felt that training can be repetitive. The Audit was also told by some of those it engaged that safeguarding training can be a burden for volunteers, that it is not always seen as relevant and that there are occasions when it should not be delivered online.

- 8.10 The Audit heard that some people are ‘stepping down’ from their roles because they can’t or don’t want to do safeguarding training and fewer people are ‘stepping up’. In response, the DBF is considering a range of measures to better reach and support parishes with regards to training activity. Ideas include establishing PSO networks within deaneries and other supportive outreach. This is good practice. Despite the challenges that such circumstances might create, the Audit fully supports the approach to mandated training and the work of the DBF to achieve full compliance.
- 8.11 Oversight of training is an area of scrutiny for both the DST and DSSG. As a standing item on the DSSG agenda, updates cover quarterly metrics, attendance levels, upcoming training planned, what is working well and areas of challenge. See Recommendation D6.
- 8.12 Core safeguarding training requirements for all those in licensed roles (Clergy, PTO and Licensed Lay Ministers), as well as Parish Safeguarding Officers are monitored by the DST on a quarterly basis. Over the last year, there were 727 e-learning courses recorded as completed and 507 sessions completed in person across the Diocese. From the training compliance documentation reviewed by the Audit, it was noted that there are some areas which require additional focus to reduce the numbers of individuals with expired training.

Recommendation D36: The DBF should engage in targeted approaches to increase the uptake of training by key roles throughout the Diocese.

- 8.13 It is positive that the trainer within the DST has access to external courses and NST sessions. The DBF should explore whether similar opportunities could be made more widely available. For example, the *Keeping Bristol Safer Partnership* (KBSP) delivers a comprehensive multi-agency training programme that is free to ‘contributing agencies’ and £100 per day for others. There may be benefits for the Diocese, in terms of cost, quality and variety by seeking access to this training for some of its workforce.

Recommendation D37: The DBF should engage in discussions with relevant safeguarding partnerships about the potential for Church Officers to access their multi-agency safeguarding training offers.

8.14 The DST is a small, effective team, in which its members are valued, supported and encouraged to be open with each other and learn. The team members exhibit a strong commitment to their work, recognise the value of ongoing learning, and have a developed understanding of the nature of the work they are exposed to.

8.15 In respect of the supervision and support provided for the DST, there is a good range of provision in place. Members of the team have access to appropriate psychological support, there is a South West region peer network and the ability to access external training opportunities. The DSO receives good professional supervision from the regional NST lead. This is highly valued by the DSO. There are arrangements in place that promote a healthy work-life balance for those in safeguarding roles, including flexible working and out-of-hours cover provided by an external company.

8.16 That said, given the context of the DSTs workload and its regular exposure to trauma, psychological support should be more defined within its arrangements. By this, the Audit believes that routine access to such support should be an expectation as opposed to 'available on request'.

Recommendation D38: The DBF should consider implementing mandatory counselling sessions for members of the DST to ensure they are sufficiently supported in the challenging role they do.

8.17 There are good arrangements in place across the Diocese to support members of the clergy. The provision of such support is made available through organisational processes

(e.g. HR) alongside broader measures carried-out by the Bishop, Archdeacons and local ministry structures.

- 8.18 Continued Ministerial Development is embedded and there is the provision of suitable counselling support to anyone dealing with a safeguarding situation if required. There is a good range of support in place for ordinands and arrangements at both local and national level to ensure that candidates have a good understanding of safeguarding and that this is embedded in their practice. Guidance is provided to support Readers and Licensed Lay Ministers (LLM) to develop a deeper understanding of maintaining appropriate boundaries and how to keep themselves safe.
- 8.19 There is a thorough process in place in the Diocese to oversee the discernment process for licensed lay and ordained ministry. The Audit recognise that it is positive that safeguarding is a theme which is explored throughout. For example, the initial registration form outlines the qualities that they are looking for, including the ability to understand safeguarding in Church communities.
- 8.20 When allegations are made against a member of the clergy, they can be helped by a trained 'Link Person' or 'Support Person'. The DST can also provide support when clergy are working as part of a 'Response Group' (and where space is created to reflect with others) or through the DST facilitating one-to-one sessions to discuss / debrief a particular case. For clergy against whom a complaint is made, national Church prescribed processes are in place that facilitate access to support. These arrangements are similarly in place for non-clergy staff. This is good practice.
- 8.21 Whilst Ministerial Development Reviews (MDRs) promote reflection, learning and improvement, an enhanced focus on safeguarding within this process is likely to accrue further benefits. For example, whilst safeguarding training is referenced, MDRs don't

systematically explore what is (or isn't) working more broadly from a safeguarding perspective. Opportunities are being missed to look more deeply into the outcomes being achieved and future areas for growth and development.

8.22 Positively, the Safeguarding Strategy Improvement Plan 2023 outlines an area for improvement as being the structure of MDRs through the inclusion of a dedicated section for safeguarding. The Audit supports this and makes the following recommendation.

Recommendation D39: The structure of the 'safeguarding section' for MDRs should specifically align to the National Safeguarding Standards. This will help shape reflection on both vocation and ministry as they relate to these areas and help to identify both personal and professional training, support and development needs.

8.23 The majority of DBF staff engaged by the Audit confirmed they had received an induction and that this covered what they needed to know about safeguarding. For PSOs, there are defined induction sessions and a meeting with the DSO on their appointment. The arrangements for other parish staff directly employed by a PCC appear to be less well-defined, with just under half of respondents to the parish workforce survey confirming they had received an induction. Clergy who are new to the Diocese undergo a formal induction process which includes a one-to-one meeting with the DSO.

Recommendation D40: The DBF should develop an audit for PCCs to establish compliance levels with induction training. Where individuals are identified who have not had induction training this should be addressed within a specific period of time, i.e. three to six months. Furthermore, this issue should be addressed on any forthcoming visitations (known as Triennial Inspections).

Part Two - Bristol Cathedral

9 Context

- 9.1 The history of Bristol Cathedral traces back to its original foundation as an abbey in 1140, strategically located just outside the original walls of Bristol on elevated ground overlooking the river. Architecturally, the Cathedral underwent significant transformations, evolving from a Romanesque style to a Gothic one between the 13th and early 16th centuries. The iconic 'hall Church' east end, initiated in 1298, stands as a testament to this architectural journey.
- 9.2 Previous donations from the people of Bristol, aided in rebuilding the nave of the Cathedral but were substantially built on the trade in sugar, tobacco and cotton, which until earlier in the century had depended on the labour of enslaved Africans. Acknowledging the complex legacy tied to enslaved labour and racism, Bristol Cathedral is actively addressing the human impact of this history.
- 9.3 Bristol's population, characterised by its diversity, experienced significant growth over the last decade, making it the second fastest-growing Core City in England and Wales. Situated at the heart of the city, the Cathedral attracts approximately 6,000 weekly visitors, with 250 routinely engaging in services and other activities. It also shares proximity with Bristol Cathedral Choir School (BCCS) and Cathedral Primary School (CPS). Despite being smaller relative to other Cathedrals, Bristol Cathedral consistently engages with young people, including the choristers attending nearby schools.

10 Progress

- 10.1 The Independent SCIE Safeguarding Audit of the Cathedral was published in January 2022 and resulted in 31 recommendations. At the time of writing, 16 have been completed, 10 remain in progress and five are unmet. The PCR2 review did not result in any specific recommendations for the Cathedral.
- 10.2 Implementation of the SCIE recommendations has resulted in a significantly higher profile of safeguarding in and across the Cathedral and better confidence levels amongst the workforce and congregation. Improvements are evident in the DST's oversight, systems and approaches to record keeping, case management, training, and DBS tracking.
- 10.3 Those actions in progress include activity to strengthen engagement with children, schools and youth groups, alongside enhanced pastoral oversight and care for choristers. The establishment of the Safeguarding Committee as a committee of Chapter, the adoption of safeguarding as a standing agenda item at key meetings and the additional scrutiny applied by the DSSG, all reflect a positive trajectory. Other work includes the ongoing promotion of values to create a culture where there is accountability.
- 10.4 The five recommendations that are yet to be met relate to seeking feedback from stakeholders, evaluating the impact of training, complaints and the development of a strategy for implementing the CofE's policy on Promoting a Safer Church.
- 10.5 For most, progress has been hindered by resourcing restraints, whilst the recommendations linked to complaints are being subsumed into the governance review linked to Charity Commission registration. Furthermore, notwithstanding the evidence that current practice reflects the principles in *Promoting a Safer Church*, this recommendation is important, and the development of the strategy should be prioritised.

11 Culture, Leadership and Capacity

- 11.1 The Cathedral endeavours to foster a safe, respectful and healthy culture. Evidence of this commitment can be seen in their efforts to create opportunities to listen to their wider community. Such meetings range from volunteer groups and staff one-to-ones to meetings with the worshipping community led by the Dean and supported by key members of the Cathedral leadership team and workforce.
- 11.2 The Dean has publicly committed to open the Cathedral up to everyone. Her drive and ambition for the Cathedral is evident in her relentless commitment to address key contemporary and historic issues. This ranges from efforts to broaden representation across the Chapter to the work of the Dean to *'Blow the doors off the Cathedral'* to ensure it is open to everyone.
- 11.3 This approach is not limited to those beyond the Cathedral doors. There is a credible focus on the health and wellbeing of the workforce and the Audit has seen evidence of an anonymous Bristol Cathedral Staff Survey (2023). This staff survey sought to understand the personal impact of a range of issues on staff. The focus of the audit included the impact of the rising cost of living, mental health and consideration of the impact of unexpected expenditure. It also sought feedback on culture, workloads, support and safeguarding whilst actively encouraging comments and suggestions. This is good practice.
- 11.4 Survey feedback highlighted some of the pressures staff felt, like finding it difficult to switch off outside work or whilst on leave. When asked if working at the Cathedral had ever negatively impacted their mental / physical health 15 members of staff said it had.
- 11.5 That said, when asked by this Independent Audit's anonymous safeguarding survey if they felt safe amongst their colleagues the overwhelming majority said they did, and most felt

that a safeguarding culture was now embedded. Furthermore, respondents also agreed or strongly agreed that Cathedral leaders acted fairly and with integrity.

- 11.6 A minority of people differed from this view and whilst the most common phrases used to describe the culture in the Cathedral were ‘welcoming’, ‘inclusive’, ‘supportive’ and ‘respectful’ a minority of other comments reflected more challenging themes. These included comments about some of the changes in leadership and how, in the opinion of the respondent(s) this has led to confusion regarding messaging, created division and fostered a perception of a lack of empathy.
- 11.7 The worshipping community reflected positive views concerning feeling safe and a view that a safeguarding culture was now embedded. The most frequently used comments to describe culture were positive and included ‘welcoming’, ‘respectful’, ‘supportive’ and ‘empathetic’. That said, an isolated comment from one respondent described the culture as ‘arrogant’.
- 11.8 The Cathedral leaders, staff, volunteers and those with direct or indirect responsibilities for safeguarding maintain a close working relationship with the DSO and DST. The Audit saw evidence of strong collaboration when required and authoritative collective decision making that put safeguarding first. This positive and constructive relationship is also evident in the Cathedral's approach to membership of the DSSG and its close collaboration with other members of that group.
- 11.9 From an overarching leadership perspective, there are clear roles and responsibilities as they relate to safeguarding with the overall accountability of the Dean being both understood and unambiguously accepted by them. The Audit has seen evidence of her authoritative practice and willingness to make difficult, necessary and sometimes unpopular decisions. The senior team, notably the Dean and Chief Operating Officer

ensure that safeguarding responsibilities are discharged and have worked hard to embed an open and responsive culture. There was no evidence that people felt they could not speak 'truth to power'. Those in key roles engaged by Auditors had a firm focus on safeguarding and could explain how what they do relates to it. They also had an understanding about pathways for advice and support.

11.10 Governance at the Cathedral is the responsibility of Chapter, which is chaired by the Dean. Chapter is aware of the need to evidence their safeguarding oversight, insight and challenge, and the Audit saw evidence of reporting from safeguarding leads (the DSO is an advisor) and welcomed the fact that safeguarding is now a standing agenda item.

11.11 As part of the governance restructure in preparation for charity commission registration in September 2023, the safeguarding committee was established as a committee of Chapter to monitor safeguarding across the Cathedral. The safeguarding committee has, by necessity been chaired by the Dean. This could be perceived as problematic. The Dean recognises this and has taken steps to identify a suitable replacement. The Audit welcomes the fact that an independent person will take over the chair and this will remove any perceived or potential conflict of interest.

11.12 The DSO is a member of the safeguarding committee. This is good practice, but it is important to remember that part of the governance role is holding those with operational responsibility to account. Qualified oversight and scrutiny are key.

11.13 The Cathedral Safeguarding and Pastoral Officer (SPO) participates in the DSSG. Whilst this is positive, the focus of the DSSG invariably tilts to the Diocese. Shared governance and oversight involving two bodies can result in the focus on one area (the larger or more prominent) dominating discussion and scrutiny. Some cathedrals have implemented an Independent Safeguarding Advisory Group (ISAG). This can increase focus on those

aspects of safeguarding that are unique to the context and environs of the Cathedral. It can also facilitate the wider participation of those who work with and support the Cathedral community, e.g., charities operating food kitchens or homeless shelters.

11.14 Given the creation of the safeguarding committee, the Cathedral has options about how it develops and whether the current configuration meets their need for independent insight and scrutiny or could be enhanced by the creation of an ISAG. They should also consider whether under the new measures they can introduce a suitably qualified person to act as Independent Chair and / or facilitate wider participation from across the Cathedral community.

Recommendation C1:

- a) The Chapter, Safeguarding Committee and DSSG should carry out a skills audit to test whether there is sufficient safeguarding expertise in their respective cohort.
- b) Whilst the governance arrangements meet the expectations of the Church and the Charity Commission, the safeguarding subcommittee could be strengthened by introducing a fundamentally and suitably qualified independent chair, (or suitably qualified non-executive member).
- c) Consideration could also be given to how it might diversify its membership to include representatives from the wider community in which it sits. For example, charities with which it works.
- d) Consideration should also be given to the benefits of creating an ISAG.

11.15 From an operational safeguarding perspective, the Cathedral employs a SPO. They are responsible for day-to-day safeguarding duties in the Cathedral. Although this is one person, they have multiple responsibilities. The role has evolved based on their ability and existing networks / relationships with the school and choristers. This represents a possible

single point of failure and the potential for a conflict of interests. The Audit is aware that the Cathedral is alive to this issue. They intend to appoint an officer to manage volunteers this year. This will provide an opportunity for them to reflect on roles and realign responsibilities.

Recommendation C2: Any future restructure should consider separating out the current responsibilities of the SPO. This will ensure that these responsibilities do not all lie with one person and will help prevent any potential conflict of interest arising from the consolidation of multiple safeguarding duties.

11.16 That said, the system is currently working, capacity is reinforced and practice reassured via the SLA between the Cathedral and Diocese. This ensures that safety plans, case management and casework advice is available from the DSO and DST.

11.17 The roles and functions of DSO and DST are discussed in detail in Part One of this report. They are a skilled and blended Safeguarding Team with significant experience. Their relationship with the Cathedral is good and whilst the COO is an effective line manager of the SPO, the Audit take the view that consolidating professional safeguarding roles under the leadership of the DSO makes sense. This would mean the SPO and any other dedicated safeguarding staff within the Cathedral would be professionally managed by the DSO ensuring professional safeguarding supervision. This would not undermine or prevent the COO maintaining day to day management of them.

Recommendation C3: The SPO and any other professional safeguarding staff within the Cathedral should be supervised by the DSO.

11.18 See **Recommendation D6** regarding a dedicated Director of Safeguarding.

Chorister Safeguarding

11.19 Based on the information gathered and analysed regarding choristers, the Audit finds the safeguarding practices surrounding this group to be good practice. Whilst areas for improvement exist, effective structures were observed to be in place and staff demonstrated proactivity as well as a robust understanding of the importance of safeguarding.

11.20 Most choristers engaged by the Audit were positive about their experience. They were able to reference positive relationships that have formed because of their role and the vast majority knew who they would go to if they had a concern. Nearly all stated that they would turn to their Chorister Tutor but showed less confidence about turning to other members of staff. That said, the Audit acknowledges the steps taken by the Cathedral to involve an independent safeguarding advocate who engages with the choristers regularly and acts as an additional point of contact for them. This is good practice.

11.21 Although reminders, posters and other prompts can help young people to recognise the team that they have around them, true enhancement comes from improved relationships. In this respect, all chorister related staff should seek to engage with them as often as they can.

11.22 Parents highlighted the pivotal role of the Chorister Tutor, who also serves as the Safeguarding and Pastoral Officer. Both of these roles shoulder much of the responsibility for ensuring good safeguarding practice. Feedback from choristers, parents and staff support the Audit's observations and affirm her excellent performance in this role. While it is positive that the Cathedral possesses such an asset, it is crucial to recognise that safeguarding is the collective responsibility of all individuals engaging with young people within the Cathedral community.

Recommendation C4: Contingency planning should be considered to ensure continuity of effective safeguarding, should the Chorister Tutor role no longer be available.

11.23 Although parents generally view chorister life positively, there remains a desire for improved communication and clarity regarding lines of responsibility. One concern expressed by parents related to supervision during services. The Audit understands that whilst music staff are available to provide support, they may be occupied with musical responsibilities during services. To address this concern, the Cathedral employs additional measures, such as the presence of DBS-checked Vergers, who are available to assist if needed. This is good practice.

11.24 For many of the concerns raised by parents, the answers exist in documentation like the Safeguarding Handbook and the Memorandum of Understanding between the school and the Cathedral. These are good examples of the Cathedral ensuring there are no ambiguities or gaps in supervision, although both are rendered invalid if not regularly communicated.

Recommendation C5: The Cathedral should ensure that information relating to the supervision and lines of responsibility for choristers is regularly communicated to parents.

Recommendation C6: The Cathedral should document the process of supervision during services and ensure this information is adequately communicated to parents.

11.25 The Audit observed good practice in relation to the prevention of risk. For example, upon the choristers' entry into the building, a message is broadcast on the Cathedral speaker, instructing visitors to refrain from taking images while the choristers are singing. However,

considering that the Cathedral welcomes guests who speak various languages, important announcements should be delivered in a range of appropriate languages.

Recommendation C7: The Cathedral should install a variety of pre-recorded languages to be played on the speaker announcement that ask the public to refrain from taking images or videos of the choristers.

11.26 The Cathedral further demonstrates good safeguarding practice by ensuring that choristers are actively involved in their own safety. For instance, choristers receive information about areas covered and not covered by CCTV surveillance. They also participate in practice drills for evacuation and invacuation plans. Moreover, the Choir Tutor has introduced choristers to an additional, concealed exit route in case of emergencies. One chorister parent reported that their child said they felt safer knowing this process.

11.27 Furthermore, all staff members wear coloured lanyards indicating their DBS status and suitability for working with young people. Radios are standard equipment for staff, with earpieces used during special events to maintain uninterrupted communication flow. These measures are considered good practice by the Audit.

11.28 Safety measures in the Song School include a dedicated chorister toilet and a key-coded lock known only to staff. However, it was noted during the Audit that the door to the toilet area in the canteen does not have a handle on one side. It was reassuringly confirmed that there is access from either side in case someone gets locked in. The Audit is aware that building works are due to commence in this area that include the removal of the door. No recommendations will be made here on the proviso that the issue is addressed promptly.

11.29 Parent details are added to *ChurchSuite*, which stores contact details and other important information about each child, such as consent forms or medical information. It is also used for registering the children once they have reached the Cathedral, ensuring a digital record is kept. The Audit observed the efficiency of having digital access to this data on the go.

11.30 An area of concern regarding the temperature in the Song School during warmer months was identified. Whilst Cathedral staff take adequate steps to address this issue, it's important to note the World Health Organisation's maximum recommended temperature for classrooms, which should not exceed 24 degrees².

Recommendation C8: The Cathedral should ensure continued efforts to mitigate the effects of heat during warmer months and install a thermometer to monitor temperatures, ensuring they remain within recommended levels.

² <https://www.nasuwf.org.uk/static/b1e20158-e2d9-456c-8b7e4b8d40668bf3/Excessive-Temperatures-Bulletin-June-2022.pdf>

12 Prevention

- 12.1 Safer recruitment policies and practices are a vital part of creating safer environments, discouraging unsuitable individuals from joining an organisation and preventing harm and abuse of children, young people and vulnerable adults. Bristol Cathedral has a range of measures in place to ensure the safer recruitment of individuals to various roles. Such measures include conducting Basic DBS checks for all staff, relevant staff undergoing safer recruitment training and the gathering of references. Indeed, the Audit is aware that the Cathedral will appoint a Volunteer Coordinator who will have responsibility for safely recruiting and growing the volunteer teams.
- 12.2 The Audit recognised several other areas of good practice. Confidential declaration forms are completed by all those working with children and / or vulnerable adults. ID badges worn by staff, volunteers and visitors indicate the level of DBS check that they have undergone.
- 12.3 An example was provided to the Audit with regards to reference gathering and, despite the pressures of time and challenges in the return of a reference, firm steps were taken to ensure they were obtained prior to the individual commencing their role.
- 12.4 The use of a 'Matrix' provides well-defined guidance on the requirements for DBS checks and relevant training for the range of roles within the Cathedral. Vetting records are stored within a secure internal system with limited access and a separate system, *ChurchSuite*, has been configured to notify relevant personnel when DBS renewals are due.
- 12.5 Notwithstanding the arrangements in place, the Audit believe that safer recruitment processes could be further strengthened by including a 'commitment to safeguarding' statement within all job adverts and job descriptions.

Recommendation C9: The Cathedral should ensure that its commitment to safeguarding is embedded in all job adverts, application forms and job descriptions.

Recommendation C10: The Cathedral should ensure that all relevant staff have completed the national Safer Recruitment training.

- 12.6 Understanding and maintaining appropriate boundaries is key for professionals and volunteers. In this respect, Bristol Cathedral provides advice within the '*Safeguarding Guidance for Bristol Staff and Volunteers*' and its Code of Conduct for those engaging with children, young people or vulnerable adults. It is positive that this guidance contains reference to online behaviours and how staff and volunteers should interact in the online environment.
- 12.7 Maintaining heightened levels of awareness about different types of abuse and risks is vital to ensure that children and adults have a developed understanding of what to look for and how to respond. Safeguarding is promoted in the Cathedral through signage, briefings provided to Chapter, full staff meetings, safeguarding sermons and briefings to volunteers and staff prior to events. It is worthy of note that as a result of visual prompts within the Cathedral, a vulnerable adult recently reached out for support.
- 12.8 The Audit holds the position that awareness raising initiatives could be strengthened by a defined system through which communication about safeguarding topics are scheduled and coordinated. The Audit therefore makes the following recommendation to amplify and increase awareness raising initiatives at the Cathedral.

Recommendation C11: The Cathedral should adopt a systematic approach to identifying key themes for its awareness raising activities. This should use, but not be limited to the following.

- Any regional intelligence on key themes, patterns and trends.
- Any key trends, themes and patterns extracted from the Diocese’s case management system.
- Workforce and community surveys.
- Workshops and other forums.
- Internal and external reviews.
- Advice from DSSG.

12.9 Whilst many of the workforce at the Cathedral were positive about the level of engagement, they receive on matters related to safeguarding, this was not a universal experience. The Audit heard feedback about the need to strengthen participation and engagement sessions with volunteers.

Recommendation C12: The Cathedral should facilitate regular meetings and sessions to appropriately engage and support volunteers.

12.10 Clear lines of communication help to make sure that all individuals connected to the Cathedral are aware of safeguarding expectations, issues, policies and how to raise concerns and access support.

12.11 The Audit found room for improvement regarding safeguarding communication with volunteers and staff at the Cathedral. This has been acknowledged, and the Cathedral has outlined this as an area requiring support from the Volunteer Coordinator when appointed.

Recommendation C13: The Cathedral should establish an email newsletter issued to volunteers and other interested parties, which should include reference to safeguarding and related subject matter.

12.12 The Cathedral's website provides a fully mobile responsive experience for users and performs well with search engine optimisation (SEO). The 'safeguarding' section is easily accessible through the primary navigation menu and provides users with relevant signposting and resources. Information is made available in a clear and logical format.

12.13 As with all good communication, this needs to be a two-way process. Actively seeking and acting on the views of children, young people and vulnerable adults is a key component to effective prevention planning. The Audit has seen positive engagement with child choristers in this respect. That said, the Audit is also aware that there is space for this practice to be strengthened in respect of vulnerable adults and makes the following recommendation.

Recommendation C14: The Cathedral should establish engagement mechanisms to consider the needs, experiences and voices of vulnerable adults and survivors within safeguarding prevention planning.

12.14 In terms of the arrangements to ensure that Cathedral staff and volunteers are sufficiently safeguarded and potential risks mitigated, the Cathedral has a statement on Lone Working. This is further supported by a Lone Working Risk Assessment for Vergers and by national guidance. That said, the Audit found that not all staff had an awareness of this guidance.

Recommendation C15: The Cathedral should take proactive steps to engage with its staff and volunteers to help them better understand guidance on Lone Working.

12.15 With regards to the Cathedral's physical infrastructure, CCTV monitoring plays a crucial role in enhancing its overall security. Staff are made aware of areas not covered by CCTV via policy, as well as being reminded of its operation during verbal briefings. On a day-to-day basis, the Head Verger and verger team are responsible for the security of the Cathedral and its immediate surroundings.

12.16 Further procedures are in place to manage safeguarding risks that are associated with the layout of the Cathedral building, such as the management of school visits. The Risk Assessment for School Visits has a section dedicated to the safeguarding of children and young people and the Cathedral has a lost child protocol in place.

Recommendation C16: The Cathedral should thoroughly review where risks could potentially arise as a result of its built environment and develop plans to mitigate these risks.

13 Recognising, Assessing and Managing Risk

- 13.1 The Cathedral is open all year round and attracts large numbers of visitors on a weekly basis. Staff and volunteers encounter a diverse range of challenges, from managing protests, festivals and other large public events to providing support for vulnerable individuals and addressing the day-to-day activities involved in religious services, dealing with misconduct and supervising safeguarding agreements.
- 13.2 The Audit observed a whole system approach to safeguarding at the Cathedral aimed at identifying, managing and mitigating risk. This framework encompasses relevant policies, protocols, guidance and efforts to raise awareness.
- 13.3 Whilst there are no safeguarding information sharing agreements with external organisations, the Audit was informed that recent changes now require visiting organisations (working with children and young people or vulnerable adults) to have a safeguarding policy. This is deemed good practice.
- 13.4 This arrangement extends to other processes and the Audit noted one occasion whereby safeguarding policy checks for an external organisation seeking a grant were not adopted because the organisation was 'well known' and worked closely with the local authority. Policy checks should be equally relevant to all organisations whether known or unknown.

Recommendation C17: Local Arrangements for safeguarding policy checks relating to external organisations should be complied with without exception.

- 13.5 A collaborative approach to safeguarding practice is strengthened through strong working relationships with the DBF, and the Cathedral Safeguarding Team. The investment in an additional staff member within the Cathedral to assist with safeguarding is recognised as

positive. There was evidence of strong external partnerships ranging from statutory involvement in safeguarding agreements, to signposting to support agencies such as Caring in Bristol and Citizens Advice. Overall, the Cathedral's arrangements enhance the opportunities to detect risk, facilitate joint decision-making, and enable the swift implementation of a safeguarding response when required.

13.6 In terms of individual cases, there is support from the DST, secured through the Cathedral's Safeguarding Support and Procedural protocol with the DBF. The effectiveness of the DST and the Audit's recommendations are set out in Part One of this report. They have equal relevance to the context of safeguarding at the Cathedral.

13.7 Case activity, at the time of the Audit, showed five ongoing concerns. Over the last two years, there have only been four safeguarding concerns closed and filed involving the Cathedral. Most were of a low level and had been dealt with through advice, guidance and support.

13.8 Whilst no definitive conclusions can be made about the volume of this activity, it is relevant to note findings from the Audit's survey involving the Cathedral workforce. Whilst the majority of respondents indicated they knew how to escalate a safeguarding concern, only 70% indicated they had confidence in the escalation process

Recommendation C18: The Cathedral should collaborate with the DST to actively engage staff and volunteers in building confidence in the safeguarding escalation process.

13.9 The Audit engaged the Cathedral Safeguarding Team during the site visit. All were confident about their safeguarding knowledge and skills and knew how to report concerns. The team have professional experience including backgrounds in teaching and youth work. Their familiarity of relevant policies and procedures was good.

- 13.10 When dip sampling cases, there was a clear example of effective decision making with regards to potential visitors to the Cathedral (who may have presented a safeguarding risk). Whilst there were representations supporting their attendance, ultimately, this was not facilitated.
- 13.11 In another case, reference was made to an informal arrangement with regard to notifying appropriate personnel about concerns relating to another visitor. Raising awareness with key personnel regarding any person who knowingly may pose a risk to children or others should form part of a formal safeguarding agreement and not be dependent on individuals outside of the process.
- 13.12 Safeguarding agreement risk assessments conducted by the Cathedral (in collaboration with the DST) adhere to national guidance and prioritise the safety of victims, potential victims and vulnerable individuals. At the time of the Audit, the Cathedral has active safeguarding agreements in place. The effectiveness of the management of these is set out in Part One of this report. They have equal relevance to the context of safeguarding at the Cathedral.
- 13.13 The Audit examined risk assessments outside the context of safeguarding plans. One referred to an away trip which identified potential risks. These included, travelling on a ferry, a focus on ensuring that Cathedral staff involved were safely recruited and trained, coupled with strict sleeping plans for under 18s. This is deemed good practice. The Audit recommends that a separate safeguarding section within generic risk assessments would strengthen arrangements and provide consistency of approach.

Recommendation C19: Generic risk assessments for everyday business, such as trips away should have a standalone section dedicated to safeguarding.

13.14 The Cathedral has been a registered charity since September 2023 and has a legal requirement to submit serious incidents to the Charity Commission. Whilst it has yet to make any reports, clear arrangements are in place.

13.15 Personal information about safeguarding cases is held by the DST on MyConcern and is compliant with UK data protection legislation and the UK General Data Protection regulations (UK GDPR). The Service Level Protocol between the Cathedral and DBF sets out clear parameters governing the legal and best practice requirements for information sharing.

14 Victims and Survivors

- 14.1 The ability of the Cathedral to engage directly with victims and survivors is somewhat limited, particularly given the DST's role in managing operational safeguarding issues and being the key point of contact for disclosures, (see Victims and Survivors in Part One).
- 14.2 In this context, whilst there is no proactive engagement with victims and survivors, the Cathedral appropriately raises awareness to emphasise the importance of safeguarding, the routes of disclosure and the process to be followed if someone reports abuse. This helps to maintain an ongoing focus on safeguarding, and by default, a focus on victims and survivors. For Cathedral staff and volunteers, these important messages are reinforced within the Safeguarding Handbook.
- 14.3 The Cathedral's website also contains a good range of information and signposting for victims and survivors, such as the [Redress scheme](#), [Safe Spaces](#), sexual and domestic violence services, modern day slavery advice and links for mental health support.
- 14.4 The Cathedral continues to focus on training compliance for those within its workforce. This helps to ensure that those most likely to encounter victims and survivors have the appropriate skills to respond sensitively and appropriately. Whilst areas for improvement have been identified (see Learning, Supervision and Support), this is broadly positive.
- 14.5 During their day-to-day work, the clergy, staff and volunteers at the Cathedral come into contact with a diverse range of people. Some will be tourists, others will include organised groups, school children, local people and worshippers. In the context of those 'in need', the Cathedral identified that people with mental health or housing needs as being the most common safeguarding issues that are encountered.

14.6 The Cathedral does not have any co-located services and is alert to the ongoing challenges facing local support services that are “*overstretched particularly with regard to mental health, housing and addiction services*”.

15 Learning, Supervision and Support

- 15.1 Developing the safeguarding knowledge, skills and experience of the workforce is recognised as a priority by Cathedral leaders. In this respect, they have ensured that a good range of opportunities are available for staff and volunteers, which continue to evolve and deliver impact. Overall, these arrangements have helped the Cathedral's workforce to understand better their safeguarding responsibilities. Most of the workforce respondents in the Audit's survey agree, stating they have seen improvements in this area.
- 15.2 The strategic approach to safeguarding training is led by the national CofE core safeguarding learning pathways (Basic Awareness, Foundation, Leadership and Senior Leadership). Staff and volunteers at the Cathedral have access to defined induction and a training programme delivered by the NST and DST. A Training Matrix provides guidance on the training requirements for individual roles.
- 15.3 Activity in this area is further supported by the availability and promotion of local policy, regular awareness raising and national resources. The work of the Cathedral on modern day slavery is one example of where a more local focus on learning has been implemented.
- 15.4 Training records for the Cathedral workforce are stored on a database. Given the database has only recently been implemented, some information remains stored in an old spreadsheet. The Cathedral recognises the need to transfer this information as soon as possible to ensure the accuracy of future data retrieval.

Recommendation C20: The Cathedral should ensure that training records data is transferred from the old spreadsheet to the new system.

15.5 The Cathedral's workforce includes a number of clergy, paid staff and over 150 volunteers. Whilst the Audit recognises that many within the workforce have completed the mandatory training, the training records identify there is scope for improving compliance. For example, the Training Matrix outlines that certain roles are required to complete the Domestic Abuse training. The Audit has not seen any records to provide reassurance that this up to date. In addition, training records for Cathedral staff identified that not all were up to date with the required safer recruitment training.

Recommendation C21: To ensure staff and volunteers complete required training and keep an up-to-date record of such compliance.

15.6 Training delivery, is primarily through the online national system which, depending on the module, incorporates involvement from either the DST or NST. The Audit is of the opinion that face-to-face training, which includes scenario-based case studies, group discussions and a focus on the specific context of the Cathedral is good practice. Expanding the current training provision to include such focus is likely to accrue significant benefits in terms of the knowledge and skills of the workforce.

15.7 The Audit also believes there should be an enhanced focus on two areas of 'theme specific' training to supplement any existing material from the NST. This includes the nature and behaviours of sex offenders and digital safeguarding. Relevant recommendations have been made for the DBF and the DST in this regard.

15.8 Whilst the Audit is aware that specific training needs were identified, resulting in the commissioning of de-escalation training, a more structured process for a training needs analysis should be adopted. This will help the Cathedral to better understand where knowledge gaps exist against the range of roles in place and the various safeguarding

issues that have a particular relevance to the Cathedral. Again, related recommendations (that include a specific focus on the Cathedral) have been made for the DBF.

15.9 In terms of training evaluation, this remains an important part of any training process. It helps to promote ongoing reflection, establishes the impact that training has had on practice and can be used to inform future changes. The Audit believes there is scope to strengthen arrangements in this respect and makes the following recommendation for the Cathedral.

Recommendation C22: In collaboration with the DBF, the Cathedral should support the implementation of an enhanced training evaluation process to test the impact of training on its workforce. Regardless of this being managed by the Cathedral or via the SLA with the DBF, random cohorts of staff and volunteers (and their managers) should be approached three months after attending training to identify specific ways in which they have used what they learnt and to provide examples of how this has made people safer and the Cathedral a safer place.

15.10 Induction processes are in place for all new staff and volunteers. Input gathered via the Audit's surveys indicated that nearly half of the Cathedral's workforce had undergone an induction and there was positive feedback about the current processes in place. That said, it is noteworthy that not everyone expressed full confidence in this area. Nearly two fifths of respondents stated that they hadn't completed an induction and a further 10% of respondents couldn't recall. This may relate to those who have been in post at the Cathedral for a long time when induction wasn't as consistent.

Recommendation C23: The Cathedral should review its induction arrangements and ensure that all volunteers and staff systematically have access to a defined programme that includes a clear focus on safeguarding.

15.11 Beyond the NST training (and any that has been developed by the DST), there is limited access to other learning opportunities. Whilst this might not be necessary for all roles at the Cathedral, building expertise is sensible and likely to make its arrangements safer. There is the potential to explore this further with the Keeping Bristol Safe Partnership (KBSP) and a recommendation has been made for the DBF in this regard.

Recommendation C24: Should the DBF join the training membership schemes for the KBSP, the Cathedral should seek to secure proportionate access for its workforce via the SLA.

15.12 A range of mechanisms exist for the Cathedral's clergy to help them deal with the challenges of their role and their exposure to potential trauma. These reflect the arrangements in place across the Diocese. Organisational support (through HR and occupational health) is available and the Bishop(s), Archdeacons and local ministry structures can provide pastoral, practical and spiritual assistance. Continued Ministerial Development is embedded and there is access to a Diocesan professional counselling service and specialist therapeutic support if required.

15.13 When allegations are made against a member of the clergy, they can be helped by a trained 'Link Person' or 'Support Person'. The DST can also provide support when clergy are working as part of a 'Response Group' (and where space is created to reflect with others) or through the DST facilitating one-to-one sessions to discuss and debrief a particular case. For clergy against whom a complaint is made, national Church prescribed

processes are in place that facilitate access to support. These arrangements are similarly in place for non-clergy staff. This is good practice.

15.14 At time of Audit and until early June 2024 a curate is on a placement in the Cathedral. There was also a curate on sporadic placement in early March and during Holy Week.

15.15 Ministerial Development Reviews (MDRs) of Cathedral clergy are part of wider Diocesan arrangements. Whilst promoting reflection, learning and improvement, an enhanced focus on safeguarding within this process is likely to accrue further benefits. Positively, the Safeguarding Improvement Plan 2023 outlines an area for improvement as being the structure of MDRs through the inclusion of a dedicated section for safeguarding. The Audit supports this and has made the following recommendation for the DBF.

Recommendation C25: The structure of the 'safeguarding section' for MDRs should specifically align to the National Safeguarding Standards. This will help shape reflection on both vocation and ministry as they relate to these areas and help to identify both personal and professional training, support and development needs.

Conclusion

16 Conclusion

- 16.1 The Bishop and Dean lead by example and are a formidable team. Each of them is committed to doing whatever is necessary to create a safer, more open and welcoming Church.
- 16.2 Whilst there are aspects of Bristol's arrangements that can be further strengthened, the DBF and Cathedral are well led, with a coherent and tangible focus on safeguarding. This is paying dividends, with heightened levels of confidence that a safeguarding culture is now embedded.
- 16.3 The Diocese and Cathedral's greatest asset is to be found in the highly experienced and dedicated Safeguarding Team. A group of professionals, deliberately built and blended to replicate a multi-agency team, they are undoubtedly the foundation upon which Bristol's improvement journey has been built. The Cathedral's safeguarding focused COO, dedicated SPO and the vergers and volunteers who work to make the Cathedral a safer space, are also key.
- 16.4 Relationships with statutory partners, including LADOs, are good and there is an appropriate shared focus on supporting Cathedral choristers between the school and Cathedral staff.
- 16.5 Governance and oversight at all levels across the DBF, DSSG and the Cathedral are strengthening and there is clearly an appetite to encourage scrutiny and facilitate greater independent challenge.
- 16.6 Visitations (known as Triennial Inspections) are safeguarding focused, safer recruitment

demonstrates good practice, pastoral care is prioritised, and training compliance is on an improved trajectory.

- 16.7 Notwithstanding the systems in place and the commitment to engage and support victims and survivors, feedback from that critically important community highlighted some significant challenges remain. Rebuilding trust will take time and the hurt caused to many in the past cannot be undone. That said, the Audit saw no evidence in any contemporary sense of covering up or excusing the inexcusable. From the Bishop and Dean to the Mission and Ministry teams, the Audit saw evidence of an unequivocal, safeguarding first approach aimed at making people safer.

Appendices

17 Appendix 1 – Bristol DBF Recommendations

Recommendation D1: The DBF should carry out bi-annual safeguarding cultural audits. These should be constructed to provide the workforce and worshipping communities with the opportunity to provide feedback on the culture within their Church body.

Recommendation D2: To deal with the positive and negative issues associated with unconscious bias, the DBF should utilise Lunch and Learn Sessions, discussions during supervision and personal development reviews in consultation with the NST (as part of any updates to training).

Recommendation D3: Visitations (known as Triennial Inspections) could be further strengthened by the adoption of consistent timeframes for follow up when remedial action is required, i.e. three-to-six-month periods.

Recommendation D4: The Chair or other representative of the DSSG should attempt to engage quarterly in outreach to relative statutory partners (Police, health, Children and Adult Social Care or alternatively, the chair of appropriate children or adult's partnerships). This should be focused with a fixed agenda to discuss current safeguarding trends, themes and patterns.

Recommendation D5: The Chair of the DSSG should consider broadening the membership of the DSSG to include representatives from the wider community within which the Diocese sits. This could, for example, involve representatives from local charities who engage with activities, such as support for the homeless and foodbanks.

Recommendation D6: In consultation with the DSO, the DSSG should consider how it could enhance its oversight and scrutiny by adopting a defined learning and improvement framework.

Recommendation D7: The DBF should consider the creation of a dedicated Director of Safeguarding role.

Recommendation D8: In order to underwrite the SLA and provide assurance for the DBF that baseline safeguarding is fit for purpose, the DBF should request that Trinity College undergo a full independent safeguarding review. The Terms of Reference for which should be agreed with the DSO.

Recommendation D9: The current safeguarding staff across the DBF and Cathedral should be consolidated. This consolidation should include the proposed Director of Safeguarding role and the assimilation of the Safeguarding and Pastoral Officer (SPO) within the DST. The SPO would remain a dedicated Cathedral resource but benefit from professional safeguarding supervision. This would enhance the overall experience within the team and provide additional resilience when faced with increased demand or extractions.

Recommendation D10: The DBF should amend the DBS risk assessment template to state that DBS checks are required every three years to replace their current version which states five years.

Recommendation D11: The DBF should ensure that its commitment to safeguarding is embedded in all job adverts, as is the case with application forms and job descriptions.

Recommendation D12: The DBF should identify areas, processes or techniques to raise awareness and encourage parishes to adopt and make accessible the template policies provided by the DBF.

Recommendation D13: The DBF should facilitate regular networking events for PSOs to learn and share good practice.

- a) The DBF should facilitate an annual PSO networking event where they are able to come together and hear from leading safeguarding professionals on new and emerging themes as they relate to their role.

Recommendation D14: The DBF should adopt the use of an email marketing system for issuing and managing the safeguarding newsletter.

Recommendation D15: The DBF should consider including a mechanism for an audience wider than PSOs, administrators and lead recruiters to subscribe to its monthly safeguarding newsletter via the website.

Recommendation D16: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, vulnerable adults, and survivors within safeguarding prevention planning.

Recommendation D17: The DBF should review and take steps to raise awareness and embed the Digital Safeguarding Policy throughout the DBF.

Recommendation D18: The DBF risk register should be developed to address contemporary and contextual issues.

Recommendation D19: The DBF should commission an external resource (operating to terms of reference set by the DSO) to review, cleanse and archive the data held on MyConcern.

Recommendation D20: Entries on MyConcern should provide a rationale for any 'inaction' on cases, where decisions have been made by the DSO / DST not to take a particular action.

Recommendation D21: The arrangements with Trinity College regarding the monitoring of safeguarding issues and agreements should be reviewed to alleviate workloads for the DST.

Recommendation D22: Whilst the development of training is a national issue, as an interim measure, the DBF should consider commissioning targeted training specifically on offender behaviours for those engaged with safeguarding agreements, such as Link workers, clergy and PSOs.

Recommendation D23: The DBF should communicate and reinforce the responsibilities for Core Group members at a local level in line with the CofE House of Bishop's Guidance.

Recommendation D24: The DBF team should raise awareness of the National Data Sharing Agreement between the National Police Chiefs' Council and the Church of England within the Diocese and raise the profile with police forces through the NST.

Recommendation D25: The DBF should develop and implement a defined escalation processes for dealing with differences of opinion regarding decision making and actions taken on safeguarding cases.

Recommendation D26: The DBF should continue to review the effectiveness of the MyConcern system and engage at a national level to ensure the system meets local needs.

Recommendation D27: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DST and NST. This will also be raised by the Audit with the NST.

Recommendation D28: Based on the Audit's observations, it is recommended that structured supervision processes be implemented locally within the DST.

Recommendation D29: Data protection training should be prioritised and completed by clergy, DBF staff and parish volunteers dealing with personal or confidential information.

Recommendation D30: When supporting a victim and survivor it is important to set check in points, that once agreed are followed up, even if only to say that there is nothing further to report (the wishes of individuals should be established, and times agreed in advance).

Recommendation D31: When engaging with a victim / survivor manage expectations and provide information about what you are going to do and what that might mean for them.

Recommendation D32: Once the developments seeking to strengthen victim / survivor engagement have been defined, the Diocese of Bristol website should include information about how victims / survivors can engage with the DBF and contribute to its ongoing developments.

Recommendation D33: The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers, about how training has informed practice and the impact it has had. This could be carried out by an external consultant to avoid extraction or diversion of DST members.

Recommendation D34: The DBF should engage with its workforce, develop and implement a specific training needs analysis framework that identifies the range of opportunities available to help identify local learning gaps. Training needs should be considered on an annual basis and used by the DST to design and / or commission local courses to supplement the NST programme.

Recommendation D35: Alongside the recommendation on sex offender training (D20), specific training sessions focused on the topic of digital safeguarding should be introduced into the training programme and made accessible to relevant Church Officers in the DBF, Cathedral and parishes.

Recommendation D36: The DBF should engage in targeted approaches to increase the uptake of training by key roles throughout the Diocese.

Recommendation D37: The DBF should engage in discussions with relevant safeguarding partnerships about the potential for Church Officers to access their multi-agency safeguarding training offers.

Recommendation D38: The DBF should consider implementing mandatory counselling sessions for members of the DST to ensure they are sufficiently supported in the challenging role they do.

Recommendation D39: The structure of the 'safeguarding section' for MDRs should specifically align to the National Safeguarding Standards. This will help shape reflection on both vocation and ministry as they relate to these areas and help to identify both personal and professional training, support and development needs.

Recommendation D40: The DBF should develop an audit for PCCs to establish compliance levels with induction training. Where individuals are identified who have not had induction training this should be addressed within a specific period of time, i.e. three to six months. Furthermore, this issue should be addressed on any forthcoming visitations (known as Triennial Inspections).

18 Appendix 2 – Bristol Cathedral Recommendations

Recommendation C1:

- a) The Chapter, Safeguarding Committee and DSSG should carry out a skills audit to test whether there is sufficient safeguarding expertise in their respective cohort.
- b) Whilst the governance arrangements meet the expectations of the Church and the Charity Commission, the safeguarding subcommittee could be strengthened by introducing a fundamentally and suitably qualified independent chair, (or suitably qualified non-executive member).
- c) Consideration could also be given to how it might diversify its membership to include representatives from the wider community in which it sits. For example, charities with which it works.
- d) Consideration should also be given to the benefits of creating an ISAG.

Recommendation C2: Any future restructure should consider separating out the current responsibilities of the SPO. This will ensure that these responsibilities do not all lie with one person and will help prevent any potential conflict of interest arising from the consolidation of multiple safeguarding duties.

Recommendation C3: The SPO and any other professional safeguarding staff within the Cathedral should be supervised by the DSO.

Recommendation C4: Contingency planning should be considered to ensure continuity of effective safeguarding, should the Chorister Tutor role no longer be available.

Recommendation C5: The Cathedral should ensure that information relating to the supervision and lines of responsibility for choristers is regularly communicated to parents.

Recommendation C6: The Cathedral should document the process of supervision during services and ensure this information is adequately communicated to parents.

Recommendation C7: The Cathedral should install a variety of pre-recorded languages to be played on the speaker announcement that ask the public to refrain from taking images or videos of the choristers.

Recommendation C8: The Cathedral should ensure continued efforts to mitigate the effects of heat during warmer months and install a thermometer to monitor temperatures, ensuring they remain within recommended levels.

Recommendation C9: The Cathedral should ensure that its commitment to safeguarding is embedded in all job adverts, application forms and job descriptions.

Recommendation C10: The Cathedral should ensure that all relevant staff have completed the national Safer Recruitment training.

Recommendation C11: The Cathedral should adopt a systematic approach to identifying key themes for its awareness raising activities. This should use, but not be limited to the following.

- Any regional intelligence on key themes, patterns and trends.
- Any key trends, themes and patterns extracted from the Diocese's case management system.
- Workforce and community surveys.
- Workshops and other forums.
- Internal and external reviews.
- Advice from DSSG.

Recommendation C12: The Cathedral should facilitate regular meetings and sessions to appropriately engage and support volunteers.

Recommendation C13: The Cathedral should establish an email newsletter issued to volunteers and other interested parties, which should include reference to safeguarding and related subject matter.

Recommendation C14: The Cathedral should establish engagement mechanisms to consider the needs, experiences and voices of vulnerable adults and survivors within safeguarding prevention planning.

Recommendation C15: The Cathedral should take proactive steps to engage with its staff and volunteers to help them better understand guidance on Lone Working.

Recommendation C16: The Cathedral should thoroughly review where risks could potentially arise as a result of its built environment and develop plans to mitigate these risks.

Recommendation C17: Local Arrangements for safeguarding policy checks relating to external organisations should be complied with without exception.

Recommendation C18: The Cathedral should collaborate with the DST to actively engage staff and volunteers in building confidence in the safeguarding escalation process.

Recommendation C19: Generic risk assessments for everyday business, such as trips away should have a standalone section dedicated to safeguarding.

Recommendation C20: The Cathedral should ensure that training records data is transferred from the old spreadsheet to the new system.

Recommendation C21: To ensure staff and volunteers complete required training and keep an up-to-date record of such compliance.

Recommendation C22: In collaboration with the DBF, the Cathedral should support the implementation of an enhanced training evaluation process to test the impact of training on its workforce. Regardless of this being managed by the Cathedral or via the SLA with the DBF, random cohorts of staff and volunteers (and their managers) should be approached three months after attending training to identify specific ways in which they have used what they learnt and to provide examples of how this has made people safer and the Cathedral a safer place.

Recommendation C23: The Cathedral should review its induction arrangements and ensure that all volunteers and staff systematically have access to a defined programme that includes a clear focus on safeguarding.

Recommendation C24: Should the DBF join the training membership schemes for the KBSP, the Cathedral should seek to secure proportionate access for its workforce via the SLA.

Recommendation C25: The structure of the 'safeguarding section' for MDRs should specifically align to the National Safeguarding Standards. This will help shape reflection on both vocation and ministry as they relate to these areas and help to identify both personal and professional training, support and development needs.

19 Appendix 3 – Glossary of Abbreviations

APCM	Annual Parochial Church Meeting
BCCS	Bristol Cathedral Choir School
CofE	Church of England
CDM	Clergy Discipline Measure
COO	Chief Operating Officer
CPS	Cathedral Primary School
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSA	Diocesan Safeguarding Advisor
DSO	Diocesan Safeguarding Officer
DSAP	Diocesan Safeguarding Advisory Panel
DSSG	Diocesan Safeguarding Steering Group
DST	Diocesan Safeguarding Team
EDI	Equality / Equity, Diversity, and Inclusion
GDPR	General Data Protection Regulations
KBSP	Keeping Bristol Safe Partnership
LADO	Local Authority Designated Officer
LLM	Licensed Lay Minister
LLR	Lessons Learned Review
LSCP	Local Safeguarding Children Partnership
MDR	Ministerial Development Review
MHFA	Mental Health First Aid
NPCC	National Police Chief's Council
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PoC	Person of Concern

PSO	Parish Safeguarding Officer
SCIE	The Social Care Institute for Excellence
SEO	Search Engine Optimisation
SIR	Serious Incident Report
SLA	Service Level Agreement
SLT	Senior Leadership Team
SPO	Safeguarding and Pastoral Officer
TEI	Theological Education Institution



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