

**Independent Safeguarding Audit of The  
Diocese of Salisbury and Salisbury  
Cathedral**

**2024**

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# 1 Introduction

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

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

- Over 265 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.
- Over 350 anonymous survey responses which gathered input from key communities connected to the Diocese and Cathedral. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the parishes, Cathedral and Diocese.
- Five focus groups. Two groups engaged children and young people, one was conducted with chorister parents and two focus groups drew input from Parish Safeguarding Officers (PSOs).
- A confidential contact form accessible via a dedicated webpage.
- In total, the Audit undertook 46 separate engagement sessions reaching 496 people.

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<sup>1</sup> [https://www.churchofengland.org/sites/default/files/2023-10/national-safeguarding-standards-and-quality-assurance-framework\\_sep23.pdf](https://www.churchofengland.org/sites/default/files/2023-10/national-safeguarding-standards-and-quality-assurance-framework_sep23.pdf)

- 1.3 The Audit report is separated into Part One, Salisbury Diocese and Part Two, Salisbury 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 Salisbury and Salisbury Cathedral.

# Part One - Salisbury Diocese

## 2 Context

- 2.1 For more than 900 years, the Diocese of Salisbury has been a regional presence of the CofE. As a Christian community of churches, schools and chaplaincies, the Diocese's footprint covers around one million people and two thousand square miles, stretching from North Wiltshire to the Jurassic Coast and the Deaneries of Jersey and Guernsey. It encompasses 465 parishes within which there are 613 individual CofE churches and worship centres. The worshipping community for the year 2022 equated to 23,427 attendees.
- 2.2 The Diocese is led by Stephen Lake, Bishop of Salisbury, and by the Diocesan Synod. The Bishop's seat is at Salisbury Cathedral. There are two Suffragan Bishops covering the areas of Ramsbury and Sherborne. In the Deaneries of Jersey and Guernsey, the respective Deans are the senior Anglican priests and have responsibility for leading and supporting the mission and ministry of the parishes and strengthening links with the wider CofE.
- 2.3 There are 311 licensed clergy, 55 paid staff and two volunteers who work directly for the Diocesan Board of Finance (DBF). At parish level, there are 1,722 Parochial Church Council (PCC) officers occupying a wide range of roles including the PCC Secretary, Treasurer, Churchwarden, Electoral Role Officer, Deanery Synod Representatives and PSOs. The majority of these roles are undertaken in an unpaid capacity. Reflecting the number of staff and volunteers in the Diocese who work or come into contact with the young and vulnerable, over the last three years, 4800 checks were undertaken with the Disclosure and Barring Service (DBS).

### 3 Progress

- 3.1 The Diocese was the subject of one of the first SCIE audits in 2015. This resulted in a range of recommendations, all of which were accepted. Given the passage of time and the change in processes, these actions are not part of the current Diocesan safeguarding audit tracker. That said, the Audit was able to evidence that the recommendations were considered. This has been done by examining emails, minutes of relevant meetings and corroboration gathered during the interview process.
- 3.2 The current diocesan safeguarding audit tracker includes information on the progress of actions from a range of audits and reviews. These include PCR2s for the Diocese (including the Channel Islands) as well as evidence of their ongoing commitment to reflect and learn. On appointment, one of the first actions initiated by the current Bishop was to commission an independent reviewer to carry out a further safeguarding audit.
- 3.3 Of the 64 recommendations from all audits and reviews since 2015, the overwhelming majority have been met or are actively in progress. Some of those in progress relate to national policy or are part of new projects that are in development, e.g., the new DBS project. Of the four recommendations that are unmet, each is related to national issues linked to the review and administration of clergy files. The Audit is assured that these issues are being progressed at a national level and that all local actions are being actively overseen by the Diocesan Safeguarding Advisory Panel (DSAP).
- 3.4 The Audit has seen evidence that the implementation of previous recommendations has positively impacted on the development of policy and the application of practice. The findings of this Audit reflect that this progress continues and where appropriate, additional recommendations are made to support the Diocese's ongoing improvement journey.

## 4 Culture, Leadership and Capacity

- 4.1 In 2015, independent auditors<sup>2</sup> found that safeguarding at Salisbury Diocese was not fully integrated into its culture and that it was not seen as everyone's business. Whilst there remains work to do, the Diocese has made substantial progress from this early position. Senior leaders have set the tone for safeguarding and their efforts have helped to create a culture that is healthier and more transparent.
- 4.2 There is now a strong and tangible focus on safeguarding that aligns with statutory guidance and best practice. This is articulated in the Diocese's vision, its governance and the behaviours of staff and volunteers. Safeguarding arrangements are well defined and supported by clear strategy, risk oversight and a range of strategic and operational meetings. These meetings have structured agendas and have appropriate representation at the right level of seniority and expertise. They are regular and most make and maintain good records.
- 4.3 A culture of collaboration and communication is also helping to raise awareness and ensure that matters of concern are appropriately escalated. Leaders maintain an active role in oversight, influence and decision making. People are talking about safeguarding and taking it seriously. Importantly, the culture at the Diocese is also characterised by its positive approach to victims and survivors<sup>3</sup>, alongside wider engagement activity.
- 4.4 This 'pivot' in culture is also being felt at parish level. The majority of parish staff and volunteers engaged by the Audit believe that a safeguarding culture is now firmly embedded within their respective areas. Many say that leaders listen to them and most feel safe in what they consider to be supportive, welcoming and respectful environments. Importantly, for those interviewed, they perceive no culture of 'inappropriate deference'. They are confident they can talk 'truth to power', raise concerns and act without fear of reprisal.

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<sup>2</sup> Social Care Institute for Excellence

<sup>3</sup> Aligning with the expectations set out by the CofE – Responding well to victims.



4.5 That said, a minority said that culture is ‘cliquey’, outdated, defensive and arrogant. Given the size of the Diocese, this is perhaps unsurprising, although negative traits such as these, if not addressed, could undermine progress. The Diocese therefore needs to build on the solid foundation it has created to ensure that as many people as possible across its footprint feel respected, valued and able to engage at all levels.

**Recommendation D1:** The Diocese should promote the need for mutual respect and demonstrate its commitment to this by actively listening to their communities. A coordinated approach across the Diocese (to include all parishes) should deliver a survey that is specifically targeted at identifying perceptions of negative culture.

The questions set out in the CofE’s ‘Healthy Culture Survey’<sup>4</sup> should be used for this purpose, although this should be further adapted. The survey should also seek evidence and examples of where and how negative cultures manifest and ask for suggestions as to how these could most effectively be addressed.

This initiative should be supported by an awareness raising strategy that engages all church groups via communications and sermons.

The outcome of the survey should be used to inform the Diocese’s approach to eradicating the remnants of a negative culture.

The findings should inform a plan of action to reinforce and spread the positive culture felt by the majority. This should be driven by church leaders at all levels and monitored by the DSAP.

4.6 Roles and responsibilities in the Diocese are well defined, and the Bishop’s overall accountability is both understood and unambiguously accepted by him. Leaders engaged by the Audit were

<sup>4</sup> <https://www.churchofengland.org/safeguarding/national-safeguarding-standards#na>

seen to have a good grip on their responsibilities and were discharging these appropriately. They have high aspirations, an appetite to learn and are leading by example. The Audit saw positive examples of appropriate authoritative practice being both demonstrated and promoted by the Bishop and his senior team. It also saw influential leadership being distributed throughout the Diocese and reflected in the work at parish level and that of the Diocese Safeguarding Team (DST).

- 4.7 A continued appetite for independent oversight and challenge is helping the Diocese on its improvement journey. Beyond this Audit programme, several independent reviews had been commissioned and there continues to be a functioning DSAP.
- 4.8 The DSAP meets regularly, maintains good records and benefits from an experienced, independent chair. It also benefits from good internal collaboration and cross-representation with the Cathedral's Independent Safeguarding Advisory Group (ISAG). Whilst combining the DSAP and the ISAG has been considered, there are no plans in place to merge these groups. The Audit agrees with this approach. Keeping the DSAP and ISAG separate allows for the maintenance of a clear focus based on the distinct contexts of the Diocese and Cathedral.
- 4.9 The work of the DSAP adds value to the Diocese's arrangements and has delivered impact by way of several improvements. Examples include a DSAP proposed policy that resulted in improved training take up from members of the clergy, an analysis of a complaint that led to improved practice in reviewing worship / safeguarding agreements and a decision by the DSAP to rotate PSOs on its membership – helping to broaden awareness and act as a sounding board for specific projects (such as the parish dashboard).
- 4.10 Whilst broadly positive, there remain ongoing challenges for the DSAP arising from poor quality data resulting from manual systems. Whilst this currently hinders its ability to fully understand performance, these limitations have been recognised and plans are underway to replace several legacy systems. The Audit also heard about the challenges experienced by the DSAP in its attempts to expand its membership and access a broader level of safeguarding expertise.

Despite inviting a range of agencies, none have been able or willing to commit. That said, from the Audit's perspective, we do not think this is necessary. In our opinion, the DSAP should continue to be independently chaired and primarily comprise 'internal' roles that have a nexus on the diocesan arrangements. Engagement with other sectors should be sought, but this should be through Diocese staff attending the established multi-agency arrangements that are already in place in local authorities across its footprint. For example, the Audit found that the Wiltshire's Vulnerable People Partnership (VPP) is eager to explore this further.

**Recommendation D2:** To broaden its opportunities for support, learning and challenge, the DSAP and the DST should:

- 1) Engage the Wiltshire VPP and other local authority partnerships to determine the key multi-agency forums within which it could be involved.
- 2) Seek to establish the relevance of other information sharing agreements with which it could be formally involved.
- 3) Engage in discussions with local authority partnerships about the potential to access multi-agency safeguarding training.

4.11 Wider questions about the purpose of DSAPs and the role of their independent chairs also exist for the Audit. These will be pursued with the NST. For example, whilst recognising the benefits of the 'advisory function' of DSAPs, the Audit believes there is merit in strengthening the chair's responsibility for scrutiny, ensuring effectiveness and reassurance. As forums led by experienced and independent chairs, DSAP could be re-defined as the primary mechanism where the 'grit' of curiosity and challenge in the Diocese is centred. There is certainly the expertise in Salisbury to do this. For this to happen, independent chairs would need to be given the authority to hold leaders to account and a 'right to roam' that more routinely tests the effectiveness of practice, performance and impact.

- 4.12 From a capacity perspective, the greater level of investment in the DST since 2020 has paid dividends. Alongside the commissioning of reviews, the strengthened oversight of DBS processes and the ongoing delivery of training, leaders at the Diocese are showing that safeguarding is a clear priority for them. The enhanced DST now comprises a blended cohort of staff and remains an asset. Team members have complementing knowledge, skills and experience developed through their respective professional backgrounds including that of their Independent Sexual Violence Advisor (ISVA). There is effective and timely support provided by the team and evidence of collaboration with external agencies. Through a Service Level Agreement (SLA), the DST provides two days a week of dedicated support to the Cathedral.
- 4.13 That said, despite the many strengths of the DST, capacity remains a concern when considering the overall improvement agenda, current pressures, and the need to respond at pace to legacy issues. There is the added dynamic, that the contexts of the Diocese and Cathedral present their own unique challenges. Even with an increased number of staff, extractions and diversions in the DST are undoubtedly having an impact on their operational bandwidth.
- 4.14 As a result, potential risks exist in several areas. Proposed mitigations are set out in the following recommendations. The Audit believes these will accrue overarching benefits and positively impact parishes. They will also enable a greater focus on the operational and case management responses by the DST and create the potential to better support the DSAP and ISAG without undermining the focus on casework.
- 4.15 Firstly, with the roll-out of new IT systems, it is the opinion of the Audit that more administration support will be needed. Once the systems are in place, this additional administration resource should not be reduced as this would have a negative impact on the DST with regards to the coordination of key tasks.

**Recommendation D3:** Administration support in the DST should be strengthened to enable the DSAs to better focus on their primary responsibilities and the enhanced support needed at parish level.

- 4.16 Secondly, the Audit believes that the full Diocese Safeguarding Advisor (DSA) establishment in the DST should be solely focused on the Diocese. Additional capacity (created by amending the SLA with the Cathedral) should be used to enhance support at parish level and growing operational demands. The Cathedral itself should seek to appoint a dedicated safeguarding advisor role for its own arrangements. This is likely to facilitate a much clearer focus and level of support for both contexts.

**Recommendation D4:** The Diocese should amend the SLA with the Cathedral and concentrate the additional capacity on its own priorities. The Cathedral should invest in a dedicated Cathedral Safeguarding Advisor (CSA).

- 4.17 From a strategic point of view, the Audit believes there is a gap in governance. The DST team leader reports directly to the Diocesan Secretary and the CSA (who is managed by the DST team leader) meets regularly with the Chapter Clerk. Both these roles have significant spans of control and whilst there is line of sight on safeguarding, this could be significantly improved if arrangements were aligned with other functions governed by both the Diocese and the Cathedral – most, if not all, benefit from a director function.
- 4.18 By creating a Director of Safeguarding, to whom the DST and the CSA would report, this would allow for strategic oversight and coordination across both the Diocese and Cathedral. Importantly, safeguarding would be the priority for this Director – not one amongst many.

**Recommendation D5:** The Diocese should create a Director of Safeguarding role. The DST and the proposed CSA should both directly report to this role, with arrangements being secured through a revised SLA.

## 5 Prevention

- 5.1 As part of its safeguarding arrangements, the Diocese has in place a good range of preventative measures. These include a focus on safer recruitment, codes of conduct, mechanisms to raise awareness, engagement, workforce safety and site safety.
- 5.2 Safer recruitment is a priority in the Diocese and processes are aligned to legislation, relevant policies and key guidance issued by the CofE. Overall, there are strengths in diocesan practice. Staff involved in recruitment are suitably trained and support is easily accessible via the Diocese's webpage. For queries about criminal record checks, specialist advice is also available via the contracted DBS provider. Useful guidance covering the minimum levels of training and checks required by different roles is embedded and there is routine promotion about the importance of safer recruitment.
- 5.3 Advertising and recording processes are two areas that would benefit from improvement. For example, opportunities are being missed by the Diocese in not using job adverts to reinforce key messages about safeguarding. This can be helpful in acting as a deterrent. From a recording perspective, despite the enormous efforts of the DST administrator responsible for the DBS system, the system itself is labour intensive and has been prone to error. This has caused confusion and frustration for many parish staff and on occasions, has resulted in incorrect or missed alerts for DBS renewals. This problem is recognised by the Diocese and will be addressed through a planned upgrade of systems.

**Recommendation D6:** The Diocese should:

- a) Implement a consistent process that ensures its commitment to safeguarding and key requirements (such as the need for self-disclosure) are embedded in all job adverts.
- b) Job descriptions at all levels in the Diocese should include a defined statement that defines their roles and responsibilities relating to safeguarding.

5.4 The DBF has in place a clear Code of Conduct. Most staff and volunteers engaging with the Audit were aware of the relevance of this code to their work. That said, given the different approaches adopted for the clergy and the differing policies and codes of conduct applied across PCCs, there was some confusion.

**Recommendation D7:** The Diocese should clarify with its workforce and parishes about the codes of conduct which apply to them in each of their specific roles.

5.5 For awareness raising, the Diocese demonstrates some good practice across a variety of contexts. The DST actively encourage PCCs to have safeguarding as a regular agenda item. The DSAP and Diocesan Synod engage in routine discussions about safeguarding, and triennial inspections by Archdeacons provides further opportunities for debate and reflection on the priority and performance of safeguarding.

5.6 In Guernsey, the Dean and Deanery Safeguarding Lead (currently one of the Vice Deans) ensure that safeguarding practice is a standing item for clergy Chapter meetings and Deanery Standing Committees. They encourage similar practice at governance meetings in parishes. Effective dialogue and collaboration are also achieved through established relationships with the DST that include annual visits to Guernsey and Jersey. That said, whilst there are regular conversations, visits to Alderney and Sark are limited. Whilst there are practical implications regarding face-to-face engagement in hard to reach areas and a temptation to default to virtual engagement, the Audit does not support such an approach. Isolation and absence of line of sight by external safeguarding professionals can represent a risk anywhere. Therefore, the DST should seek out opportunities to engage with residents whilst conducting annual or bi-annual safeguarding focused site visits.

**Recommendation D8:** The DST should include Alderney and Sark in visits to ensure insight and oversight of relevant safeguarding matters.

- 5.7 Staff and volunteers commented positively to the Audit about the focus on safeguarding during day-to-day discussions. PSO workshops provide a regular and constructive forum for safeguarding discussions and there was strong engagement with a range of youth groups in many parishes. Whilst there are reminders and written communications, the value of messages being delivered verbally was a clear preference expressed to the Audit.
- 5.8 The Audit also saw evidence of material that referenced safeguarding information and promoted good practice. Communications largely reflect appropriate language targeted to the different audiences engaged. Methods of communication range from face-to-face briefings and the content of sermons to virtual and email / newsletters, as well as use of the internet and social media platforms.
- 5.9 When asked about the use of posters, most children and young people from the five parishes engaged by the Audit, were aware of their use. Indeed, the children from the church hosting the meeting were able to point out the relevant signage at the entrance, in the building and on the back of cubicle doors. The posters whilst still relevant, showed signs of age, in that they hadn't just been put up in the anticipation of the Audit. This is good practice.
- 5.10 The Diocese's website has a strong, clean and modern theme and is mobile responsive. It is positive that the 'safeguarding' section has prominence and strong visibility. Within the Diocesan safeguarding webpage, there is clear and consistent signposting to internal help and external support, the ability to book safeguarding training, and access DBS guides, tools and policies.
- 5.11 Notwithstanding these strengths, the safeguarding webpage could be further enhanced by a prompt to subscribe to the safeguarding newsletter and better use of the sub-menu (below 'Safeguarding Training') in conjunction with an interrogation of its analytics to ensure the most frequently sought information is prominent and easy to access.



**Recommendation D9:** The Diocese should review any analytics associated to the safeguarding webpage to ensure that the use of the sub-menu is optimised to user needs. For example, if analytics evidence that Safer Recruitment and DBS tools are one of the most frequently accessed resources on the page, then this could be made more easily accessible and prominent via an additional button in the sub-menu below ‘Safeguarding Training’. The Diocese should provide a more prominent option for a website visitor to stay up to date by subscribing to the Safeguarding Newsletter.

5.12 With regards to the messages communicated, these are aligned to the strategic priorities of the Diocese. For example, there has recently been a strong focus on domestic abuse. Whilst positive, there are likely to be benefits in taking a more systematic approach to identifying what should be communicated and when. The world of safeguarding is fast paced and standing still is falling behind. In this respect, adopting a dynamic approach to messaging and having a framework that harvests intelligence for these purposes is key.

**Recommendation D10:** An intelligence-led approach should be adopted to inform awareness raising activities and should be subject to dynamic review throughout the year.

This should be informed by:

- Regional intelligence on key themes, patterns and trends.
- An analysis of 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 DSAP and ISAG.

5.13 As part of its overall prevention agenda, there is evidence that the Diocese seeks to understand the needs, experiences and voices of children, vulnerable adults and victims / survivors. This has included contact with children as part of strategy development, the ongoing activity at the

DSAP and the work of the DST and ISVA. At DBF and parish level, there are some excellent examples of youth engagement, including established groups and a peer mentoring scheme. The work of the DST routinely involves collaboration with survivors who act as a ‘sounding board’ around new policies and processes. Most recently, survivors engaged with the Diocese have been encouraged to participate in the NST victim and survivors national survey and have supported some of the domestic abuse workshops run locally.

- 5.14 In terms of the arrangements to ensure that DBF staff are sufficiently safeguarded and potential risks mitigated, there is a Lone Working Policy in place. Beyond the DBF, these issues are addressed in the Parish Safeguarding Handbook and supported by national guidance.
- 5.15 Guidance covering the structural environment and risk assessments across the Diocese are covered by the CofE’s Safer Environments and Activities guidance which is aimed at fostering a secure and protective environment for all involved parties.

## 6 Recognising, Assessing and Managing Risk

- 6.1 Arrangements in place across the Diocese support the identification, management, and mitigation of risk. These include relevant policies, awareness raising and training that make identification more likely. They cover defined reporting routes that facilitate swift access to expertise, advice and senior management oversight. They also involve clear processes that provide structure for collaboration and planning.
- 6.2 In respect of individual cases, safeguarding concerns are properly triaged by the DST. Decisions about further action routinely involve discussions across a range of stakeholders and are agreed at the appropriate level of management.
- 6.3 At the time of the Audit, there were around 200 open concerns with the DST (although some of these were pending closure). In the last 12 months, nearly 500 concerns were received by the DST. The nature of risk and harm varies across this cohort, with some having involved advice or guidance, others relating to contemporary issues of risk across the DST's footprint and others linked to non-recent cases of abuse. Of those cases managed by the DST, they can involve onward referrals to statutory authorities, the management of individuals within the worshipping community and / or trigger the initiation of a CofE Core Group or disciplinary processes, such as the Clergy Disciplinary Measure (CDM). The DST make timely decisions and take appropriate action on safeguarding cases.
- 6.4 Of the DBF workforce completing the Audit's survey, 100% indicated they knew where to locate relevant safeguarding policies. A good degree of confidence was also expressed about reporting concerns and handling disclosures. Whilst this was largely mirrored across parishes, a small number were unclear. With the size and turnover of staff and volunteers in parishes, this will remain a work in progress for both the DST and the NST. At a local level, deficits in understanding can and should be addressed through the local clergy, PCCs and PSOs prioritising and promoting awareness, encouraging learning and seeking out opportunities for support. Proactivity in this space makes people safer.

- 6.5 Risk assessments led by the DST are undertaken when a known concern / risk exists about a church officer, or for former offenders in certain high-risk categories who wish to attend church services or activities. They follow national guidance, are focused, and firmly centred on victims, potential victims and the vulnerable. This is positive and reflects a 'safeguarding first' approach to practice. Recording is consistent, with assessments detailing review dates, involved agencies and defined actions to mitigate risk. There is evidence of leaders across the Diocese taking appropriate authoritative action to mitigate risk. For cases involving members of the public, there is equally firm evidence of partnership working, collaboration and the sharing of information with statutory agencies.
- 6.6 With regards to those circumstances where safeguarding agreements are required, the Audit saw evidence of effective practice by the DST. These set clear prohibitions and actions regarding expected behaviours. Agreements are clearly defined, proportionate and authorised appropriately. Scheduled reviews allow for oversight of compliance, ongoing refinement and for those involved in the process to address any emerging issues.
- 6.7 A multi-agency approach to developing safeguarding agreements is also evident, with there being routine input from both the police and probation service. Decision making is influenced through the sharing of information and professional expertise. Alongside mitigating the risk derived from an individual, their safety and welfare is also properly considered.
- 6.8 An Auditor met with a person subject to a safety plan. This 'respondent' had been convicted of an offence relating to children and sentenced to a period of imprisonment. Whilst incarcerated they had come to faith and upon release sought the opportunity to engage in public worship at a local church. Following multi-agency engagement, risk assessment and the development of a safety plan, access to a parish church was facilitated. Conditions in this plan include sharing information with particular staff, specific requirements about the time of service that they should attend (the early service is not routinely attended by significant numbers of children), where they

should sit and agreement that they will not engage with children. Whilst the incumbent is the key contact, significant and appropriate levels of support are provided by the DST. During the discussion it became apparent that meetings outside of the precincts of the church, with people who were unaware of the potential risks, need further consideration. It was not clear that if the respondent met someone outside the church (in a context where children were present) that they would proactively inform the incumbent. Furthermore, notwithstanding the positive, supportive and insightful relationship the incumbent had developed with the respondent, their healthy scepticism could be further supported by specialist training that addressed the patterns of behaviour related to such individuals. In many cases, those subject to a form of monitoring / oversight, can display patterns of minimising and self-justifying.

**Recommendation D11:** Safety plans should always include requirements to report when a respondent meets with someone they know through the church.

**Recommendation D12:** Those directly engaged on behalf of the church to support individuals on a safety plan should be provided with specific offender behaviour-based training. This should include insights via case studies and an overview of minimising, self-justifying and victim blaming behaviours. The Audit recognises that overarching responsibility for the training curriculum in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Diocese with the opportunity to apply interim mitigation measures.

6.9 There is clarity that if the subject of the agreement relocates to another church or Diocese, information will be shared with the new settings. This is good practice.

6.10 Core Groups for cases arising across the Diocese regarding Church Officers are routinely facilitated and are effective at overseeing individual safeguarding cases. They are ordinarily timely, managed well and comprise relevant representation. Auditors saw evidence that Core

Groups actively consider the support needs of all involved parties, with plans being trauma informed and sensitive. Feedback provided to the Audit from victims / survivors very much reinforced the benefits of this focus. A link person and pastoral support are identified and offered to 'respondents' in a letter sent by the Bishop at the commencement of a Core Group.

- 6.11 There is evidence that the Diocese continues to identify and submit Serious Incident Reports (SIRs) in line with Charity Commission expectations. The SIRs seen by the Audit found decision making and supporting rationale to be appropriate. Those involved in the oversight of the SIR process recognise the need to improve timeliness and this is agreed and welcomed by the Audit.
- 6.12 There is no defined escalation process to help manage differences of opinion about the decisions and action taken on safeguarding cases. Where such instances occur, DSAs have access to guidance from the Pathfinder Safeguarding Regional Lead and / or the NST, the DSAP, and other safeguarding colleagues (such as statutory partners where appropriate, other Diocese safeguarding teams with anonymised information). If there are differences of opinion about safeguarding cases with external organisations, the DST can refer to the other organisations escalation policy. At parish level, issues can be escalated to the DST.

**Recommendation D13:** The Diocese should implement a defined escalation process that provides a formal structure to managing differences of opinion as they relate to the decisions and actions on safeguarding cases. This process should be applicable to all staff within all jurisdictions covered by Salisbury Diocese and Cathedral.

- 6.13 From a practice perspective, support from the DST is highly valued. There is an internal culture of mutual support, with the response to safeguarding concerns reflecting a spirit of collaboration and effective teamwork. This approach extends beyond the Church. There are consistent levels of engagement with Wiltshire's Designated Officer for Allegations (DOFA)<sup>5</sup> and other Local

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<sup>5</sup> The DOFA is a Local Authority role that is responsible for the management of allegations against staff and volunteers as part of Wiltshire's local multi-agency safeguarding arrangements.

Authority Designated Officers (LADOs) and the Audit also saw examples of effective partnership working with the police and local authorities. Positively, a LADO told the Audit that allegations are taken seriously by the DST and proactively followed up. He further noted the enthusiasm with which the team engage in appropriate and relevant training.

- 6.14 Good relationships are also being maintained with the voluntary and community sector and this has helped facilitate help for people on matters such as domestic abuse and homelessness. There is confidence in the competence of the DST to seek out other support networks as required. That said, tighter engagement with Wiltshire's Vulnerable People Partnership and other local authorities (as previously recommended for the DST in this report) may help broaden the team's awareness of the services available and prompt the formation of new relationships with the third sector.
- 6.15 The safeguarding case management system in Salisbury covers the Diocese, Cathedral and the Channel Islands. Implemented in 2022, this national system is a centralised secure database. It is user friendly and allows for safeguarding concerns to be reported, recorded and managed. Whilst seen as a positive development, there is room for improvement both in terms of the system itself and the application of its functionality.
- 6.16 The Audit recognises this as an issue for the NST. However, it is worth reflecting on the fact that some of the system's terminology is outdated, referring to historic abuse as opposed to non-recent abuse. There is no simple mechanism to identify SIRs reported to the Charity Commission and cases involving other agencies can't be easily distinguished. Furthermore, when records were migrated, reporting dates in some of the records were altered automatically by the system. Whilst not an issue going forward, there are likely to be legacy issues as they relate to accuracy.

- 6.17 During the Audit's fieldwork, the system held over 200 open concerns and 780 that were closed. For those that were open, these included ongoing safeguarding agreements, non-recent cases and a number where advice had been sought. The Audit heard that this was not necessarily a true reflection of activity as some of the cases have as yet not been marked closed.
- 6.18 Nearly 90 concerns were allocated to the DST as opposed to a named individual. In the opinion of the Audit, this runs the risk of capacity pressures being hidden, responsibility being diluted and increasing drift. Furthermore, the Audit believed there were opportunities for the DST to enhance its analysis of the system's data, by way of routinely monitoring the themes, patterns and trends of safeguarding. This could help contribute to the development of strategy and the meeting of defined training needs. Alongside the recommendations set out below, the Audit will engage the NST on some of the wider areas of improvement identified.

**Recommendation D14:** Further to the DST proposing the resources required, short-term appropriately qualified external support could be sought to rapidly update any inaccurate records.

**Recommendation D15:** The DST should prioritise the closing of outstanding concerns. Where additional capacity is required to help achieve this, this should be provided to help resolve this issue at pace.

**Recommendation D16:** The monitoring of patterns and trends of safeguarding concerns should be an adopted practice in the DST to identify emerging risk or training needs. This should be undertaken quarterly, with data shared with the DSAP and ISAG.

**Recommendation D17:** All open concerns should have an individual case owner allocated to them.



**Recommendation D18:** For all concerns where advice has been sought from the DST, case records should include a clear record of any action suggested by the relevant DSA or Caseworker.

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

6.20 Beyond these formal arrangements, the Audit saw the value of the strong relationships built by Diocese and Cathedral staff with external partners. These are accruing benefits in terms of trust, confidence and close partnership working. There will naturally be enhanced confidence in information sharing, although strengthening the formal framework in this respect should be further explored by the Diocese.

**Recommendation D19:** On behalf of the Diocese and Cathedral, the DST should engage the Wiltshire VPP and any other relevant safeguarding partnership. They should seek to establish the relevance of other information sharing agreements with which it should be formally involved.

6.21 Communication dealing with specific safeguarding concerns are secure in the sense they use work related e-mail accounts and password protected word documents. Whilst adding a level of protection, given the sensitive nature of the information with which the Diocese and Cathedral are dealing, more robust security should be mandated for third-party communication by way of using an encrypted email solution.

**Recommendation D20:** The Diocese and Cathedral should mandate the use of encrypted email software for external communication with third parties involving any safeguarding case.

6.22 From a broader systems perspective, the DST use the nationally prescribed case management system and two others to store personal information. Personnel data is stored on an online system and any paper copies of files are kept in locked filing cabinets.

## 7 Victims and Survivors

- 7.1 The Diocese has survivor representation on the DSAP, and the Audit was told that, wherever possible, efforts are made to consult and co-produce with victims / survivors. For example, the Audit saw evidence of this in the work undertaken on domestic abuse. The training developed involved contributions from a victim / survivor and an opportunity to hear about their experiences. The Audit was also reassured that the development of policy and strategy seeks similar engagement. In fact, the mission statement of the DST was created by a survivor.
- 7.2 That said, representing the views of one victim / survivor, or indeed the views of many, neither represents all, nor means that one person's experience will resonate elsewhere. One survivor engaged by the Audit highlighted how material they had seen from a particular source external to the DBF, whilst claiming to represent victims' voices, did not echo theirs. They reinforced the need to pause and think and to perhaps caveat messages by recognising that no one can accurately speak to everyone's experience. This level of sensitivity and reflection may be valuable as the DST move forward creating messages that acknowledge the limits of collective representation.
- 7.3 The Diocese has put in place measures to ensure that victims / survivors who disclose are engaged with the right people and supported by a caring, trauma informed approach. Indeed, the DST team leader is an exemplar in this sense and her absolute adherence to this approach has made a difference to those she has supported. Not all staff, however, will have the same ability and ensuring the system responds well should go beyond reliance on one individual.
- 7.4 The Audit saw evidence of a committed, professional, and focused approach by the DST. That commitment could be further enhanced if everyone was fully trained and supported in delivering planned and trauma informed practice. The Audit welcomes the fact that the DST team leader is already committed to taking this forward and recognises the impact of the work done by the ISVA.

7.5 Lines of communication with victims / survivors need to be agreed and consistent. Changes in representation, engagement and support must be thoughtfully managed. The Audit heard good evidence from some victims / survivors about how this had been done. Feedback also highlighted how changes, no matter how well intentioned, can be destabilising and how a failure to engage in the manner developed by a previous safeguarding professional could have a negative impact.

**Recommendation D21:** When a point of contact for a victim / survivor changes, a transition plan should be agreed and expectations set regarding the level and frequency of support. This plan should be developed and agreed with the victim / survivor.

7.6 The small number of victims / survivors the Audit engaged with felt that more needed to be done and worried that other victims and survivors needed to see change, before they could disclose. They also accepted (that to greater or lesser degree) things had improved. Very few were confident that their feedback to senior leaders was being reflected in practice. It is therefore important to ensure that when victim / survivor feedback is taken on board, that it is acknowledged, and feedback is provided as to any changes made. As and when appropriate, feedback should also include the difference that has been made.

**Recommendation D22:** Those engaged with victims and survivors should ensure that advice is captured and that where this is used to inform changes, feedback (with consent) should be provided through a pre-agreed channel.

7.7 In Salisbury, the Audit saw evidence of the commitment to support victims and survivors put into practice. Those who have suffered church related abuse can and do access a range of support. The Audit saw how the Diocese provided interim financial support when needed and how it demonstrated flexibility to fund particular and appropriate counselling. Several victims / survivors referenced the value of being engaged in this way. This is good practice. That said, ensuring that such support does not undermine the independence and control for the victim or survivor is also important. The victim / survivor should make the decisions about what is best for them and

their engagement with counsellors. The provision of such support should not be undermined by anyone, no matter how well intentioned. This can happen when church officers engage in matters that should at least be agreed in advance with the victim / survivor or, at best, led by them.

**Recommendation D23:** Policy should reflect that whenever possible victims and survivors in receipt of support should lead on how, when and where they engage with that provision, including counselling and any engagement with external professionals supporting a victim or survivor should not be made without their knowledge, and whenever possible, their agreement.

- 7.8 The Audit also heard from one victim / survivor who had met the Bishop. It was clear that this had a positive impact. The victim / survivor was impressed by the Bishop's approach to safeguarding and his commitment to dealing with safeguarding matters robustly. The records that the Audit has seen highlight that these assurances were more than mere rhetoric and corroborated the victim / survivors view of the Bishop's genuine commitment to drive change.
- 7.9 The majority of victims / survivors who engaged with the Audit had very negative, non-recent experiences concerning poor practice. This included the use of scripture as a mechanism to manage 'forgiveness', the involvement of a press officer in their case (reinforcing a view that the issue was about reputation management), or others (from the church) with titles that suggested responsibilities and authority they did not have.
- 7.10 In the past, most had also experienced the use of subtle and not so subtle victim blaming language or pressure to take responsibility for protecting others. No similar concerns were expressed about current practice. That is not to say the Diocese gets everything right all the time, and the Audit's recommendations highlight some room for improvement in this context. However, the overriding trajectory with regards to victim / survivor engagement, care and support is positive.

7.11 The victims / survivors engaged by the Audit had different experiences. They had been met with varying degrees of challenge when seeking support and most had lived many years of their lives maintaining the secret of the abuse they had suffered. One summed it up as living with a secret, after suffering at the hands of a trusted member of the church. Like many others, they didn't tell anyone for years because they'd been made to believe it was their fault that they, as a child, were somehow to blame. When they came to a time in their life when they wanted to know more about what had happened, the system was slow and the few documents that were released were so heavily caveated as to be virtually useless.

7.12 Dealing with the issues at the centre of church law and administration is outside the remit of the Audit, but it is worth highlighting that when safeguarding professionals at a local level attempt to obtain information on behalf of a victim / survivor, the system itself, (based on its need to comply with data protection and the rights of others) fails the most vulnerable.

**Recommendation D24:** When applying for or supporting a victim or survivor to gain access to information about their case, consideration should be given to providing them with recourse to legal funding.

## 8 Learning, Supervision and Support

8.1 The importance of creating opportunities to positively impact on the knowledge, skills and experience of the workforce is understood and actioned by the Diocese. Its strategy sets out an aspiration for a 'healthy Christian community' and the role that training (and other development opportunities) can have in improving behaviours, relationships and culture. Progress in this context can be seen in several areas. Firstly, training mandated by the NST has facilitated accessibility and a wider reach into the Diocese. Secondly, the funding of a dedicated trainer has helped build knowledge, relationships and a familiarity with the safeguarding agenda and the DST. Thirdly, there has been a shift in culture, with most staff and volunteers better understanding why training is so important for them.

8.2 Overall, feedback is positive about the quality and delivery of training, although there remain differences of opinion about learning style and content. For example, some PSOs identified the potentially traumatic nature of training for those who are new into role and inexperienced in safeguarding. They felt that online delivery could hinder access to support if this was required. For the national leadership sessions, there was a view that these didn't need to be split over two sessions. The Audit agrees, however, recognises that this is an issue for the NST.

**Recommendation D25:** The DST should ensure that the PSO cohort is fully alert to the support available to them to cope with the demands of their role, including the impact of attending training.

8.3 Many of those engaged by the Audit valued the work of the DBF's trainer in delivering face-to-face training and focusing on the local context of Salisbury and its respective parishes. This trainer has since left, and after consulting with other areas, the DST is planning to introduce freelance trainers as opposed to recruiting an in-house replacement. Whilst seeing the value in both methods, the DBF should keep this change under review.

8.4 Furthermore, with the NST providing Basic and Foundation level training for the workforce via online self-taught modules, the Diocese has been able to effectively concentrate its own resources on local priorities or areas of interest, such as Domestic Abuse. This is good practice, although a more routine methodology to identify learning needs could help the Diocese better understand where knowledge gaps exist.

**Recommendation D26:** The Diocese should introduce a training needs analysis process that routinely seeks the views of all relevant stakeholders about their learning requirements at a local level.

8.5 Pending the completion of this proposed analysis, the Audit also believes there should be a concentrated focus on two areas of ‘theme specific’ training. Firstly, there should be opportunities for church officers to develop a much more detailed understanding about the nature of sex offenders. Whilst noting the inclusion of this topic within NST training, detailed learning about predators and the nature of offending is both a relevant and contemporary issue for the Church. Secondly, digital safeguarding was highlighted as an issue where there were potential knowledge deficits.

**Recommendation D27:** The Diocese should develop or commission specific training that is focused on sex offenders and digital safeguarding. The Audit recognises that overarching responsibility for the training curriculum in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Diocese with the opportunity to apply interim mitigation measures.

8.6 Enhancing learning through implementing ‘role specific’ sessions is also seen by the Audit as a way of strengthening knowledge. Developed for defined cohorts of staff, these sessions could help improve the familiarity of safeguarding and its application in certain circumstances. Targeted sessions with church wardens, for example, could accrue benefits in terms of their understanding about individual responsibilities in the context of their role.



**Recommendation D28:** The Diocese should engage with the National Safeguarding Team to consider how some training could be appropriately adapted at a local level to address role and geographic specific context.

8.7 At present, the evaluation of training is limited to the quality of courses and there is little focus on any longer-term testing of impact. This leaves a gap in the Diocese's understanding of whether training is directly influencing practice and making people safer. The current manual system does not easily allow for analysis of trends.

**Recommendation D29:** The Diocese should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers, about how training has helped their practice.

8.8 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 Diocese a safer place.

8.9 Oversight of training is an area of scrutiny for both the DST and DSAP, although this has its limitations. There is no dedicated Learning Management System and the systems to track compliance are labour intensive, bureaucratic and lack intuition. That said, systems are changing, and some important data can be retrieved. This shows broadly positive performance, with 87% of relevant staff having completed the leadership pathway course in the last three years and 97% compliance from licensed roles.

8.10 Whilst in post, the DBF's trainer had access to external courses, NST sessions and made strong connections with a range of local safeguarding professionals. The Diocese should explore whether similar opportunities could be made more widely available. For example, Wiltshire VPP 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 D30:** The Diocese should engage in discussions with the Wiltshire VPP and other local authorities about the potential to access its multi-agency safeguarding training offer.

## Clergy Support

- 8.11 The Diocese has in place a range of mechanisms to assist its clergy. These include a Continuing Ministerial Development (CMD) programme, reflective practice groups, a clergy counselling scheme, annual retreats and access to a spiritual director / accompanier. Debrief sessions are also available from the DSOs or the ISVA as appropriate.
- 8.12 The Diocese also provides a good range of support (and challenge) for its ordinands. Whilst at Sarum College, they receive leadership level training and specific sessions from the DST. On placement, curates are also supported to complete a safeguarding audit of their parish and to then complete a theological reflection about trustworthiness (based on their safeguarding audit). This is good practice.
- 8.13 Ministerial Development Reviews (MDRs) also add value to the clergy through facilitating reflection, learning and improvement. That said, an enhanced focus on safeguarding within this process could accrue further benefits. Whilst training is referenced, MDRs are missing opportunities to explore what is working well from a safeguarding perspective, the outcomes being achieved, and future areas for growth and development.

**Recommendation D31:** The Diocese should strengthen the focus on safeguarding practice within the MDR process. Revised arrangements should align with the national safeguarding standards and be developed in collaboration with the DST.

## Supervision and Support of Safeguarding Roles

- 8.14 The DBF operates an effective and timely induction programme, enhanced by employees having a 1:1 meeting with a DSA on appointment. There is an expectation this takes place prior to any engagement with children, young people and adults at risk. The majority of staff believe induction covers what they need to know about safeguarding.
- 8.15 For those working in the DST, they form a close-knit team where there is mutual support, respect and good working relationships. Team members engage locally, regionally, and nationally and demonstrate a strong desire to contribute to developments and share expertise. They prioritise their own CPD, having attended various training events delivered by the NST, local authorities and others. They remain alive to the nature of their work and the personal impact this can have upon them. Where required, the team has access to a good range of support, including the availability of psychological support. Some, but not all members of the team, have regular wellbeing sessions with a counselling supervisor.
- 8.16 That said, given the context of the DSTs workload and its routine exposure to trauma, psychological support should be more defined within the DST's support systems. By this, the Audit believes that routine access to such support should be an expectation as opposed to 'available on request'.

**Recommendation D32:** The Diocese should consider implementing mandatory wellbeing support sessions from a counsellor for members of the DST, to ensure they are sufficiently supported in the challenging role they do.

- 8.17 There is also an appetite for innovation, with the team being an early adopter for the National Casework Management System and helping to develop the NST's Virtual Library and Leadership Pathway training course. The Diocese is also taking the lead in a national project to combine and streamline a number of different IT systems. As one of the 'Pathfinder Diocese',

the team benefit from support and dedicated input from the NST. This includes the DST team leader receiving supervision from the NST's Regional Safeguarding Lead.

- 8.18 For PSOs, there is scope to create a more systematic approach to their support. For a small number engaged by the Audit, they reflected concerns about the volume and complexity, of what they perceived to be unrealistic expectations, and how these run the risk of making people 'switch off'. Some also reflected their feelings of isolation. Whilst not unfamiliar issues to the Diocese, maintaining the confidence and competence of PSOs is a critical issue that requires ongoing consideration by leaders.

**Recommendation D33:** Beyond ensuring ongoing access to existing training and support, the Diocese should review what else could be done to help PSOs in the crucial role they occupy.

- 8.19 Alongside the recognition events already planned by the Bishop, the Diocese should consider introducing arrangements that facilitate regional peer support, access to mentoring and supportive supervision.
- 8.20 The Diocese should also support and sponsor an annual PSO conference. This should link to the overarching learning and improvement framework led by the safeguarding team. It would provide an opportunity to highlight the good work done, expose PSOs to external speakers, providing an insight on survivor's experiences and deliver scenario based contextualised training.

# Part Two - Salisbury Cathedral

## 9 Context

- 9.1 Salisbury Cathedral has a rich and fascinating history and is the home of one of the last surviving manuscripts of the Magna Carta. It is an impressive landmark and a focal point for both the local community and many visitors. Its functions are wide ranging, with the Cathedral's 82 full-time equivalent staff and some 620 volunteers managing a busy programme of events, activities, and day-to-day business.
- 9.2 To put this in context, the Cathedral receives more than nine thousand visitors a week. In the last year, it has held 616 individual events and hosted 104 school visits involving 3299 children. 1700 pupils also attended the 'leavers services' in July 2023. An average of 500 people attend the Cathedral each week for weekday worship and attendance on a Sunday is more than 350.
- 9.3 The Cathedral is a registered charity and led by its Dean, The Very Revd Nicholas Papadopoulos and the Chapter. As the corporate body, the Chapter is comprised of four Executive members (the Dean and the three Residentiary Canons) and up to eight non-executive members. The Cathedral is also supported by a 'Vicar of the Close' and is in the process of appointing a new 'Missioner for Young People'. Other roles include, but are not limited to, the Head Verger, Vergers, Floor Manager, Head Caretaker, Caretakers, Shop Manager, Shop Assistants and Welcome Desk staff. The Cathedral benefits from the help of many volunteers and has a close working relationship with the Cathedral School, at which its choristers are supported by the School's Chorister Tutor.

## 10 Progress

- 10.1 The SCIE audit of the Cathedral was published in January 2019 and made 15 recommendations for improvement. Most of these have been completed, some were delayed during the pandemic (but are now in progress) and others were subsumed into the Cathedral's safeguarding priorities. These priorities focus on meeting the needs of vulnerable people and signposting to other appropriate agencies, developing an understanding of domestic abuse, appropriate responses and guidance for frontline staff as well as a programme of work to make the Cathedral a dementia friendly environment. Work remains ongoing and is being led and overseen by appropriate clergy and Cathedral staff. The Cathedral's Independent Safeguarding Advisory Group (ISAG) provides an additional layer of scrutiny.
- 10.2 PCR2 audits provided positive feedback on safeguarding practice at the Cathedral. Whilst a further examination of the recommendations indicates that these findings are based on evidence, the Audit takes the view that communicating outcomes across the Cathedral community acts as reassurance that the voices of children and adults are being heard. This therefore should remain an ongoing requirement.
- 10.3 Evidence of a continued focus on safeguarding and an appetite to reflect and learn is evident in the Cathedral's response to a number of safeguarding issues and its recent commissioning of an independent learning review of an ongoing case at the end of 2023. At the time of writing, the case review has yet to be completed and a criminal investigation is ongoing. Despite this, the Audit has seen sufficient evidence to form a view that the Cathedral has responded in an appropriate and timely manner.
- 10.4 The Audit has seen evidence that the implementation of previous recommendations has positively impacted on the development of policy and the application of practice. The findings of this Audit reflect that this progress continues and where appropriate, additional recommendations are made to support the Cathedral's ongoing improvement journey.

## 11 Culture, Leadership and Capacity

- 11.1 The 2019 SCIE audit identified that the culture of safeguarding at the Cathedral was widely acknowledged to be a work in progress. Efforts in this respect have continued and whilst there remain some stubborn challenges, there is evidence of improvement.
- 11.2 Governance arrangements allow for safeguarding performance at the Cathedral to be overseen and for activity (both strategic and operational) to be tracked, independently scrutinised and peer reviewed. The Dean and Chapter Clerk maintain a direct role in oversight, influence and decision making, with safeguarding being a standing item at meetings of the Chapter and the Cathedral's Executive Team. Nearly all senior roles discharge their responsibilities effectively and help to promote a positive culture in which safeguarding is a priority.
- 11.3 Collaboration is evident through the Cathedral's ongoing interface with the DST and DSAP. The Dean and Chapter Clerk hold regular meetings with the DSA and there has been engagement with the regional lead from the NST. Good communication initiatives exist by way of sermons, newsletters, surveys and monthly staff briefings. These are helping the Cathedral to raise awareness and to proactively open conversations about areas of concern. Appropriate safeguarding information is displayed on public noticeboards, although these might in some spaces, have a somewhat limited profile. Whilst recognising there are limitations (given the Cathedral's infrastructure), there could be benefit accrued by making this available in other public spaces, such as in the Cathedral's washrooms.

**Recommendation C1:** To facilitate information being easy to access, the Cathedral should consider including relevant safeguarding material in other public spaces beyond the general noticeboards.



11.4 Most people feel safe at the Cathedral. There is evidence that leaders act with integrity, that they listen and demonstrate a compassionate and caring attitude. For those who work, volunteer or worship at the Cathedral, many see it as welcoming, supportive and reflective. That said, for some, this is not their perception. A small minority have concerns about the priority being afforded to safeguarding, conflicts of interest and potential barriers to reporting. The sufficiency of the arrangements as they relate to choristers, the Cathedral and the Cathedral School are a particular point of reference.

11.5 Notwithstanding the evidence of progress and the work of the Cathedral in 2022<sup>6</sup>, the root causes of these concerns and their impact on culture require further consideration. Whether systemic or issues relating to individual competence, such concerns (whether perceived or real) have the potential to significantly impact on how people feel.

**Recommendation C2:** The Cathedral should deliver a survey that is specifically targeted at identifying perceptions of negative culture across all its stakeholders.

11.6 The questions set out in the CofE's 'Healthy Culture Survey'<sup>7</sup> should be used for this purpose, although these should be further adapted. The Cathedral's survey should also seek evidence and examples of where and how negative culture manifests, what the barriers are to escalating concerns and ask for suggestions as to how these could be addressed.

11.7 This initiative should be supported by an awareness raising strategy that engages all stakeholders of the Cathedral.

11.8 The outcome of the survey should be used to inform the Cathedral's approach to eradicating the remnants of a negative culture and improving practice.

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<sup>6</sup> The Cathedral ran a staff survey in 2022, with follow up staff engagement events.

<sup>7</sup> <https://www.churchofengland.org/safeguarding/national-safeguarding-standards#na>

- 11.9 The findings should inform a plan of action to reinforce and spread the positive culture felt by the majority. This should be driven by Cathedral leaders at all levels and monitored by the ISAG.
- 11.10 Roles and responsibilities in the Cathedral are broadly well defined, the Dean's accountability is clear, and arrangements reflect the expectations of both the CofE and statutory requirements.<sup>8</sup> There is a leadership commitment to strengthen safeguarding, as seen through the recent uplift in the DSA support from the DST and the Cathedral's strategic priority to support and develop its staff and volunteers. There is also an acknowledgment that more can be done.
- 11.11 The overwhelming majority of leaders have a good grip on their responsibilities. Senior roles, such as the Chapter Clerk and the Dean, provide a layer of credible support, effective decision making and authoritative practice. There is a reassuring 'safeguarding first' approach to the management of cases, consistency with the CofE's expectations<sup>9</sup> and a rigour in mitigating risk. This level of leadership has been sustained despite the challenges seen in some cases involving the Cathedral's workforce. These have required compliance with regulations that prevent the transparent explanation of actions. Doing the right thing in such circumstances has, on occasion, resulted in a personal impact on decision makers.
- 11.12 The leadership as it relates to the Cathedral's choristers is a specific area for improvement. Whilst those responsible in this area have undertaken training and demonstrated a commitment to safeguarding, ambiguity in the leadership arrangements are impacting on practice, decision making, trust and confidence. The key leadership team in this regard, the Canon Precentor, the Director of Music, Assistant Director of Music and the Chorister Tutor must ensure that each understands their role and responsibilities. This is critically important when it comes to the line management and supervision of frontline staff, for example the vergers and children and young people themselves. To this end, the Audit makes the following recommendation:

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<sup>8</sup> Such as those issued by the Charity Commission.

<sup>9</sup> Responding Well to Victims and Survivors of Abuse.

**Recommendation C3:** Those responsible for oversight of choristers need to re-visit and reinforce their safeguarding training as it relates to their chorister specific duties. This should be developed and delivered by the DST and whilst not limited to, should include:

- a) The importance of effective information sharing,
- b) Their responsibility when it comes to supervision and support of their line managed staff, including checking the status of staff training and vetting,
- c) Good record keeping and
- d) Once re-training is complete, individual levels of understanding should be formally assessed by the DSA.

11.13 Further analysis of the Cathedral's safeguarding arrangements for choristers is addressed in a separate section of the report.

11.14 The ISAG was established in 2016. This forum provides opportunities for independent oversight and the implementation of initiatives aimed at strengthening the Cathedral's arrangements. In 2022 for example, the ISAG identified the need to enhance safeguarding awareness for certain groups within the Cathedral. This led to the development of specific workshops for education volunteers.

11.15 Membership of the ISAG is defined, there is regular attendance, and a new chair has recently been appointed. However, the voluntary nature of this role runs the risk of compromising the ISAG and its ability to provide independent leadership and hold leaders to account. Building on its appetite to learn and improve, the following recommendation is made to support the ISAG's integrity and the credibility of the scrutiny to which the Cathedral is exposed. This will help its improvement journey.

**Recommendation C4:** Similar to the arrangements for the DSAP, the independent chair of the ISAG should be a paid role.

11.16 There are good links between the ISAG and DSAP and the cross representation at each forum has supported the ability to share experiences and expertise. Whilst combining the ISAG and DSAP has been considered, there are no plans in place to merge these groups. The Audit agrees with this approach. Keeping both forums separate allows for a clear focus based on the distinct contexts of the Cathedral and Diocese.

11.17 There are no roles within the Cathedral solely focused on safeguarding. The Chapter Clerk is the operational lead, the Canon Precentor is the Chapter's representative who is also a Safeguarding Governor at the Cathedral School. The HR Manager is responsible for DBS processes and, together with the Volunteers Manager, the wider safer recruitment arrangements and training. The vergers are the immediate point of contact for matters that arise on the Cathedral floor. Most staff with responsibilities for safeguarding are confident they can fulfil these within their contracted hours. That said, they have other duties to perform so safeguarding is one of the many priorities they have. This is why their relationship with the DST is so important.

11.18 For casework, the DST provides support through a Service Level Agreement (SLA) that now includes a DSA for two days a week. This resource reflects a recent uplift in capacity and has been a positive step in strengthening capacity. Whilst recognising the effectiveness of this support, safeguarding arrangements could be further enhanced if this resource was directly 'owned' by the Cathedral. This would mitigate the risk of any impact arising due to pressures in the DBF and allow for a dedicated Cathedral Safeguarding Advisor (CSA) to have a singular focus on the Cathedral's context.

11.19 Furthermore, recognising the span of control of the Chapter Clerk, the recommendation made for the Diocese to create a Director of Safeguarding role has equal relevance for the Cathedral. This role could provide the direct line management support for the CSA and have the responsibility to lead on the strategic oversight and coordination of the Cathedral's safeguarding arrangements.

11.20 Given the connectivity with the DBF and the Cathedral School, alongside its unique responsibilities for the safety of choristers and the Cathedral's infrastructure, there is a clear rationale supporting this suggestion. Importantly, safeguarding would be the priority for this role, not one amongst many.

**Recommendation C5:** The Cathedral should invest in a dedicated Safeguarding Advisor that has a sole focus on safeguarding activity in the Cathedral. This role should be employed by the Cathedral and report to a proposed Director of Safeguarding (that will have responsibility for the Cathedral's and Diocese's arrangements).

**Recommendation C6:** The Cathedral should enter into a SLA with the Diocese covering the funding and responsibilities of the proposed Director of Safeguarding.

## Chorister Safeguarding

11.21 The Cathedral's approach to safeguarding choristers is supported by policy and an awareness of the priority that needs to be afforded to this group of children. That said, the Audit identified areas of oversight and practice that require immediate improvement.

11.22 Some of the leadership arrangements for the Cathedral's choristers are insufficiently robust and this has resulted in weaker practice in a variety of contexts. There has been divergence from the Chorister Contract including but not limited to, ambiguity concerning the responsibility of the Chapter and school and the handling of issues linked to the care and wellbeing of choristers. It was also clear that there was an unhelpful level of ambiguity regarding chorister parents understanding of who was responsible for their children at particular times and places. It was clear this has caused confusion, anxiety and uncertainty amongst the majority of parents and carers engaged by the Audit.

11.23 Multiple instances have arisen at the Cathedral where concerns about choristers have been re-directed to the school without being appropriately considered or recorded first by those responsible for choristers in the Cathedral. As some of the Cathedral's staff also occupy positions at the school (such as the Chorister Tutor / Head of Boarding), boundaries may have become blurred and led to confusion. It is essential that there is absolute clarity in this context.

**Recommendation C7:** The Cathedral should ensure that all staff and volunteers fully understand that any incident taking place on Cathedral grounds is unequivocally the responsibility of the Cathedral to respond to (in line with defined reporting arrangements). This clarification should be evident in all communication with chorister parents, including relevant policies and training materials.

**Recommendation C8:** The Cathedral should work with the Cathedral School to assess the feasibility of separating the Chorister Tutor and Head of Boarding roles. This evaluation should also consider addressing gender dynamics in the form of identifying an additional female Chorister Tutor. This could help with capacity and offer choice for choristers in respect of who they can approach for support.

11.24 Whilst supervision of the choristers has recently undergone some positive changes, there remains scope for improvement. One such area relates to the functions of the Chorister Tutor and what happens when this role is extracted from its core duties. The Audit heard of occasions where this had resulted in choristers being left unsupervised. There also remains a lack of clarity on who assumes responsibility for choristers during 'off-term boarding' and during specific events or tours.

**Recommendation C9:** In line with the written agreement in place between the Cathedral and Cathedral School, the Chorister Tutor(s) (when present as the responsible party for the choristers in the Cathedral) should not undertake any wider duties during services without appropriate delegation of care to another member of staff, which has been clearly communicated to parents.

**Recommendation C10:** The Cathedral and school should review and revise all relevant policies governing the care of choristers outside of term time and during specific events and tours. This arrangement should expressly forbid the delegation of supervisory or care responsibilities to anyone who not a formal employee, a vetted adult volunteer or someone contracted to either the Cathedral or school.

**Recommendation C11:** The Cathedral should develop and implement a specific 'Missing Child' policy covering the arrangements for choristers when both on-site and off-site.

11.25 In terms of communication and engagement, positive practice was noted in weekly chorister meetings providing a dedicated space for conversation and relaxation. Additionally, the direct involvement of the Bishop and the Dean was viewed favourably in terms of enhancing chorister wellbeing.

11.26 There is less assurance about the Cathedral's communication and engagement with parents and carers. Despite a Chorister Parent Representative Group being established, issues relating to its frequency, administration and the sharing of concerns ultimately resulted in fractured relationships and the group being disbanded. For some parents and carers, they are concerned that raising concerns can have repercussion for their child's role in the choir. Creating spaces for safe dialogue, relationship building, and problem resolution are key. It is understood that the Headteacher, Chapter Clerk, Canon Precentor and Director of Music are taking action to address this. In addition, the following recommendation is made.

**Recommendation C12:** The Cathedral should re-establish the Parent Representative Group. Terms of Reference should be defined that set out its purpose, membership and administration. It should be chaired by the Cathedral School Headteacher, include the Chorister Tutor(s), the CSA and relevant Cathedral staff. The group should facilitate authentic communication that can explore what is working well and what needs to improve from a chorister perspective

11.27 Ongoing challenges were being experienced by some choristers in terms of their mental health and the physical impact upon them given the intense scheduling of rehearsals and events. A key concern expressed to the Audit related to the vocal health of choristers and the lack of clear arrangements that help support the early identification of emerging problems. While primarily a matter of welfare, it's important to note that welfare issues can escalate into safeguarding issues, as outlined in Working Together to Safeguard Children 2023.



**Recommendation C13:** The Cathedral should ensure regular training and refresher training for music staff on the vocal health of choristers.

**Recommendation C14:** The Cathedral should implement a defined schedule that ensures all choristers routinely visit the Chapter's Voice Specialist. Any recommendations made concerning a chorister's care should be formally recorded and reviewed by the voice specialist regularly.

## 12 Prevention

- 12.1 As part of its safeguarding arrangements, the Cathedral has in place a good range of preventative measures. These include a focus on safer recruitment, codes of conduct, mechanisms to raise awareness, engagement, workforce safety and site safety.
- 12.2 Safer recruitment is a priority at the Cathedral. Processes are aligned to legislation, relevant policies and key guidance issued by the CofE. Recruiters at the Cathedral are suitably trained, support is easily accessible and there is routine promotion about the importance of this issue. The Cathedral has developed some useful guidance to outline the minimum level of training and criminal record checks for certain roles.
- 12.3 Pre-recruitment activity is also strong. Applications are clear and easy to navigate, including a 'self-disclosure' and 'confidential declaration' form. This process applies to all roles, including clergy, employees, ordinands and volunteers who are to be in substantial contact with children and / or adults experiencing, or at risk of abuse or neglect. References are appropriately sought and there is a defined process in place for seeking criminal records checks. Arrangements are also in place at the Cathedral for re-checking staff on a three yearly cycle (reduced from five years). This is good practice. That said, in one instance, the Audit identified a member of staff where this timescale had lapsed.

**Recommendation C15:** The Cathedral should review its records for criminal records checks to ensure no other staff or volunteers miss the local requirement for three yearly re-checks.

- 12.4 During its fieldwork, the Audit heard that volunteer servers do not require any level of criminal record check and yet their role may bring them into contact with the young, vulnerable and indeed, the Cathedral's choristers. Based on this feedback, the following recommendation is made.

**Recommendation C16:** The Cathedral should review the functions of volunteer servers and other roles where a DBS check is currently not required. For each role, this should establish whether a check necessary and at what level. To note, a basic check can be undertaken for any position or purpose.

12.5 As with the Diocese, advertising as part of safer recruitment is an area that would benefit from improvement. For example, opportunities are being missed by the Cathedral in not using job adverts to reinforce key messages about safeguarding. This can be helpful in acting as a deterrent.

**Recommendation C17:** Job descriptions at all levels in the Cathedral should include a defined statement that defines their responsibility for safeguarding.

12.6 The Cathedral has an up-to-date Staff Handbook and Volunteer Handbook, both of which are comprehensive and signpost to relevant policies. Of those who completed the Audit's survey for the Cathedral workforce, the significant majority confirmed they follow the Code of Conduct. There was some uncertainty expressed as to whether this applied to all staff and volunteers.

**Recommendation C18:** The Cathedral should clarify and communicate the applicability of the Code of Conduct to the various roles in place across its workforce

12.7 With a focus on preventing harm, the Cathedral delivers a range of awareness raising activity. This is ordinarily routine, and includes information being publicly displayed in the Cathedral. At the time of the Audit's visit, there was clear signage, details of safeguarding contacts and a poster to encourage participation with the Audit.

12.8 The Cathedral's website also has a strong, clean and modern theme and is mobile responsive. Its safeguarding webpage provides clear messaging, contact information and access to key documents. The Audit identified this could be strengthened by promoting access to other services and emphasising what action to take in an emergency. The 'raise a safeguarding concern or complain' button directs users to the CSA's email address.

**Recommendation C19:** The Cathedral safeguarding webpage should include information on what do if someone has an immediate concern or is at risk of immediate harm. It should also be enhanced to include information about other local / national support services (including the local authority and Wiltshire VPP).

**Recommendation C20:** The Cathedral should seek reassurance that the CSA's inbox is routinely covered when the CSA is absent from work. This will ensure escalated concerns are dealt with promptly.

12.9 There is evidence of meaningful and appropriate discussions at the Cathedral about safeguarding. Examples range from sermons being delivered, safeguarding being an item on the agenda at key meetings and discussions during volunteer safety update sessions. The work by ISAG led to specific awareness for certain groups within the Cathedral.

12.10 Other than for individual safeguarding cases, none of the Cathedral's staff participate in forums convened by statutory agencies such as Wiltshire VPP, the Community Safety Partnership or Health & Wellbeing Boards. All these settings have a clear focus on the safeguarding prevention agenda and would be useful to engage with. As a first step, contact with the Wiltshire VPP should be prioritised. This recommendation has already been covered for the DST.

12.11 As part of its overall prevention agenda, there is also evidence that the Cathedral seeks to capture the voices of key stakeholders. Opportunities to listen to the volunteer workforce are

regular and a worker dedicated to engaging young people is due to be appointed. However, the membership of the ISAG in this context could be strengthened.

**Recommendation C21:** The ISAG should replicate the arrangements in the DSAP and seek to ensure there is routine victim / survivor representation at its meetings.

12.12 Robust practice was seen in the day-to-day functioning of the Cathedral and the work undertaken to ensure those who visit, and worship are made safer. Risk assessments undertaken by the education team are focused, clear and shared with schools beforehand. Concerns were expressed about variability in supervision arrangements, which for schools, were often set based on their resources as opposed to the Cathedral's preferred expectations.

**Recommendation C22:** The Cathedral should issue guidance for schools detailing a flexible approach to adult / child ratios for school visits to the Cathedral. This guidance should allow the Cathedral to consider the individual circumstances of each school and empower the education team to make a professional judgement about the acceptability of the visit, based on a clear assessment of risk.

12.13 To help emphasise the importance of the Cathedral's risk assessment, some small yet important changes could be made to the tool itself. As written, it is very 'health and safety' centric, with no reference to the term safeguarding. Given that all the risks being mitigated are likely to fall under the wider definition of safeguarding, it would be sensible to restructure this to include a section focused on safeguarding. Whilst to some, this might not seem significant, for busy professionals, emphasising its focus can help focus minds.

**Recommendation C23:** The Cathedral should amend its risk assessment tool which is used to assess and mitigate risks for visits to the Cathedral, to include a specific section on safeguarding.

12.14 Those working or volunteering at the Cathedral are its 'eyes and ears' and remain committed to ensuring that people are both welcomed, feel safe and are safe. In respect of their safety, the Cathedral has in place a lone working policy, that is augmented with a generic risk assessment tailored to address specific circumstances. This is good practice.

12.15 That said, the Audit heard of some specific instances where volunteers could be exposed to lone working, such as through individual tours of the tower. Decisions as to whether to facilitate these are often left to the volunteer. The national guidance on Safer Environment and Activities emphasises the importance of avoiding lone working situations.

**Recommendation C24:** Tower tours should not proceed if only one person presents for the tour. This measure is crucial to avoid situations where a volunteer and an individual may find themselves isolated in secluded areas.

12.16 With regards to the Cathedral's physical infrastructure, it comprises a multitude of offices and secluded areas. Amongst these spaces, the seclusion of the chorister's practice room stands out as a particular concern. Balancing tradition and the promotion of a secure environment is essential for the harmonious existence of the Cathedral as both a cultural institution and a safe haven for those visiting.

12.17 For security, the Cathedral employs a multi-layered approach. During the day, the Floor Manager and Vestry Team address general concerns such as unattended bags or if a member of the public is displaying concerning behaviours. Panic buttons are strategically located around the Cathedral, and there is a radio call system to allow for immediate contact with key staff. In case of a significant security incident, procedures involve the Executive Team. For major security incidents, Wiltshire Police Counter Terrorism team conducts risk assessments in collaboration with the Cathedral. The Audit was advised of work with external organisations for the contracting of security functions.

12.18 CCTV monitoring plays a crucial role in enhancing the overall security of the Cathedral. Whilst not monitored around the clock, the Cathedral’s Floor Manager primarily oversees the footage, ensuring a vigilant eye on critical areas. The stored and recorded footage serves as a valuable resource for reviewing incidents or potential security breaches. To bolster the Cathedral’s arrangements, CCTV coverage could be expanded to several areas identified as vulnerable.

**Recommendation C25:** The Cathedral is encouraged to expand CCTV coverage in the Cathedral to include the area towards the Chapter Office, St Ann’s Gate and the chorister’s practice room.

## 13 Recognising, Assessing and Managing Risk

- 13.1 The Audit heard how staff can be required to manage risks that range from high profile visits, public events and incidents involving structures and people, to allegations of inappropriate behaviour, misconduct, and recent and non-recent abuse. The fact that risk can arise from people connected to the Cathedral, the wider church or those worshiping in or visiting it, was recognised and the vast majority of those engaged by the Audit were confident that any concerning behaviour would be quickly identified and reported. The Audit shares this view.
- 13.2 Arrangements in place at the Cathedral support the identification, management, and mitigation of risk. These include relevant policies, awareness raising and training that make identification more likely. They cover defined reporting routes that facilitate swift access to expertise, advice and senior management oversight. They also involve clear processes that provide structure for collaboration and planning.
- 13.3 In respect of individual cases, safeguarding concerns are properly triaged. Decisions about further action routinely involve discussions across a range of stakeholders and are agreed at the appropriate level of management.
- 13.4 Whilst numbers of safeguarding cases at the Cathedral remain relatively low<sup>10</sup>, demand is showing a trajectory of growth, with cases being varied and presenting a range of different challenges. They have involved both contemporary issues and non-recent allegations of abuse. Several have triggered onward referrals to statutory authorities, and / or engaged the Cathedral's disciplinary process.

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<sup>10</sup> At the time of writing, the Cathedral was managing four active cases.



- 13.5 In the cases seen by the Audit, there was evidence of good practice by the CSA and the Cathedral team, with timely decisions and appropriate action being taken to investigate and mitigate risk. There was also evidence of collaboration with and referrals to statutory authorities, as well to the Cathedral's disciplinary process. Most staff and volunteers were confident they understood how to escalate a concern and were equally confident in being able to handle a disclosure. However, a system is only as reliable as its weakest link. It was therefore concerning that a small number were unclear about where to find the relevant policies and procedures. This is a matter that can and should be addressed via awareness raising, supervision and support.
- 13.6 Risk assessments led by the CSA are focused and firmly centred on victims, potential victims and the vulnerable. This is positive and reflects a 'safeguarding first' approach to practice. Recording is consistent, with assessments detailing review dates, involved agencies and defined actions to mitigate risk. There is evidence of leaders taking authoritative action through suspensions, dismissals and individuals being excluded from the Cathedral and its grounds. For cases involving members of the public, there is equally firm evidence of partnership working, collaboration and the sharing of information with statutory agencies.
- 13.7 With regards to those circumstances where safeguarding agreements are required, the Audit saw evidence of effective practice. Whilst none were in place at the time of the Audit, cases led by the CSA and DST included clear prohibitions and actions regarding expected behaviours. Agreements were clearly defined, proportionate and authorised appropriately. Scheduled reviews allowed for oversight of compliance, ongoing refinement and for Core Group members to address any emerging issues.
- 13.8 A multi-agency approach to developing safeguarding agreements was also evident, with there being routine input from both the police and probation service. Decision making was influenced through the sharing of information and professional expertise. Alongside mitigating the risk derived from an individual, their safety and welfare was also properly considered.

- 13.9 Whilst not directly related to a case in the Cathedral, this section and its recommendations in Part One of the report apply to anyone involved in Safety Plans in the Cathedral.
- 13.10 See paragraph 6.8 and Recommendation D11 and D12.
- 13.11 There is clarity that if the subject of the agreement relocates to another church or diocese, information will be shared with the new settings. This is good practice.
- 13.12 Core Groups are routinely facilitated and are effective at overseeing individual safeguarding cases. They are ordinarily timely, managed well and comprise relevant representation. These key forums are often chaired by someone who is independent of the Cathedral, such as an Archdeacon from within the Diocese. This helps to promote reflection and enhance the credibility of decision making. Auditors saw evidence that Core Groups actively considered the support needs of all involved parties, with plans being trauma informed and sensitive. Feedback provided to the Audit from victims / survivors very much reinforced the benefits of this focus.
- 13.13 There is no escalation process to help manage differences of opinion about the decisions and action taken on safeguarding cases. Recommendations made for the Diocese address this point and apply to the Cathedral's arrangements.
- 13.14 From a practice perspective, support from the DST and the CSA is highly valued. There is an internal culture of mutual support, with the response to safeguarding concerns reflecting a spirit of collaboration and effective teamwork. This approach extends beyond the Church.
- 13.15 There are consistent levels of engagement with Wiltshire's Designated Officer for Allegations (DOFA)<sup>11</sup> and the Audit also saw examples of effective partnership working with the police and

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<sup>11</sup> The DOFA is a Local Authority role that is responsible for the management of allegations against staff and volunteers as part of Wiltshire's local multi-agency safeguarding arrangements.

local authorities. Positively, the DOFA told the Audit that allegations are taken seriously by the DST and proactively followed up. He further noted the enthusiasm with which the team engage in appropriate and relevant training.

13.16 Good relationships are also being maintained with the voluntary and community sector and this has helped facilitate help for people on matters such as domestic abuse and homelessness. There is confidence in the competence of the DST to seek out other support networks as required. That said, tighter engagement with Wiltshire's Vulnerable People Partnership (as previously recommended for the DST in this report) may help broaden the team's awareness of the services available and prompt new relationships to develop with the third sector.

13.17 Consistent with its status and the requirements of the Charity Commission, there is evidence that the Cathedral continues to identify and submit Serious Incident Reports (SIRs). Relevant cases are considered by senior leaders, with the Chapter making the final decision as to whether SIRs are sent or not. The SIRs seen by the Audit found decision making and supporting rationale to be appropriate.

13.18 Given the fact that the Cathedral is supported by a CSA and a SLA with the DST which includes the management of concerns via the safeguarding case management system, please refer to paragraph 6.15 - 6.18 and see Recommendations D14, D15, D16, D17, and D18.

13.19 The Cathedral advised the Audit that all personal information is stored and shared in ways which are compliant with data protection legislation and the General Data Protection Regulations (GDPR). Testing in this context was limited, although for safeguarding concerns arising in the Cathedral, there is a layer of reassurance with the use of the newly implemented system.

13.20 The SLA in place across the DBF and Cathedral sets out clear parameters governing the legal and best practice requirements for information sharing. Both bodies are signed up to relevant

agreements issued by the CofE and there is a defined agreement in place with the police covering the work of the DST.

13.21 Beyond these formal arrangements, the Audit saw the value of the strong relationships built by Diocese and Cathedral staff with external partners. These are accruing benefits in terms of trust, confidence and close partnership working. There will naturally be enhanced confidence in information sharing, although strengthening the formal framework in this respect should be further explored.

**Recommendation C26:** On behalf of the Cathedral and Diocese, the DST should engage the Wiltshire VPP and any other relevant safeguarding partnership seek to establish the relevance of other information sharing agreements with which it should be formally involved.

13.22 Communication dealing with specific safeguarding concerns are secure in the sense they use work related email accounts and password protected word documents. Whilst adding a level of protection, given the sensitive nature of the information with which the Cathedral and Diocese are dealing, more robust security should be mandated for third-party communication by way of using an encrypted email solution.

**Recommendation C27:** The Cathedral should mandate the use of encrypted email software for external communication with third parties involving any safeguarding case.

13.23 From a broader systems perspective, the Cathedral provided reassurance that it had strong measures in place to protect its IT systems. These are supervised and reviewed by a contracted IT support provider. The Cathedral has Cyber Essential Certification.

## 14 Victims and Survivors

- 14.1 See the section on Victims and Survivors in Part One of this report.
- 14.2 The ISAG does not have victim or survivor representation but the Cathedral is aware of this and the need to establish engagement. Additional opportunities to promote collaboration with victims / survivors could also be achieved through improved signage, communications and awareness raising across the Cathedral's footprint.
- 14.3 That said, whilst engagement has generally been reactive and related to non-recent church-based abuse from the 1970s and 1980s, the Auditors saw evidence of the Cathedral supporting survivors who came forward to report contemporary concerns. The Cathedral is supported in such cases by the DST and ISVA. It also has a well developed partnership with Wiltshire local authorities DOFA / LADO.

**Recommendation C28:** The Cathedral via the ISAG should expedite its efforts to provide supportive and appropriate pathways to engage victims / survivors. This should be benchmarked against the approach adopted by the DST and DSAP.

## 15 Learning Supervision and Support

- 15.1 The importance of developing the safeguarding knowledge skills and experience of the workforce is recognised by Cathedral leaders. There is a defined induction process, formal training courses and other events that are relevant and of good quality. Opportunities to learn are appreciated and there is evidence of good practice. That said, there is an inconsistency in how learning is delivered across the Cathedral, with a noted variability in compliance and who receives what and when.
- 15.2 For example, whilst most staff have completed their mandatory training, for the much larger cohort of volunteers (and some specific roles in the Cathedral), there is scope for improvement. Furthermore, whilst many have received an induction and considered it to be sufficient from a safeguarding perspective, this is not the same experience for everyone. The Audit heard feedback about the need to strengthen induction arrangements, particularly for volunteer servers. The Audit agrees.

**Recommendation C29:** The Cathedral should review its induction arrangements and ensure that all volunteers systematically have access to a defined programme that includes a clear focus on safeguarding.

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

- 15.3 Whilst the DST helpfully tracks training compliance for some of the Cathedral's workforce, this process does not cover everyone. For those not in scope, monitoring arrangements remain

reliant on the 'active management'<sup>12</sup> of a spreadsheet that by its nature, lacks intuition. Whilst this is far from ideal, the planned roll out of a new system will allow for training compliance to be monitored for all roles in both the Cathedral and across parishes. This is positive. Once implemented, this new system has the potential to significantly strengthen oversight and support both managers and the workforce in keeping up to date with their required learning.

15.4 In terms of the type and availability of training, locally designed sessions led by the CSA have been highly valued in complementing the NST programme. Involving scenario-based case studies, group discussions and a focus on the specific contexts of the Cathedral and Diocese, this training reflects best practice.

15.5 In the opinion of the Audit, expanding the availability of this face-to-face training and targeting each session towards particular groups of staff (such as volunteer servers, vergers etc) will accrue significant benefits.

15.6 Similar to the findings in the Diocese, the Audit also believes there should be a concentrated focus on two areas of 'theme specific' training. Firstly, there should be opportunities for staff and volunteers to develop a much more detailed understanding about the nature of sex offenders. Whilst noting the inclusion of this topic within NST training, detailed learning about predators and the nature of offending is both a relevant and contemporary issue for cathedrals. Secondly, digital safeguarding was highlighted as an issue where there were potential knowledge deficits.

**Recommendation C31:** In conjunction with the DST, the Cathedral should develop a mandatory programme of CSA delivered, face to face training that is targeted at specific groups of staff working or volunteering in the Cathedral. The CSA should add additional role-specific training where appropriate.

<sup>12</sup> In 2019, SCIE found that the spreadsheet in place at the Cathedral required 'active management'.

**Recommendation C32:** The Cathedral should ensure that attendance at these training sessions is appropriately recognised through the issuing of certification.

**Recommendation C33:** The Cathedral should develop or commission specific training that is focused on sex offenders and digital safeguarding. The Audit recognises that overarching responsibility for the training curriculum in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Cathedral with the opportunity to apply interim mitigation measures.

**Recommendation C34:** The Cathedral should ensure the CSA courses are evaluated in line with an enhanced evaluation process. This should include a post course evaluation and a follow up survey (3-6 months afterwards) that seeks how training had been applied in practice, made people safer and / or strengthened arrangements.

- 15.7 A range of support systems are in place for the Cathedral's clergy to help them cope with the challenges of their role and potential trauma. In the main, these derive from the DST, the Diocesan Archdeacons and the ISVA. There is also access to psychological support.
- 15.8 For clergy against whom a complaint is made, prescribed processes are in place that facilitate access to personal, pastoral and practical support. These arrangements are similarly in place for non-clergy staff. This is good practice. If at any point, there is a concern that a member of Cathedral staff (in any capacity) is a risk to themselves, an assessment is undertaken and considered formally through the core group process. This is equally good practice.
- 15.9 Ministerial Development Reviews (MDRs) of Cathedral clergy form part of the Diocesan MDR scheme and are conducted by (or on behalf of) the Bishop. MDRs add value to the clergy through facilitating reflection, learning and improvement. That said, an enhanced focus on safeguarding within this process could accrue further benefits. Whilst training is referenced,



MDRs are missing opportunities to explore what is working well from a safeguarding perspective, the outcomes being achieved, and future areas for growth and development. The recommendation made for the Diocese (see paragraph 8.13 and Recommendation D31) covering MDRs has equal relevance to the Cathedral and is set out below.

**Recommendation C35:** The Diocese should strengthen the focus on safeguarding practice within the MDR process. Revised arrangements should align with the national safeguarding standards and be developed in collaboration with the DST.

15.10 There is good collaboration between the Cathedral and the DBF. The support from the DST and the CSA are stabilising features for Cathedral staff and through their routine engagement, there is a sense this ‘virtual team’ have good relationships and operate with focus and best intentions. The connections of the DST with the wider safeguarding system have obvious benefits too. This is particularly relevant given the CSA’s familiarity with statutory agencies and the support that can be provided in the management of individual cases.

15.11 More generally, the DST and CSA are well supported to undertake their roles, although demand and capacity are issues which have attracted recommendations elsewhere in the Audit. Support for those in Cathedral safeguarding roles is available from the DST, the Chapter Clerk or other senior staff. There is also access to an Independent Employee Assistance provider.

# Conclusion

## 16 Conclusion

- 16.1 This round of Audits follows the SCIE and PCR2 processes that began in the Diocese in 2015 and in the Cathedral in 2019. Salisbury, to its credit, volunteered to be the first. Whilst there were (and continue to be) areas for improvement, the positive trajectory across the Diocese and Cathedral are a testament to their commitment to create an environment where people can come together, to visit, work, worship and thrive.
- 16.2 During the Audit, senior leaders demonstrated a willingness to open themselves to direct challenge and provided access to all areas and no questions were off limits. To the cynic, this may sound like rhetoric, but the real strength in Salisbury is its people. From the leadership teams to the volunteers, there was an absence of hubris, no defensiveness and a desire to learn.
- 16.3 Much of this can be directly attributed to the leadership of the Bishop. He is a relentless advocate of safeguarding and his commitment is demonstrated by deeds not just words. However, their greatest overall strength and potential lies in the fact that Salisbury's safeguarding practice is built on a foundation provided by their in-house professional safeguarding team. A team that has grown in numbers, confidence and competence since 2020. A team that places victims and survivors, the young and the vulnerable at the centre of what they do. Their commitment to a trauma informed approach was palpable.
- 16.4 Continuing to invest in their impressive improvement journey will be key to their success.

# Appendices

## 17 Appendix 1 - Salisbury Diocese Recommendations

**Recommendation D1:** The Diocese should promote the need for mutual respect and demonstrate its commitment to this by actively listening to their communities. A coordinated approach across the Diocese (to include all parishes) should deliver a survey that is specifically targeted at identifying perceptions of negative culture.

The questions set out in the CofE's 'Healthy Culture Survey'<sup>13</sup> should be used for this purpose, although this should be further adapted. The survey should also seek evidence and examples of where and how negative cultures manifests and ask for suggestions as to how these could most effectively be addressed.

This initiative should be supported by an awareness raising strategy that engages all church groups via communications and sermons.

The outcome of the survey should be used to inform the Diocese's approach to eradicating the remnants of a negative culture.

The findings should inform a plan of action to reinforce and spread the positive culture felt by the majority. This should be driven by church leaders at all levels and monitored by the DSAP.

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<sup>13</sup> <https://www.churchofengland.org/safeguarding/national-safeguarding-standards#na>

**Recommendation D2:** To broaden its opportunities for support, learning and challenge, the DSAP and the DST should:

- 1) Engage the Wiltshire VPP and other Local Authority Partnerships to determine the key multi-agency forums within which it could be involved.
- 2) Seek to establish the relevance of other information sharing agreements with which it could be formally involved.
- 3) Engage in discussions with Local Authority Partnerships about the potential to access multi-agency safeguarding training.

**Recommendation D3:** Administration support in the DST should be strengthened to enable the DSA's to better focus on their primary responsibilities and the enhanced support needed at parish level.

**Recommendation D4:** The Diocese should amend the SLA with the Cathedral and concentrate the additional capacity on its own priorities. The Cathedral should invest in a dedicated CSA.

**Recommendation D5:** The Diocese should create a Director of Safeguarding Role. The DST and the proposed CSA should both directly report to this role, with arrangements being secured through a revised SLA.

**Recommendation D6:** The Diocese should:

- a) Implement a consistent process that ensures its commitment to safeguarding and key requirements (such as the need for self-disclosure) are embedded in all job adverts.
- b) Job descriptions at all levels in the Diocese should include a defined statement that defines their responsibility for safeguarding.

**Recommendation D7:** The Diocese should clarify with its workforce and parishes about the codes of conduct which apply to them in each of their specific roles.

**Recommendation D8:** The DST should include Alderney and Sark in visits to ensure insight and oversight of relevant safeguarding matters.

**Recommendation D9:** The Diocese should review any analytics associated to the safeguarding webpage to ensure that the use of the sub-menu is optimised to user needs. For example, if analytics evidence that Safer Recruitment and DBS tools are one of the most frequently accessed resources on the page, then this could be made more easily accessible and prominent via an additional button in the sub-menu below 'Safeguarding Training'. The Diocese should provide a more prominent option for a website visitor to stay up to date by subscribing to the Safeguarding Newsletter.

**Recommendation D10:** An intelligence-led approach should be adopted to inform awareness raising activities and should be subject to dynamic review throughout the year.

This should be informed by:

- Regional intelligence on key themes, patterns and trends.
- An analysis of 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 DSAP and ISAG.

**Recommendation D11:** Safety plans should always include requirements to report when a respondent meets with someone they know through the church.

**Recommendation D12:** Those directly engaged on behalf of the church to support individuals on a safety plan should be provided with specific offender behaviour-based training. This should include insights via case studies and an overview of minimising, self-justifying and victim blaming behaviours. The Audit recognises that overarching responsibility for the training curriculum in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Diocese with the opportunity to apply interim mitigation measures.

**Recommendation D13:** The Diocese should implement a defined escalation process that provides a formal structure to managing differences of opinion as they relate to the decisions and actions on safeguarding cases. This process should be applicable to all staff within all jurisdictions covered by Salisbury Diocese and Cathedral.



**Recommendation D14:** Further to the DST proposing the resources required, short-term appropriately qualified external support could be sought to rapidly update any inaccurate records.

**Recommendation D15:** The DST should prioritise the closing of outstanding concerns. Where additional capacity is required to help achieve this, this should be provided to help resolve this issue at pace.

**Recommendation D16:** The monitoring of patterns and trends of safeguarding concerns should be an adopted practice in the DST to identify emerging risk or training needs. This should be undertaken quarterly, with data shared with the DSAP and ISAG.

**Recommendation D17:** All open concerns should have an individual case owner allocated them.

**Recommendation D18:** For all concerns where advice has been sought from the DST, case records should include a clear record of any action suggested by the relevant DSA or Caseworker.

**Recommendation D19:** On behalf of the Diocese and Cathedral, the DST should engage the Wiltshire VPP and any other relevant safeguarding partnership. They should seek to establish the relevance of other information sharing agreements with which it should be formally involved.

**Recommendation D20:** The Diocese and Cathedral should mandate the use of encrypted email software for external communication with third parties involving any safeguarding case.

**Recommendation D21:** When a point of contact for a victim / survivor changes, a transition plan should be agreed and expectations set regarding the level and frequency of support. This plan should be developed and agreed with the victim / survivor.

**Recommendation D22:** Those engaged with victims and survivors should ensure that advice is captured and that where this is used to inform changes, feedback (with consent) should be provided through a pre-agreed channel.

**Recommendation D23:** Policy should reflect that whenever possible victims and survivors in receipt of support should lead on how, when and where they engage with that provision, including counselling and any engagement with external professionals supporting a victim or survivor should not be made without their knowledge, and whenever possible, their agreement.

**Recommendation D24:** When applying for or supporting a victim or survivor to gain access to information about their case, consideration should be given to providing them with recourse to legal funding.

**Recommendation D25:** The DST should ensure that the PSO cohort is fully alert to the support available to them to cope with the demands of their role, including the impact of attending training.

**Recommendation D26:** The Diocese should introduce a training needs analysis process that routinely seeks the views of all relevant stakeholders about their learning requirements at a local level.

**Recommendation D27:** The Diocese should develop or commission specific training that is focused on sex offenders and digital safeguarding. The Audit recognises that overarching responsibility for the training curriculum in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Diocese with the opportunity to apply interim mitigation measures.

**Recommendation D28:** The Diocese should engage with the National Safeguarding Team to consider how some training could be appropriately adapted at a local level to address role and geographic specific context.

**Recommendation D29:** The Diocese should implement a specific evaluation process that seeks to capture evidence from staff, volunteers and their managers, about how training has helped their practice.

**Recommendation D30:** The Diocese should engage in discussions with the Wiltshire VPP and other local authorities about the potential to access its multi-agency safeguarding training offer.

**Recommendation D31:** The Diocese should strengthen the focus on safeguarding practice within the MDR process. Revised arrangements should align with the national safeguarding standards and be developed in collaboration with the DST.

**Recommendation D32:** The Diocese should consider implementing mandatory wellbeing support sessions from a counsellor for members of the DST, to ensure they are sufficiently supported in the challenging role they do.

**Recommendation D33:** Beyond ensuring ongoing access to existing training and support, the Diocese should review what else could be done to help PSOs in the crucial role they occupy.

## 18 Appendix 2 - Salisbury Cathedral Recommendations

**Recommendation C1:** To facilitate information being easy to access, the Cathedral should consider including relevant safeguarding material in other public spaces beyond the general noticeboards.

**Recommendation C2:** The Cathedral should deliver a survey that is specifically targeted at identifying perceptions of negative culture across all its stakeholders.

**Recommendation C3:** Those responsible for oversight of choristers need to re-visit and reinforce their safeguarding training as it relates to their chorister specific duties. This should be developed and delivered by the DST and whilst not limited to, should include:

- a) The importance of effective information sharing.
- b) Their responsibility when it comes to supervision and support of their line managed staff, including checking the status of staff training and vetting.
- c) Good record keeping
- d) Once re-training is complete, individual levels of understanding should be formally assessed by the DSA.

**Recommendation C4:** Similar to the arrangements for the DSAP, the independent chair of the ISAG should be a paid role.

**Recommendation C5:** The Cathedral should invest in a dedicated, safeguarding advisor that has a sole focus on safeguarding activity in the Cathedral. This role should be employed by the Cathedral and report to a proposed Director of Safeguarding (that will have responsibility for the Cathedral's and Diocese's arrangements).

**Recommendation C6:** The Cathedral should enter into a Service Level Agreement with the Diocese covering the funding and responsibilities of the proposed Director of Safeguarding.

**Recommendation C7:** The Cathedral should ensure that all staff and volunteers fully understand that any incident taking place on Cathedral grounds is unequivocally the responsibility of the Cathedral to respond to (in line with defined reporting arrangements). This clarification should be evident in all communication with chorister parents, including relevant policies and training materials.

**Recommendation C8:** The Cathedral should work with the Cathedral School to assess the feasibility of separating the Chorister Tutor and Head of Boarding roles. This evaluation should also consider addressing gender dynamics in the form of identifying an additional female Chorister Tutor. This could help with capacity and offer choice for choristers in respect of who they can approach for support.

**Recommendation C9:** In line with the written agreement in place between the Cathedral and Cathedral School, the Chorister Tutor(s) (when present as the responsible party for the choristers in the Cathedral) should not undertake any wider duties during services without appropriate delegation of care to another member of staff, which has been clearly communicated to parents.

**Recommendation C10:** The Cathedral and school should review and revise all relevant policies governing the care of choristers outside of term time and during specific events and tours. This arrangement should expressly forbid the delegation of supervisory or care responsibilities to anyone who not a formal employee, a vetted adult volunteer or someone contracted to either the Cathedral or school.

**Recommendation C11:** The Cathedral should develop and implement a specific “Missing Child” policy covering the arrangements for choristers when both on-site and off-site.

**Recommendation C12:** The Cathedral should re-establish the Parent Representative Group. Terms of Reference should be defined that set out its purpose, membership and administration. It should be chaired by the Cathedral School Headteacher, include the Chorister Tutor(s), the CSA and relevant Cathedral staff. The group should facilitate authentic communication that can explore what is working well and what needs to improve from a chorister perspective

**Recommendation C13:** The Cathedral should ensure regular training and refresher training for music staff on the vocal health of choristers.

**Recommendation C14:** The Cathedral should implement a defined schedule that ensures all choristers routinely visit the Chapter’s Voice Specialist. Any recommendations made concerning a chorister’s care should be formally recorded and reviewed by the voice specialist regularly.

**Recommendation C15:** The Cathedral should review its records for criminal records checks to ensure no other staff or volunteers miss the local requirement for three yearly re-checks.

**Recommendation C16:** The Cathedral should review the functions of volunteer servers and other roles where a DBS check is currently not required. For each role, this should establish whether a check necessary and at what level. To note, a basic check can be undertaken for any position or purpose.

**Recommendation C17:** Job descriptions at all levels in the Cathedral should include a defined statement that defines their responsibility for safeguarding.

**Recommendation C18:** The Cathedral should clarify and communicate the applicability of the Code of Conduct to the various roles in place across its workforce

**Recommendation C19:** The Cathedral safeguarding webpage should include information on what do if someone has an immediate concern or is at risk of immediate harm. It should also be enhanced to include information about other local / national support services (including the local authority and Wiltshire VPP).

**Recommendation C20:** The Cathedral should seek reassurance that the CSA's inbox is routinely covered when the CSA is absent from work. This will ensure escalated concerns are dealt with promptly.

**Recommendation C21:** The ISAG should replicate the arrangements in the DSAP and seek to ensure there is routine victim / survivor representation at its meetings.

**Recommendation C22:** The Cathedral should issue guidance for schools detailing a flexible approach to adult / child ratios for school visits to the Cathedral. This guidance should allow the Cathedral to consider the individual circumstances of each school and empower the education team to make a professional judgement about the acceptability of the visit or not based on a clear assessment of risk.

**Recommendation C23:** The Cathedral should amend its risk assessment tool which is used to assess and mitigate risks for visits to the Cathedral, to include a specific section on safeguarding.



**Recommendation C24:** Tower tours should not proceed if only one person presents for the tour. This measure is crucial to avoid situations where a volunteer and an individual may find themselves isolated in secluded areas.

**Recommendation C25:** The Cathedral is encouraged to expand CCTV coverage in the Cathedral to include the area towards the Chapter Office, St Ann's Gate and the chorister's practice room.

**Recommendation C26:** On behalf of the Cathedral and Diocese, the DST should engage the Wiltshire VPP and any other relevant safeguarding partnership seek to establish the relevance of other information sharing agreements with which it should be formally involved.

**Recommendation C27:** The Cathedral should mandate the use of encrypted email software for external communication with third parties involving any safeguarding case.

**Recommendation C28:** The Cathedral via the ISAG should expedite its efforts to provide supportive and appropriate pathways to engage victims / survivors. This should be benchmarked against the approach adopted by the DST and DSAP.

**Recommendation C29:** The Cathedral should review its induction arrangements and ensure that all volunteers systematically have access to a defined programme that includes a clear focus on safeguarding.

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

**Recommendation C31:** In conjunction with the DST, the Cathedral should develop a mandatory programme of CSA delivered, face to face training that is targeted at specific groups of staff working or volunteering in the Cathedral. The CSA should add additional role-specific training where appropriate.

**Recommendation C32:** The Cathedral should ensure that attendance at these training sessions is appropriately recognised through the issuing of certification.

**Recommendation C33:** The Cathedral should develop or commission specific training that is focused on sex offenders and digital safeguarding. The Audit recognises that overarching responsibility for the training curriculum in this area will lie with the NST. However, it would be remiss not to identify the inherent contemporary safeguarding risk and provide the Cathedral with the opportunity to apply interim mitigation measures.

**Recommendation C34:** The Cathedral should ensure the CSA courses are evaluated in line with an enhanced evaluation process. This should include a post course evaluation and a follow up survey (3-6 months afterwards) that seeks how training had been applied in practice, made people safer and / or strengthened arrangements.

**Recommendation C35:** The Cathedral should strengthen the focus on safeguarding practice within the MDR process. Revised arrangements should align with the national safeguarding standards and be developed in collaboration with the DST.

## 19 Appendix 3 – Glossary of Abbreviations

CDM	Clergy Disciplinary Measure
CMD	Continuing Ministerial Development
CofE	Church of England
CPD	Continuing Professional Development
CSA	Cathedral Safeguarding Advisor
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DOFA	Designated Officer for Allegations
DSA	Diocesan Safeguarding Advisor
DSAG	Diocesan Safeguarding Advisory Panel
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
DST	Diocese Safeguarding Team
GDPR	General Data Protection Regulations
HR	Human Resources
ISAG	Independent Safeguarding Advisory Group
ISVA	Independent Sexual Violence Advisor
LADO	Local Authority Designated Officer
MDR	Ministerial Development Review
NPCC	National Police Chief's Council
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
SCIE	The Social Care Institute for Excellence
SIR	Serious Incident Report
SLA	Service Level Agreement
VPP	Vulnerable People Partnership



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