Independent Safeguarding Audit of Truro Diocesan Board of Finance and Truro Cathedral

2024

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Introduction

1 Introduction

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

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

- 382 documents being collated and analysed prior to the Audit's fieldwork.
- 30 interviews with staff and volunteers, external partners, victims and survivors and other stakeholders.
- 497 anonymous survey responses (a good return given Truro is one of the smaller Diocese), 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.
- Six focus groups took place. Two engaged with 32 children and young people, one was conducted with five chorister parents, one focus group drew input from eight Parish Safeguarding Officers (PSOs), one with 11 Cathedral Volunteers, and one with nine clergy within the Diocese.
- A confidential contact form, accessible via a dedicated webpage.

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

- In total, the Audit undertook 43 separate engagement sessions reaching 592 people.

1.3 The Audit report is separated into Part One, Truro Diocesan Board of Finance (DBF) and Part Two, Truro 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 Truro and Truro Cathedral.

Part One - Truro Diocesan Board of Finance

2 Context

2.1 The Diocese of Truro is set in the primarily rural peninsula of Cornwall, with two parishes in Devon, and also includes the Isles of Scilly. Its Cathedral is located in the centre of Truro. The area boasts a rich history and vibrant culture, shaped by its distinctive geography. The Isles of Scilly, located 28 miles from the mainland, add to its unique charm. Cornwall is often perceived as a holiday destination renowned for its rugged coastline and scenic beauty.

2.2 The 2021 Census revealed a total population of 570,300 in Cornwall and the Isles of Scilly, a figure that doubles in peak holiday months due to seasonal tourism and second homeowners. A quarter of the population are aged over 65, partly due to retirees relocating to the region.

2.3 Despite its allure, Cornwall grapples with socio-economic challenges. As one of the UK's regions with the highest ratios of average wages to house prices, there is an acute shortage of affordable housing, driven by factors like retirees, holiday homes and the Airbnb market. This has resulted in over 800 families living in temporary accommodation. Moreover, more than a quarter of the population earns less than the real living wage, the impact of which can be seen in the distribution of over 36,000 emergency food parcels in the Diocese up to March 2023, with over 12,000 of these for children under 16 years old.

2.4 Registered with the Charity Commission, the Diocese, one of the smallest in the Church of England, oversees 306 churches, including the iconic Truro Cathedral, which has a worshipping community of 8,145 individuals. Despite its challenges, Cornwall remains a resilient community shaped by its rich heritage and natural beauty.

3 Progress

3.1 The DBF was subject to an audit by the Social Care Institute for Excellence (SCIE) in 2017 and underwent the Past Cases Review 2 process (PCR2) in 2020, which was completed in February 2021. The SCIE audit identified 28 specific issues for the DBF to 'consider' and the PCR2 made 28 local recommendations. An individual case review published by the DBF in 2018 also made several recommendations for improvement.

3.2 Due to the data loss of its action plan spreadsheet, the DBF was unable to provide the Audit with this collated account of its response to these processes. That said, the Audit's examination of relevant documentation and the key lines of enquiry it pursued during interviews have, for the most part, provided a good degree of reassurance. Appropriate governance arrangements have supported the oversight and delivery of improvements, with many recommendations being subsumed into the DBF's strategy and associated workstreams. Some that remain outstanding are part of ongoing projects and others have been awaiting developments at a national level. This latter point is significant, in that the Audit identified a small number of recommendations that could have been actioned without the need for national direction. These are set out in within this report and relate to the provision of training and the arrangements for Blue files.

3.3 Overall, activity to implement the recommendations and the DBF's ongoing focus on learning and improvement have had a positive impact. The findings of this Audit reflect that this progress continues and where appropriate, additional recommendations are made to support the DBF's ongoing improvement journey.

4 Culture, Leadership and Capacity

4.1 There is significant evidence that the DBF has worked consistently since the SCIE Independent Safeguarding Audit in 2018 and this Audit has seen evidence of it working to build an engaged and safeguarding focused culture.

4.2 In 2019, 2020 and 2022, the DBF carried out health and wellbeing surveys with Church House staff, conducted a Clergy Wellbeing Survey in 2022 and a parish focused safeguarding survey in 2023. Whilst these surveys reflect a range of views and understandable levels of anxiety linked to the period affected by COVID19, they generally show a positive and engaged culture and one in which people have felt able to share their feelings.

4.3 The findings from the 2024 Independent Audit Survey of DBF and parish workforces reflected the positive trajectory they are on. The overwhelming number of those engaged reported improvements in safeguarding arrangements, higher levels of awareness and confidence, and feeling safe. The vast majority felt that safeguarding was now embedded in their culture and the most frequently used descriptions were ‘supportive’, ‘respectful’, and ‘nurturing’.

4.4 The parish worshiping community reflected similar findings across all areas, with most people reporting that they felt safe in their parish, which they most frequently described as ‘inclusive’, ‘happy’ and ‘nurturing’. Whilst this is positive, the Clergy and office holders must retain focus and continue to drive improvement.

4.5 That said, it is important that every voice is listened to, and a safeguarding first approach demands reflection on what is not right and what could be done better. Engaging and reassuring the majority that safeguarding practice is improved and improving is only one test. It is essential that where and when concerns are raised that they are investigated, understood and appropriate responses triggered.

4.6 Looking back, the Clergy Wellbeing Survey in 2022 highlighted a commitment to ministry and a recognition of support from the Bishop, but was less confident in the support provided by the DBF to Clergy. This issue should be revisited.

Recommendation D1: A specific deep dive survey of Clergy wellbeing (focused on the areas of concern identified in the 2022 exercise) should be carried out.

4.7 Furthermore, a minority of responses from the DBF and parish workforces and parish community indicated that some people did not feel safe, that they did not believe safeguarding awareness has been raised or that it was now embedded and that they lacked confidence in the escalation process. Whilst these numbers were very low (ranging from 0.4% to 6%), such concerns should be subject to reflection and further consideration. Sharing this report could be the catalyst for engaging in further conversations about safeguarding in the respective settings.

Recommendation D2:

A. The DBF should carry out a focused workforce survey of its Clergy, staff and volunteers to test safeguarding awareness and workforce confidence in the escalation processes including knowledge of the Whistleblowing Policy. The survey should provide an option for respondents to suggest solutions relating to the issues raised.

B. Each parish should carry out a focused workforce and worshipper survey to test safeguarding awareness and confidence in the escalation processes including knowledge of the Whistleblowing Policy. The survey should provide an option for respondents to suggest solutions relating to the issues raised. In respect of small parishes in which such an approach might not be feasible, alternative approaches such as discussion groups, feedback forms (following the discussion) and awareness raising regarding the escalation process and whistleblowing should be covered.

4.8 The Audit did see evidence that the concerns raised in surveys and other feedback mechanisms were considered at appropriate management levels. In the case of the 2022 Wellbeing Survey, appropriate action was taken and feedback provided to staff. Responses from the DBF have included (amongst other initiatives) introducing free onsite confidential health checks for staff, the publication of the new Domestic Abuse Policy and the provision of additional training, incorporating safeguarding discussions as an agenda item in staff meetings and a review of lone working arrangements.

4.9 In a recent example involving a face-to-face feedback session regarding culture, safer recruitment and conduct, an escalation by a member of the clergy led to an appropriate safeguarding intervention by the Diocesan Safeguarding Team (DST). This triggered a visitation by the Archdeacon focused on the culture and safeguarding practice within the parish concerned. This is good practice.

4.10 Whilst some stubborn challenges remain, they are recognised by leaders and the Audit is reassured by their continued commitment to embed a safeguarding culture in all contexts.

4.11 Leadership of the Diocese has recently passed to a new Bishop. They are unequivocal in their acknowledgement of their safeguarding responsibilities and ultimate accountability. They are equally clear about the role of the Diocesan Safeguarding Officer (DSO) and the need to be guided by them on safeguarding related matters. The Audit also saw evidence of the Bishop applying authoritative practice on issues linked to training and conduct.

4.12 Safeguarding arrangements are defined and supported by strategy. A range of strategic and operational meetings support oversight and delivery and have appropriate representation at the right level of seniority and expertise.

4.13 The Bishop has a good relationship with the new Dean and is well supported by an active and safeguarding focused Diocesan Secretary. Senior leaders engaged by the Audit had a firm focus on safeguarding as it relates to their individual functions, an understanding of pathways for advice and support and the need to consistently raise awareness across the Diocese. Interviews, focus groups and survey feedback all evidence a positive trajectory in this regard.

4.14 An examination of records demonstrates that minutes of meetings of Diocesan governing bodies include appropriate reference to, and oversight of safeguarding activity. Minutes from the Synod highlighted (during one session focused on feedback from the General Synod) the importance of language, tone and the need to consider the impact on others.

It is a positive that such challenge is recorded and reflected upon.

4.15 Other records, including minutes of the Bishop's Diocesan Council (BDC) and the DBF evidence an active insight and commitment to safeguarding issues. The Diocesan Secretary (in partnership with the DSO) reports on key issues regarding personnel, safeguarding in parishes and strategic developments (along with an appropriate risk register) including national issues, not least the Jay Report. The focus on the voice of survivors and the work led by the Diocesan Secretary in this regard is good practice.

4.16 The minutes of the November 2023 BDC evidenced detailed consideration of how safeguarding should be integrated as a thread through all areas of the DBF. The Audit agrees with this approach, as it does with the description of the role and responsibilities developed for the Lead Trustee for Safeguarding.

4.17 Prior to a Visitation (swearing in), Churchwardens are required to have completed their safeguarding training at the 'Basic' or 'Foundation' level and at a minimum, have registered to complete the leadership module. Furthermore, this has been driven forward despite a level of resistance from some wardens. This determined approach is good practice.

4.18 The Audit has had sight of the Archdeacons' Articles of Enquiry / Questions (for Annual Visitations). This is a positive approach but could be further strengthened. For example, beyond the basic questions regarding training, the use of the Parish Dashboard and a free text box, a specific brief on relevant DBF and parish themes would help achieve consistency. Such prompts should include the promotion of safeguarding material and

policies, speaking to the PSO (questioning if there isn't one) and addressing any issues that are relevant from a pre-brief by the DST concerning that particular setting. If areas for improvement are identified, they should be recorded in a specific section of the report. This section should stipulate timeframes for remedial action (three to six months).

Recommendation D3: In consultation with the appropriate individuals, the DST / DSO should provide advice to strengthen the current Archdeacons' Articles of Enquiry / Questions.

Director of Safeguarding

4.19 The Audit recognises that capacity for safeguarding is an issue and that this can impact on spans of control and the blurring of roles and responsibilities for some. Looking ahead, it is also clear that across society there is a growing number of people in need, demand for safeguarding services and support are likely to increase and there is potential for significant change to the Church's safeguarding arrangements.

4.20 In order to address this, the DBF (in consultation with the Cathedral Leadership Team) should consider the creation of a dedicated Director of Safeguarding. This is likely to help strengthen the strategic lens on safeguarding at a local level, as well as ensuring greater regional and national engagement.

4.21 This strategic role would cover both the DBF, the Cathedral and by inference, activity within parishes. It would help create the strategic space for driving coordinated improvement and provide the capacity for enhanced decision making, oversight, change management and challenge.

4.22 We believe that such a role will align to other 'functions' within the Church and create a senior leadership role for whom safeguarding is *the* priority, not one amongst many. Ultimately, this is an issue for the Bishop, Dean and senior leaders to consider in the context of how this might work for Cornwall.

Recommendation D4: The Bishop and Dean should consider the creation of a dedicated Director of Safeguarding. This role would be part of the most senior leadership team and provide direct insight from a safeguarding perspective and support the oversight and operational delivery of the DST.

Diocesan Safeguarding Advisory Panel (DSAP)

4.23 The DSAP is well led by a qualified solicitor with extensive experience, including that of a Local Authority Designated Officer (LADO). Their Terms of Reference (ToR) are current and reflective of contemporary practice, with a particular focus on survivors. The DSAP agenda is well structured and focused on key safeguarding themes and supported by good attendance from key internal and external representatives.

4.24 The Chair has worked well engaging with external statutory bodies, resulting in some regular attendance at DSAP. This reflects good practice. Given the pressures currently faced by statutory partners, such attendance is not always consistent. The Chair should ensure that they have a contingency in place to go to them if and when necessary. This will ensure they maintain line of sight on key contextually relevant safeguarding trends and themes.

4.25 There is evidence of a much closer working relationship with the Cathedral, whilst this is welcome, the range of issues facing the DBF and the Cathedral are different and require individual focus. That is not to say the Cathedral should not have a representative on the DSAP, they should. However, siniiny and oversight at the Cathedral, will require its own dedicated independent panel (this is discussed in Part Two).

4.26 Notwithstanding, the well-structured agenda and clear ToRs, the Audit believes that the DSAP could be strengthened by adopting a learning and improvement framework. This framework should systematically address issues raised by victims / survivors, children, young people, adults, and staff. It should utilise data from audits, reviews, and training feedback, alongside any relevant external learning and feedback on trends from local safeguarding partners.

Recommendation D5: The DSAP should develop a learning and improvement framework to focus its insight and oversight role. This should be evidence and data driven and targeted at agreed areas of need / development and or risk.

4.27 Strengthening the remit and focus of DSAP as a forum that is beyond advisory will enhance the Church's sufficiency regarding scrutiny and reassurance. The Audit has identified this as an issue for national consideration.

Diocesan Safeguarding Team (DST)

4.28 The investment made in the DST since the SCIE and PCR2 audits is evident. They are

well led by a DSO with considerable safeguarding experience, including that gained in the statutory sector. They are made up of a highly capable and blended team with a range of relevant and complementary skills.

4.29 There are high levels of confidence in their competence. In the opinion of the Audit, they are an asset and the foundation upon which the Diocese safeguarding framework is built.

4.30 Under the DSO's leadership, they provide safeguarding advice, case management and training across the DBF, parishes and via a Service Level Agreement (SLA), provide other aspects of safeguarding support to the Cathedral.

4.31 There is effective administrative support that helps the team to manage its core functions and a dedicated role to support governance and the implementation of local arrangements.

4.32 There is confidence in the DST regarding their engagement and collaboration with key external agencies and they have a good relationship with safeguarding partners in local authorities. During interview with a LADO, they expressed significant confidence in referrals from the DSO / DST.

4.33 The increase in capacity of the team and the roles they occupy has been positive and delivered impact. That said, capacity remains a challenge when considering the overall improvement agenda, the known areas of pressure and the fact that the contexts of DBF, parishes and the Cathedral present their own unique challenges.

4.34 Alongside the Director role, the Audit believes there are opportunities to strengthen capacity by way of assimilating other relevant roles under the direct supervision of the DSO. This could include the Safeguarding Administrator function and the Cathedral Safeguarding Lead / Volunteer Manager.

4.35 For the Cathedral role, this would remain a dedicated Cathedral resource but benefit from professional safeguarding supervision and support. Such a move would provide additional critical resilience when faced with increased demand / extractions.

Recommendation D6: All safeguarding focused resources, regardless of where they currently sit, should be consolidated under the direct supervision of the DSO.

5 Prevention

5.1 Effective safer recruitment practice is evident within the DBF and across the Diocese as a whole. The House of Bishops' guidance (Safer Recruitment and People Management) is followed, processes are aligned to legislation and a range of measures support this important area of work. This includes training for key personnel, establishing role descriptions, supporting and promoting the use of the Parish Dashboards and the Safeguarding Hub, through to reference gathering and role-specific vetting and barring checks. Furthermore, specialist advice for criminal record checks is available from the contracted Disclosure and Barring (DBS) provider and a process is in place to support parishes that are unable to fulfil the position of Lead Recruiter.

5.2 There is an established procedure for assessing and actioning 'positive' returns on DBS checks and the renewal process has moved from five years to a three-year cycle. However, the Audit is aware that there is yet to be a full transition to these new arrangements and makes the following recommendation.

Recommendation D7: The DBF should ensure that all staff and volunteers are up to date with DBS checks and are within the three-year cycle.

5.3 The DBF promotes its commitment to safeguarding and safer recruitment on a dedicated webpage, accessible via the *'Working with us'* section of its website. Whilst this is good practice, advertising and general awareness raising could be strengthened. For example, within the recruitment process, opportunities to reinforce key messages about the DBF's commitment to safeguarding are being missed. This is a helpful way of setting out expectations from the beginning of an employment journey and sends out a clear message of deterrence.

Recommendation D8: The DBF should ensure that its commitment to safeguarding is embedded in all job adverts, application forms and job descriptions.

5.4 The DBF provides safeguarding governance and safer recruitment tools to parishes via the Parish Dashboards and the Safeguarding Hubs. The DBF is committed to supporting, encouraging and mentoring parishes in their adoption and embedding of this tool. Support is provided by the DBF through a range of methods. This includes newsletters, explainer videos, online FAQs, PSO sessions and other engagements with parish officers. Whilst good practice, online access to this material should be made easier. See **Recommendation D9.**

5.5 Understanding and maintaining appropriate boundaries are key requirements for staff and volunteers. These issues are addressed through a range of policies and guidance, for example, the Staff Handbook, IT Acceptable Use Policy, Social Networking Policy and the Code of Conduct.

5.6 The DBF's Code of Conduct is set out within the Staff Handbook, easily accessible one-page posters and a templated Volunteer Agreement is available for use in parishes. Whilst positive, making these resources more easily accessible via the Diocesan website would enhance the profile of the Code of Conduct. **See Recommendation D9.**

5.7 Raising awareness of different types of abuse and promoting appropriate actions are key components to strong safeguarding practice. The DBF has committed to raising awareness of different types of abuse and harm that may occur to children, young people and adults. To do this, it utilises a range of effective communication methods, for example,

via newsletters: one by the Archdeacons, one by the DST and another disseminated to Churchwardens. Topics covered within such newsletters range from the promotion of safeguarding training, updates on practice related to Safety Plans and reminders for parishes to display a safeguarding statement on their websites. Other measures include physical signage with parishes via the use of posters. The Audit saw good practice through a display of awareness-raising material from the Mothers' Union's *'RISE UP Against Domestic Abuse'* campaign. Further promotional activities have involved the themes of modern slavery and trafficking. The Audit also saw innovative approaches to signage through the use of lanyards to reinforce key messaging on the four R's (Recognise, Respond, Record & Report).

5.8 Other measures utilised in the prevention of abuse include effective and meaningful discussions about safeguarding across the Diocese. The Audit saw examples of this in practice via quarterly meetings between the DSO and the Bishop, regular reports by the DST to the Diocesan Synod and Bishop's Diocesan Council and briefings provided to the Episcopal College, the Church House staff team and '*Simon Says*' sessions. Furthermore, the Safeguarding Team attends the annual briefing of Churchwardens during the Archdeacon's visitation.

5.9 The DBF has recently established safeguarding drop-in sessions providing an informal mechanism for PSOs to share their experiences, learn from one another and seek input from the DST. This is good practice. Whilst attendance at the drop-in sessions has been relatively low, it is worthy to note that feedback from PSOs described the value and benefit of the session as "*really useful*". This good practice should be nurtured and further developed. See **Recommendation D33.**

5.10 Arrangements are in place via a monthly NST / DSO online session and a bi-annual DSO conference to help the DST to connect and share learning with other Diocesan Leads. The Audit found a positive example whereby an engagement with the DST and another Diocese led to an exchange of learning strategy documents, an agreement to share newsletter content and sharing a roll out programme for the Parish Dashboard.

5.11 Strong communication is key to effective prevention across the Diocese. Clear lines of communication help to make sure that everyone engaged with the Church is aware of safeguarding expectations, issues, policies and how to raise concerns and access support. The DBF has adopted a range of methods in this regard, including podcasts, Safeguarding Sundays and other regular sermons, online drop-in sessions for PSOs, newsletters to various groups and online communication via the website and social media channels. A recent safeguarding sermon from the Bishop demonstrates good practice by connecting scripture and theology to safeguarding.

"Our commitment to safeguarding isn't just a technical, tick-box exercise that we have to go through, but a gospel imperative which comes from the very heart of our faith in Jesus".

5.12 The Diocese's website presents a strong, modern theme that loads quickly, performs well with search engine optimisation (SEO) and is mobile-responsive. The 'safeguarding' section is prominently featured and is easily accessible. There is guidance directing users to internal assistance, external support, safeguarding training, and a range of DBS guides, tools and example role descriptions. That said, the Audit found that users faced challenges

in locating information, and the site's arrangement and navigation created barriers to the access of key information. For example, the 'Volunteer Agreement – Code of Conduct' and 'Whistleblowing Policy' were absent from the Safeguarding Documents, Forms & Links section. When information is difficult to find on a website, this can frustrate the user and impact the reach of important material. The Audit holds the opinion that practice in this respect could be strengthened.

Recommendation D9: The DBF should re-design the safeguarding webpage adopting a multi-level navigation menu aligned with hierarchical principles where information is organised in order of importance to users. A section on how to report a safeguarding concern should take primacy followed by a re-ordering of other sections that are most frequently accessed.

This should ensure that support material resources are categorised into logical groups and are easily accessible.

The DBF should review all supporting materials it provides and consolidate these on its website (this should include the addition of the Volunteer Agreement – Code of Conduct and the Whistleblowing Policy).

5.13 As with all good communication, this needs to be a two-way process. Actively seeking and responding to the views of children, young people and vulnerable adults is a key component of effective prevention planning. The Audit has seen good practice by the DBF in recently hosting a Trauma Informed Conference where delegates heard directly from a victim / survivor. The Audit also saw a positive instance where a victim / survivor's input was sought to develop a 'covenant' to enable re-engagement with the Church. That said, engagement, an issue previously identified by SCIE in respect of children and young people, remains an area for improvement.

Recommendation D10: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, vulnerable adults, and survivors within safeguarding prevention planning.

5.14 The DBF has policy, guidance and procedures in place to help make people safer when lone working. Such measures include a Lone Working Policy, a Guide for Staff When Lone Working, a Lone Working risk assessment template and a Lone Worker flow chart. This is good practice and has been reinforced by newsletters and drop-in communications.

5.15 The Audit assessed preventative measures and risks associated with buildings. As the DBF is in the process of moving building, this is an ongoing area that is actively being considered. Guidance covering the structural environment and risk assessments across the Diocese are covered by the CofE's Safer Environments and Activities guidance. This is aimed at fostering a secure and protective environment for all involved parties. Furthermore, it is reassuring that the DST has facilitated several sessions addressing issues of personal safety, reactions to threats and violence and the creation of a safe area at home, in the Church and in public spaces, to ensure the mitigation of potential harm.

5.16 Clergy personal files are well managed by the Diocese. There are clear processes in place for their structure and secure storage. A red 'cover sheet' allows for the quick identification of files that include any safeguarding related issues. Within the limitations of the current recording systems, this is both simple and good practice.

5.17 There are good arrangements for content to be reviewed when clergy move to the Diocese, with practice being supported by the experience and professional curiosity of the Lay

Chaplain. Any issues of concern identified result in the engagement of the DSO.

5.18 That said, in line with a PCR2 recommendation, the Audit believes these arrangements should be further strengthened with the DSO also reviewing these files on receipt.

Recommendation D11: The DSO should review all Blue files for new clergy joining the Diocese.

5.19 The Audit recognises the good practice planned for the DSO to undertake 'exit interviews' with clergy who are leaving. This will facilitate the handover of relevant information, including any soft intelligence held.

5.20 There remains an ongoing risk in the overall security arrangements for Blue files given they are all in 'hard copy'. This is not unique to any one area. At worst, there could be a catastrophic loss of the files by way of fire or other damage. In the Audit's opinion, Blue files need to move to an electronic records management system and this view will be shared with the NST.

6 Recognising, Assessing and Managing Risk

6.1 Arrangements are in place that support the recognition, assessment, and management of risk across the Diocese. These include the functions of the DST, safeguarding policies and guidance, awareness raising and training. Clear and established reporting pathways exist and overall, these structures increase the likelihood of early risk detection, collaborative decision making, assessment and timely interventions.

6.2 The DBF risk register covers key corporate issues. There is a separate safeguarding risk register, with concerns and control measures well documented. This allows for a specific focus on safeguarding and is considered good practice. There is appropriate oversight with recorded review dates, and deep dives at executive level. Registers should however, go beyond the obvious and consider context. It may be helpful for the DBF to think further about how risk is described in the context of the Church's new national standards and contemporary safeguarding issues. This could help better articulate how risk could manifest from pressures, such as the cost-of-living crisis, increased demand and the exponential rise of mental ill-health. Leaders are alive to the potential risks arising from the proposed changes articulated in the Jay report.

Recommendation D12: The DBF safeguarding risk register should be developed to address contemporary and contextual issues and think about how risk is described in the context of the Church's new national standards.

6.3 The Audit saw evidence of good practice with safeguarding concerns being appropriately triaged at a low threshold to encourage contact. This process is as much about providing advice and guidance as it is about building trust, confidence and relationships with those

in safeguarding roles. This helps create the conditions where concerns are more likely to be escalated to the DST. It allows for a good line of sight on issues where risk might not be properly understood by the reporting person.

6.4 Whilst this approach is good practice, the Audit recognise the work demands on the DST. Progressive thinking has resulted in innovative ideas within the team to help manage these increasing pressures. Whilst yet to be implemented, suggestions include the potential to issue advice and guidance across the Diocese to deal with concerns that do not meet the safeguarding threshold. These will be supported by the introduction of behavioural contracts. Further work is required in this respect and will need to be accompanied by relevant training, procedures and guidance.

6.5 The national case management system, MyConcern has been adopted and implemented. Whilst feedback indicates the system is far from ideal, the DST make good and effective use of it.

6.6 At the time of the Audit, there were three new concerns, and 40 open concerns. 36 concern recorded on the system were graded as low risk – meaning advice, information and triage only, and four were recorded as medium risk – meaning safeguarding issues had been identified, the need for assessment and the requirement for risk management. There were 415 cases filed. No cases were graded as high risk. The Audit was informed that some of the current cases could be closed and archived.

Recommendation D13: The DST should prioritise cleansing the data on MyConcern and

archive any outstanding cases that are ready to be ‘filed’.

6.7 The nature of the cases managed by the DST represent a range of threats, risks and harms. Some involve contemporary concerns whilst others relate to non-recent abuse and / or serious criminal conduct. The recording of the rationale for decision-making (as it relates to cases where specific actions aren't deemed necessary) is an area identified as requiring improvement.

Recommendation D14: Entries on MyConcern should provide a rationale for any 'inaction' on cases, where decisions have been made by the DSO / DST not to take a particular action.

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

- Onward referrals to statutory authorities.
- The management of individuals within the worshipping community.
- The provision of / signposting to support.
- The initiation of disciplinary processes, such as the Clergy Disciplinary Measures (CDM).

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

6.10 For safeguarding agreements, these appropriately set clear prohibitions and actions regarding expected behaviours, consistently record review dates and contain written signatures from relevant stakeholders, including the *respondent*. Each case is presented to the Diocesan Safeguarding Case Management Group for professional discussion. This

is good practice. The DST are in the process of reviewing all safeguarding agreements as it transitions to safety plans in line with national guidance. The files viewed by the Audit are well-defined, proportionate and authorised appropriately. There is evidence of a multi-agency approach, with routine information sharing with the Police, Probation Service and LADOs. Alongside mitigating the risk derived from an individual, the safety and welfare of those posing the risk is also properly considered. The Audit was informed that the DST provide significant and appropriate levels of support to help parishes monitor individuals subject to safeguarding agreements.

6.11 The Audit saw evidence of a strong willingness to learn, take authoritative action and improve practice in monitoring safety plans. To strengthen this approach, we recommend specific targeted training for reference groups and the wider cohort of people involved in monitoring respondents. Recommendations relating to sex offender training, context specific training and that for particular roles are set out in the Learning, Supervision and Support section of this report.

6.12 The number of agreements (nine) at the time of the Audit does not reflect the amount of work and time required by the team to set up, monitor and continually review these arrangements. The longevity of some agreements (being in place for many years), continue to impact the capacity within the DST. This is creating pressures, including out of hours working and the ability of the DST to manage the demands placed on it.

6.13 To help address this issue, the DST is testing criteria within the agreements to see if the threshold for a safety plan is still met, or whether, based on the facts known, it would be

disproportionate to continue with such a measure. The team remain mindful of the potential for risk, measures of control and the need to ensure appropriate safeguarding arrangements remain in place.

6.14 The efforts by the DST in drafting guidance about safety plans, addressing what to do if a respondent doesn't sign the agreement and consideration of a necessary and proportionate response, shows a wider, deeper and realistic understanding about what is required across the DBF.

6.15 As with any initiative that tackles complex issues, there is a need to ensure there is capacity to learn and adapt as the implementation process proceeds. The Audit suggests that the DBF should consult the NST regarding the proposed new approach to safety plans.

Recommendation D15: The DST should consult the NST about its new proposals to introduce a system to terminate safety plans in specific cases. The Audit believe the NST should be a critical component to the overall approach to safety plans and will raise this with them.

Recommendation D16: National guidance should be revisited to include information about what to do when respondents refuse to sign safety plans. The Audit will raise this with the NST.

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

6.17 There is a clear availability of practice guidance at a national level concerning Core Groups (referred to in the Diocese of Truro as a Safeguarding Case Management Group (SCMG)), and comments to the Audit indicate the system works well within the Diocese. The forum allows for challenge and discussion and the involvement of statutory bodies, as and when required. This is deemed good practice. During interviews, the Audit was made aware that the Head of Communications and Marketing Does not routinely attend SCMG (Core Group) meetings. The Audit consider their role to be central to reputational management in dealing with serious incidents, specifically involving Church officers.

Recommendation D17: The Head of Marketing and Communications should routinely attend Core Group discussions.

6.18 The DBF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. Support and practice guidance is available at a national level regarding SIR referrals. The Audit was informed that one case had met the threshold for a Safeguarding SIR in the last 12 months, although there appeared to be some confusion regarding process. The referral to the Charity Commission aligned with national guidance and the NST was appropriately informed.

Recommendation D18: The DST should familiarise itself with the national guidance regarding the criteria for SIR reports to the Charity Commission.

6.19 The DBF has several Information Sharing Agreements (ISA) in place with other organisations and with Truro Cathedral. Whilst positive such arrangements exist, they do not necessarily ensure smooth pathways to information sharing. One of the key challenges highlighted was information sharing between the police and the CofE. Whilst governed via

a national data sharing agreement, it was evident that timely responses remain a challenge. There were clearly frustrations indicating the '*Church is not really listened to'* and *'the police not supporting the faith community*.' For most, they felt that information sharing was primarily based on good relations with the police or other agencies.

Recommendation D19: The DBF should raise awareness of the National Data Sharing Agreement between the National Police Chiefs' Council and the Church of England within the Diocese and raise the profile with police forces through the NST.

6.20 The Audit was told there is a defined escalation process in place to manage differences of opinion about the decisions and action taken on threshold cases as discussed at the case management group. Where such incidents occur, the DSO will refer the issues to the NST Regional lead or NST Case Managers for advice. Unresolved conflict complaints can be raised with the Bishop, DSAP chair or Dean as appropriate. This approach allows for professional challenge and scrutiny around safeguarding decisions.

6.21 The newly implemented national *MyConcern* safeguarding case management system in Truro covers the DBF and Cathedral. It is a centralised and secure database, allowing for safeguarding concerns to be reported and recorded. There is the facility to attach relevant case reports, correspondence and documentation in one place. The system allows the DST to identify thematics for the DSAP from across the Diocese and Cathedral.

6.22 Whilst seen as a positive development, there is room for improvement, both in terms of the national system itself and the application of its functionality. For example, some of the system's terminology is outdated and there is no simple mechanism to identify useful information, such as when SCMG / Core Groups have been convened or where the DST

have received referrals from external agencies.

6.23 There are widespread frustrations among users, with the system being described as "*a little bit clunky… and a case of making do*" with the general consensus being that it lacks the full functionality to meet the needs of the DST. One significant area of concern is the inability to share information across dioceses regarding individuals of concern. This not only poses a risk, but also impacts time management, as the team resort to phone calls and efforts to gather and disseminate information when necessary. The long-term impact of the adopted system is not yet known, but despite these obstacles, the DST is making best use of it within the known limitations.

Recommendation D20: The DBF should continue to review the effectiveness of the MyConcern system and continue to engage at a national level to ensure the system meets local needs.

6.24 There is a defined process in place to support the quality assurance of safeguarding cases. This involves supervision meetings every four weeks with the DSO, (which is chaired by the NST Regional Safeguarding Lead) and a safeguarding case management group, which allows for discussions on threshold cases.

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

Recommendation D21: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DST and NST. This will also be raised by the Audit with the NST.

6.26 Arrangements for internal supervision within the DST are considered good. The frequency of discussions and meetings, and access to the NST Regional Safeguarding Lead for the wider team is a strength. The Audit suggest current sessions would benefit from a structured framework, with agendas and links to performance portfolios to enable refection and forward planning. The Audit were advised there may be resistance to performance appraisals but suggest this approach would allow for more routine management oversight, which is likely to help identify any potential practice issues and development needs for the team.

Recommendation D22: Structured supervision processes should be implemented locally within the DST with links to performance portfolios.

6.27 In the absence of daily oversight of the DSO by a suitably qualified manager with safeguarding expertise, the DSO role is exposed to being a single point of failure. Whilst much of the casework seen was good quality, everyone is prone to human error. The proposed Director of Safeguarding (See Recommendation D4) is intended to help address this issue.

6.28 The storage of personal information held by the DST on MyConcern is compliant with UK data protection legislation and the UK General Data Protection Regulations (UK GDPR). Additional arrangements include the use of passwords, files being securely stored on SharePoint, restricted access management to sensitive information and multi-factor

authentication on accounts. The Diocese achieved a Cyber Essentials Plus accreditation in 2023.

6.29 The approach to data protection is strengthened by the inclusion of UK GDPR for all staff during induction. Findings from the Audit's DBF and parish workforce surveys indicated most respondents were aware of the Diocesan's privacy notice in respect of data protection.

6.30 The approach to data protection is positive and further strengthened by the Information Sharing Agreement in place between the DBF and the Cathedral setting out clear parameters governing the legal and best practice requirements for information sharing.

7 Victims and Survivors

7.1 For many victims and survivors, disclosing the abuse they have suffered can be exceptionally challenging. Some will carry their pain in silence, others will come forward, but only when they are ready to do so. The decisions that need to be made in this respect will never be easy, but in the absence of any witnesses, they are ultimately decisions for victims and survivors alone.

7.2 In this context, it is essential that all Church bodies create the conditions that build confidence amongst victims and survivors that they will be heard and taken seriously, and that help and protection will be effective. To do this, strong leadership, a healthy culture and robust arrangements for enduring support are key.

7.3 From a leadership perspective, there is absolute focus by the DBF on collaborating with victims and survivors and learning from their experiences. The Audit found senior leaders to be committed to this agenda, going beyond '*a box ticking exercise'* and ensuring that active and meaningful engagement is '*lived and breathed'*. As examples, the DBF has proactively reached out to wider victim and survivor groups, and the DSAP has amended its Terms of Reference to highlight the need for a greater focus on victim / survivor views. This has included extending its membership to ensure the voices of survivors are appropriately represented.

7.4 Supporting this aspiration, the DST undertakes a range of activities to establish effective partnerships with victims / survivors. This is helping to shape and influence the delivery of safeguarding initiatives, such as developing awareness raising materials and the recent

safeguarding conference facilitated by the DBF. Through this conference, victims and survivors of Church-based abuse were able to share their experiences, pose challenges and highlight their priorities for the Church.

7.5 Another example can be seen in the promotion of victim / survivor voices that are to be included as part of a video shown at Archdeacon's Annual Visitations. Auditors heard of the Archdeacon's determination to make safeguarding '*real*' for Churchwardens, to help them recognise that it can happen in their parishes and to dispel the myth that abuse is an '*up-country*' problem.

7.6 The DBF follow the guidance outlined by the House of Bishop's 'Responding Well to Victims and Survivors of Abuse'. Positively, practice seen by the Audit evidenced that victims and survivors were being engaged, supported with care and compassion, signposted to relevant support and provided with the information and assistance they required. That said, some victims and survivors who responded to the Audit's survey shared different experiences. Whilst acknowledging these were low in number (and that there was no way of establishing whether their concerns were contemporary or not), there was less confidence expressed about the support received and the attitude of the Church more generally. Whilst no recommendations are made, such views are important reminders about the need for managerial oversight on casework and the need to maintain comprehensive quality assurance processes. Both help to oversee practice and facilitate opportunities to respond to identified deficits.

7.7 The DBF has been active in developing a deeper understanding of trauma-informed practice across the Diocese, illustrating the appropriate focus on research and the ongoing

efforts to embed this approach across the local system. The Audit recognises this as positive.

7.8 Acknowledging that it can be extremely difficult for victims and survivors to come forward and share their stories, creating the right environment for them to do so is critical. The Audit saw evidence of both conventional and innovative approaches in this regard. These ranged from online information, signage and guidance documents, through to an interactive '*LOUDFence*' initiative and the '*If I told you, what would you do?*' exhibition. Material available on the Diocesan website includes key contacts, reporting routes and details of statutory agencies. It also sets out the DBF's Survivor Care Charter, Authorised Listeners service and links to the guidance from the CofE on spiritual abuse.

7.9 Locally, there is a clear system of therapeutic support in place, which ensures rapid access to appropriate, funded external support for victims and survivors. Provision is tailored to meet the needs of the individual and usually consists of between six and 12 sessions, depending on the professional advice received. The DBF can act as a conduit to the national interim support scheme and the national redress scheme when finalised.

7.10 With regards to reporting abuse, the Audit saw evidence of good compliance with many of the national standards on victims and survivors. Via its analysis of casework, there were examples of effective practice with victims and survivors of non-Church based abuse and those seeking support on broader safeguarding and welfare issues.

8 Learning, Supervision and Support

8.1 Supported by a defined strategy, a clear programme and dedicated personnel, safeguarding training is appropriately prioritised by the DBF. The Diocesan Training Strategy 2021-24 covers the key components of an effective system for learning and development. The training programme mirrors the national framework and there are ongoing efforts to ensure both fidelity and compliance. The DBF's safeguarding trainer is experienced and well supported by the Safeguarding Operational Assistant (SOA) and a small pool of volunteer trainers.

8.2 The impact of these arrangements is helping to develop knowledge, skills and experience of the workforce and can be evidenced across several areas. For example, training mandated by the NST has led to improved training accessibility across the Diocese. Previously, training sessions were delivered locally and all were in person. Funding of a dedicated trainer has helped to build knowledge, enhance relationships and raise awareness about safeguarding. Significantly, there has also been a shift in culture, with most of the staff and volunteers engaged by the Audit confirming they had seen improvements in the local approach to safeguarding.

8.3 Feedback on the administration, quality and delivery of training is also positive, although there remain some differences of opinion about learning style and content. These are known to the DBF. For example, some participants continue to struggle with online delivery and others have concerns about sessions being too heavily focused on the religious context of safeguarding.

8.4 In response to these issues, the DBF has been successful in helping to facilitate access to training where required. This has included support for those with hearing or visual impairments and volunteers delivering face-to-face training with cohorts of PSOs. Overall, the local training offer continues to be as inclusive and respectful as possible to individual needs. This is good practice.

8.5 With regards to course content, this was a new and interesting perspective for the Audit, having relevance to those who work for the Church, but who aren't particularly religious. As part of the leadership sessions, the trainer has been able to explain the nuance of such content and whilst this issue attracts no recommendation, it will be shared with the NST.

8.6 Whilst face-to-face training was the main method of delivery prior to the introduction of the NST programme, this is now infrequent. The trainer's time is spent overseeing the national sessions and delivering online leadership courses. Furthermore, whilst other DST members might join a session to introduce themselves, they do not participate in any direct delivery. In this regard, despite some ad-hoc events and ongoing awareness raising, the focus in Truro has predominantly been on the NST's core pathways.

8.7 Whilst this continues to provide the 'baseline training' for the workforce, the DBF could further build on initiatives that have already proven to be successful. For example, widening the cohort of volunteer trainers to provide more face-to-face training would help to extend choice and facilitate 'on-hand' support. Where this has already taken place with PSOs, training has been valued and effective. There is also merit in exploring how such arrangements could be grown and sustained as part of Truro's plans for deaneries. Creating regional hubs for PSO trainers and PSO support networks could help localise

delivery and build on the ‘soft but impactful’ outcomes of training – such as peer support, networking, and relationships.

Recommendation D23: The DBF should seek to widen its cohort of volunteer trainers and develop plans for how the provision of regional face-to-face training could be formally integrated into the emerging strategic plans for deaneries.

8.8 The Audit acknowledges that the DBF has been focused on ensuring fidelity to the national programme, and whilst recognising the importance of this approach, it has somewhat hindered the DBF's understanding and response to local need. There is no formal process for a training needs analysis and too much reliance has been placed on the NST to deliver solutions against local priorities.

8.9 For example, one of the local recommendations arising from the PCR2 process suggested dedicated training and the provision of fact sheets to help '*increase knowledge and understanding of behaviours and strategies of sex offenders.'* Whilst the PCR2 also made a national recommendation on this issue (albeit explicitly focused on Senior Clergy), the Audit has been unable to identify any material to provide reassurance that training on sex offenders is sufficiently robust.

8.10 In the Audit's opinion, there should be nothing to prevent the DBF from taking the lead on any training that has been identified as a local requirement. Indeed, in the context of sex offenders, the Audit is aware of a serious case in which there were clear knowledge deficits resulting in poor practice. The provision of relevant training (that had already been identified by the PCR2) could have helped in this context.

8.11 To support the DBF adopt a more routine methodology to identify learning needs and to better understand where knowledge gaps exist, the following recommendation is made.

Recommendation D24: The DBF should introduce a training needs analysis process that routinely seeks the views of all relevant stakeholders about their learning requirements at a local level.

8.12 Pending the completion of this proposed analysis, the DBF should also respond at pace by implementing theme specific training on sex offenders (including a relevant component on digital safeguarding). Whilst the NST should be engaged, this should not delay local delivery of this training to all relevant Church officers.

Recommendation D25: The DBF should develop or commission specific training that is focused on sex offenders, meets the recommendations set out in the PCR2 and incorporates relevant information on digital safeguarding.

8.13 There is also merit in implementing 'role specific' sessions as a way of improving 'buy-in'. Developed for specific cohorts of staff, these sessions could help improve the familiarity of safeguarding and its application in certain circumstances. For example, whilst acknowledging the efforts made in improving training compliance, targeted sessions for Churchwardens could help this group better understand their individual responsibilities in the context of their role.

Recommendation D26: The DBF should develop and implement role specific training sessions for defined cohorts of its staff and volunteers. These sessions should be defined as part of the local programme and supplement national training. To support capacity, all members of the DST (particularly the DSO and Deputy DSO) should support the DBF trainer in delivering these sessions. Where practical, these should be face-to-face.

8.14 At present, the evaluation of training is limited to the NST leadership sessions. There is no coordinated overview of the other courses being delivered. This leaves a gap in the DBF's local understanding about whether training is directly influencing practice and making people safer. As a potential solution, for all courses being delivered, cohorts of staff and volunteers (and their managers) could be approached three months after training to identify the specific ways in which they have used what they learnt in practice. They could be asked to provide examples of how this has helped them to make people safer and be asked about any unmet training needs.

Recommendation D27: The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers, and their managers about how training has helped their practice. As part of this process, questions about unmet training needs should be asked.

8.15 Oversight of training is an area of scrutiny for the DBF, including the work of the DSAP. Effective support from the SOA and DBF trainer helps to collate and present a range of performance information for interrogation. This is routinely considered, with actions and timescales for improvement evident within relevant minutes. Current data shows positive performance by most roles, except for Churchwardens and Pastoral Ministers attending leadership training. Deadlines have been appropriately set in this regard, letters have been sent by the DST and there are further mitigations in place to ensure compliance.

8.16 As part of their Continuing Professional Development (CPD), the DBF trainer has continued to access a range of internal and external learning opportunities. Whilst positive, the pressures to maintain delivery mean there is an inherent risk that CPD could be de-prioritised. In this sense, the trainer's learning needs are likely to benefit for a more structured arrangement. This should seek to forward plan learning and development opportunities, taking advantage of any relevant support from the NST and the local children

and adult safeguarding structures in Cornwall.

Recommendation D28: In discussion with the DSO, CPD opportunities for the DBF's safeguarding trainer (and other DST members) should be forward planned (as far as possible) and identified in the context of their ability to respond to local training needs.

8.17 There are a range of resources in place across the Diocese to assist the clergy. The DBF is signed up to the *Mindful Employer Scheme* and retains in-house mental health first-aiders. It has been recognised in the *Cornwall Healthy Workplace Scheme* (a quality mark for health and wellbeing in the workplace) and continues to promote monthly wellbeing initiatives, flexible working and social activities. The DBF can facilitate access for clergy to attend retreats, occupational health services, counselling and other confidential support. Debrief sessions are also available from the DSO / DDSO as appropriate.

8.18 There is a good range of support in place for ordinands to help them learn about safeguarding. Much of this is defined at a national level. Alongside a focus on safeguarding as part of the selection process (including a psychological assessment and questions crafted around safeguarding concerns), there is access to formal training, and at Diocesan gatherings of the Community of Vocation a safeguarding 'mini-teach' is included.

8.19 Good practice identified in other dioceses could warrant further exploration by the DBF. For example, the DST could look to deliver 'role specific' training with this cohort and whilst on placement, curates could be supported to complete a safeguarding Audit of their parish (and to then complete a theological reflection about trustworthiness).

Recommendation D29: The DBF should explore opportunities to strengthen the support for

curates based on the good practice already identified within published Audits.

8.20 Ministerial Development Reviews (MDRs) also add value to the clergy by facilitating reflection, learning and improvement. Locally, these are led by independent clergy and lay people from within the Diocese. They take place routinely and have a focus on safeguarding. The preparation framework provides appropriate prompts for clergy to reflect on their growth and development. For example, questions cover training requirements and how clergy members are contributing to a positive safeguarding culture, a focus on victims and survivors, and how they ensure people feel able to challenge. The Audit saw examples of anonymised MDRs where comprehensive conversations about safeguarding had clearly taken place. This is good practice.

8.21 In the Audit's opinion, the MDR process could be further strengthened if more explicitly aligned with the National Safeguarding Standards. Whilst most are covered in the preparation documentation, this is less specific within the MDR evaluation form or the facilitators evaluation form. Improving the content in this respect could help concentrate reflection about what is working well, the outcomes being achieved, and future areas for growth and development across all aspects of the standards.

Recommendation D30: In consultation with the DST, the MDR process should be reviewed, and amendments made for safeguarding prompts / questions and recording within the preparation and the evaluation forms to fully align with the National Safeguarding Standards.

8.22 The DBF operates an induction process that is delivered via targeted meetings with key roles and the sharing of relevant material. There is also a requirement to complete several online training modules and for certificates to be submitted to the Head of Operations on

completion. These include safeguarding basic awareness, health and safety, manual handling, cyber security and GDPR. Overall, arrangements are strong, with a significant majority of the DBF's workforce confirming they had been given an induction on starting.

8.23 At a parish level, there is an expectation that the DBF's Safer Recruitment and People Management processes are followed and that local induction forms part of this. These arrangements are supported by specific PSO induction sessions that are arranged and delivered by the DST. However, in response to the Audit's parish workforce survey, only a quarter of staff and volunteers confirmed they had received an induction when starting in their role. Some will have been in post for several years, and hence there may be some legacy issues impacting on this position (or confusion as to what constitutes induction or training). Regardless, the DBF should seek to further promote its expectations in this respect to ensure there are clear induction processes for all new staff and volunteers within parishes.

Recommendation D31: The DBF should promote awareness across all Parochial Church Councils (PCC) about the importance of induction events for new staff and volunteers.

8.24 The DST operates as an effective team. There is a blend of skills, mutual support, defined supervision arrangements and good working relationships. Team members engage locally, regionally, and nationally and demonstrate a strong desire to contribute to developments and share their expertise. For example, the DSO regularly meets with his Methodist counterpart for Cornwall and has built up a close relationship with the Diocese of Exeter. He has also recently been co-opted onto the National Executive Dashboard Group and acts as its Chair. There are equally strong connections with local statutory agencies (including the LADO) and other services supporting the young and vulnerable.

8.25 As one of the 'Pathfinder Diocese', the team benefit from support and dedicated input from the NST. This includes the DSO receiving supervision from the NST's Regional Safeguarding Lead. This is valued and supportive. However, as identified in other audits, 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 DBF should consider implementing mandatory counselling sessions for members of the DST to ensure they are sufficiently supported in the challenging role they do.

8.26 PSOs engaged by the Audit recognised the value of the DST and the support that it provides to parishes. That said, they equally acknowledged the limitations of such a small team. For several PSOs, they reflected concerns about the pressure of their role and the growing demands placed upon it. Whilst not an unfamiliar issue within many dioceses, maintaining the commitment of this critical cohort of volunteers is essential for effective safeguarding. Ideas about how more structured support could be provided should be explored by the DBF. This should link with the emerging deanery plans and concentrate on how to improve access to peer support, mentoring and supportive supervision.

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

Recommendation D34: The DBF should consider sponsoring an annual PSO conference / recognition event to highlight the work of PSOs, expose them to external speakers and deliver scenario-based training.

Part Two - Truro Cathedral

9 Context

9.1 Truro Cathedral stands as the sole cathedral in Cornwall, with its roots tracing back to St Mary's parish church in Truro, which later transitioned into the Cathedral. The Cathedral's construction, initiated in 1880 and completed in 1910, saw the incorporation of one aisle from the former parish church, now known as St Mary's Aisle. This unique architectural feature distinguishes Truro Cathedral as the only cathedral in the Church of England with an embedded parish church.

9.2 Responsibility for the Cathedral, including St Mary's Aisle, lies with the Cathedral Chapter and the Dean, who oversee all aspects, from expenditure to staff management. Although St. Mary's Parish Church Council continues to collect fees for weddings and funerals held in the Aisle, it does not engage in fundraising or control Cathedral activities.

9.3 The Cathedral's multifaceted role extends beyond religious functions to encompass education, heritage preservation, civic ceremonials and community engagement. Music forms an integral part of Cathedral life, with a significant proportion of its professional singers being children. Notably, the choir has evolved over time, admitting girls for the first time in 2015. All choristers receive education at Truro School.

9.4 In terms of population, Truro encompasses approximately 23,100 residents, with regular Cathedral attendance averaging around 150 individuals for Sunday services and 10-15 for weekday gatherings. Special services and events draw significant participation, with over 8,000 attendees recorded in 2022. Additionally, the Cathedral attracts numerous visitors annually, estimated at 350,000 based on extrapolated data from footfall counters.

9.5 Despite its smaller size and rural location, Truro Cathedral remains a vibrant hub of spiritual and cultural activity, reflecting the resilience and dynamism of its community amidst the challenges of its environment.

10 Progress

10.1 The Cathedral was subject to an audit by the Social Care Institute for Excellence (SCIE) in 2019 and underwent the Past Cases Review 2 process (PCR2) in 2020. The SCIE audit identified 38 specific issues for the Cathedral to 'consider' and the PCR2 made 36 local recommendations. In 2022, the Cathedral was exposed to further scrutiny by way of a Visitation. Triggered by the former Bishop of Truro, several recommendations linked to safeguarding were also made.

10.2 Whilst progress can be evidenced across many areas of the Cathedral, the context of its previous arrangements (as found by the Visitation) is likely to have hindered its capacity to provide the necessary grip, pace and impact against all areas of improvement. Indeed, the Visitation identified the need for the Cathedral's action plan to take account of all past review findings and to incorporate learning from other national reviews. This in itself suggests that previous planning had been somewhat insufficient. The position is now significantly more secure.

10.3 There is greater confidence from a leadership perspective, and whilst residual issues remain, the focus on safeguarding improvement is an absolute priority for the new Dean. A refreshed focus, consistent engagement and support from dedicated safeguarding professionals are yielding a positive impact. In many areas, this is resulting in an improved safeguarding culture, better practice and higher levels of awareness. In this respect, the future trajectory of the Cathedral is positive.

11 Culture, Leadership and Capacity

11.1 In the aftermath of a critical Visitation Report in 2023, which focused on life, culture, relationships and governance in the Cathedral, it is unsurprising that a range of stubborn and diverse challenges remain. Some are linked to structure; many to policy, practice and behaviour and the residual fallout from the Visitation. A new Dean has been appointed and recognises that addressing these issues is critical to the future health and wellbeing of the Cathedral community.

11.2 Feedback from surveys, interviews and focus groups has been mixed. That said, there was significant support and a sense of optimism from many engaged by the Audit. They believed that the Cathedral was now on a positive trajectory and that the new Dean was making a difference. The Audit was told by many that he is challenging the issues that needed to be addressed and that he is determined to build a better, more inclusive and welcoming culture.

11.3 Whilst it could be argued that the improvement journey is still in its early stages, feedback from the independent Audit survey of the Cathedral workforce mirrored some of the optimism reflected in face-to-face interviews. Less than two percent of the work force stated that they didn't feel safe amongst their colleagues and less than four percent disagreed that a safeguarding culture was now embedded throughout the Cathedral.

11.4 From a worshipping community perspective, whilst many were neutral on a number of issues, such as how complaints are dealt with and whether safeguarding now has a higher profile, over 90% said they felt safe.

11.5 Some of the stubborn challenges are exposed in the descriptions used by a minority to describe the culture as cliquey, arrogant and outdated. That said, the overwhelming majority from the workforce and worshippers used phrases such as welcoming, supportive and Inclusive.

11.6 From interviews and focus groups it was clear to the Auditors that a small group of individuals feel hurt, and some aggrieved by any suggestion that toxicity may have existed in the past. Indeed, when one person raised the issue in a focus group they were quickly challenged by others. Interestingly, no one in the workforce survey disagreed with the statement that the *Cathedral leadership actively communicates their position on treating other people with dignity, respect, sensitivity and fairness*.

11.7 The Audit has seen evidence of a number of positive initiatives to inform, engage and motivate those who work or worship in the Cathedral. These include, the Long Table community lunch, sermons addressing key issues and promoting values that can build, maintain and proactively develop a healthy culture. This approach is complemented by a range of face-to-face meetings with key stakeholders including chorister parents, the back row of the choir and meetings with the congregation and new chorister scholars.

11.8 The Dean has been focused in his efforts to better engage, communicate with and inform the Cathedral's congregation. He held an initial meeting with them in 2023 and a further three are planned in 2024. Furthermore, the Dean's Newsletter has been developed to ensure that readers (the congregation) know what is happening on a day-to-day basis. This is good practice. However, the challenge should not be underestimated. A significant minority of the worshipping community did not believe leadership listens carefully when

they express their opinions and concerns, and whilst well over half believed Cathedral leaders act fairly and with integrity, nearly a quarter did not agree.

11.9 Building a better culture will take time and courageous leadership. It takes time for new initiatives to bed-in and for people to see that a new regime is not simply ticking boxes, but making real and meaningful change. Critically, from the Audit's perspective, having engaged with many people across the cathedral communities, it will take courage to challenge the few who simply will not change, or those that say they will, but won't or cannot. The overwhelming majority of those engaged agreed that it was in everyone's interest to acknowledge the Visitation findings, accept the need for change and be part of it. A small number disagreed but could produce no evidence to support their position. For them, given that their resistance is not linked to safeguarding principles but a belief that the criticism of the Cathedral was wrong, it is perhaps time to reflect and move on.

11.10 The new Dean is robust and direct in his commitment to deliver change. He is focused on what is best for the Cathedral community and unequivocally accepts his responsibility and accountability for safeguarding. As a former Head teacher and Designated Safeguarding Lead, he is well equipped for the task at hand. During an interview with the Auditors, he was clear about the challenges and opportunities and how to engage and embrace different views and positions.

"*As far as I am concerned, I would rather people were free to disagree with me and each other and have a diversity of views and that somehow together, we reached a cohesiveness in terms of action, outcome and impact.*"

11.11 The Audit has seen substantial evidence of his grip, focus and impact at all levels. His senior leadership team support his vision and there is evidence that both the Cannon Chancellor and Chief Operating Officer have proactively increased their knowledge and awareness of safeguarding. This is reflected in the range of training courses they have undertaken. The Cathedral team are knowledgeable and able to signpost pathways to help and support. They collaborate well across the wider safeguarding community including the DSO and DST.

11.12 Chapter is the governing body of the Cathedral and is chaired by the Dean. A review of previous minutes highlighted that safeguarding had only been discussed by exception, when there was considered to be a rationale for doing so. This issue was highlighted in September 2023 by Chapter and in October 2023 safeguarding was addressed in detail. This included the Safeguarding Lead's report and focused on meaningful discussions concerning a range of relevant strategic and appropriate operational issues. Whilst this is positive, a skills audit of membership could help diversify and strengthen its insight, oversight and ability to challenge.

Recommendation C1: Chapter should consider carrying out a skills audit to ensure that its representation meets its governance needs.

11.13 It is worthy of note that at the time of the Cathedrals preparation for this Audit, two determinations from the Visitation Report remained outstanding. The first that *'the Chapter Lead is held to account through key performance measures such as compliance with training, vetting and case management.* The second, *that the Chapter lead for*

safeguarding must review the capacity and capability of the safeguarding team and arrangements with the diocese, to ensure that the team is properly resourced and empowered to deliver a robust response to any emerging issues. It should clarify the relationship with the Diocese to ensure that boundaries are clear, and vulnerabilities minimized. This should be carried out with external specialist support.'

11.14 Both have been considered and initial work undertaken. The Audit takes the view that these issues can be met via a reinforced and consolidated approach to the partnership with the DSO, DST and Cathedral Safeguarding Team.

11.15 These recommendations are addressed in Part One of the report. They relate to the provision of an overarching Director of Safeguarding who would sit on and be a member of the Leadership teams. This person would have oversight at a strategic level across the DBF, parishes and Cathedral, act as a strategic advisor to senior leaders and governing bodies and provide support to the operational Safeguarding Team. They would also provide the capacity to deliver any future (safeguarding) business transition **(See Recommendation D4).**

11.16 The recommendation regarding consolidation of those involved in the delivery of safeguarding practice **(See Recommendation D6)** would bring the Cathedral Safeguarding Officer (CSO), and Volunteer Manager / Safeguarding Coordinator within the DST framework. Each of these individuals is recognised for the good work they do and the difference they make. This recommendation is not a criticism, but an opportunity to provide them with a professional safeguarding pathway. Moving them into the DST will ensure that their supervision and professional development is supported and overseen by

a suitably qualified safeguarding professional. This move would not undermine the management relationship within current structures.

11.17 The Safeguarding Committee is a Committee of Chapter and as such, reports on matters related to safeguarding and governance. During the Audit it was being chaired by the Dean. Whilst he has been highly effective and the committee has considered, addressed and made authoritative decisions on key safeguarding issues, the chair should not be held by the Dean. The Dean agrees. At the time of writing a process is underway to select a different chair. Therefore, the Audit does not make a recommendation in this regard. However, a wider skills audit should take place to ensure that membership is optimised from a safeguarding perspective.

Recommendation C2: A skills audit of the Chapter's Safeguarding Committee should be conducted to ensure that its representation is fit for purpose and meets its safeguarding governance needs.

11.18 The DSAP is discussed in Part One of the report. Whilst the close working relationship with the Cathedral is productive and provides a line of sight regarding wider safeguarding issues across the DBF, the Audit takes the view that the Dean should consider the benefits of an Independent Advisory Group (ISAG) for the Cathedral. The Cathedral, by its nature is unique and hosts a range of different events whilst facilitating daily services and welcoming tourists. The adoption of an ISAG (used successfully in another area) would facilitate independent scrutiny with a Cathedral focus, enable wider and more diverse representation from the community within which the Cathedral sits and feed directly into the Cathedral's governance framework. In the opinion of the Audit, this aligns with the

Dean's vision of it being "*…Cornwall's great cathedral, which is here for everybody".*

Recommendation C3: The Dean and Chapter should consider the benefits of adopting an Independent Safeguarding Advisory Group, the options by which it could be achieved and the added benefits (not least inclusion) that such an initiative could bring.

Truro Cathedral Choristers

11.19 Through speaking with choristers and their parents, interviewing key staff and observing rehearsals, it is clear that the safeguarding of choristers is a high priority at the Cathedral and is embedded into daily practice.

Capacity

11.20 The Director of Music takes the lead responsibility for chorister safeguarding. This sits alongside other functions that include managing the Cathedral choir, training choristers, coordinating music for Cathedral events and services, liaising with Truro School and parents, overseeing departmental administration, leading the music team, organising various events and trips, and serving as a member of the senior management team.

11.21 Whilst the Director's job description encompasses all of these tasks, the Audit recognised the associated pressures and working hours attached to this role (60-70 hours per week). Notwithstanding the availability of support from an Assistant Director, there are inherent challenges attached to the Director's capacity. Put simply, when safeguarding is one priority amongst many, insufficient time can exacerbate the risk of things going wrong.

Recommendation C4: Reassess the Director of Music's responsibility for administrative tasks associated with the choristers and explore avenues for administrative support.

11.22 During rehearsals, notable dynamics were evident between the Director and Assistant Director and the choristers, showcasing a positive and respectful approach. Their use of positive reinforcement effectively resonated with both the boys and girls.

11.23 Other staff working with the choristers include three choir assistants, who also serve as

choir chaperones. The Director described the choir assistants as people with "*tremendous warmth"* and stated that the choristers feel they can trust them. Positive comments were also provided regarding the choir mentors' regular communication about the individual challenges faced by some. Focus group discussions with choristers echoed this sentiment, with many stating that they would confide in or seek support from choir mentors and assistants.

Supervision

11.24 Strong relationships are further enhanced through the presence of an appointed chaperone during evening rehearsals and other services. When services involve both boys and girls, two chaperones are present. This is good practice.

11.25 During a group discussion, choristers voiced concerns about feeling unsafe in the Cathedral's car park, a covered public area used for entering and exiting the building. Previous incidents, involving members of the public using drugs and alcohol, have heightened apprehensions among the choristers. Nonetheless, the Audit determined that Cathedral and School staff respond to these risks appropriately. Staff ensure choristers are always supervised and guided through alternative routes when necessary. The Audit saw evidence of robust risk assessments and therefore makes no recommendations in this area.

Information Sharing

11.26 Safeguarding staff in the Cathedral facilitate the timely exchange of information relating to choristers, including relevant care and safety plans between the School and the Cathedral. However, neither the Director nor the Assistant Director have access to the MyConcern

system. Given the Director's responsibilities, including oversight of chorister safeguarding, there is merit in this role being given access to this platform.

Recommendation C5: To strengthen oversight of chorister safeguarding, access to the MyConcern platform should be considered for the Director of Music.

11.27 Collaboration between the Cathedral and School in relation to the health and welfare of choristers is good, although the logistics of holding full team meetings on a regular basis were described as '*difficult*' and '*ad-hoc'*. This is due to timing and the location of those involved. The Director described these meetings as "*informed catch ups",* but stressed that should there be a safeguarding issue with a chorister, this will be formally recorded and forwarded to the Cathedral Safeguarding Officer.

11.28 It is positive to note that the newly appointed Choir Chaplain is setting up a termly choir pastoral meeting to include the Director and Assistant Director, the School's Designated Safeguarding Lead (DSL) and the choir mentors. This meeting intends to address pastoral considerations for the choristers. This is good practice.

11.29 An information sharing agreement is in place between Truro School and the Cathedral. The agreement details the information to be shared and is clear that anything shared must be "*proportionate to the purpose"*. Whilst broadly sufficient, the agreement does not currently stipulate a review date.

Recommendation C6: The information sharing agreement between Truro Cathedral and the School should include a review date to ensure that the agreement remains relevant, effective, and compliant over time.

Parent Views and Communication

11.30 Feedback from parents regarding their children joining the choir included phrases such as "*the best thing that has happened to our entire family*," "*priceless,*" "*such a gift to have*," and "*fantastic.*" Parents expressed confidence in the security of their children while they are in the Cathedral and on trips. However, one concern held by some parents (and the Director) emphasised the need to extend the duration of termly pastoral meetings involving Cathedral and School staff and parents of choristers. Safeguarding remains a standing item on the agenda, addressing various concerns such as the security codes for the padlocks on the crypt gate, appropriate use of mobile phones by older children and safeguarding matters relating to public visitors. Parents also highlighted the need to allocate time at the end of meetings for questions. Although not specifically falling under the remit of safeguarding, some parental inquiries remain unresolved, which could impact relationships.

Recommendation C7: Sufficient time should be allocated during termly chorister parent meetings for parents to raise any issues or concerns they may have. In instances where issues or concerns are not fully addressed during the meeting, the Director of Music should ensure these are followed up in a timely manner.

Safeguarding Policy

11.31 In the 2023 Cathedral Safeguarding Policy, Annex B: "Chorister Supervision", provides comprehensive guidance on the duties and obligations of those overseeing the welfare of choristers. To promote uniformity in the document's review procedure, the Audit makes the following recommendation.

Recommendation C8: The Truro Cathedral Safeguarding Policy should include a designated date for review.

11.32 The revised “Code of Conduct for Choristers”, updated in September 2023, recognises the complexities of interacting with choristers across different age groups. It provides clear instructions outlining behavioural expectations for all Cathedral staff and volunteers. The Audit considers this to be good guidance for staff.

12 Prevention

12.1 Safer recruitment policies and practices play a critical role in creating safer environments, deterring unsuitable individuals from joining an organisation and preventing the abuse of children, young people and vulnerable adults. The Cathedral has a range of measures in place to ensure the safer recruitment of individuals to various roles. Such measures include completing an application form and a confidential declaration, conducting DBS checks (subject to the meeting the set criteria), repeat DBS checks and referencing. On appointment, new candidates must complete Basic Awareness and Foundations safeguarding training.

12.2 It is important for the Cathedral to set out its expectations and commitment to safeguarding within its recruitment process. As with the DBF, there are opportunities to consistently reinforce such messaging within adverts and job descriptions. The Audit makes the following recommendation in this regard.

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

12.3 The Parish Safeguarding Dashboard and Safeguarding Hub have been adopted by the Cathedral. This provides the ability to monitor and assess the recruitment of volunteers. The Audit notes that there is ongoing work to ensure that legacy records are migrated and makes the following recommendation.

Recommendation C10: The Cathedral should ensure that all its data has been migrated to the Parish Safeguarding Dashboard and Safeguarding Hub.

12.4 Positive action has been taken to ensure safer recruitment arrangements remain

sufficiently robust. This includes retrospective action. An example of this was seen by the Audit in the work undertaken to resolve the issue of long-standing volunteers, for whom they do not hold an application form or references. This is good practice and should be continued. Furthermore, the Audit notes there have been discussions about adding Cathedral volunteers to the staff system, '*Breathe'*. The Audit would support this.

12.5 A Code of Conduct is in place for Cathedral staff and volunteers, and in recognition of the unique and 'influential' role that certain positions hold, there is a separate code in relation to choristers. This code establishes a specific focus on understanding and maintaining appropriate boundaries with respect to choristers. This is good practice.

12.6 Amplifying and raising awareness about the different types of abuse and the risks that people can face helps people know what to look for and how to respond. In this respect, the Audit saw substantial evidence of safeguarding being promoted prominently throughout the Cathedral via innovative and novel approaches. These included posters, a safeguarding noticeboard and weekly emails issued by the Dean. The Cathedral had also developed specific child-friendly messaging (in video form) and thought-provoking exhibitions, such as the '*If I Told You, What Would You Do?'* project and '*LOUDFence'*.

12.7 Safeguarding is a subject that is addressed at different levels in the Cathedral. It is a standing agenda item at Chapter meetings, discussed at Senior Management Team meetings and the Dean has regular discussions with individuals and groups. Opportunities to engage the Cathedral's worshipping community are also adopted. During one 'Safeguarding Sunday' sermon, the Dean asserted: *"Safeguarding is something that is not solely about policy and procedure but is about the very heart of Almighty God who wants*

everyone to be safe and flourish'."

12.8 Arrangements are in place at the Cathedral to facilitate the sharing of best practice and learning from others. This includes the membership of the Cathedral Safeguarding Advisors Network, the SLA between the DBF and the Cathedral, and recently adopted practice whereby the DST proactively works from the Cathedral offices to increase communication and accessibility to the Cathedral workforce.

12.9 Whilst many volunteers engaged by the Audit reflected positive views about both safeguarding communication and engagement at the Cathedral, this was not the experience of all. For example, whilst the DST newsletter adds clear value, it is not always of relevance to the specific context of those working in Cathedral. This is an area acknowledged by the Cathedral as one it would like to improve.

Recommendation C11: The Cathedral should engage its workforce to determine how safeguarding communication and engagement (with a focus on the specific context of the Cathedral) could be improved.

12.10 The Cathedral's website provides a fully responsive user experience and performs well with search engine optimisation (SEO). The 'safeguarding' section is prominent and easily accessible through the primary navigation menu. The safeguarding webpage itself provides users with relevant 'calls to action' and information is made available in a clear and logical format.

Recommendation C12: The Cathedral should consider any additional signposting and resources which may be of benefit to visitors of the safeguarding webpage.

12.11 The Audit recognises that strong communication is a two-way process and seeking and acting on the views of children, young people and vulnerable adults is a key component to effective prevention planning. The Audit has seen positive engagement with child choristers and is also aware that a member of the DST attended *'Empowering Children'* training. Furthermore, the Cathedral is exploring opportunities to strengthen how the voice of junior choristers and their parents can be heard. This is good practice. In respect of hearing the voices and views of vulnerable adults, there remains scope for improvement.

Recommendation C13: The Cathedral should establish engagement mechanisms to formally consider the needs, experiences and voices of vulnerable adults and survivors within safeguarding prevention planning.

12.12 There is a Lone Working Policy in place for Church Officers within the Cathedral. The policy states that there are '*often occasions when staff may find themselves to be working alone in the Cathedral or the Old Cathedral School'*. It also states a number of issues to consider before carrying out work alone, including ensuring that mobile phones are charged, easily accessible and in good working condition. If someone undertaking lone work does not have a phone, then they are *'prohibited from undertaking lone working activity'.* Whilst it is positive to have this policy in place, the Audit found that not all staff and volunteers had an awareness of this guidance, with one commenting "*if you are on your own in the Cathedral and no vergers or clergy are about it can be a worry if any issues arise*". To this effect, The Audit makes the following recommendation.

Recommendation C14: The Cathedral should take proactive steps to engage with its staff and volunteers to help them better understand guidance on lone working.

12.13 Proactive steps have been taken at the Cathedral to mitigate risks which are associated with the physical layout of the building. One such risk involved two wrought iron gates leading from the Cathedral floor to the Crypt (where the junior choristers rehearse). A temporary solution has been put in place and the Audit understands that more permanent and 'heritage appropriate' solutions are being sought. The Audit supports this and whilst no recommendation is made, strengthening security at this site needs to happen at pace. The Cathedral has also taken steps to review its CCTV coverage and reassuringly, acknowledges that this needs to be improved. The Audit concurs.

12.14 Further procedures are in place through the provision and use of walkie talkie radios and panic alarms for staff and volunteers in the Cathedral. That said, not all of the workforce was aware that these were operational and available for them to use.

Recommendation C15: The Cathedral should promote and make all relevant staff / volunteers aware of the availability and practice as it relates to walkie talkie radios / panic alarms.

Recommendation C16: Safeguarding practice linked to the physical layout of the building should be further enhanced by the Cathedral carrying out a structural survey to identify any areas within its structure which could represent a risk to a child or vulnerable adult.

13 Recognising, Assessing and Managing Risk

13.1 The Cathedral is open all year round and attracts large numbers of visitors on an annual basis. Staff and volunteers encounter a diverse range of challenges, from managing protests, concerts and other large public events, to dealing with matters of misconduct, providing support for vulnerable individuals and addressing the day-to-day activities involved in religious services.

13.2 The Audit observed a whole system approach to safeguarding at the Cathedral aimed at identifying, managing and mitigating risk. This framework encompasses a dedicated and experienced Safeguarding Team, relevant policies, protocols, guidance and efforts to raise awareness.

13.3 The Cathedral has its own safeguarding risk register with concerns and control measures well documented. This demonstrates that safeguarding is a key organisational priority. The findings regarding risk registers for the DBF are set out in Part One of this report and have equal relevance to the context of safeguarding at the Cathedral.

13.4 The DBF and Cathedral Safeguarding Partnership Working Agreement, reflects a strong commitment to work together to implement the safeguarding polices of the House of Bishop's and the Archbishop's Council. This is good practice.

13.5 Information sharing arrangements extend to other processes, including a requirement on visiting organisations (working with children and young people or vulnerable adults), to provide their safeguarding policy, and the names and contacts of chaperones, in advance

of coming to the Cathedral.

13.6 A collaborative approach to safeguarding practice is further strengthened through strong working relationships with the DBF, the Cathedral and external partnerships, ranging from statutory involvement in casework, to signposting to support agencies such as First Light, Safer Futures and social care. Overall, the Cathedral's arrangements enhance the opportunities to detect risk, facilitate joint decision-making, and enable the swift implementation of a safeguarding response when required.

13.7 In terms of individual cases, there is support from the DST, secured through the DBF and Cathedral Information Sharing Agreement (ISA), which supports a robust response to safeguarding concerns. The effectiveness of the DST and the Audit's recommendations are set out in Part One of this report. They have equal relevance to the context of safeguarding at the Cathedral.

13.8 Case activity, at the time of the Audit, showed two ongoing concerns. There were eighteen safeguarding concerns closed and filed. These ranged from criminal activity to lower-level issues resulting in support, signposting or advice and guidance.

13.9 Whilst no definitive conclusions can be made about the volume of this activity, it is relevant to note findings from the Audit's survey involving the Cathedral's workforce. Whilst most respondents indicated they knew how to escalate a safeguarding concern, a fifth of respondents indicated they didn't have, or were unsure if they had confidence in the escalation process.

Recommendation C17: In partnership with the DST, the Cathedral should proactively engage with its workforce to promote confidence in the reporting and escalating concerns.

13.10 Notwithstanding the good range of policies in place, the Audit noted the absence of readily accessible guidance on how to deal with unexpected events or unforeseen risk at the Cathedral. Of note, the Audit were advised there are no clear procedures for situations such as a child being reported missing, or what to do if someone threatening came into the premises. The Audit believe greater emphasis must be placed on these issues.

Recommendation C18: There should be clear and easily accessible guidance to follow in the event of unexpected disruptions and unforeseen risks such as a terrorist attack or threatening person coming into the Cathedral premises.

Recommendation C19: There should be clear and accessible guidance regarding procedures to be followed in the event of the report of a missing child or vulnerable person within the Cathedral.

13.11 When dip sampling cases, there were good examples of effective decision making with regards to potential visitors to the Cathedral who may have presented a safeguarding risk. The Audit noted an occasion where professional curiosity led to questioning the proposed attendance of an individual, which in turn resulted in the escalation of concerns to the senior management team, NST and police. Another concern referred to an individual with spent criminal convictions. The DSO took positive steps to prevent their participation in a Cathedral event. This demonstrates confidence and competence in safeguarding decision making. These actions show the willingness to question, challenge, and monitor the

compliance with safeguarding arrangements.

13.12 At the time of the Audit, the Cathedral had no safeguarding agreements in place. The effectiveness of the management of these is set out in Part One of this report.

13.13 The Cathedral has recently been registered as a charity and has a legal requirement to submit Serious Incident Reports to the Charity Commission. Whilst it has yet to make any reports, clear arrangements are in place.

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

14 Victims and Survivors

14.1 The Audit recognises that there is a somewhat limited ability for the Cathedral to engage directly with victims and survivors. This is largely due to the SLA in place between the Cathedral and the Diocese, which allows for the provision of operational safeguarding issues, advice and support from the DST.

14.2 In light of this arrangement, while there is no direct engagement with victims and survivors, the Cathedral proactively engages in awareness raising activities to break down taboos, share learning, discuss issues, build understanding, change attitudes, and encourage reporting and prompt action. This plays a critical role shaping the culture and environment for victims and survivors. For Cathedral staff and volunteers, these important messages are reinforced within the Team Member Handbook.

14.3 As discussed previously in this report, the Cathedral has adopted innovative initiatives to engage, support and facilitate disclosures. The interactive '*LOUDFence*' and the '*If I told you, what would you do?*' exhibition demonstrate good practice in this respect. Whilst measuring impact from such events can be challenging, the Audit acknowledges that the purpose of such engagement with clergy, staff, volunteers, visitors, and worshipers is to create opportunities to reflect, engage and share. The Audit is aware that this event resulted in increased awareness and received positive feedback. This is acknowledged as good practice.

14.4 Annual safeguarding conferences have provided opportunities for victims and survivors of Church-based abuse to share their experiences, pose challenges and highlight their priorities. As previously noted (see Victims and Survivors in Part One), a delegate

commented on the significant knowledge they took away from the most recent event; '*noticing where the power lies'* and the '*notion of "Biblical Terrorism"*'. Indeed, following a victim / survivor's presentation at one such event, this resulted in a disclosure being made.

14.5 The Cathedral's website provides an opportunity for sharing information and signposting for victims and survivors. The website provides users with the ability to report a safeguarding concern either via an online contact, email or telephone. This is good practice. The Audit notes that the Safeguarding Policy is prominent and includes information on Authorised Listeners, how to respond to concerns and disclosures and the Cathedral's commitment to take seriously any allegations of abuse (recent or non-recent). While this is good practice, the Audit holds the opinion that key information within the policy could be made more easily accessible within the webpage. See **Recommendation C12.**

14.6 Training compliance for staff and volunteers is an ongoing priority for the Cathedral. This provides those individuals who would be most likely to encounter victims and survivors with the knowledge and skills to respond appropriately and sensitively. Whilst the Audit notes there is scope for strengthening this (see Learning, Supervision and Support), this is broadly positive.

14.7 During their day-to-day roles, the clergy, staff and volunteers at the Cathedral come into contact with a diverse range of people. Some will be tourists, others will include organised groups, school children, local people and worshippers. The Audit found that the Cathedral workforce demonstrated an understanding of how to respond to those 'in need' and that participation in Mental Health First Aid training had been beneficial.

15 Learning, Supervision and Support

15.1 There are good systems in place to support the learning and development needs of the Cathedral's workforce. A clear Diocesan training strategy aligns with the CoE's Safeguarding Learning and Development framework, and there is a defined training programme. The overall arrangements are effectively supported by a range of key personnel. The specific work of the CSO, the Volunteer Manager / Safeguarding Coordinator, the DBF's Safeguarding Trainer and the Safeguarding Operational Assistant has been significant in this context and warrants highlighting.

15.2 Learning opportunities mirror those available for other Church officers across the Diocese. In this sense, much of the detail set out in Part One of this report is of equal relevance. Safeguarding training aligns to the national programme and whilst sessions are usually 'attended' online, the Cathedral has facilitated group and individual courses for those unable to do so. This is good practice, offering a degree of choice and inclusivity towards training.

15.3 Other events led or hosted by the Cathedral also demonstrate good practice and have supplemented the NST programme, including the Diocese's safeguarding conference (held in March 2024 at the Cathedral), which had a focus on *'trauma informed approaches'* and provided an opportunity to hear directly from victims, survivors, and safeguarding experts. For more on this, see the Victims and Survivors section of this report.

15.4 Feedback to the Audit on the administration, quality and delivery of training was generally positive. This was reflected in survey results, interviews across varying roles and

evaluations relating to the leadership sessions. For some staff, they felt that training could be sharper. A new and interesting perspective for the Audit involved comments that content was too heavily focused on religion. This had relevance to those who work for the Church, but who aren't particularly religious. As part of the leadership sessions, the trainer has been able to explain the nuance of such content and whilst this issue attracts no recommendation, it will be shared with the NST.

15.5 Overall, opportunities to learn are appreciated by staff and volunteers in the Cathedral and there is evidence of impact across several areas. Most at the Cathedral recognised training as being relevant to their role and most believed that safeguarding was now embedded in the Cathedral's culture. Furthermore, the significant majority were confident in managing a disclosure and knowing what to do if they were worried about someone's behaviour. Effective training will undoubtedly have played its part in this progress. This is positive.

15.6 That said, opportunities to provide more theme specific and role specific training are also likely to accrue benefits for the Cathedral. Developing a training offer that covers the unique safeguarding context of the Cathedral is seen as important by the Audit. For example, the nuance of what a verger or education volunteer should know is likely to be different when compared to a Churchwarden in a parish setting. Developing a better understanding of the training needs in the Cathedral and creating targeted seminars that build on the NST programme will add significant value. Good practice has already been seen by the Audit in another cathedral where their CSO led such sessions as focused seminars.

Recommendation C20: In collaboration with the DST, the Cathedral should ensure that a bespoke training needs analysis for its staff and volunteers is available as part of any developed process.

Recommendation C21: In collaboration with the DST and in line with the recommendations for the DBF to create role specific training, the Cathedral should identify the different cohorts of clergy, staff and volunteers for whom this would be relevant and seek the support of the CSO to facilitate these.

15.7 Training data is appropriately scrutinised by leaders and compliance is generally good for both staff and volunteers. At the time of writing, 93% of the Cathedral's workforce were up to date with 'basic' training and 100% were up to date at 'foundation' level. Leadership training was less strong, with 69% compliance. Deficits in this respect largely link to staff as opposed to the volunteer cohort.

Recommendation C22: The Cathedral should ensure that all staff and volunteers who have outstanding training, complete this within the next three months. Clergy and leaders should complete this within two months.

15.8 At present, the evaluation of training is limited to the NST leadership sessions and led by the DST's trainer. There is no coordinated overview of the other courses being delivered. This leaves a gap in the local understanding about whether training is directly influencing practice and making people safer. As a potential solution, for all courses being delivered, cohorts of staff and volunteers (and their managers) could be approached three months after training to identify the specific ways in which they have used what they learnt in practice. They could be asked to provide examples of what difference this has made and about any unmet training needs. A relevant recommendation has been made for the DBF in this respect, although the Cathedral should seek to ensure it is engaged in any developments.

Recommendation C23: To help determine the impact of training on making people safer, the Cathedral should ensure that the implementation of any enhanced evaluation process by the DBF includes the provision of disaggregated data for its own staff and volunteers.

15.9 For most staff and volunteers who have attended an induction session, they believe it covered what they needed to know about safeguarding. That said, nearly half of the respondents to the Audit's workforce survey at the Cathedral indicated they had never been given one. A further 14% couldn't recall. In this sense, whilst noting the additional leadership focus in this area, there is merit in the Cathedral seeking further reassurance that its arrangements are sufficient.

Recommendation C24: The Cathedral should review its induction arrangements and ensure that all staff and volunteers systematically have access to a defined programme that includes a clear focus on safeguarding.

Recommendation C25: All staff and 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 can be undertaken in groups and should be mandatory (regardless of a person's length of service and the training received).

15.10 A range of systems are in place for the Cathedral's clergy to help them cope with the challenges of their role and potential trauma. These match the broader arrangements in place across the Diocese. Alongside Human Resources (HR) and occupational health support, help is available for pastoral, practical and spiritual assistance. Continued Ministerial Development is embedded and there is access to counselling and other support services. Furthermore, when an allegation of abuse or complaint is made against a

member of the clergy, as per policy, they will be helped by a Link Worker. Debrief sessions are also available from the DSO / CSO as appropriate. This is good practice.

15.11 Arrangements for ordinands or curates at the Cathedral are defined, and echo those set out in Part One of the report. Alongside a focus on safeguarding as part of the selection process (including a psychological assessment and questions crafted around safeguarding concerns), there is access to formal training and at Diocesan gatherings of the Community of Vocation, a safeguarding 'mini-teach' is included.

15.12 Ministerial Development Reviews (MDRs) of Cathedral clergy were weak and largely absent until six months ago. With a refreshed leadership focus, these are now taking place and arranged through the DBF. The preparation framework provides appropriate prompts for clergy to reflect on their growth and development. For example, questions cover training requirements and how clergy members are contributing to a positive safeguarding culture, a focus on victims and survivors, and how they ensure people feel able to challenge. The Audit saw examples of anonymised MDRs where comprehensive conversations about safeguarding had clearly taken place. This is good practice.

15.13 In the Audit's opinion, the MDR process could be further strengthened if more explicitly aligned with the National Safeguarding Standards. Whilst most are covered in the preparation documentation, this is less specific within the MDR evaluation form or the facilitators evaluation form. Improving content in this respect could help concentrate reflection about what is working well, the outcomes being achieved, and future areas for growth and development across all aspects of the standards. A related recommendation has been made in this regard for the DBF.

Recommendation C26: There should be a structured focus on safeguarding practice within the MDR process. In collaboration with the DBF, arrangements for Cathedral clergy should be similarly revised to ensure that discussions cover a review of safeguarding (in line with the National Safeguarding Standards) and that these are formally recorded within all MDR documentation.

15.14 Overall, there is good collaboration between the Cathedral, CSO and wider members of the DST. This results in effective professional support for those in safeguarding roles at the Cathedral, providing them with access to expert advice and guidance.

Conclusion

16 Conclusion

Further to the SCIE and PCR2 processes in 2017 and 2019, good progress has been made by the DBF and more recently, by the Cathedral. Whilst there is more work to do, the Audit is reassured that the Bishop and Dean are continuing to drive and prioritise safeguarding across their respective areas of influence.

Strengths in Truro's current safeguarding arrangements are evident at both a strategic and operational level. These have been built upon the foundations of focused leadership, the expertise and commitment of the DSO / DST and the maintenance of strong links with statutory partners. The contributions made by the many volunteers in parishes and those who support the Cathedral have also been highly significant.

Good practice was seen by the Audit through the collective focus on the voice of survivors, care for choristers, innovative and engaging outreach at the Cathedral and the *working with us* approach to safer recruitment. Training, awareness raising, communication strategies (not least online), the intelligent use of thresholds and the triaging, allocation and overall management of cases are also helping to make people safer.

That said, there are areas that could be strengthened, and some stubborn challenges remain. Critically, the most senior leaders recognise this and are committed to pushing ahead with the improvement journey they now lead. To do so they will need to address any residual negativity regarding culture and consider how to reinforce operational capacity. The recommendations within this report are designed to help them do just that.

Appendices

17 Appendix 1 – DBF Recommendations

Recommendation D1: A specific deep dive survey of Clergy wellbeing (focused on the areas of concern identified in the 2022 exercise) should be carried out.

Recommendation D2:

A. The DBF should carry out a focused workforce survey of its Clergy, staff and volunteers to test safeguarding awareness and workforce confidence in the escalation processes including knowledge of the Whistleblowing Policy. The survey should provide an option for respondents to suggest solutions relating to the issues raised.

B. Each parish should carry out a focused workforce and worshipper survey to test safeguarding awareness and confidence in the escalation processes including knowledge of the Whistleblowing Policy. The survey should provide an option for respondents to suggest solutions relating to the issues raised. In respect of small parishes in which such an approach might not be feasible, alternative approaches such as discussion groups, feedback forms (following the discussion) and awareness raising regarding the escalation process and whistleblowing should be covered.

Recommendation D3: In consultation with the appropriate individuals, the DST / DSO should provide advice to strengthen the current Archdeacons' Articles of Enquiry / Questions.

Recommendation D4: The Bishop and Dean should consider the creation of a dedicated Director of Safeguarding. This role would be part of the most senior leadership team and provide direct insight from a safeguarding perspective and support the oversight and operational delivery of the DST.

Recommendation D5: The DSAP should develop a learning and improvement framework to focus its insight and oversight role. This should be evidence and data driven and targeted at agreed areas of need / development and or risk.

Recommendation D6: All safeguarding focused resources, regardless of where they currently sit, should be consolidated under the direct supervision of the DSO.

Recommendation D7: The DBF should ensure that all staff and volunteers are up to date with DBS checks and are within the three-year cycle.

Recommendation D8: The DBF should ensure that its commitment to safeguarding is embedded in all job adverts, application forms and job descriptions.

Recommendation D9: The DBF should re-design the safeguarding webpage adopting a multi-level navigation menu aligned with hierarchical principles where information is organised in order of importance to users. A section on how to report a safeguarding concern should take primacy followed by a re-ordering of other sections that are most frequently accessed.

This should ensure that support material resources are categorised into logical groups and are easily accessible.

The DBF should review all supporting materials it provides and consolidate these on its website (this should include the addition of the Volunteer Agreement - Code of Conduct and the Whistleblowing Policy).

Recommendation D10: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, vulnerable adults, and survivors within safeguarding prevention planning.

Recommendation D11: The DSO should review all Blue files for new clergy joining the Diocese.

Recommendation D12: The DBF safeguarding risk register should be developed to address contemporary and contextual issues and think about how risk is described in the context of the Church's new national standards.

Recommendation D13: The DST should prioritise cleansing the data on MyConcern and archive any outstanding cases that are ready to be 'filed'.

Recommendation D14: Entries on MyConcern should provide a rationale for any 'inaction' on cases, where decisions have been made by the DSO / DST not to take a particular action.

Recommendation D15: The DST should consult the NST about its new proposals to introduce a system to terminate safety plans in specific cases. The Audit believe the NST should be a critical component to the overall approach to safety plans and will raise this with them.

Recommendation D16: National guidance should be revisited to include information about what to do when respondents refuse to sign safety plans. The Audit will raise this with the NST.

Recommendation D17: The Head of Marketing and Communications should routinely attend Core Group discussions.

Recommendation D18: The DST should familiarise itself with the national guidance regarding the criteria for SIR reports to the Charity Commission.

Recommendation D19: The DBF should raise awareness of the National Data Sharing Agreement between the National Police Chiefs' Council and the Church of England within the Diocese and raise the profile with police forces through the NST.

Recommendation D20: The DBF should continue to review the effectiveness of the MyConcern system and continue to engage at a national level to ensure the system meets local needs.

Recommendation D21: Referred cases resulting in no further action and / or the provision of advice / guidance should be included as part of the supervision discussions between the DST and NST. This will also be raised by the Audit with the NST.

Recommendation D22: Structured supervision processes should be implemented locally within the DST with links to performance portfolios.

Recommendation D23: The DBF should seek to widen its cohort of volunteer trainers and develop plans for how the provision of regional face-to-face training could be formally integrated into the emerging strategic plans for deaneries.

Recommendation D24: The DBF 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 D25: The DBF should develop or commission specific training that is focused on sex offenders, meets the recommendations set out in the PCR2 and incorporates relevant information on digital safeguarding.

Recommendation D26: The DBF should develop and implement role specific training sessions for defined cohorts of its staff and volunteers. These sessions should be defined as part of the local programme and supplement national training. To support capacity, all members of the DST (particularly the DSO and Deputy DSO) should support the DBF trainer in delivering these sessions. Where practical, these should be face-to-face.

Recommendation D27: The DBF should implement a specific evaluation process that seeks to capture evidence from staff, volunteers, and their managers about how training has helped their practice. As part of this process, questions about unmet training needs should be asked.

Recommendation D28: In discussion with the DSO, CPD opportunities for the DBF's safeguarding trainer (and other DST members) should be forward planned (as far as possible) and identified in the context of their ability to respond to local training needs.

Recommendation D29: The DBF should explore opportunities to strengthen the support for curates based on the good practice already identified within published Audits.

Recommendation D30: In consultation with the DST, the MDR process should be reviewed, and amendments made for safeguarding prompts / questions and recording within the preparation and the evaluation forms to fully align with the National Safeguarding Standards.

Recommendation D31: The DBF should promote awareness across all Parochial Church Councils (PCC) about the importance of induction events for new staff and volunteers.

Recommendation D32: The DBF should consider implementing mandatory counselling sessions for members of the DST to ensure they are sufficiently supported in the challenging role they do.

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

Recommendation D34: The DBF should consider sponsoring an annual PSO conference / recognition event to highlight the work of PSOs, expose them to external speakers and deliver scenario-based training.

18 Appendix 2 – Cathedral Recommendations

Recommendation C1: Chapter should consider carrying out a skills audit to ensure that its representation meets its governance needs.

Recommendation C2: A skills audit of the Chapter's Safeguarding Committee should be conducted to ensure that its representation is fit for purpose and meets its safeguarding governance needs.

Recommendation C3: The Dean and Chapter should consider the benefits of adopting an Independent Safeguarding Advisory Group, the options by which it could be achieved and the added benefits (not least inclusion) that such an initiative could bring.

Recommendation C4: Reassess the Director of Music's responsibility for administrative tasks associated with the choristers and explore avenues for administrative support.

Recommendation C5: To strengthen oversight of chorister safeguarding, access to the MyConcern platform should be considered for the Director of Music.

Recommendation C6: The information sharing agreement between Truro Cathedral and the School should include a review date to ensure that the agreement remains relevant, effective, and compliant over time.

Recommendation C7: Sufficient time should be allocated during termly chorister parent meetings for parents to raise any issues or concerns they may have. In instances where issues or concerns are not fully addressed during the meeting, the Director of Music should ensure these are followed up in a timely manner.

Recommendation C8: The Truro Cathedral Safeguarding Policy should include a designated date for review.

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

Recommendation C10: The Cathedral should ensure that all its data has been migrated to the Parish Safeguarding Dashboard and Safeguarding Hub.

Recommendation C11: The Cathedral should engage its workforce to determine how safeguarding communication and engagement (with a focus on the specific context of the Cathedral) could be improved.

Recommendation C12: The Cathedral should consider any additional signposting and resources which may be of benefit to visitors of the safeguarding webpage.

Recommendation C13: The Cathedral should establish engagement mechanisms to formally consider the needs, experiences and voices of vulnerable adults and survivors within safeguarding prevention planning.

Recommendation C14: The Cathedral should take proactive steps to engage with its staff and volunteers to help them better understand guidance on lone working.

Recommendation C15: The Cathedral should promote and make all relevant staff / volunteers aware of the availability and practice as it relates to walkie talkie radios / panic alarms.

Recommendation C16: Safeguarding practice linked to the physical layout of the building should be further enhanced by the Cathedral carrying out a structural survey to identify any areas within its structure which could represent a risk to a child or vulnerable adult.

Recommendation C17: In partnership with the DST, the Cathedral should proactively engage with its workforce to promote confidence in the reporting and escalating concerns.

Recommendation C18: There should be clear and easily accessible guidance to follow in the event of unexpected disruptions and unforeseen risks such as a terrorist attack or threatening person coming into the Cathedral premises.

Recommendation C19: There should be clear and accessible guidance regarding procedures to be followed in the event of the report of a missing child or vulnerable person within the Cathedral.

Recommendation C20: In collaboration with the DST, the Cathedral should ensure that a bespoke training needs analysis for its staff and volunteers is available as part of any developed process.

Recommendation C21: In collaboration with the DST and in line with the recommendations for the DBF to create role specific training, the Cathedral should identify the different cohorts of clergy, staff and volunteers for whom this would be relevant and seek the support of the CSO to facilitate these.

Recommendation C22: The Cathedral should ensure that all staff and volunteers who have outstanding training, complete this within the next three months. Clergy and leaders should complete this within two months.

Recommendation C23: To help determine the impact of training on making people safer, the Cathedral should ensure that the implementation of any enhanced evaluation process by the DBF includes the provision of disaggregated data for its own staff and volunteers.

Recommendation C24: The Cathedral should review its induction arrangements and ensure that all staff and volunteers systematically have access to a defined programme that includes a clear focus on safeguarding.

Recommendation C25: All staff and 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 can be undertaken in groups and should be mandatory (regardless of a person's length of service and the training received).

Recommendation C26: There should be a structured focus on safeguarding practice within the MDR process. In collaboration with the DBF, arrangements for Cathedral clergy should be similarly revised to ensure that discussions cover a review of safeguarding (in line with the National Safeguarding Standards) and that these are formally recorded within all MDR documentation.

19 Appendix 3 – Glossary of Abbreviations

APCM	Annual Parochial Church Meeting
BDC	Bishop's Diocesan Council
CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
CPS	Cathedral Primary School
CSO	Cathedral Safeguarding Officer
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
DSL	Designated Safeguarding Lead
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
EDI	Equality / Equity, Diversity and Inclusion
GDPR	General Data Protection Regulations
HR	Human Resources
ISA	Information Sharing Agreement
LADO	Local Authority Designated Officer
LLM	Licensed Lay Minister
LLR	Learning Lessons Reviews
LSCP	Local Safeguarding Children Partnership
MDR	Ministerial Development Review
MHFA	Mental Health First Aid
NPCC	National Police Chief's Council

NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PoC	Person of Concern
PSO	Parish Safeguarding Officer
SCIE	The Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SEO	Search Engine Optimisation
SIR	Serious Incident Report
SLA	Service Level Agreement
SLT	Senior Leadership Team
SOA	Safeguarding Operational Assistant
SPO	Safeguarding and Pastoral Officer
TEI	Theological Education Institution

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