Independent Safeguarding Audit of Newcastle Diocesan Board of Finance and Newcastle 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, having a particular focus on Diocese Boards of Finance (DBFs) and Cathedrals. They take account of the CofE's new National Safeguarding Standards that provide the structure for this report.[1]

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

- Over 400 documents were collated and analysed prior to the Audit's fieldwork.
- A range of interviews with Church officers (staff and volunteers), external partners, victims, survivors and other stakeholders.
- 382 anonymous survey responses which gathered input from key communities connected to the Church. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the DBF, the Cathedral and parishes.
- Four focus groups.
- A confidential contact form accessible via a dedicated webpage.
- In total, the Audit undertook 36 separate engagement sessions reaching 80 people.

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

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

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

Part One - Newcastle Diocesan Board of Finance

2 Context

2.1 Newcastle Diocese, located in the north-east of England, stretches from the River Tyne to the Scottish border, encompassing the local authority areas of Newcastle upon Tyne, North Tyneside and Northumberland. Spanning 2,110 square miles, it holds the distinction of being the most northerly Diocese within the CofE.

2.2 From the bustling city of Newcastle upon Tyne to the tranquil landscapes of Northumberland, the region exhibits a diverse array of communities, each with its own character and identity. Areas within the Diocese face challenges of significant rurality and multiple deprivation.

2.3 The latest census data reports a population of approximately 831,600 within the Newcastle Diocese area. Organised into 12 Deaneries within two Archdeaconries, the Diocese is structured to effectively deliver to its population. Additionally, the Newcastle Diocesan Education Board plays a significant role as one of the largest providers of schools in the region.

2.4 There are a total of 12,300 individuals actively engaged in worship, with average weekly attendance standing at 9,400 and Sunday attendance averaging 7,600.

3 Progress

3.1 Overall, the SCIE and PCR2 processes made 35 recommendations / considerations for improvement. These ranged from issues such as safer recruitment, training and case management to record keeping, welfare, DBS renewal and raising awareness about safeguarding procedures. The overwhelming majority of these recommendations have been met, whilst a small number have been incorporated into other workstreams and a few remain linked (and reliant upon) policy being delivered at a national level.

3.2 The SCIE audit was published in March 2017 and resulted in 10 considerations, all of which were accepted. Before the current Diocesan Safeguarding Advisor (DSA) took up her post, her predecessor created an action plan to coordinate the work arising from SCIE, but this was not utilised. An overview paper was provided to the Audit team, explaining that actions were subsumed into subsequent annual safeguarding plans between 2017 and 2019. Decisions related to the implementation of actions were overseen by the Diocesan Safeguarding Advisory Panel (DSAP).

3.3 The Audit is satisfied that the SCIE considerations have been met, or where these remain subject to ongoing work, there is a rationale for why. With the DSA being a Board Member in the 'Safeguarding Systems Together Project', and through the creation of the Safeguarding Operations role, there is a clear understanding about the importance of integrating and utilising systems to monitor these processes.

3.4 In terms of resourcing, the DBF makes use of external consultants with expertise in safeguarding. They have been involved in Lessons Learned Reviews (LLRs) and conducting risk assessments. There is a conscious effort to develop processes and procedures, and this effort should continue. It was reported that the impact of a student

social work placement has been multi-faceted, having increased both capacity and engagement with children, as well as introducing a fresh professional perspective into the Diocesan Safeguarding Team (DST).

3.5 The PCR2 was carried out between January 2020 and April 2021. The 25 recommendations were collated into an action plan. Oversight and implementation of this action plan was led and signed off by the DSAP. There was a follow up review of all PCR2 cases which led to the creation of a file note.

3.6 In terms of capacity, casework is an ongoing area that requires more attention, supervision and resources. Not least because of the absence of thorough oversight and associated record keeping. This is a concern given that the narrative surrounding Recommendation 18 of PCR2 (2021) largely reflects similar themes e.g. relying on the organisational memory of a few individuals:

'[An]other concern the [Independent Reviewers] IRs [one of whom is now an external consultant for the DBF] all shared about internal culture was how far the Diocese relies on the organisational memory of a few key individuals. These people may be seen as disguising the deficiencies of the record-keeping systems and the old culture of too many difficult things being left unsaid or unrecorded.'

3.7 Recommendation 18 of PCR2 therefore suggested that the Diocese should conduct a succession planning exercise, to measure and mitigate the risk of losing key individuals. The DSA acknowledged that they could be perceived to be in a vulnerable position in this regard. That said, they explained that this was mitigated by working long hours (including when sick) and by commissioning an external consultant when they had been physically unable to work. In the view of the Audit, this is insufficient reassurance. The use of external consultants is a contingency rather than a succession plan and once again highlights a

lack of resilience within the DST. More formal succession planning must be factored into the existing arrangements for the DST to allow for the loss and replacement of key staff and to ensure continuity of experience and corporate memory.

3.8 Noteworthy work being carried out, as referenced within the PCR2 action plan, includes the '*If I told You What Would You Do?*' project co-created by victims and survivors of Church-based abuse, which has now been incorporated into national guidance.

3.9 Beyond SCIE and PCR2, the external consultants commissioned by the DBF also completed five LLRs, which took place between 2022-23. Recommendations were collated and analysed, and themes from these informed a continuously reviewed action plan. A sub-group was constructed to monitor the implementation of learning from these LLRs, and this was strategically overseen by DSAP. The plan identified 12 areas where action was needed and all of these have been met or have been overtaken by national processes, such as CDM procedures, Link Person training and the information sharing agreement between the Church and police. Some key outcomes to emerge from these LLRs at a local level include the Lead Officer for the Chaplaincy to Survivors role and the creation of training for core group members (which was shared with the NST).

3.10 The DBF's collaboration with Sunderland University[2] included an independent and anonymised stakeholder survey of its in-house safeguarding function. This provided insights relevant to PCR2. Findings were generally positive, however this varied across roles. For example, it identified that wardens have little interaction with the DST.

3.11 An area of friction identified by some Churchwardens referenced the completion of safeguarding training at Leadership level. It was corroborated by the Audit that working

[2] https://www.newcastle.anglican.org/safeguarding/sunderland-university-collaboration/

with Churchwardens still requires improvement. Work is ongoing and a Churchwarden currently sits on DSAP. A working group is commencing activity on next steps following this research.

3.12 A second stakeholder survey (SWOT analysis) initiated in May 2023, has contributed to the development of the Diocesan Safeguarding Strategy and other decisions. Sunderland's research concluded that *'safeguarding is not yet embedded into Church life and culture'*. Whilst there is evidence of good progress being made, the Leadership, Capacity and Culture section of this current report highlights that while the trajectory is now positive, some stubborn challenges remain.

4 Culture, Leadership and Capacity

4.1 Interviews, surveys and other feedback indicates that culture has improved under the current leadership in Newcastle. The vast majority of respondents to the DBF workforce survey stated that they have seen improvements in the overall safeguarding arrangements and that they believe a safeguarding culture is now embedded. This view was mirrored in the parish workforce and worshipping community surveys. Reassuringly, nearly all felt safe in their own churches. The most frequently used words to describe culture were welcoming, supportive and respectful.

4.2 That said, not all respondents were positive. A minority did not feel that a safeguarding culture was embedded, with a few stating they did not feel safe. To this end, it is important that the DBF does not become complacent and that it periodically offers opportunities for communities to provide feedback and insight. Whilst anonymised surveys and feedback from focus groups is helpful, the DBF should also proactively encourage signposting to whistleblowing (just over half of the DBF workforce were aware of whistleblowing procedures) and other reporting pathways. Furthermore, it should test that everyone in a position of influence is leading by example.

Recommendation D1: The DBF should routinely raise awareness about whistleblowing across the workforces operating in the DBF, the Cathedral and parishes. They should do this by:

a) Promoting awareness using traditional and digital communication strategies.

b) Testing awareness by using anonymised surveys.

c) Reinforcing awareness and contextual understanding through focus group engagement, utilising case studies and prompts.

d) In conversation, what leaders say and do matters. Leaders should frequently and routinely raise the issue of the importance of safeguarding.

Recommendation D2: Implement leadership audits highlighting an individual leader's active and authoritative approach to safeguarding. For example, instances where a senior leader has challenged inappropriate conduct and taken steps to highlight and report safeguarding concerns. This might include providing words of advice and instigating disciplinary processes as well as public statements, official communications and participation and support provided to individuals and groups including victims / survivors.

Recommendation D3: As part of its use of surveys, focus groups and other engagement activity, the DBF should ensure it routinely tests awareness about whistleblowing processes and seeks feedback for areas of improvement.

4.3 The Audit saw evidence of good practice in the efforts made by the DSA and others to actively listen to those involved in safeguarding roles across the Diocese. Such initiatives include PSO networking opportunities, in-person and online lunchtime listening events and other outreach activities. These activities include providing face-to face-tutorials, training and familiarisation sessions for those who are unable to complete online courses.

4.4 The insight provided by Dashboard data has enabled the DST to target additional support to parishes with lower compliance. This direct assistance has helped to embed the Safeguarding Hub and Dashboard system. This is good practice. It is also worthy of note that the DBF was an early adopter of the Dashboard, which thanks to the hard work and dedication of the staff and volunteers in parishes, is available for use across the Diocese.

4.5 There was substantial evidence of good collaboration by the DBF with internal teams, the DSAP, the Cathedral, young people, schools, statutory agencies and local charities. A range of co-production initiatives have resulted in the building of websites, digital media guidance and harm reduction activities with local organisations. Specific examples include the DBF working with the Fire Brigade (preventing deaths by fire) and local charities such

as Wearside Women in Need and Harbour in the *Ask Me Ambassadors* project, (funded by the Northumbria Police and Crime Commissioner).

4.6 The DBF's greatest strength and most consistent collaborative endeavour is in the work it has undertaken with victims and survivors. The support of the DSA, and more recently the appointment of a Lead Officer for the Chaplaincy to Survivors, is to be commended. Facilitating such co-production, promoting and providing ongoing support to the victims and survivors who created the '*If I Told You What Would You Do?'* programme, has been essential. To this end, maintaining a dedicated role is key.

4.7 Given the critical capacity issues discussed later in the report, the Audit takes the view that the Lead Officer for the Chaplaincy to Survivors role should not be diluted or diverted into areas that are not directly linked to their primary skill set. Notwithstanding the fact that the Audit was told that the post-holder 'accepted' to undertake an additional post (15 hours) with a separate job description as interim Cathedral Safeguarding Advisor (CSA). The reality is that lines of accountability can be blurred and utilising them as a part-time interim CSA (given they are neither trained or experienced in such a specific role) is unhelpful and potentially unfair.

Recommendation D4: The remit of the Lead Officer for the Chaplaincy to Survivors should not be used for activities beyond a clearly defined range of survivor related support activities (including training).

Leadership

4.8 The Bishop of Newcastle inherited some difficult challenges regarding culture, but during her first year she has made good progress. She is unambiguous with regards to her role, responsibilities and ultimate accountability for safeguarding.

4.9 One of her first strategic decisions after taking up the role was to instigate a governance review. Its aim is to streamline governance structures and to improve coordination and oversight. The governance review is currently in a consultation phase, involving engaging with and listening to others. The Audit considers this to be a relevant and sensible area of focus.

4.10 The Audit has seen and heard evidence of the Bishop's vision, engagement with others and when appropriate, her authoritative practice. She has made difficult but appropriate safeguarding decisions and leads by example, not least when addressing issues related to the conduct of clergy, Church staff and volunteers.

4.11 The Bishop has a good relationship with the new Dean, who supports her vision to simplify governance and further enhance engagement with the Cathedral.

4.12 The Bishop is also supported by a longstanding Diocesan Secretary and by senior leaders on her staff who are firmly focused on safeguarding. They understand their individual functions and can signpost to appropriate safeguarding support and advice. Many take the opportunity to raise the profile of safeguarding whilst exercising their day-to-day roles.

4.13 Safeguarding arrangements are defined and supported by strategy, with a range of strategic and operational meetings facilitating oversight and delivery. These meetings have appropriate representation at the right level of seniority and expertise.

4.14 The Bishop's Council / Standing Committee is chaired by the Bishop (Diocesan Synod President). As the governing body of the DBF it is charged with overseeing activities ranging from the development of strategy and policy, to ensuring that all statutory and legal requirements are met. Whilst it also encompasses the DBF (Chaired by a Cannon), it does not currently incorporate the functions of the Diocesan Mission and Pastoral Committee.

4.15 The current configuration includes ex-officio and elected members as well as several officers in attendance. Whilst all members of the Council are individually and collectively responsible for a range of issues related to safeguarding (for example, the submission of safeguarding related Serious Incident Reports to the Charity Commission), those with a routine relationship with safeguarding responsibilities include the Dean of the Cathedral Church of St Nicholas, both Archdeacons and the Diocesan Secretary.

4.16 There are several lay members on the Council and current vacancies may provide an opportunity to broaden and diversify membership. It could also consider a range of options to strengthen professional safeguarding insight and oversight. This could include co-opting the DSAP Chair and adopting the recommendation to appoint a Strategic Director of Safeguarding (see below).

Recommendation D5: The Bishops Council should carry out a skills audit to ensure that it has optimised the opportunities to engage individuals with the skills, abilities and lived experience necessary to safeguard contemporary Church communities. This will also help to ensure relevant and robust challenge during briefings on safeguarding issues.

4.17 Safeguarding is a standing agenda item and a review of the minutes of meetings (over the last twelve months) demonstrates that safeguarding matters are presented and discussed. Topics have included progress related to the recommendations from IICSA, the rollout of the Dashboard, lessons from LLRs, capacity and other issues, including the Jay report. That said, there is little evidence of challenge and the format appears to be tilted towards briefing. Moving forward, there needs to be a greater emphasis on professional curiosity and challenge. See Recommendation D5 above.

4.18 Safeguarding is also a standing agenda item on the Bishops Staff Team Meetings. The DSA is an officer in attendance and provides updates and reports. These generally cover

casework, DBS checks, training, the Parish Dashboards and other safeguarding related events and initiatives.

4.19 It is clear from the minutes of both the Council and Bishops Staff Team that significant reliance is placed on the verbal and written reports from the DSA. It is less clear that these are subject to robust scrutiny and challenge. The Audit found no evidence that the known capacity issues facing the DST had been substantially addressed, understood or considered as a potential risk via these forums.

Blue Files

4.20 Whilst (at the time of writing) permission has yet to be granted for the Audit to see Blue Files, the Bishop's staff provided a comprehensive overview of the process for their receipt, examination and storage. Notwithstanding the Audit's reservations about consultants reviewing Blue Files, mentioned later in this report, the system in place to manage the files is robust and supported by templates and prompts. This aspect represents good practice.

Archdeacons

4.21 The Archdeacons of Northumberland and Lindisfarne have a sharp focus on safeguarding and between them deliver a number of key functions. These include holding safeguarding meetings, chairing core groups, carrying out visitations, disseminating information and prompting relevant activities across the Diocese. The Audit saw examples of safeguarding alerts and information about good practice being cascaded by the Archdeacons to Area Deans.

4.22 Both Archdeacons bring a balanced and sensible approach to their work and reflect upon which of them (given the particular circumstances and any potential conflict of interest) should chair core groups, a role for which they have received training.

4.23 They have a structured and well-planned methodology for visitations utilising a safeguarding template that now incorporates the Parish Safeguarding Dashboard, which the Audit notes has achieved exemplary compliance rates. This is good practice. That said, they are aware that dashboards themselves are only as good as the information within them, and that moving forward, dip sampling content will help with quality assurance.

Recommendation D6: During future visitations (and in consultation with the DSA), data from Parish Safeguarding Dashboards should be dip sampled as part of reassurance testing by Archdeacons.

4.24 Both Archdeacons spoke highly of the DSA and Chapter Safeguarding Lead (CSL). They were also alive to the issues regarding capacity and the tensions this created in some working relationships.

The Diocesan Safeguarding Advisory Panel

4.25 The DSAP is well chaired by an individual with a credible statutory background in both operational and strategic roles. Its membership brings together a range of representatives from the DBF, parishes, Cathedral and to its credit, statutory bodies.

4.26 The DSAP could be further strengthened by diversifying and broadening its membership to include representatives from the wider community within which the Diocese sits. This could, for example, involve more representatives from local charities who engage with activities, such as support for mental health, the homeless and foodbanks. This would potentially enhance local insight, consolidate partnerships and provide diverse external challenge.

Recommendation D7: The Chair of the DSAP should consider broadening the membership of the DSAP to include more representatives from the wider community within which the Diocese sits, particularly local charities with a focus on supporting the young and vulnerable.

4.27 The focus of the DSAP is appropriate and it operates to clear terms of reference regarding scrutiny, support and constructive challenge. The minutes reflect much of that which is considered at other governance and management meetings, but the DSAP's approach is appropriately more granular and better aligned to the National Safeguarding Standards.

4.28 The minutes also provide a sense of the wide range of safeguarding work that is ongoing across the Diocese, covering specific projects and updates from the Cathedral. It is clear from the Cathedral updates that safeguarding resourcing is an issue and that delays in funding (including a suggestion that a decision had been made to await the outcome of the Jay report in Nov 2023, reiterated in the Strategy Task and Finish Group Action Log in Feb 2024) were creating potential risks. The minutes of the December meeting reflect the Diocesan Secretary's acknowledgement of the need to establish an interim arrangement. This was addressed by the appointment of an interim CSA in January 2024. The Audit takes the view that this did not sufficiently mitigate the known risks. The individual appointed to the interim role acknowledges that they do not have the necessary experience and simply act as a conduit, passing all concerns to the DSA. This compounds the problem as it creates the impression on paper that capacity has been addressed when in essence, it has not.

4.29 When asked about capacity within the DST, the DSAP chair acknowledged that it was a concern. Notwithstanding the fact that capacity is occasionally addressed, no decisive action has been taken to expedite support beyond the use of consultants and the Lead Officer for the Chaplaincy to Survivors taking on a second post as interim CSA. As stated

in the above paragraph the Audit takes the view that this has not mitigated the risk or reduced concerns regarding capacity. This is an issue that should be captured and monitored within risk registers.

4.30 The DSAP chair also acknowledged that capacity issues in the DST have created some tensions and frustrations.

Recommendation D8: The Council, Bishops Staff Team and DSAP should operate and maintain contemporary risk registers. Each should target and assess the areas of risk most relevant to their oversight responsibilities, e.g. strategic and / or operational.

4.31 As with other DSAPs across the CofE, the panel's effectiveness depends on the goodwill and relationships developed by the chair. This is a weakness insofar as the role would provide greater reassurance if it operated on the basis of authority rather than personal influence. This is not a commentary on the Newcastle DSAP, but a reflection on the national system and limitations currently placed upon them. This matter will be raised in the Audit's first annual report.

4.32 As an independent scrutiny body, the DSAP Chair should be remunerated. There are a variety of levels applied across different DSAPs. Whilst it is for the NST and others to decide on the appropriate level of payment, a good benchmark would be the average currently paid to safeguarding partnership chairs. No independent chair should be working as a volunteer.

Recommendation D9: The DBF should remunerate the role of DSAP Chair. This should be fixed against an appropriate comparator role and based on an average across similar roles. The approach to remuneration of such posts is not uniform and the Audit will make a recommendation to the NST in this regard in due course.

Director of Safeguarding

4.33 The Audit has identified the lack of in-house safeguarding capacity in the DBF as a critical issue. It can negatively impact on the ability to manage strategic oversight and operational delivery, which can result in the blurring of roles and responsibilities. This position is not sustainable.

4.34 Whilst the DBF has an admirable appetite to innovate, collaborate and develop new policy and practice, it does not have the depth of resource to match its ambition. The current system is stretched and reliant on key staff working excessive hours and the deployment of external consultants.

4.35 The Diocese does not operate in a vacuum and context is key. In that regard, given the growing numbers of people in need, it is likely that pressure on safeguarding resources will increase. Furthermore, given the recent Jay Report, it is possible that there will be significant change to the CofE's safeguarding arrangements. All of which evidences a need for greater strategic insight and operational capacity.

4.36 To address this, the DBF (in consultation with the Cathedral's leadership team) should consider the creation of a dedicated Director of Safeguarding role. This is likely to help strengthen the strategic lens on safeguarding at a local level, as well as ensuring greater regional and national engagement.

4.37 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 enhance capacity for decision making, oversight, change management and challenge.

4.38 Such a role would 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 Newcastle. In that regard, it is important to consider that the appointment of a Director of Safeguarding role would, by default, create a Safeguarding Directorate, reinforcing the level of internal safeguarding independence and scrutiny.

Recommendation D10: 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. It would provide direct insight from a safeguarding perspective and support the oversight and operational delivery of the DST.

The Diocesan Safeguarding Team (DST)

4.39 The DST is made up of a DSA, a Safeguarding Operations Officer (predominantly providing admin support and organisation training events), the Lead Officer for the Chaplaincy to Survivors (who is also currently the interim CSA) and two external consultants, who provide support in specific areas and help address gaps during sickness or extractions. They operate an MOU with the Cathedral and work with Lindisfarne College of Theology, a Theological Education Institution (TEI) within Newcastle and others in respect of PCR2 Recommendation 24.

4.40 Whilst led by an experienced safeguarding professional, the DST suffers from a critical lack of capacity. Notwithstanding the expertise and commitment of the current DSA, who is highly thought of by those whom she supports, there is simply too much work for such a small team.

4.41 The DBF, parishes, and, to some degree, the Cathedral are therefore reliant on the goodwill of the DSA. The DSA works exceptionally long hours and is stretched between strategic responsibilities, the provision of training, the oversight of operational delivery and case work. Many key tasks are therefore delegated to external consultants. Such tasks

include case management, scrutiny of the Blue Files, safety planning and some aspects of training, as well as completing LLRs. The latter may well create a conflict of interest, given that their independence as reviewers could be questioned. That said, the Audit has been told that the DSA will no longer use those external consultants for LLRs.

4.42 Whilst high-quality consultants (such as those engaged by the DSA) can provide added value, specialist knowledge and surge capability, they are not an alternative to a properly qualified, resourced and supported in-house Safeguarding Team. Their use as part of a long-term strategy has the potential to impact upon resilience, hinder proper succession planning and as such, undermine the good work that the DSA has led. In the context of Newcastle, the primary focus of the consultants on operational casework has resulted in the DSA being less engaged and less sighted on what is perhaps their most important function.

4.43 Furthermore, this is the first time that the Audit has seen a system whereby external consultants are given full access to Blue Files. Whilst the DSA might have delegated responsibility for external consultants to review incoming files of newly appointed clergy, the Audit takes the view that this is not appropriate and is a task which should be carried out by a member of the DST, preferably the DSA. This will help to build the DSA's knowledge about those whom they support across the Diocese and help inform induction and other training requirements.

Recommendation D11: Except in exceptional circumstances and with the relevant permissions, Blue Files should be viewed (when appropriate) by a member of the DST, preferably the DSA.

4.44 The Audit has seen the good work done, initiatives developed and support provided by this small team. They have a good relationship with statutory partners and feedback from the LADO reflected some engagement. The DST has real potential to become an exemplar, but it must be urgently reinforced. Waiting for the imposition of the Jay report (as some have suggested) is not a sensible safeguarding option. Risk will not pause and safeguarding will not wait.

4.45 Moving forward the DBF must consolidate its DST. This cannot be a paper exercise in which people who do one thing, are given a title that implies they also have the skills to do another. It will therefore require investment in the right people, with the right skills. If the role of Director of Safeguarding is accepted, other roles should include a DSA responsible for case management, oversight and the supervision of the operational team. Notwithstanding that some roles may already exist, a review of resources should seek to ensure that the operational team is made up of people with complimentary skills (preferably from statutory backgrounds) to manage cases, deliver training and administer support.

4.46 Furthermore, safeguarding roles within the Cathedral should be consolidated within the DST and professionally supervised by the DSA, or if Recommendation D10 is accepted, then by the then Director of Safeguarding. Such roles would include the CSA and any other dedicated safeguarding resource. This would not undermine their line management by the relevant Cathedral Leader.

Recommendation D12: The DBF should immediately review and reinforce its DST with a focus on building capacity and resilience. In doing so, it should consult with other DSTs to establish how best to achieve a blended, multi-disciplinary team.

4.47 Throughout the Audit, concerns were raised by a range of staff and leaders concerning what was reflected by many as a difficult relationship between the Cathedral and DBF (in respect of safeguarding). Some went further and described the relationship as unhealthy.

4.48 Since the completion of the SCIE and PCR2 reviews, there have been issues concerning capacity and succession planning**.** Improvement in this regard is still required. The Audit found that there is currently an unhelpful level of ambiguity and frustration concerning the relationship between the Cathedral and the DBF. This has manifested in some unhelpful positioning and conflict between senior staff. Furthermore, questions linked to the provision of the existing Memorandum of Understanding (MoU) regarding support from the DBF to the Cathedral needs to be addressed. There must be absolute clarity concerning case management and levels of sensible and constructive collaboration.

Recommendation D13: The Bishop and Dean should ensure that immediate work is undertaken to resolve any ambiguity concerning working practices between the Cathedral and the DBF. Where required, changes should be set out within the arrangements covered by the MoU.

5 Prevention

5.1 The DBF has implemented robust safer recruitment processes that align with the House of Bishops guidance, *Safer Recruitment and People Management*. Staff are appropriately selected, interviewed and undergo DBS checks. They participate in induction training and the Audit noted good practice in relation to removing 'digital barriers' for those who struggle to use technology. These practices include visiting individuals' homes to assist with online form filling, providing offline induction training (for both staff and volunteers) and other supportive measures.

5.2 Staff in leadership positions who are directly involved in recruitment have received appropriate safer recruitment training and understand the guidance issued by the CofE. The Audit was reassured that where a candidate has not (or refuses to) complete safer recruitment requirements, the DBF does not allow them to commence their role / position. This includes work shadowing arrangements and the DBF's policy of not beginning any employment until a DBS check has been carried out.

5.3 To further strengthen its preventative arrangements in this context, key messages relating to safeguarding could be better reinforced throughout the various stages of recruitment.

Recommendation D14: The DBF should ensure that its commitment to safeguarding is embedded throughout all job adverts, application forms and job descriptions.

5.4 The Audit noted that a number of individuals involved in recruitment-related tasks (such as DBS checks, the management of references and confidential declarations) have yet to complete the CofE's safer recruitment training and should do so to eliminate any gaps. For some others, their previous training exceeds three years and requires renewal.

Recommendation D15: The DBF should ensure that all staff who undertake any duty as part of the recruitment process undergo safer recruitment training according to the CofE's guidelines. This training should be renewed if it was taken more than three years ago.

5.5 It is good practice to ensure that those responsible for tasks such as criminal record checks have been appropriately vetted themselves. The Audit found that this was not always happening.

Recommendation D16: The DBF should ensure that all staff who undertake any duty as part of the recruitment process have an up-to-date DBS certificate.

5.6 As a key element to the prevention of abuse and neglect, the DBF demonstrates good practice in raising awareness about safeguarding. It uses a variety of methods of communication to engage various audiences. This includes training sessions, sermon content, PSO forums, parish workshops, Churchwarden lunches and the '*If I Told You, What Would You Do?*' initiative.

5.7 The DBF also use digital communication, such as online newsletters and social media channels. Good practice was also highlighted in relation to conversations with young people from parish youth groups. These covered explaining staff ratios and the implementation of safeguarding training sessions for Beyond Youth staff and volunteers.

5.8 The Diocese of Newcastle's website presents a modern theme that loads quickly, performs well with search engine optimisation (SEO) and is mobile-responsive. The 'Safeguarding' section is prominently featured and easily accessible, with the DST being visible on the first page. There is a wide range of guidance within the tab, directing users to support groups, templates, resources, social media guidance and more. A voluntary digital charter

is made available for those who would like to pledge their commitment to fostering a more positive atmosphere online.

5.9 Including the voices of victims and survivors of Church-based abuse, a peer support group helps to develop and approve awareness raising materials and other activities. From a prevention perspective, this helps to ensure that content is appropriately written and targeted. This is good practice.

5.10 A comprehensive range of material is made available for Church officers across the Diocese, including lone working guidance and a Diocesan handbook that features a code of conduct. The CofE's code of safer working practice complements individual parish codes of conduct for volunteers in leadership positions and PCC members.

5.11 The Audit observed evidence of appropriate risk assessments for Church activities where potential safeguarding risks were identified.

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 safeguarding policies, guidance, awareness raising and training**.** Clear and established reporting pathways also exist and overall, these structures should increase the likelihood of early risk detection and timely interventions.

6.2 The DBF's strategic risk register covers key corporate issues and includes safeguarding. It has oversight from the DSA, senior staff and the Bishop's Council, with concerns, review dates and control measures being well documented. However, at the time of its submission to the Audit, the risk register had last been updated in June 2023. Furthermore, the emphasis on safeguarding was relatively limited and failed to capture risks such as those associated with the lack of professional safeguarding capacity within the DST.

6.3 In its current form, the risk register does not go beyond the obvious or consider context. Going forward, it may be helpful for the DBF to think about how risk is described in relation to the CofE's National Safeguarding Standards. This could help better articulate how risk could manifest from pressures such as the cost-of-living crisis, the exponential rise of mental health concerns or the impact of the Jay report. The Audit also suggests that developing a separate safeguarding risk register for the DBF would be beneficial. This would allow more thorough scrutiny and focus on safeguarding concerns.

Recommendation D17: The DBF should develop a standalone safeguarding risk register to allow for more focus and scrutiny on safeguarding concerns. This should be reviewed and updated at a minimum cycle of quarterly.

Recommendation D18: The DBF's safeguarding risk register should be developed to clearly identify risks as they relate to the CofE's National Safeguarding Standards.

6.4 In terms of operational practice, the Audit saw evidence of an approach to safeguarding where referrals are allocated to external safeguarding consultants as opposed to this work being undertaken directly by the DSA.

6.5 This collaboration allows for access to subject matter experts, which makes sense in many respects. However, these arrangements can also be problematic. For example, whilst the DSA commits both focus and energy to their role, the Audit found that they do not have a sufficient grip on all cases. Whilst this may in part relate to the chronic capacity issues evident throughout the Audit, the fact is, the DSA's involvement and oversight of casework is 'light-touch'. This creates an absence in the rigour of management scrutiny and direction. Recording and practice across the entire pathway requires immediate strengthening.

Recommendation D19: The DSA, supported by investment from the DBF, should take steps to ensure that case management, scrutiny, record keeping and oversight of practice is strengthened across the entire safeguarding pathway. This should include the DSA conducting and recording monthly management reviews of active cases on MyConcern.

6.6 Newcastle was an early adopter of the new national case management system (MyConcern) which allows for a more consistent approach to recording. At the time of the Audit, there was one new concern and 64 open concerns. Of those open, all were graded as low risk, meaning advice / information and triage only. There were 100 cases filed. The Audit noted several cases which they considered had been inaccurately graded, with the actual risk being higher than articulated. That said, the new grading tool on MyConcern had only been released a month prior to the Audit. Using this tool will undoubtedly support appropriate risk rating moving forward and will no doubt become good practice.

Recommendation D20: Now that the risk rating tool is available on MyConcern, open cases should be reviewed by the DSA as a priority.

6.7 Because of the work demands placed on the DSA, they told the Audit that they had yet to find the time to get familiar with the MyConcern system. This also illustrates some of the capacity issues facing the DSA. In the Audit's opinion, amongst all the priorities for the DST, the effectiveness of casework is one of the most important. This aspect of work needs to be high quality and tightly managed. It is where risk is most acute and where the impact on people's lives is most tangible.

6.8 Regardless of the expertise of those undertaking casework, having arrangements in place where practice is not being thoroughly recorded and scrutinised by the DSA represents a risk. For example, in some cases, the Audit saw evidence of a failure to apply professional curiosity, assess and prioritise risk, identify potential criminal offences and engage with appropriate multi-agency partners. This risk can be exacerbated when the individual charged with managing the cases such as the interim CSA is inexperienced and heavily reliant on the supervision (via a MoU) of the DSA.

Recommendation D21: The DBF should review the work priorities of the DST and ensure that the arrangements in place for delivering and managing casework are properly resourced, effectively delivered and robustly line managed.

Recommendation D22: The DSA should receive additional training on the case management system MyConcern.

6.9 The Audit noted the DST comprises individuals possessing diverse skill sets, not all of which are aligned to safeguarding. The Audit believes this adds undue pressure on the DSA.

6.10 Notwithstanding the experience of the DSA and the recognition of the good work undertaken by other team members, there is a critical need to further develop and improve the DST's overall structure by way of capacity and complementing skill sets. This is addressed in the Culture, Leadership and Capacity section in Part One of this report.

6.11 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 or serious criminal conduct. Whilst there was evidence of some good record keeping (and the attaching of minutes and reports in the system), improved recording of the rationale for decision making would better evidence professional judgement and strengthen casework.

Recommendation D23: Recording on MyConcern should be improved to more consistently detail the rationale for why certain decisions have been made. This recording should clearly explain why action or inaction on individual cases has been decided.

6.12 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.

6.13 The DBF has adopted the new national risk assessment and safety plan templates including the revised monitoring arrangements for respondents to safety plans, allowing for a more consistent practice and common approach across the Diocese.

6.14 Safety plans set out clear prohibitions and actions regarding expected behaviours, consistently record review dates and contain a space for written signatures from relevant stakeholders, including the respondent. The plans viewed by the Audit were well defined,

proportionate and authorised appropriately although there was an absence of a DSA signature on some. There was evidence of a multi-agency approach, with information sharing with the Police, LADOs and the Probation Service. Alongside mitigating the risk derived from an individual, the safety and welfare of those posing the risk was also properly considered.

Recommendation D24: The DSA should always provide a signature to safety plans.

6.15 The 15 safety plans in place at the time of the Audit, do not reflect the amount of time and effort required by the team to set up, monitor and continually review these arrangements. The longevity of some plans (being in place for many years) impact the capacity within the DST. The Audit also noted some uncertainty regarding the safety plan process when respondents refuse to sign agreements. The Audit believe the NST should take account of this issue when drafting and or amending national policy. In fact, when it comes to complex safety planning, the Audit is considering the NST's role and will raise this issue with them.

6.16 The Audit met with a respondent to a safety plan. They articulated their frustration at the process, outlining a lack of available support. This conflicts with Audit's findings that noted the clear offer of support forming part of the planning process.

6.17 This meeting also showed the Audit some of the real, sensitive and challenging issues facing Church officers in these circumstances. Concerningly the respondent was unclear whether any restrictions applied outside of their immediate Church area. The Audit raised this with the DSA who took swift action to update the monitoring section of the respondent's safety plan. The Audit recognises this is a national issue and will raise it as such with the NST. In the interim period, to ensure safer practice the following recommendation should be implemented by the DST.

Recommendation D25: All existing safety plans should be reviewed to include the following statement as part of a respondent's monitoring arrangements.

'*The subject of this plan must inform the Reference Group and DSA or DSA's representative if they want to attend a different Church or different Church activity to the Church / Church activity outlined in this plan. The DSA / DSA representative will then liaise with the other named Church to establish another Safety Plan and Reference Group to support this attendance'.*

6.18 Some concerns were raised that those working with respondents may demonstrate a 'collusive' stance (not the Audit's phraseology) driven by a potential need to 'rescue' the subject. Given the Church's position on redemption and forgiveness this is perhaps unsurprising. That said, it is concerning. Specialist training is required for those who work directly with respondents so that they better understand the nature and behaviours of sex offenders. The recommendations made for the DBF to progress its plans for training has relevance in this respect. It involves clergy, reference groups and the wider cohort of people involved in monitoring respondents to safety plans.

6.19 There is availability of national practice guidance covering core groups. These are chaired by an Archdeacon and the Audit saw evidence of effective decision making for suspensions, disbanding group activities and challenging PTOs. Findings indicate the system works well within the Diocese. There have been nine core groups convened between 2023 and the time of the Audit. They allow for discussion and input from relevant safeguarding personnel including the DSA, PSOs and a representative from the Communications Team. There is evidence of referrals to statutory bodies, including LADOs and the police. The Audit was advised there is a lack of training regarding core group procedures at a national level and will raise this issue with the NST.

6.20 The DBF has a MoU with the Cathedral for the provision of safeguarding services and support. While positive, this does not necessarily ensure smooth pathways for information sharing. The Audit found there appeared to be some confusion within the DBF about what the arrangements mean in practice when it comes to the oversight of safeguarding referrals involving the Cathedral.

Recommendation D26: The accountability and responsibilities of the DST outlined in the MoU for safeguarding services and support between the Cathedral and DBF should be clearly communicated.

6.21 The DBF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. Support and 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. The referral to the Charity Commission aligned with national guidance and the NST was appropriately informed.

6.22 The Audit was informed there is no defined process to escalate concerns about differences of opinion on safeguarding judgements. To promote a culture of curiosity and challenge, this should be urgently addressed.

Recommendation D27: The DBF should implement clear procedures for escalating differences of opinion regarding case management decisions.

6.23 Whilst there are routine professional supervision sessions for the DSA scheduled with the NST regional lead, there is no daily professional line management for the DSA. The DSA highlighted that this is a challenge as their line manager, whilst a highly effective CEO, the Diocesan Secretary, is not someone who is hugely experienced in supervising

safeguarding matters. For example, cases are not discussed nor overseen by him. This creates a gap in the support for the DSA and the quality assurance processes of the DBF as a whole. This issue can be addressed by the recommended Director of Safeguarding. The wider team have monthly supervision sessions with the DSA.

6.24 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 protected passwords and designated users for specific cases.

6.25 The Audit was advised that clergy, staff and volunteers do not receive training on data protection, information sharing and how to identify a data subject request. It is positive, however, that survey findings for the DBF and parish workforces indicated the majority of respondents were aware of the Diocesan's privacy notice in respect of data protection.

6.26 The approach to data protection is further strengthened by the MoU in place between the DBF and the Cathedral, setting out the requirement for compliance with data protection arrangements.

Recommendation D28: Clergy, staff and volunteers should receive training on data protection, information sharing and how to identify a data subject request.

7 Victims and Survivors

7.1 The impact of abuse suffered by victims and survivors cannot be underestimated. The disclosure of abuse they have endured 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 disclosure process and 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 Whatever the nature and circumstances of a disclosure, it is essential for all Church bodies to create the conditions that build confidence amongst victims and survivors. They need to be heard, taken seriously and know 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 to learn from their experiences. The Safeguarding Strategy 2023 – 2026 provides direction and focus in this respect and outlines how it aims:

"To make safeguarding personal: to learn from children, families and adults at risk and from survivors who have used parish/Diocesan services; to ensure that the response to safeguarding incidents and concerns is proportionate and as nonintrusive as possible, is appropriate to the risk presented and ensures people remain at the centre of any processes…To work in partnership with colleagues (in the statutory and voluntary sector) to facilitate co-operation and collaboration in a transparent and productive way."

7.4 Supporting these objectives, the DBF undertakes a range of activity to establish effective and meaningful engagement with victims / survivors. As examples, the DBF has created a Lead Officer for the Chaplaincy to Survivors for this function. The role acts as the main

point of contact for victims and survivors of Church-based abuse from across the Diocese. It provides pastoral care, advocacy and pathways to support from external partners. This is good practice.

7.5 Furthermore, there has been proactive outreach by the DBF through the formation of a peer support group for anyone who has been harmed by any form of abuse in a Church / faith context. It is noteworthy that the numbers of survivors engaging with this group have increased. The impact of their work is seen through their paper '*Moral injury and church-related abuse: a new framework for ritual created by survivors*' being presented at the annual conference of the International Centre for Moral Injury at Durham University in April 2024.

7.6 The Auditors spoke to a number of victims and survivors, including those who led the co-production of much of the work (for example the '*If I told You What Would You Do?*' project) now being cascaded beyond the Diocese of Newcastle. They brought authenticity to the challenging conversations taking place across the Diocese by those they engaged and those reached and influenced by their work. This represents outstanding practice.

7.7 Another initiative reflecting good practice is a recently established group focused on pastoral care in a safeguarding setting. This group will have input in the shaping of a new role for pastoral care (for complainants and respondents).

7.8 The DBF follow the guidance outlined by the House of Bishop's '*Responding Well to Victims and Survivors of Abuse'*. To facilitate the ease of access to key information, the DBF has produced summaries and briefing documents covering subjects such as '*What is a Support Person*' and '*Information for Complainants'*. It is also noteworthy that other resources initiated by the DBF under the '*If I Told You, What Would You Do?*' project have been highlighted and disseminated nationally by the CofE.

7.9 The Audit saw positive practice which demonstrated victims and survivors were being supported with care and compassion and provided with the information and assistance they required. One victim / survivor commented to the Audit that *"Safeguarding seems like more of a priority, and attempts have been made to improve".*

7.10 That said, not everyone's experience is the same, and some victims / survivors who responded to the Audit's survey shared different experiences. While 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 and response by the Church more generally. Whilst no recommendations are made, such views are important reminders of the need for a trauma-informed approach, managerial oversight on casework and the need to maintain comprehensive quality assurance processes.

7.11 The DBF has taken steps to embed a practice and culture which is trauma informed. An example of this can be seen in the training sessions offered to incumbents and PSOs on '*How to be Trauma-Informed & Trauma-Responsive'*. Further work undertaken by the DBF to develop a deeper understanding of what it means to be 'trauma-informed' is evidenced through the paper abstract submitted by a group of survivors in the Diocese, which includes some members of the peer support group, for the academic conference '*Narratives of Moral Injury in European and International Contexts'.*

7.12 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. Pathways to help and support victims / survivors are available via the Diocese website on

the webpage ‘Reporting Abuse and Finding Support’. This provides easy access to get support from *Safe Spaces* or from services around broader safeguarding issues. Contact information to report abuse to local authorities is also available on this webpage.

7.13 Newcastle DBF reported that there are no specific challenges in accessing local support services and indeed local services are found to be ‘responsive and helpful’.

8 Learning, Supervision and Support

8.1 Training, learning and development opportunities across the Diocese are supported by a range of systems, processes and resources. Many of these align with the CofE's Safeguarding Learning and Development framework and reflect the requirements of the National Safeguarding Standards.

8.2 However, there is no defined safeguarding training strategy in place. The Audit believes this is a gap. While the Diocese's Safeguarding Strategy 2023-26 references training (with a training needs analysis providing supporting information), the absence of a singular strategy dilutes the clarity required in this context.

Recommendation D29: The DBF should develop and publish a stand-alone Safeguarding Training Strategy. As a minimum, this should outline the key principles of safeguarding training, the key responsibilities of staff and volunteers, the role and function of the DST / relevant staff and the framework for safeguarding training covering need analysis, delivery and evaluation.

Strategic priorities should be defined based on NST requirements and local analysis of needs.

A specific action plan should set out how these priorities will be met.

8.3 Responsibility for safeguarding training sits with the DSA. They report regularly to both the DSAP and relevant senior leaders and this facilitates routine oversight of performance. Over the last year, there were 1473 recorded attendances at safeguarding training across the Diocese. As of January 2024, Safeguarding Parish Dashboard data showed circa. 70% compliance with safeguarding training for key roles.

8.4 The DSA understands the value of their direct involvement in training, with such contact helping to build relationships and confidence. They are supported by a range of resources, including a part-time trainer, the interim CSA, a student social worker and external consultants who all help with training delivery. However, the DSA also understands there are capacity issues. Recent staff absences were noted to have placed additional pressures on the DSA in maintaining the programme and covering other work demands.

8.5 NST training is supplemented by additional learning opportunities that help to develop the skills, knowledge and experience of the workforce. There is a good range of material available on the Diocese's website, such as the '*lunch and learn*' videos. Other good practice seen by the Audit includes the DST delivering Safeguarding Parish Dashboard familiarisation sessions, bitesize briefings, trauma informed / response training, workshops facilitated by the Disclosure and Barring Service and the regular hosting of PSO forums.

8.6 Safeguarding training is primarily delivered online, although face-to-face training is supported where required. This involves the DST hosting *'familiarisation sessions'* to assist Church officers who might wish to run training in a parish setting, alongside dedicated in-person sessions for Basic, Foundation and Domestic Abuse courses. This is good practice that recognises the mix of learning styles that will exist across such a diverse workforce.

8.7 That said, the Audit believes a more structured approach to a '*train the trainer'* methodology could create defined capacity and better resilience. Whilst the Audit heard of PSOs that had delivered training in a range of locations, there did not appear to be a defined 'pool' of trainers that could coordinate their support at a parish level. The foundations for such an approach have already been built by the DSA, and some targeted work to enhance these arrangements could add value in a number of areas.

Recommendation D30: The DBF should develop a defined pool of safeguarding trainers. It should build on its existing familiarisation sessions, by introducing a defined 'train the trainers' programme that supports trainers with content, helps them with techniques for delivery and involves regular support sessions / meetings for them.

8.8 The Audit believes that centering plans around Newcastle's Deaneries could also help. For example, embedding expectations for safeguarding training pools to be part of the formal architecture in Deaneries could provide a framework for both equity and resilience of provision.

Recommendation D31: The DBF should explore how the commitment, resourcing and arrangements for volunteer trainers could be integrated into the governance arrangements for Deaneries.

8.9 Feedback to the Audit on the administration, quality and delivery of training has been positive. This was reflected in survey results, interviews and the various documentation examined. At both DBF and parish level, the significant majority of the workforce has seen improvements in safeguarding awareness raising and training provision. High confidence was also expressed regarding the actions needed in response to a safeguarding concern; confidence that is likely to have been developed through effective training provision and the wider efforts of the DST.

8.10 For a small number of survey respondents, they felt that training should focus more on the local context for safeguarding. One respondent highlighted how there was very little regarding 'vulnerable elderly people'.

8.11 Overall, however, the Audit is reassured that the combination of NST training and local initiatives are providing a solid offer to the local workforce. Helping with 'horizon scanning'

for key issues, the DSA maintains good connections and collaborates with a range of colleagues locally, regionally and nationally.

8.12 In terms of potential improvements, there are opportunities to build on the clear strengths already in place. The first, and perhaps most obvious, relates to capacity within the DST. Whilst there is the imaginative use of a range of different roles to help in this area, the demands of maintaining a comprehensive system of training analysis, delivery and evaluation, require simplifying, further investments and / or a realigning of existing resources.

8.13 The dedicated training role within the DST amounts to 300 hours per year (or just over eight weeks of full-time activity). This is insufficient to provide the coordination of end-to-end training processes. Whilst this might not be within the current post-holder's remit, the Audit thinks it should be. As it stands, the DSA leads on a substantial amount of training activity. While there are many strengths to this, their capacity to manage this activity alongside strengthening the DST's approach to casework is not considered to be tenable.

Recommendation D32: The DBF should redesign the training role in the DST so that it has overall responsibility for coordinating the safeguarding training pathway. This should include responsibility for analysis, programme design and delivery and evaluation. Given existing demands, alongside the recommendations made within this report, the Audit believes this role should be secured at no less than 0.5FTE.

8.14 From the Audit's findings (and from those referenced by Sunderland University's research with Newcastle Diocese in 2023[3]), the Audit also believes that the use of 'role specific' training should be further developed. Whilst this exists in some contexts (such as for

[3] https://www.newcastle.anglican.org/safeguarding/sunderland-university-collaboration/

PSOs), widening opportunities that are unique to certain roles should be explored. For example, Sunderland University found that whilst training was perceived positively, there was disparity in how this was received and experienced by Churchwardens. Developing targeted sessions for Churchwardens could help this group better understand their individual responsibilities in the context of their role.

8.15 To develop an improved insight into which cohorts of staff and volunteers might benefit from such training, any future training needs analysis should attempt to isolate these roles and the rationale for why targeted training would be beneficial.

Recommendation D33: The DBF should review its training needs analysis process to ensure this adequately covers the full range of roles in place across the Diocese. The analysis should be used to identify where additional 'role specific' training might be of benefit.

8.16 The Audit believes there should also be a concentrated focus on two areas of 'theme specific' training. Firstly, there should be opportunities for Church officers to develop a much more detailed understanding about the nature of sex offenders. Whilst noting the inclusion of this topic within NST training, detailed learning about predators and the nature of offending is both a relevant and contemporary issue for the Church. Positively, the DSA informed the Audit that plans were already in place to progress such training using one of the existing consultants (who has relevant experience in this area). This training will be targeted at incumbents, PSOs and Churchwardens.

8.17 Secondly, given the growth in incidents across all of society where social media and technology are being used to either abuse or facilitate abuse, a greater understanding of digital safeguarding is also likely to make people safer. Again, positively the DBF has already taken some steps in this space through the creation of its digital media guidance. Targeted training on this topic is likely to support its application.

Recommendation D34: The DBF should progress at pace with implementing its planned training on sex offenders. Further consideration should be given to the range of relevant staff and volunteers for whom this training is likely to be relevant, beyond incumbents, PSOs and Link Persons.

Recommendation D35: To accompany the DBF's Digital media guidance, training on digital safeguarding should be introduced and be accessible to relevant Church officers in the DBF, Cathedral and parishes.

8.18 In terms of training evaluation, information is collated, analysed and regularly reported to the Bishop and the DSAP. That said, beyond the leadership sessions, the evaluation process itself is primarily focused on compliance, as opposed to any longer-term testing of impact. This leaves a gap in the understanding about how the full range of training is influencing practice. As a potential solution, for all courses being delivered (whether local or via the NST), 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 D36: 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 need should be asked.

8.19 All clergy were reported as having completed the required levels and for the DBF, the Audit was advised that there were no members of its staff who were '*out and about in parishes*' who had not completed their required training level within the last three years.

8.20 In terms of its own learning needs, there is clear support in place for the DST. Team members are part of the NST pathfinder pilot, a pillar of which includes peer supervision. They have access to external training opportunities, for which the DBF will provide funding. The DSA also attends DSA networking days, online monthly forums and benefits from supervision from the NST regional lead. The consultants engaged by the DST can also provide advice, guidance and learning opportunities by way of their relevant expertise.

8.21 The DBF has in place a range of mechanisms to support its clergy through 'organisational' processes (such as HR and occupational health) alongside broader arrangements delivered by the Bishop, Dean, Archdeacons and local ministry structures (such as pastoral, practical and spiritual assistance). Continued Ministerial Development is embedded and there is access to a Diocesan counselling and wellbeing services. The Audit was informed that opportunities to access education and learning, resources to work in a trauma-informed and responsive way and peer support were also available to help clergy members.

8.22 That said, the Audit recognises that from the most junior to the most senior clergy within the Diocese, they will be facing a range of pressures arising from their exposure to safeguarding issues. As a matter relevant to all areas, the Audit will address this in more detail as part of its annual evaluation.

8.23 During pre-ordination, pre-licensing or pre-authorisation training, candidates undertake specific training in safeguarding, as well as in associated pastoral themes. The DBF remains engaged in a working group to address National PCR2 recommendation 24. This set out the following: '*Diocesan Safeguarding Advisory Panel Chairs along with the appropriate persons responsible for vocations and ministry to reach out to TEIs and other Church bodies to ensure a whole system approach to safeguarding and adherence to best practices'*.

8.24 Whilst work is noted as ongoing, good practice seen by the Audit in other areas includes ordinands being provided with a checklist to help them review the safeguarding arrangements in their new parish or benefice. Other initiatives seen include new incumbents having a six-month review with their Archdeacon and ordinands being required to undertake a safeguarding audit whilst on placement (and to then complete a theological reflection about trustworthiness based on their safeguarding audit). Whilst no recommendation is made, the DBF may wish to give these areas consideration.

8.25 Ministerial Development Reviews (MDRs) add value to the clergy through facilitating reflection, learning and improvement. Whilst no MDRs were made available to the Audit, revised templates for MDRs and the self-assessment process are in the process of being developed. Positively, these have specific sections on safeguarding that pose several relevant questions. They are likely to help with more structured discussions about what is working well from a safeguarding perspective, the outcomes being achieved, and future areas for growth and development.

8.26 Arrangements for induction are in place across the Diocese. For those working in the DBF, this includes pre-read material, a welcome pack and dedicated meetings with people in key roles. The welcome pack has a dedicated section on safeguarding.

8.27 Positively, the majority of DBF staff engaged by the Audit confirmed they had received an induction. However, less than half of respondents to the parish workforce survey confirmed they had received one. This is likely to relate to the length of time that some have been in their roles, although for those that did receive an induction, most said it included what they needed to know about safeguarding. For PSOs, they have access to a defined safeguarding induction session led by the DST. This is seen by the Audit as good practice.

8.28 For clergy new to incumbency, a safeguarding checklist is provided. The DST also meets with new clergy as part of a scheduled lunch that take place quarterly. Where deemed necessary, the DST can arrange a 1:1 induction. This could be in circumstances where the new incumbent needs to be made aware of specific safeguarding issues relevant to their new position. In the opinion of the Audit, whilst recognising the benefits of this 'relational model' of induction, arrangement should be strengthened to facilitate more structured and timely conversations.

Recommendation D37: All new clergy should receive a formal, face to face induction session with a member of the DST.

8.29 The DST is a small team and one under pressure. Whilst team members engaged by the Audit demonstrated a strong commitment to their roles, understood the nature of the work they are exposed to and have access to a range of support, the Audit recognises the potential for routine exposure to trauma. Given the need to maintain stability in such a small team, The Audit believes that the availability of psychological support should be more defined within its arrangements. By this, the Audit believes that routine access to such support should be an expectation as opposed to 'available on request'.

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

8.30 Dedicated support for PSOs via regular forums and an annual recognition event / garden party are also positive. This allows for PSOs to catch up on news, connect with others, to discuss relevant issues and be recognized for the important job they do.

Part Two - Newcastle Cathedral

9 Context

9.1 Newcastle Cathedral, formerly known as the Parish Church of St. Nicholas, has a rich history dating back to the 12th or 13th centuries. Situated at the southernmost end of the Diocese of Newcastle, it is one of four parish churches in the city of Newcastle upon Tyne.

9.2 With a population of approximately 310,000 residents, Newcastle is a bustling city known for its two prominent universities. Despite economic challenges, the Cathedral continues to draw a substantial number of visitors, estimated at around 110,000 annually, who come to attend worship services, events, seek sanctuary, or simply explore its historic beauty.

9.3 One of the notable architectural features of the Cathedral is its lantern tower which was constructed in the 15th century. Historically, a fire was lit at night in the lantern tower to serve as a navigational aid for boats on the River Tyne, symbolising hope and safety. Today, the Cathedral's Lantern Initiative embodies this spirit by offering support to individuals facing various life challenges. Newcastle Cathedral’s core values ensure that they welcome diverse members of the community, including those experiencing homelessness, addiction, mental health issues and seeking asylum.

10 Progress

10.1 The Independent Social Care Institute for Excellence (SCIE) safeguarding audit of the Cathedral was published in July 2019 and resulted in 29 recommendations. At the time of writing, 25 have been completed and four remain in progress. The Cathedral opted to be involved in the Diocesan PCR2. The Chapter believe that there were a number of factual inaccuracies within the report relating to the Cathedral's recommendations. Nevertheless, this Audit is satisfied that of the recommendations the Cathedral accepts, these have been actioned. The Cathedral has also implemented learning from a National Learning Lessons Review (LLR) in response to the conviction of William Scott Farrell (WSF) and another local LLR.

10.2 The Cathedral produced a collated safeguarding action plan from which actions arising from SCIE, WSF learning and the Cathedral's annual review of safeguarding were subsumed. This was reviewed yearly and discussed monthly at Chapter. In addition, it is also reviewed at DSAP. Actions that had not been met were carried over to the subsequent year's planning.

10.3 In relation to SCIE considerations, actions which remain ongoing relate to training for volunteers, the creation of a learning and development strategy and embedding more straightforward messages about safeguarding and an understanding of those working and worshipping in the Cathedral. Also acknowledged within the Cathedral's action plan is that not all departments have conducted an annual review of risk assessments for activities involving children, young people and vulnerable adults. These actions will be visited further in the main body of this report.

10.4 The Lantern Initiative was developed (in part) in response to a SCIE recommendation to develop a group for vulnerable individuals which is trauma informed. All staff and volunteers must complete co-produced and co-delivered 'Radical Welcome' training in conjunction with the Cathedral's mantra '*All are welcome, and all feel safe*'. This initiative will be further discussed in this report.

10.5 The Cathedral has also sought to improve the physical safety of the Cathedral through a radio communication system and CCTV. The Audit were informed that there has been further investment in CCTV coverage at the Cathedral. This is good practice.

10.6 The implementation of a more diverse Safeguarding Committee with independent chairing by a safeguarding professional has improved the governance of safeguarding at the strategic level. However, it is recognised that there is still more to be done to increase independent membership. Discussions about safeguarding are also being held regularly in Chapter meetings.

10.7 One LLR relating to the Cathedral was published in January 2024. Chapter was waiting on information from statutory authorities but decided to proceed with developing a formal action plan, which has now been agreed. Six recommendations arise from this LLR, all of which are documented with set timescales and defined actions. Themes emerging from this LLR showed failings in processes, procedures, core group proceedings and record keeping.

10.8 The Cathedral has established an Audit and Risk Committee in compliance with its registration with the Charity Commission under the Cathedral Measure 2021. Its purpose is to scrutinise Cathedral safeguarding, auditing documentation and interviewing previous safeguarding leads in safeguarding roles. In 2023, the Safeguarding Committee carried out an internal audit of policies and procedures, including the Digital Media Safeguarding

Policy, the procedure for responding to concerns and allegations, the Safer Recruitment Policy and the Complaints Policy. Going forward the Audit and Risk Committee will oversee internal audits undertaken by the Safeguarding Committee.

10.9 Whilst conscientious efforts have been made to address recommendations, progress at the Cathedral has been hindered by workforce pressures arising from illness and staff retention. There is also some tension evident in the relationship between the DBF and the Cathedral. These overarching cultural and capacity issues will be further addressed in the main body of this report. In terms of casework, there are concerns about access, data migration and the training available to effectively use the case management system.

11 Culture, Leadership and Capacity

11.1 The Cathedral has been working to explore and improve its culture, outreach and inclusion opportunities over recent years. Triggered by some non-recent incidents and allegations of stubborn and inappropriate attitudes, they facilitated workshops and sought feedback from key stakeholders, including members of Chapter, the NLHF Project Delivery Board, volunteers, Churchwardens and worshippers. This process informed how the Cathedral has developed and reshaped its values.

11.2 From a workforce perspective, the improvement journey is gaining traction. Feedback from interviews, focus groups and surveys indicates that the culture across the Cathedral is on a positive trajectory. Whilst the response rate was relatively low (44), most staff and volunteers indicated that there is now better awareness and improved safeguarding arrangements. Whilst most believed that safeguarding was embedded in culture, a fifth remained neutral on this issue, indicating that many have yet to form an opinion. Reassuringly, almost all felt safe amongst their colleagues. Although this presents a positive picture, more work is needed to fully embed the culture that the Cathedral aspires to deliver.

Recommendation C1: The Cathedral should utilise a variety of mechanisms including, scenario-based workshops, externally facilitated focus groups and anonymous surveys to periodically review and assess progress on embedding a safeguarding culture. Outcomes should be reviewed by the Chapter Safeguarding Committee, the Independent Safeguarding Advisory Group (if adopted - see Recommendation C3) and presented to Chapter.

11.3 The Cathedral now hosts a range of impressive initiatives and actively engages and supports several external and internal partnerships. These initiatives include the Loud

Fence, *'If I Told You, What Would You Do?'*, Radical Welcome, Empowering Worth and the work of the Lantern Initiative.

11.4 Such endeavours serve as platforms to connect with and involve diverse communities. Particularly noteworthy is the Cathedral's concerted effort to engage individuals who have been marginalised, including those who have felt disconnected from traditional religious institutions. This commitment to inclusivity is exemplified by the pride exhibition, co-produced with staff, volunteers and worshippers and the Songs of Sanctuary initiative, working with marginalised people within the city to tell their stories through music.

11.5 Through the efforts of staff and volunteers, the Cathedral has cultivated an ethos of making everyone welcome. This is perhaps best evidenced through their Radical Welcome value. The Auditors saw this in action, with members of the street life community being welcomed into the Cathedral during the day. In essence, people using the Cathedral for shelter, food, healthcare and safety. Amongst other initiatives, the Cathedral has formed a partnership with the Oswin Project. This valuable project helps those with criminal records find employment, training and support.

11.6 Effectively supporting this community, while simultaneously ensuring that safeguarding is neither paused nor minimised for others is important, not least for the children and young people who visit the Cathedral, the choristers and the Cathedral's own staff.

11.7 Many of the front-line staff and volunteers in the Cathedral support the aims of such initiatives but felt that they can be diversions from their regular duties. Whilst the Audit was told that the staff involved in this work had received de-escalation training, a low level of confidence in competence was evident when this was tested. In the opinion of the Audit, there is a need to ensure that these roles are appropriately resourced, trained and remunerated.

Recommendation C2: The Cathedral should:

- Establish the full nature of any concerns held by staff via an anonymous survey or other appropriate form of engagement. Allowing them to share their concerns and ideas about how best it can be supported.
- Assess the adequacy of their risk assessment process.
- Assess whether staff carrying out such duties with the enhanced responsibilities attached to their role are appropriately remunerated.

11.8 Governance structures and membership in the Cathedral i.e. The Chapter and Chapter Safeguarding Committee are appropriately configured. It was evident that the Chapter's Safeguarding Committee has made considerable progress, largely driven by the current Chapter Safeguarding Lead (CSL), but there is more work to be done.

11.9 The Audit acknowledges the move away from the CSL chairing the Safeguarding Committee (to minimise conflicts of interest) and agrees with this approach. Furthermore, the Audit takes the view that governance and safeguarding oversight at Chapter could be further strengthened by carrying out a skills, diversity and inclusion audit. This would provide the opportunity to broaden representation. As part of this process, Chapter could consider a number of options, one could be co-opting an external non-executive member with credible, statutory safeguarding experience. Such a person could provide a strong independent expert voice at Chapter. They could also chair and provide the link to the Safeguarding Committee.

11.10 To further strengthen its position or as an alternative to changes in Chapter and / or the Chapter Safeguarding Committee, the Cathedral could increase and enhance expert scrutiny by creating an Independent Advisory Group for the Cathedral (ISAG). This works well in other areas and provides the equivalent of a DSAP but with a Cathedral focus. This is not to suggest that a member of Cathedral staff should not sit on DSAP (and vice versa).

Recommendation C3: The Cathedral should carry out a skills, diversity and inclusion audit to broaden and strengthen the membership of its governing bodies and safeguarding oversight functions. This should include consideration of the creation of an ISAG.

11.11 The Dean unambiguously accepts his responsibility and accountability for safeguarding. He has quickly developed a good understanding of some of the negative legacy issues and residual challenges. Forming a good early relationship with the Bishop, he is well supported by an active and committed CSL.

11.12 The CSL is due to move on. It is critical that their replacement has a good understanding of safeguarding and both the legacy and contemporary challenges they face. These include the critical limitations on current safeguarding capacity. To this end, and to support the induction of the new CSL, steps should be taken to evaluate the Cathedral's ability to effectively manage the risks associated with its current commitments in the context of safeguarding capacity limitations.

Recommendation C4: The Safeguarding Committee should construct and present a risk assessment regarding the level of risk, mitigations and capacity to deliver, matched against the activities and interrelated risks that currently co-exist. This should result in an options paper for Chapter on what it can, should and should not continue until capacity is appropriately managed and support is increased.

11.13 Given the transition in personnel and the lack of safeguarding capacity, the Dean needs to ensure that the Cathedral's senior leadership team operate with an enhanced level of grip, focus and pace. There was concern during the Audit that some senior leaders need to refresh their understanding of the Cathedral's safeguarding policies and practices, especially those that fall within their own area of responsibility. For example, clarifying who

is responsible for risk assessments and whether they are being operated in line with the policy they oversee.

11.14 It is critical that those with a leadership and governance responsibility avoid assuming that others know what is happening and are applying policy and mitigating risk. Oversight, supervision and support of those responsible for frontline delivery is critical.

Recommendation C5: The Dean should engage with senior leaders with responsibility for safeguarding functions and reinforce with them the need to ensure that safeguarding is not lost within the range of their other responsibilities.

11.15 The CSL does not have the capacity to manage and mitigate all safeguarding risks relating to the Cathedral. The strategic nature of this role is undermined when it is also required to deploy operationally.

11.16 The current position regarding the provision of support to the Cathedral via an MoU is delegated to an interim CSA who also holds a separate post as the Lead Officer for the Chaplaincy to Survivors. In the opinion of the Audit, this is not sustainable. This arrangement neither alleviates the current pressure on the DSA nor mitigates the risks within the Cathedral. Whilst highly skilled and able regarding victim and survivor support and advocacy, the interim CSA does not have a safeguarding background that would equip them for this role. Simply 'bolting-on' this function to an existing member of staff carries a range of avoidable risks.

11.17 This is an area of concern that leadership has been aware of for some time. Indeed, it has generated debate and discussion at appropriate meetings in the DBF, Cathedral and at DSAP. However, it has not been escalated to any risk registers. This position needs to be urgently addressed.

Recommendation C6: The Cathedral should ensure that its relevant risk registers are reflective of current safeguarding needs and incorporate all identified risks related to the Cathedral's initiatives.

11.18 The issue of a lack of capacity has manifested in increased levels of anxiety and pressure. This in turn has led to levels of frustration in key relationships and heightened ambiguity concerning the application of the MoU between the Cathedral and DSA and support regarding case management. This too needs to be urgently addressed at the most senior levels in both the Cathedral and DBF.

Recommendation C7: In line with the Audit's recommendations about reinforcing safeguarding capacity in the DBF / DST, senior leaders need to ensure that capacity issues as they relate to the Cathedral are also factored into any solutions.

Chorister Safeguarding

11.19 Through analysis of submitted documentation and interviews with key staff, choristers and parents / carers, the Audit is satisfied that there are sufficient safeguarding arrangements in place to ensure the welfare of choristers.

11.20 A healthy attitude towards safeguarding is evident amongst those who work with the choristers and the Song School is viewed by choristers as a safe and nurturing environment. Access to the Song School requires entering through two doors with key codes, which is good practice. However, all choristers engaged by the Audit stated that they knew the codes, which are also displayed on the Song School whiteboard. The Audit observed the proximity of both Song School entrances to sleeping bags and adults from the street life community. Displaying and sharing key codes with choristers therefore could pose a risk to their safety. An adult is present when choristers enter and exit the Song

School and choristers were able to explain that this also applies to moving around the building. Given this supervision, it is unnecessary for choristers to know the entry codes. This issue was acknowledged by the Director of Music but remains a recommendation for further action.

Recommendation C8: The Cathedral should ensure door codes are regularly changed and shared only among Cathedral staff. All choristers and chorister parents should use designated entry and exit points where chorister staff are present.

11.21 Choristers who use the Song School for rehearsals have access to dedicated toilets. However, the Training Choir, ChoriStarters, and Mini-ChoriStarters use the Education Room and Volunteer Hub, where the toilets are public and located in areas frequented by the street life community. The Audit found that current procedures ensure a child is supervised when using these toilets. However, this supervision often results in only one adult being left with the remaining choristers instead of the ideal two. The Audit understand that capacity and risk assessments around the Lantern Initiative are an issue in this area. Refer to Recommendation C19 and C22 in the Prevention section for further details.

11.22 The Cathedral has carried out the appropriate DBS checks and safeguarding training for staff working directly with choristers. This is good practice.

11.23 The ‘Chorister Sickness and Safeguarding’ section within the ‘Emergency Evacuation and Safety Plan’ details procedures for when a chorister is sick, such as ensuring two adults remain with the chorister until a parent or carer is available. It also outlines steps to take if the toilets within the Song School are unavailable. Whilst this is good practice, it is possible that those working with the choristers may not know to check for chorister guidance in this particular place. It would be more effective to include this information within a specific policy or guidance dedicated to encompassing all aspects of safeguarding choristers.

Recommendation C9: A specific Chorister Safeguarding Policy / Handbook should be created which details all safeguarding procedures and arrangements for choristers. This should be easily accessible for those working with choristers and chorister parents / carers.

11.24 The Interim CSA and a social work student engaged with choristers about safeguarding and identifying their '*safety superheroes'*. They also created child-friendly safeguarding posters to display in the Cathedral, explaining what safeguarding is and identifying who children can speak to if they need help. When Auditors spoke with choristers, they were able to recall this lesson and identify trusted adults within the Cathedral who they would approach with any concerns or worries. This is good practice.

11.25 The aforementioned child-friendly posters were not yet visible in the Cathedral building at the time of the site visit. Although a seemingly insignificant task, it could be the vital reminder for a young person in distress. The Audit welcomes the assurance that they were displayed immediately after the site visit and that the posters contain pictures of trusted adults. Given this commitment, the Audit does not make a formal recommendation in this regard.

11.26 Those in leadership roles who work with the choristers know to seek advice from those with safeguarding responsibility in the Cathedral, such as the interim CSA and CSL, for any potential safeguarding concerns. However, the Audit noted that low-level but important handover information was not being consistently recorded or shared. Effective record keeping is crucial for identifying patterns of behaviour and / or concerns, enabling appropriate action to be taken by staff. Practice in this regard could be strengthened by the adoption of a formal and embedded daily hand-over process. The logbook / spreadsheet or other mechanism used to record this should be frequently and routinely examined and signed off by the Director of Music.

Recommendation C10: The Cathedral should implement a central record keeping system regarding relevant handover information. This can be achieved by the creation and use of a daily handover logbook / spreadsheet or similar mechanism. The logbook / spreadsheet or other mechanism used to record this should be frequently and routinely examined and signed off by the Director of Music.

11.27 It was noted that meetings between leadership staff at the Cathedral were described as 'ad-hoc', as the Lead Chorister Supervisor role is a job share position. This makes it difficult to have regular meetings to discuss the choristers and related safeguarding matters. A lack of regularly scheduled meeting for chorister parents and carers also exists. The Cathedral Choir Association is in place primarily for the organisation and support of events and does not allow for the opportunity to discuss safeguarding in a regular capacity.

Recommendation C11: Chorister staff at the Cathedral should consider ways to ensure safeguarding is a standing agenda item in staff meetings.

Recommendation C12: The Cathedral should set up a dedicated pathway for chorister parent communication and feedback that includes safeguarding as a standing agenda item.

11.28 The Lead Chorister Supervisors have a Chorister Department mobile number for parents and carers to contact, which is good practice. Given the communication with chorister parents and carers, it would be equally beneficial for the Director of Music to have a work issued phone to ensure communication does not have to take place through a personal device.

Recommendation C13: The Director of Music should be provided with a work mobile phone for communication with parents and carers.

12 Prevention

12.1 One of the most pressing themes throughout this Audit has been the impact of resource limitations on risk management. The more you engage risk, the more you are required to mitigate that risk. This is where the Cathedral is met with several challenges in relation to prevention. However, amongst these challenges, lie a range of strengths that should not be overshadowed by ongoing capacity issues.

12.2 The Audit notes positively the distribution of the Safer Recruitment Policy, which is also discussed at staff breakfast meetings, irrespective of whether the staff are regularly involved in recruiting. This practice ensures that all staff have a clear understanding of what is expected.

12.3 Policies and processes related to safer recruitment should comply with the House of Bishops' guidance on Safer Recruitment and People Management. However, tasks perceived as onerous can become challenging to implement. The current Cathedral policy has been described as such, requiring recruiting managers to contact referees before interview. While obtaining references before employment is crucial, doing so before an interview adds an administrative burden that does not proportionately mitigate risk.

Recommendation C14: The Cathedral should review its recruitment procedures and seek to streamline these, whilst continuing to align with House of Bishops' guidance.

12.4 The 360-degree review conducted prior to the Audit sparked the realisation for the Cathedral that not all individuals working or volunteering there had completed the necessary training or checks. However, it is commendable that the Cathedral staff responsible for the Single Central Record (SCR) and related management tasks were proactive in their follow-up, ensuring the completion of relevant information once these

gaps were identified. Although this process is ongoing, the Audit noted the swift and robust approach taken. That said, some issues were identified regarding inconsistent portal access to historical records.

Recommendation C15: The Cathedral should ensure that the Church of England portal access to historical records is proportionate to the user's needs. Any identified flaws in access should be promptly addressed to prevent 'bottlenecking' around those with access.

12.5 Whilst the Audit welcomes the fact that advertisements for vacancies include hyperlinks to a job information pack referencing safeguarding, this position could be further strengthened by placing a simple safeguarding commitment on the face of any material promoting the position. This practice should apply to any role.

Recommendation C16: The Cathedral should ensure that its commitment to safeguarding is embedded throughout all job adverts, application forms and job descriptions.

12.6 For volunteers, the Cathedral has developed a '*Volunteers Expectations*' document as a two-page form. This is good practice for setting out intentions for this group. However, at the time of submitting documentation to the Audit team, the Cathedral itself did not have a code of conduct for its staff. This gap had been identified by the Cathedral and was scheduled as an action to be taken forward by Chapter.

Recommendation C17: The Cathedral should seek to implement at pace a code of conduct for all staff.

12.7 Within the Cathedral building, an ethos of safeguarding is clearly visible through displays of various inspiring initiatives such as the LOUDfence, "*If I Told You, What Would You Do?*", and Jagged Edges. The Cathedral also employs a range of communication methods

to engage different audiences, including face-to-face briefings, sermon content, and digital communications such as online newsletters and social media channels. For example, it was positive to note that the newsletter for volunteers is sent both digitally and in print, catering to the demographic of volunteers in the Cathedral.

12.8 As mentioned in earlier parts of this report, the Audit welcomes the assurance that steps have been taken to create and display child-friendly signposting in the Cathedral building (see paragraph 11.25).

12.9 The Cathedral's website presents a modern theme that loads quickly, performs well with search engine optimisation (SEO) and is mobile-responsive. The 'Safeguarding' section is accessible from the homepage, with the Safeguarding Team and contact details visible on the first page. Policies are clearly listed and a focus on victims and survivors of Church-based abuse is promoted, which is good practice. However, given the significance of the Lantern Initiative on Cathedral life and its subsequent implications for safeguarding, there should be a dedicated page that accurately reflects the community it serves. Some articles exist but are not easily located and images used in Lantern Initiative projects only showcase some of the community served. Displaying the Cathedral's values more prominently on the webpage could provide a segue into this.

Recommendation C18: The Cathedral should display the Lantern Initiative more prominently on its website to give visitors a true reflection of their visit. It should ensure that links are working correctly and imagery accurately reflects the community a visitor is likely to encounter.

12.10 Good practice was observed with a coded door leading to rooms used by various groups, including school visits. To address the lack of coding on the lift, the Cathedral added a locked door on the top floor for extra security. However, there remain issues in relation to physical safety. As highlighted throughout this report, the Lantern Initiative is a

commendable project, especially given the bravery required to introduce such a program in a cathedral setting. For every area of risk the Audit was sighted in, there was equal measure of the spirit of the Radical Welcome embodied by those working within it.

12.11 However, the positivity that emanates from this initiative cannot be viewed in isolation as it so frequently overlaps with other vulnerable groups such as young choristers, school groups, tourists, as well as Recovery Church participants and elderly volunteers.

12.12 These overlapping groups have led to frequent safeguarding incidents. To address these issues, the Audit makes several urgent recommendations to ensure the Cathedral is adequately prepared to manage the risks associated with the Radical Welcome value. Each recommendation is based on specific examples observed by the Audit team.

12.13 Capacity constraints remain a pressing issue. There have been instances, albeit less frequent, where only one or two Vergers are on duty and the Cathedral Education Team faces similar capacity challenges during school visits. This has resulted on occasions where children during a school visit were exposed to a potential risk. This has included children being exposed to the inappropriate behaviour of others.

12.14 It is important to note that Cathedral staff took appropriate action in response to all these incidents, including varying choristers' entrance to the building and regular checks to ensure that no one uses secluded areas of the Cathedral to sleep. The Audit is also aware that better arrangements for CCTV are being considered.

12.15 Whilst capacity remains the most prevalent problem to solve, there are other steps that could address and mitigate some of these issues. Vergers or trained Lantern Initiative staff must be easily contactable, even if they are in different areas of the Cathedral.

Recommendation C19: All staff who move around the Cathedral, engage with children and young people, or routinely engage with vulnerable members of the public as part of the Lantern Initiative must always wear radios.

Recommendation C20: CCTV should be installed in all secluded areas of the Cathedral and monitored as required i.e. post-incident or allegation. Retention and storage of such material should be compliant with UK GDPR legislation.

12.16 During the Audit site visit, the team noted the increased traffic from the street life community that arises from nurse visits. Other times of high traffic occur when there is bad weather or sudden changes in local laws, such as Sunderland City Council's recent decision to issue on-the-spot fines and dispersal orders to people on the street. This change in law resulted in approximately 60-80 people relocating to Newcastle City Centre, a proportion of whom made their way to the Cathedral.

12.17 Relationships built with members of the local street life community through the Lantern initiative require time and continuous input. Having such a large number of new faces presents a significant risk. This is particularly concerning when school visits, choristers and other young visitors to the Cathedral are passing through the very spot in which the street life community gather, in order to enter the building, use the café, toilets or education room.

Recommendation C21: A robust risk assessment should be created to consider how the Lantern Initiative interacts and overlaps with children and young people in the Cathedral. This assessment should be reviewed frequently to ensure the Cathedral is responsive to any changes that may heighten the level of risk within shared spaces.

Recommendation C22: The Cathedral should consider reducing, changing the arrangements around, or eliminating school visits during the street life community's peak visiting times.

12.18 The Audit was made aware of some anxieties amongst staff and parents of young people regarding the potential risk posed by engaging a Radical Welcome approach. To ensure that both the community served by the Cathedral and those responsible for taking decisive action when a risk arises understand their boundaries and expected behaviours, the Cathedral should make this message clearly visible within the building and through their digital presence. It is important to inform people that if they see something concerning, they can find a staff member who will act appropriately. Additionally, visiting schools should be comprehensively briefed on what they may encounter during a trip, including detailed information on 'what you are likely to see' and 'safety measures in place', to better inform their own risk assessment and staff ratios. This information should be part of the digital pack received from the Education Team, with a follow-up conversation as additional good practice.

Recommendation C23 The Cathedral should ensure posters and signposting are displayed around the premises that set ground rules for acceptable behaviour, outline the actions staff members will take and specify the consequences of breaching these behaviour rules. In line with the ethos of Radical Welcome, these posters should be inclusive, using visuals and accessible fonts and formatting.

Recommendation C24: Include a comprehensive briefing of the Cathedral's Radical Welcome value in the digital pack for visiting schools or choirs, detailing exactly what they may encounter and the safety measures in place.

13 Recognising, Assessing and Managing Risk

13.1 The Cathedral is open all year round and attracts a large number of visitors on an annual basis. Staff and volunteers encounter a diverse range of challenges, from managing protests, gala dinners, guided tours, 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 the work of the CSA, relevant policies, protocols, guidance and efforts to raise awareness. While appointing a CSA is considered good practice, this is an interim position and the current arrangements for this post are not considered sufficient. This issue is discussed in Part One of the report.

13.3 The importance of awareness raising should not be underestimated as evidenced by a case where an individual contacted the Cathedral after seeing safeguarding posters displayed in the building. The display of safeguarding contact numbers is good practice. However, the Audit recommends implementing a rota to ensure calls for support are responded to. During the Audit, a call to a number shown on a poster went unanswered.

Recommendation C25: Those who display contact numbers on posters offering support should operate on a rota basis to ensure that calls are always answered and responded to.

13.4 The Cathedral's risk register / dashboard addresses a range of corporate issues, including safeguarding. Whilst the new Audit and Risk Committee have been developing a system, it has not yet been applied. The risk register was last updated in June 2022 and concerns

and control measures are well documented. The findings regarding risk registers for the DBF have equal relevance to the context of safeguarding at the Cathedral.

13.5 The DBF and Cathedral Safeguarding MoU, reflects a strong commitment to work together to implement the safeguarding policies of the House of Bishop's and the Archbishop's Council. This is good practice. The Audit findings regarding compliance with the MoU highlight some issues that have been set out in Part One of this report.

13.6 The Cathedral does not have any safeguarding information sharing agreement with other organisations, however, information sharing arrangements extend to other processes, including a requirement on visiting schools to have an agreement in place that clearly defines their safeguarding responsibilities. For any events which involve vulnerable adults or children, organisations must submit an up-to-date copy of its Safeguarding Policy. This is good practice.

13.7 A collaborative approach to safeguarding practice is further strengthened through external partnerships, ranging from signposting to support agencies to local projects such as the Lantern Initiative. This programme hosts various groups, providing support for those with disabilities or those struggling with addiction and organises events addressing critical safeguarding issues such as domestic abuse and sexual violence. 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.

13.8 In terms of individual cases, support from the DST, is a key factor outlined in the DBF and Cathedral MoU, which supports a robust response to safeguarding concerns. When dip sampling these cases, the Audit noted the terms and conditions of the MoU with the DBF were not being fully applied, resulting in a lack of grip and pace in terms of dealing with some safeguarding concerns.

Recommendation C26: The DBF and Cathedral should ensure the approach to safeguarding concerns adhere with the requirements set out in the MoU.

13.9 At the time of the Audit, case activity involved two ongoing concerns at the Cathedral. There was one safeguarding concern closed and filed. These cases ranged from criminal activity to lower-level issues resulting in support, signposting or advice and guidance. There were reportedly nine cases in 2023 with two resulting in referrals to statutory authorities (one to children's social care and one to police).

13.10 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 the number of respondents was small, they indicated they knew how to escalate a safeguarding concern, however almost a third (30%) of respondents indicated they neither agreed or disagreed, didn't have, or were unsure if they had confidence in the escalation process.

Recommendation C27: In partnership with the DST, the Cathedral should proactively engage with its workforce to promote confidence in reporting and escalating concerns.

13.11 Notwithstanding the good range of policies in place, the Audit noted the absence of a defined process to escalate concerns about differences of opinion regarding safeguarding judgements. This is addressed in the DBF risk section of the report.

13.12 At the time of the Audit, the Cathedral had three safety plans in place. Cathedral plans are developed by the DST. This means they risk assess the respondent, write the safety plan and ensure review processes are carried out. The process is then applied by the Cathedral staff. 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. The Audit was informed that one case had met the threshold for a safeguarding SIR in the last 12 months. The referral to the Charity Commission aligned with national guidance and the NST was appropriately informed.

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). Where sensitive documents are shared these are password protected via the secure system 'WeTransfer'. The approach to data protection is further strengthened by the MoU in place between the DBF and the Cathedral, setting out the requirement for compliance with data protection arrangements.

14 Victims and Survivors

14.1 The context of cathedrals is such that engagement and outreach to victims / survivors is somewhat unique. As previously outlined in this report, there is an MOU in place between Newcastle Cathedral and the Newcastle DBF for the provision of safeguarding services and support. As such, the section on Victims and Survivors in Part One of this report should also be referenced.

14.2 The Audit recognises the strengths and innovation demonstrated through the appointment of a Lead Officer for the Chaplaincy to Survivors within the DST and believe that this role should formally extend to victims / survivors in the Cathedral. As previously highlighted in this report the Lead Officer for the Chaplaincy to Survivors has taken on an additional post as interim Cathedral Safeguarding Advisor (CSA). Whilst the Audit believes that the skills and experiences brought through this dual footprint regarding victims and survivors is a strength, it does not address (as is acknowledged by the interim CSA) the need for an appropriately qualified safeguarding professional to support the Cathedral's safeguarding arrangements (see Recommendation D4, also paragraph 4.7, 4.28 and 11.16 in this report).

14.3 Acknowledging that it can be extremely difficult for victims and survivors to come forward and share their lived experiences, creating the right environment for them to do so is critical. The Audit saw evidence of both conventional and creative approaches in this regard. These ranged from online communication, physical signage and guidance documents, through to an impactful 'LOUDFence' initiative and an exhibition of survivor's art, poetry and music called 'Jagged Edges'.

14.4 The Audit saw evidence of Newcastle Cathedral demonstrating good practice through a range of initiatives in which they actively engage with victims / survivors, learn from their experiences, provide appropriate support and help them to access relevant local services. Noteworthy examples of these are seen through the 'LOUDFence' Project and Lantern Initiative. Newcastle Cathedral themselves recognise the positive impact that working closely with victims / survivors has had on the safeguarding culture, practice and clarity of purpose and ministry at the Cathedral.

14.5 Further opportunities for the Cathedral to engage with victims / survivors are available via arrangements with the DST (e.g. the Peer Support Group) which have been outlined previously in Victims and Survivors in Part One of this report.

14.6 The Cathedral follows the requirements set out in the "Responding Well to Victims and Survivors of Abuse" House of Bishops' Guidance and work with the DST to identify suitable pastoral support and in some cases counselling. Safe Spaces is also promoted throughout communal areas across the site along with a range of other helplines. This is good practice.

15 Learning, Supervision and Support

15.1 Training opportunities for staff and volunteers at the Cathedral are primarily facilitated through the work of the DST, with support also being provided by the interim CSA since January 2024. They mirror those available for other Church officers across the Diocese. Because of this, much of the detail set out in Part One of this report is of equal relevance.

15.2 The absence of a defined strategy for training has been identified as a gap and a recommendation has been made for the DBF to implement one. Strategic training priorities as they relate to the Cathedral should be factored into this work.

Recommendation C28: The Cathedral and DBF should collaborate on developing a Diocese-wide training strategy. This should include specific reference to the strategic training priorities for the Cathedral.

15.3 Safeguarding training aligns to the national programme and whilst most sessions are held online, there are options for face-to-face delivery. *'Familiarisation sessions'* (led by the DST) assist Church officers who might wish to run training, alongside dedicated in-person sessions for Basic, Foundation and Domestic Abuse courses. This is good practice, offering a degree of choice and inclusivity towards training. That said, beyond the work of the interim CSA, the Cathedral has no 'pool' of volunteer trainers to provide support in this context. Given its unique environment in terms of safeguarding, the Audit believes this should be an area of focus going forward and additional support for training in the Cathedral should be provided.

Recommendation C29: In line with the recommendation for the DBF to develop a defined pool of trainers, the Cathedral should seek to identify at least two members of its workforce to form part of this cohort.

15.4 Feedback to the Audit on the administration, quality and delivery of training has been positive. This was reflected in survey results, interviews and the various documentation examined. Most of the Cathedral's workforce recognised seeing improvements in safeguarding awareness raising (75%) and training provision (64%). High confidence was also expressed about the actions needed in response to a safeguarding concern; confidence that is likely to have been developed through good training and wider awareness raising initiatives.

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.

15.6 That said, opportunities to provide more theme specific and role specific training (as set out in Part One of this report) are also likely to accrue benefits for the Cathedral. Developing a training offer that covers the safeguarding context of the Cathedral is seen as important by the Audit.

15.7 For example, the nuance of what a Cathedral staff volunteer should know is likely to be different when compared to a volunteer 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 CSA led such sessions as focused seminars.

Recommendation C30: In collaboration with the DST, the Cathedral should ensure that a bespoke training needs analysis for its staff and volunteers is developed as part of the recommendation made to the DBF for improving this process.

Recommendation C31: 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 staff and volunteers for whom this would be relevant and seek the support of the DSA / CSA to facilitate these.

15.8 Compliance is generally good for clergy, staff and volunteers, although the Audit was informed that incomplete records on the Diocese CMS system meant that true figures (at the time of these being submitted to the Audit) were not accurately captured. The precise reasons for these incomplete records are not known but are likely to link to workforce pressures in the DST arising from staff absences. Regardless, the following recommendation is made.

Recommendation C32: The Cathedral should ensure that all staff and volunteers who have outstanding training, complete this within three months of the publication of this Audit.

15.9 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 local understanding about whether training is directly influencing practice and making people safer at the Cathedral. The Audit has made a recommendation for the DBF to implement an enhanced evaluation framework for safeguarding training across the Diocese. The Cathedral should seek to ensure it is engaged in any developments.

Recommendation C33: To help determine the impact of training in 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.

15.10 Most staff and volunteers confirmed they had received an induction session on joining the Cathedral and that it covered what they needed to know about safeguarding.

15.11 The DBF has in place a range of mechanisms to support its clergy as set out in Part One of the report. This includes 'organisational' processes (such as HR and occupational health) alongside broader arrangements for pastoral, practical and spiritual assistance. Continued Ministerial Development processes and a Diocesan counselling and wellbeing services are also in place. That said, the written submission from the Cathedral to the Audit identified that staff were always aware of the specific support available to them and beyond this found accessing support difficult on occasion.

Recommendation C34: The Dean should ensure that all clergy at the Cathedral are made aware of the various avenues of support currently available to them.

The Dean should commission work to consider the suitability and accessibility of such support for Cathedral staff and volunteers.

15.12 The Audit recognises that from the most junior to the most senior clergy across the Diocese, they will be facing a range of pressures arising from their exposure to safeguarding issues. As a matter relevant to all areas, the Audit will address this in more detail as part of its annual evaluation.

15.13 Arrangements for ordinands or curates at the Cathedral echo those set out in the narrative for the DBF. In addition to completing safeguarding learning to leadership level, ordinands, readers and licensed lay ministers all receive induction (a refresher at 18-24 months), a safeguarding induction and Radical Welcome Training.

15.14 Ministerial Development Reviews (MDRs) of Cathedral clergy have been largely absent for over 12 months. This is due to a new MDR process being designed. Whilst no MDRs were made available to the Audit, both the revised template for MDRs and the self-assessment process have specific sections on safeguarding that pose several relevant questions. These are likely to help with more structured discussions about what is working well from a safeguarding perspective, the outcomes being achieved, and future areas for growth and development. Under the new Cathedral Measure 2021, clergy members who work at the Cathedral participate, as with all staff, in the Cathedral's appraisal process. This is good practice.

Conclusion

16 Conclusion

16.1 The Bishop and the new Dean are determined to drive the improvement journey across Newcastle and strengthen the safeguarding arrangements as they exist within the DBF, the Cathedral and at parish level. They have ambitious plans to realign governance and to further develop the initiatives, outreach and partnerships that have been built and that continue to be supported.

16.2 There is no doubt that good work continues to be done by the DST. The level of collaboration that the Audit has seen with external agencies and the investment in a range of different safeguarding projects is impressive. An appetite to innovate is evident and seen through the excellent work to support and co-produce some outstanding initiatives with victims and survivors. The quality of these resources means they have application beyond the footprint of Newcastle.

16.3 The potential to maintain a positive trajectory is however, undermined by a critical lack of capacity in the DST. The current arrangements are largely insufficient when considering the team's breadth of responsibilities and the growing demands that are being placed upon it. The deficits in the DST's current ability to perform to its optimum level run the risk of undermining everything it has achieved thus far.

16.4 Moving forward, the DBF and the Cathedral need to recognise the levels of anxiety that have been created by stretching this resource to its limits. The consequences have been seen in workforce resilience, practice quality and strained relationships. An authoritative response is required. As a priority, the DBF needs to urgently reinforce the capacity and capability of its DST with qualified, in-house staff.

16.5 Whilst cost is always an issue, not least in a smaller Diocese, the reality is that this is a challenge that cannot be ignored and needs resolving. The scale of safeguarding activity is not simply measured by the number of open cases, it includes the range of projects that support the young and vulnerable and deliver the CofE's national standards. All of this work adds additional layers of complexity, risk and ultimately needs to be resourced at an appropriate level.

Appendices

17 Appendix 1 – DBF Recommendations

Recommendation D1: The DBF should routinely raise awareness about whistleblowing across the workforces operating in the DBF, the Cathedral and parishes. They should do this by:

a) Promoting awareness using traditional and digital communication strategies.

b) Testing awareness by using anonymised surveys.

c) Reinforcing awareness and contextual understanding through focus group engagement, utilising case studies and prompts.

d) In conversation, what leaders say and do matters. Leaders should frequently and routinely raise the issue of the importance of safeguarding.

Recommendation D2: Implement leadership audits highlighting an individual leader's active and authoritative approach to safeguarding. For example, instances where a senior leader has challenged inappropriate conduct and taken steps to highlight and report safeguarding concerns. This might include providing words of advice and instigating disciplinary processes as well as public statements, official communications and participation and support provided to individuals and groups including victims / survivors.

Recommendation D3: As part of its use of surveys, focus groups and other engagement activity, the DBF should ensure it routinely tests awareness about whistleblowing processes and seeks feedback for areas of improvement.

Recommendation D4: The remit of the Lead Officer for the Chaplaincy to Survivors should not be used for activities beyond a clearly defined range of survivor related support activities (including training).

Recommendation D5: The Bishops Council should carry out a skills audit to ensure that it has optimised the opportunities to engage individuals with the skills, abilities and lived experience necessary to safeguard contemporary Church communities. This will also help to ensure relevant and robust challenge during briefings on safeguarding issues.

Recommendation D6: During future visitations (and in consultation with the DSA), data from Parish Safeguarding Dashboards should be dip sampled as part of reassurance testing by Archdeacons.

Recommendation D7: The Chair of the DSAP should consider broadening the membership of the DSAP to include more representatives from the wider community within which the Diocese sits, particularly local charities with a focus on supporting the young and vulnerable.

Recommendation D8: The Council, Bishops Staff Team and DSAP should operate and maintain contemporary risk registers. Each should target and assess the areas of risk most relevant to their oversight responsibilities, e.g. strategic and / or operational.

Recommendation D9: The DBF should remunerate the role of DSAP Chair. This should be fixed against an appropriate comparator role and based on an average across similar roles. The approach to remuneration of such posts is not uniform and the Audit will make a recommendation to the NST in this regard in due course.

Recommendation D10: 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. It would provide direct insight from a safeguarding perspective and support the oversight and operational delivery of the DST.

Recommendation D11: Except in exceptional circumstances and with the relevant permissions, Blue Files should be viewed (when appropriate) by a member of the DST, preferably the DSA.

Recommendation D12: The DBF should immediately review and reinforce its DST with a focus on building capacity and resilience. In doing so, it should consult with other DSTs to establish how best to achieve a blended, multi-disciplinary team.

Recommendation D13: The Bishop and Dean should ensure that immediate work is undertaken to resolve any ambiguity concerning working practices between the Cathedral and the DBF. Where required, changes should be set out within the arrangements covered by the MoU.

Recommendation D14: The DBF should ensure that its commitment to safeguarding is embedded throughout all job adverts, application forms and job descriptions.

Recommendation D15: The DBF should ensure that all staff who undertake any duty as part of the recruitment process undergo safer recruitment training according to the CofE's guidelines. This training should be renewed if it was taken more than three years ago.

Recommendation D16: The DBF should ensure that all staff who undertake any duty as part of the recruitment process have an up-to-date DBS certificate.

Recommendation D17: The DBF should develop a standalone safeguarding risk register to allow for more focus and scrutiny on safeguarding concerns. This should be reviewed and updated at a minimum cycle of quarterly.

Recommendation D18: The DBF's safeguarding risk register should be developed to clearly identify risks as they relate to the CofE's National Safeguarding Standards.

Recommendation D19: The DSA, supported by investment from the DBF, should take steps to ensure that case management, scrutiny, record keeping and oversight of practice is strengthened across the entire safeguarding pathway. This should include the DSA conducting and recording monthly management reviews of active cases on MyConcern.

Recommendation D20: Now that the risk rating tool is available on MyConcern, open cases should be reviewed by the DSA as a priority.

Recommendation D21: The DBF should review the work priorities of the DST and ensure that the arrangements in place for delivering and managing casework are properly resourced, effectively delivered and robustly line managed.

Recommendation D22: The DSA should receive additional training on the case management system MyConcern.

Recommendation D23: Recording on MyConcern should be improved to more consistently detail the rationale for why certain decisions have been made. This recording should clearly explain why action or inaction on individual cases has been decided.

Recommendation D24: The DSA should always provide a signature to safety plans.

Recommendation D25: All existing safety plans should be reviewed to include the following statement as part of a respondent's monitoring arrangements.

'*The subject of this plan must inform the Reference Group and DSA or DSA's representative if they want to attend a different Church or different Church activity to the Church / Church activity outlined in this plan. The DSA / DSA representative will then liaise with the other named Church to establish another Safety Plan and Reference Group to support this attendance'.*

Recommendation D26: The accountability and responsibilities of the DST outlined in the MoU for safeguarding services and support between the Cathedral and DBF should be clearly communicated.

Recommendation D27: The DBF should implement clear procedures for escalating differences of opinion regarding case management decisions.

Recommendation D28: Clergy, staff and volunteers should receive training on data protection, information sharing and how to identify a data subject request.

Recommendation D29: The DBF should develop and publish a stand-alone Safeguarding Training Strategy. As a minimum, this should outline the key principles of safeguarding training, the key responsibilities of staff and volunteers, the role and function of the DST / relevant staff and the framework for safeguarding training covering need analysis, delivery and evaluation.

Strategic priorities should be defined based on NST requirements and local analysis of needs.

A specific action plan should set out how these priorities will be met.

Recommendation D30: The DBF should develop a defined pool of safeguarding trainers. It should build on its existing familiarisation sessions, by introducing a defined 'train the trainers' programme that supports trainers with content, helps them with techniques for delivery and involves regular support sessions / meetings for them.

Recommendation D31: The DBF should explore how the commitment, resourcing and arrangements for volunteer trainers could be integrated into the governance arrangements for Deaneries.

Recommendation D32: The DBF should redesign the training role in the DST so that it has overall responsibility for coordinating the safeguarding training pathway. This should include responsibility for analysis, programme design and delivery and evaluation. Given existing demands, alongside the recommendations made within this report, the Audit believes this role should be secured at no less than 0.5FTE.

Recommendation D33: The DBF should review its training needs analysis process to ensure this adequately covers the full range of roles in place across the Diocese. The analysis should be used to identify where additional 'role specific' training might be of benefit.

Recommendation D34: The DBF should progress at pace with implementing its planned training on sex offenders. Further consideration should be given to the range of relevant staff and volunteers for whom this training is likely to be relevant, beyond incumbents, PSOs and Link Persons.

Recommendation D35: To accompany the DBF's Digital media guidance, training on digital safeguarding should be introduced and be accessible to relevant Church officers in the DBF, Cathedral and parishes.

Recommendation D36: 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 need should be asked.

Recommendation D37: All new clergy should receive a formal, face to face induction session with a member of the DST.

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

18 Appendix 2 – Cathedral Recommendations

Recommendation C1: The Cathedral should utilise a variety of mechanisms including, scenario-based workshops, externally facilitated focus groups and anonymous surveys to periodically review and assess progress on embedding a safeguarding culture. Outcomes should be reviewed by the Chapter Safeguarding Committee, the Independent Safeguarding Advisory Group (if adopted - see Recommendation C3) and presented to Chapter.

Recommendation C2: The Cathedral should:

- Establish the full nature of any concerns held by staff via an anonymous survey or other appropriate form of engagement. Allowing them to share their concerns and ideas about how best it can be supported.
- Assess the adequacy of their risk assessment process.
- Assess whether staff carrying out such duties with the enhanced responsibilities attached to their role are appropriately remunerated.

Recommendation C3: The Cathedral should carry out a skills, diversity and inclusion audit to broaden and strengthen the membership of its governing bodies and safeguarding oversight functions. This should include consideration of the creation of an ISAG.

Recommendation C4: The Safeguarding Committee should construct and present a risk assessment regarding the level of risk, mitigations and capacity to deliver, matched against the activities and interrelated risks that currently co-exist. This should result in an options paper for Chapter on what it can, should and should not continue until capacity is appropriately managed and support is increased.

Recommendation C5: The Dean should engage with senior leaders with responsibility for safeguarding functions and reinforce with them the need to ensure that safeguarding is not lost within the range of their other responsibilities.

Recommendation C6: The Cathedral should ensure that its relevant risk registers are reflective of current safeguarding needs and incorporate all identified risks related to the Cathedral's initiatives.

Recommendation C7: In line with the Audit's recommendations about reinforcing safeguarding capacity in the DBF / DST, senior leaders need to ensure that capacity issues as they relate to the Cathedral are also factored into any solutions.

Recommendation C8: The Cathedral should ensure door codes are regularly changed and shared only among Cathedral staff. All choristers and chorister parents should use designated entry and exit points where chorister staff are present.

Recommendation C9: A specific Chorister Safeguarding Policy / Handbook should be created which details all safeguarding procedures and arrangements for choristers. This should be easily accessible for those working with choristers and chorister parents / carers.

Recommendation C10: The Cathedral should implement a central record keeping system regarding relevant handover information. This can be achieved by the creation and use of a daily handover logbook / spreadsheet or similar mechanism. The logbook / spreadsheet or other mechanism used to record this should be frequently and routinely examined and signed off by the Director of Music.

Recommendation C11: Chorister staff at the Cathedral should consider ways to ensure safeguarding is a standing agenda item in staff meetings.

Recommendation C12: The Cathedral should set up a dedicated pathway for chorister parent communication and feedback that includes safeguarding as a standing agenda item.

Recommendation C13: The Director of Music should be provided with a work mobile phone for communication with parents and carers.

Recommendation C14: The Cathedral should review its recruitment procedures and seek to streamline these, whilst continuing to align with House of Bishops' guidance.

Recommendation C15: The Cathedral should ensure that the Church of England portal access to historical records is proportionate to the user's needs. Any identified flaws in access should be promptly addressed to prevent 'bottlenecking' around those with access.

Recommendation C16: The Cathedral should ensure that its commitment to safeguarding is embedded throughout all job adverts, application forms and job descriptions.

Recommendation C17: The Cathedral should seek to implement at pace a code of conduct for all staff.

Recommendation C18: The Cathedral should display the Lantern Initiative more prominently on its website to give visitors a true reflection of their visit. It should ensure that links are working correctly and imagery accurately reflects the community a visitor is likely to encounter.

Recommendation C19: All staff who move around the Cathedral, engage with children and young people, or routinely engage with vulnerable members of the public as part of the Lantern Initiative must always wear radios.

Recommendation C20: CCTV should be installed in all secluded areas of the Cathedral and monitored as required i.e. post-incident or allegation. Retention and storage of such material should be compliant with UK GDPR legislation.

Recommendation C21: A robust risk assessment should be created to consider how the Lantern Initiative interacts and overlaps with children and young people in the Cathedral. This assessment should be reviewed frequently to ensure the Cathedral is responsive to any changes that may heighten the level of risk within shared spaces.

Recommendation C22: The Cathedral should consider reducing, changing the arrangements around, or eliminating school visits during the street life community's peak visiting times.

Recommendation C23 The Cathedral should ensure posters and signposting are displayed around the premises that set ground rules for acceptable behaviour, outline the actions staff members will take and specify the consequences of breaching these behaviour rules. In line with the ethos of Radical Welcome, these posters should be inclusive, using visuals and accessible fonts and formatting.

Recommendation C24: Include a comprehensive briefing of the Cathedral's Radical Welcome value in the digital pack for visiting schools or choirs, detailing exactly what they may encounter and the safety measures in place.

Recommendation C25: Those who display contact numbers on posters offering support should operate on a rota basis to ensure that calls are always answered and responded to.

Recommendation C26: The DBF and Cathedral should ensure the approach to safeguarding concerns adhere with the requirements set out in the MoU.

Recommendation C27: In partnership with the DST, the Cathedral should proactively engage with its workforce to promote confidence in reporting and escalating concerns.

Recommendation C28: The Cathedral and DBF should collaborate on developing a Diocese-wide training strategy. This should include specific reference to the strategic training priorities for the Cathedral.

Recommendation C29: In line with the recommendation for the DBF to develop a defined pool of trainers, the Cathedral should seek to identify at least two members of its workforce to form part of this cohort.

Recommendation C30: In collaboration with the DST, the Cathedral should ensure that a bespoke training needs analysis for its staff and volunteers is developed as part of the recommendation made to the DBF for improving this process.

Recommendation C31: 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 staff and volunteers for whom this would be relevant and seek the support of the DSA / CSA to facilitate these.

Recommendation C32: The Cathedral should ensure that all staff and volunteers who have outstanding training, complete this within three months of the publication of this Audit.

Recommendation C33: To help determine the impact of training in 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 C34: The Dean should ensure that all clergy at the Cathedral are made aware of the various avenues of support currently available to them.

The Dean should commission work to consider the suitability and accessibility of such support for Cathedral staff and volunteers.

19 Appendix 3 – Glossary of Abbreviations

APCM	Annual Parochial Church Meeting
CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
CSA	Cathedral Safeguarding Advisor
CSL	Chapter Safeguarding Lead
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
FTE	Full-time equivalent
GDPR	General Data Protection Regulations
HR	Human Resources
IICSA	The Independent Inquiry into Child Sexual Abuse
ISAG	Independent Advisory Group for the Cathedral
LADO	Local Authority Designated Officer
LLM	Licensed Lay Minister
LLR	Learning Lessons Review
LSCP	Local Safeguarding Children Partnership
MDR	Ministerial Development Review
MoU	Memorandum of Understanding
NCEA	Northumberland Church of England Academy
NST	National Safeguarding Team

PCC	Parochial Church Council
PCR2	Past Cases Review 2
PoC	Person of Concern
PSO	Parish Safeguarding Officer
PTO	Permission to Officiate
SCIE	The Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SEO	Search Engine Optimisation
SIR	Serious Incident Report
SLA	Service Level Agreement
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TEI	Theological Education Institution
WSF	William Scott Farrell

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