

Independent Safeguarding Audit of St Edmundsbury and Ipswich Diocesan Board of Finance and St Edmundsbury Cathedral

2026

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Introduction

1 Introduction

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

- Over 540 documents being collated and analysed prior to the Audit's fieldwork.
- A range of interviews being held with Church officers (staff and volunteers), external partners, victims, survivors and other stakeholders.
- 609 anonymous survey responses being received, which gathered input from key communities connected to the Church. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the DBF, the Cathedral and parishes.
- Six focus groups.
- A confidential contact form being made available via a dedicated webpage.
- In total, the Audit undertook 36 separate engagement sessions reaching 88 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, St Edmundsbury and Ipswich DBF and Part Two, St Edmundsbury Cathedral. This has been done to ensure that each audited body is able to focus on its own strengths and areas for identified improvement.
- 1.4 The report has been reviewed for factual accuracy by both the DBF and the Cathedral.

Part One - St Edmundsbury and Ipswich Diocesan Board of Finance

2 Context

- 2.1 Established in 1914, the Diocese of St Edmundsbury and Ipswich spans a territory of more than 14,000 square miles. The region is defined by its predominantly rural landscape, encompassing a network of market towns and small villages alongside the primary urban hub of Ipswich. Geographically, the Diocese covers the majority of Suffolk, with the exception of the Lowestoft area, and includes a single parish in Essex.
- 2.2 The Diocese is organised into three geographic archdeaconries: Ipswich, Sudbury, and Suffolk. This framework supports 443 parishes and 481 places of worship. Collectively, these centres of faith serve a total regional population of approximately 684,000, with a regular worshipping community of about 17,600 people.
- 2.3 The local economy is anchored by the Port of Felixstowe, which serves as a critical gateway for international trade, yet much of the Diocese remains deeply rural. Approximately 40% of the population lives in countryside villages or along the 50-mile coastline. While the county is not ranked as the most deprived in England overall, these scenic areas often mask "hidden" pockets of severe isolation. In fact, 40 local areas within the Diocese rank among the 20% most deprived in the nation, and rising food insecurity now sees over 7,000 people relying on food banks every month.
- 2.4 These socio-economic pressures are reflected within the life of the church, where youth and children's ministries are currently sparse. The Diocese is committed to a vision of "growing younger," but this mission faces significant demographic and structural hurdles. Success depends on revitalising ministry for the next generation while navigating a projected 4% decline in the local population of children and young people.

3 Progress

- 3.1 St Edmundsbury and Ipswich Diocesan Board of Finance (DBF) has undergone both a SCIE Safeguarding audit and a PCR2. The SCIE audit, published in August 2016, resulted in 26 'considerations' for the DBF to consider. Additionally, the PCR2 report, published in March 2022, made 17 recommendations. These covered a variety of areas, including supervision arrangements, policy and procedure, oversight of training and stakeholder engagement.
- 3.2 All considerations proposed within the DBF's previous SCIE Audit were accepted and included within a dedicated action plan of which the previous Head of Safeguarding had ownership. The current DSO has not had any input on this. That said, the Audit Team is satisfied with progress made.
- 3.3 The PCR2 report resulted in 17 recommendations, with all but one recommendation taken forward and included within a dedicated action plan. The only recommendation not actioned was in relation to a training needs analysis for those who require further risk management training. This was due to a lack of resource and an absence of national training. This is an area which will be revisited in the *'Recognising, Assessing and Managing Risk'* section of this report. This action plan was overseen by the PCR2 reference group which reported into DSAP, with most areas seeing considerable progress.
- 3.4 The Audit heard that the DSO also contributed to a Lessons Learned Review (LLR) for a local Safeguarding Partnership regarding a church officer. The individual was removed from their post, a core group was held and a review was completed of the case and core group which was chaired by a member of the NST. The general outcome was that the process had worked well.

- 3.5 An independent LLR was recently commissioned by the acting Diocesan Bishop. This LLR was in relation to a formal complaint made in response to the Cathedral's handling of a safeguarding concern. The intervention and support by the Regional Safeguarding Lead (RSL) have added a level of reassurance to the Audit Team and the Audit has heard of activity being undertaken to improve processes. This LLR contains learning for both the DBF and the Cathedral.
- 3.6 Complementing its broader improvement agenda, the DBF has strengthened its safeguarding infrastructure through a proactive, data-driven approach to compliance and culture. By integrating yearly reviews and questionnaires, the team now aligns in-person training schedules directly with local needs while embedding the National Safeguarding Standards and cultural change dialogues into parish interactions. Operational efficiency has been further enhanced by the introduction of Safeguarding Hubs, a direct response to officer feedback, and a rigorous internal audit that rectified specific gaps in Clergy DBS and training records. Furthermore, high-level collaboration with the Suffolk Public Protection Unit has ensured that church safety plans for registered offenders are robustly reviewed and updated, demonstrating a commitment to both administrative excellence and community safety.

4 Culture, Leadership and Capacity

DBF Culture

- 4.1 Feedback captured via the Audit's surveys highlights a strong, positive trend in safeguarding improvements across the diocese. The DBF, parish workforce, and the wider worshipping community overwhelmingly report feeling safe in their places of work and worship. Survey respondents expressed high satisfaction with enhanced safeguarding measures, demonstrating both an increased awareness of their importance and greater confidence in their ability to raise concerns without fear of reprisal.
- 4.2 Audit discussions strongly corroborate these survey findings, with prevailing attitudes characterising the diocesan and parish culture as 'welcoming', 'supportive', and 'inclusive'.
- 4.3 The Audit heard that over recent years, there has been a noticeable, positive shift in how safeguarding is perceived. It is increasingly recognised as a shared responsibility across the entire community, moving away from being viewed solely as an issue for specific roles.
- 4.4 This cultural shift is underpinned by the Diocesan Safeguarding Team (DST), whose approach has been praised for being professionally grounded, rather than solely faith-based, ensuring that safeguarding is always the unequivocal priority. Furthermore, the DBF has actively reinforced this supportive environment by stepping in to assist parishes during periods of stress and capacity constraints.
- 4.5 A prime example of the diocese's commitment to a safer, healthy, and restorative culture is the '*United in Solace and Grace*' initiative. Created and led by victims and survivors from the diocese, alongside a representative from a survivor charity, this programme exemplifies trauma-informed practice. By creating safe spaces, building knowledge, and advocating for survivors, the initiative has had a profoundly positive impact across the

diocese and Cathedral, successfully changing perspectives and deepening the community's understanding of why safeguarding is so vital.

- 4.6 Despite these significant advancements, there is less consensus on whether a robust safeguarding culture is now fully embedded at every level. While the DBF and parish workforces remain overwhelmingly confident that it is, a significant minority of the wider worshipping community remains unsure. This indicates that, whilst the overall trajectory is highly positive, ongoing engagement is required to ensure the new safeguarding culture permeates fully throughout congregations.

Leadership and Governance

- 4.7 In the 12 months leading up to the Audit, the DBF experienced an unprecedented period of turnover, navigating the tenures of three Bishops. This high degree of change was further compounded by the ongoing absence of a suffragan bishop, creating a landscape where the potential for disruption was exceptionally high.
- 4.8 However, the defining characteristic of the DBF's leadership over the past year has been its remarkable resilience. Despite turbulence at the highest levels of the DBF structure, the core operations and strategic direction have not wavered.
- 4.9 This continuity is a direct testament to the agility and dedication of the broader senior management team. Rather than being destabilised by the rapid episcopal turnover, the senior team has worked effectively through the transition, absorbing the additional pressures and ensuring that the DBF's vital work continued without interruption.
- 4.10 At the time of the Audit, the Acting Diocesan Bishop held ultimate accountability for safeguarding, a responsibility he unequivocally accepted. Although his interim position limited his ability to drive long-term change, the Audit found clear evidence of his steady

leadership. His approach was defined by a strong balance of authoritative oversight, strategic advocacy, and pastoral awareness.

- 4.11 In terms of decision-making and professional boundaries, auditors examined material underlining his firm stance on compliance matters, specifically clergy DBS checks and training. Crucially, he clearly differentiated between his duty to hold individuals to account and the necessity of allowing the DST to manage operational decisions without interference.
- 4.12 Beyond maintaining compliance, the Acting Diocesan Bishop actively advanced the safeguarding agenda at a wider strategic level. He promoted proactive scrutiny and championed safeguarding within the Synod. Furthermore, he balanced this robust oversight with genuine pastoral care, consistently demonstrating insightful empathy for the pressures faced by the overstretched DST.
- 4.13 Amongst others, the Acting Diocesan Bishop was supported by two part-time interim Bishop's Chaplains, a reflective and supportive Diocesan Secretary and collegiate and committed Archdeacons.

The Diocesan Secretary

- 4.14 The Diocesan Secretary brings a wealth of experience across finance, HR, property, and leadership within the NHS and charity sectors, underpinned by a strong, values-driven church background. Having previously held different roles across the DBF, he possesses a deep and nuanced understanding of the local context.
- 4.15 Despite stepping into his current role unexpectedly and without a formal induction, he has demonstrated considerable adaptability and a resolute commitment to safeguarding. Within the diocese, he is widely regarded as a constructive enabler of safeguarding rather than a gatekeeper.

Recommendation D1: Administration and Reporting Line of the DSO

- a) To strengthen strategic oversight, escalation pathways, and accountability, the DBF should realign the DSO's reporting line from HR directly to the Diocesan Secretary. This facilitates the administration of sickness and leave, ensuring that capacity, risk, and systemic issues are appropriately escalated without compromising the DSO's operational independence.
- b) If the proposed Director of Safeguarding model is adopted, this post would manage the DST and be formally accountable to both the DBF and the Cathedral Chapter (via agreed reporting and assurance arrangements). This structure ensures a clear separation of strategic accountability from operational delivery, while promoting consistent diocesan-cathedral alignment, clear responsibilities, and robust safeguarding oversight across the diocese.

Archdeacons

- 4.16 The Archdeacons demonstrate a strong, collegiate team culture and a clear personal commitment to safeguarding. They routinely weave safeguarding into rural dean meetings, visitations and parish conversations, reinforcing the idea that “we’re all in this” and that safeguarding should be part of the Church's DNA.
- 4.17 They already use structures such as triennial visitations, parish visits, and Monday senior staff meetings to surface and share safeguarding issues. One Archdeacon sits on DSAP and consciously acts as a conduit between DSAP and senior staff, feeding in concerns such as training blockages and DBS/complaints backlogs.
- 4.18 They demonstrated good insights into the risk of “paper compliance” (policies existing but not being truly inhabited) and value honesty from parishes about where they are struggling, rather than box-ticking.

4.19 Despite these strengths, there are clear opportunities to support and develop the Archdeacons' safeguarding impact and consistency. They do not routinely receive structured safeguarding briefings before visits, meaning they are not always fully sighted on safety plans or key risks in the parishes they visit. Knowledge of safety plans is therefore partial and sometimes discovered reactively rather than proactively.

Recommendation D2: Before visits (formal or informal), the safeguarding team should provide each Archdeacon with a concise briefing pack: local safety plans, recent incidents, relevant national trends (e.g. rising domestic abuse, changing patterns of offending) and dashboard highlights for that Archdeaconry. After visits, Archdeacons should feed back in a short written debrief so that learning, emerging risks and practice gaps are captured and can inform safety planning, serious incident reporting and wider diocesan oversight.

4.20 The Archdeacons currently have a mixed but evolving role in Safeguarding Case Management Groups (SCMG). Historically, the Suffragan Bishop chaired all SCMGs across the diocese, with Archdeacons mainly attending rather than chairing. Archdeacons should not chair core SCMGs where they are in the direct disciplinary line of the subject (for example, their own incumbents), but they can chair when they are de-conflicted by geography or role.

4.21 The Audit heard that the Registrar attends such meetings and acknowledges this as good practice. Alongside a nominated safeguarding advisor, this provides specialist support for chairs.

4.22 In order to further enhance practice, ensure deconfliction and uniformity of approach, all Archdeacons and if agreed a pool of suitably selected others (e.g., Area Deans) should be trained and appropriately supported to chair Core Group meetings.

Recommendation D3: To ensure impartial and appropriate chair selection, alongside suitable composition, environment, training, and ongoing support and supervision, the DBF should:

- a) Create a dedicated pool of suitably qualified individuals to act as chairs.
- b) Mandate rigorous conflict of interest checks for all prospective chairs prior to their appointment.
- c) Strictly limit the number of participants in core groups to maintain focus and efficiency.
- d) Ensure that any individuals with a conflict of interest are explicitly excluded from participating in the core group.
- e) Ensure all core groups operate within a neutral, trauma-informed setting.
- f) Implement mandatory foundational training for all core group members.
- g) Provide targeted training for Archdeacons and any others acting as chairs. This programme must cover their specific roles and responsibilities, advanced facilitation skills for highly sensitive meetings, and clear guidance on appropriate escalation pathways.
- h) Provide independent, professional supervision to ensure chairs are fully equipped and supported to manage the complex challenges inherent in these functions.
- i) Clearly establish and embed best practice regarding support and escalation pathways so that chairs are never left isolated when managing difficult situations.

The Diocesan Safeguarding Officer DSO

4.23 The DSO has a credible statutory background, is reflective and considered and is responsible for the stability of safeguarding practice in what have been extremely challenging times. They are an asset to the diocese.

4.24 The DSO is supported by a highly effective ADSO (who also has a credible statutory and related background) and a professional dedicated trainer and Admin assistant.

4.25 To its credit, the DBF has an open invitation to the DSO to attend any of the governance or oversight meetings she wishes. Whilst well intended, this fails to acknowledge that one of the primary issues that undermines their ability to attend is bandwidth. Up to and until this is addressed, the DSO will be unable to provide the consistent authoritative expert voice. This capacity issue can best be addressed by the provision of a Director of Safeguarding, highlighted later in this report.

Clergy (Blue) Files

4.26 The Bishop's Office manages Clergy (Blue) Files. While some positive practices were noted, such as the clear identification of safeguarding concerns, several areas require immediate attention to meet national standards.

4.27 At present, an access log is not maintained to capture external access to these sensitive files. Additionally, the DSO does not routinely read Blue Files for new incumbents, only examining them when a problem arises. Physical storage is also a concern; files were observed being stored in plastic boxes rather than fireproof cabinets.

4.28 There is a significant gap regarding Ministerial Development Reviews (MDRs). The Audit found that some members of the clergy have not had an MDR in over two years, and evidence of these reviews was absent from the sampled Blue Files.

Recommendation D4: To address the issues highlighted in the Audit's examination of Clergy Files, the DBF should:

- a) Introduce a robust access log within each Blue File to capture the signature and rationale for every instance of external access.
- b) Rectify file security by investing in fireproof, lockable cabinets for all active Clergy Files.
- c) Expedite the MDR process within a specific timeframe and ensure the DSO helps to integrate mandatory safeguarding themes into the review format.

Governance

- 4.29 The DBF operates governance and oversight meetings that meet the expectations of the Church and other relevant requirements, such as those issued by the Charity Commission.

The Bishops Council and Diocesan Board of Finance (DBF)

- 4.30 As part of its core role, the Council has intensified its scrutiny of structural deficits, cash flow pressures, and Diocesan Synod vacancies. The Audit also noted that the Council has actively addressed safeguarding accountability. This included reviewing the diocese's alignment with the National Safeguarding Standards ahead of the 2025 INEQE Audit and examining the impact of the Makin Report on victims and survivors.
- 4.31 Much of this oversight is reflected in trustee activity, as captured within DBF minutes. These efforts have ranged from ensuring the completion of safer recruitment and basic safeguarding training, to reviewing the safeguarding support provided to the Cathedral.
- 4.32 While this provides a positive foundation, and the Audit recognises that the transition from observational oversight to a more systematic, scrutiny-based approach is already underway, a structured framework is needed. Combining the authority of the DBF with the effective use of the DSAP will help focus enhanced governance. This shift must drive a three-year programme of work to test not only the adoption of the National Safeguarding Standards, but also their tangible impact.

Recommendation D5: To move from observational oversight to proactive scrutiny, the DBF should work with the Diocesan Safeguarding Advisory Panel (DSAP) to co-design a three-year programme of work. By aligning the DBF's ultimate accountability with the DSAP's independent assurance, the two bodies can establish a shared schedule of systematic, thematic deep dives. Together, they should agree on specific DBF oversight questions and expectations of the DSAP, including the testing of policy and practice alongside data-driven impact analysis.

This programme should at a minimum encompass the following key areas:

- a) Mandate assurance from the DSAP, supported by the DSO and external audits, to demonstrate that the diocese is genuinely aligned with the National Safeguarding Standards.
- b) Confirm that DBF leadership is actively enabling a proactive culture of care, rather than a reactive culture of compliance.
- c) Use assessments from the DSAP and direct feedback from the DSO to ensure the DST possesses the necessary capacity, financial backing, and leadership support to deliver safe outcomes.
- d) Tackle issues highlighted by the DSAP, DSO, or other reviews by deploying specific, targeted financial or structural interventions to resolve them.
- e) Mandate the DSAP and DSO to evaluate the effectiveness of these protocols, requiring concrete evidence that they are actively mitigating risk.
- f) Ensure that operational risks identified by the DSAP or DSO are accurately captured and addressed on the DBF's strategic risk register.
- g) Gather input from the DSAP, the DSO, and, where appropriate, victims and survivors themselves, demonstrating that their voices remain central to the design and delivery of the diocese's safeguarding practices.
- h) Resource victim and survivor support structures effectively, and secure confirmation from the DSAP that survivors experience this support as timely, trauma-informed, and compassionate.
- i) Require the DSAP and DSO to confirm that insights from case reviews and audits are not just recorded but are systematically transforming frontline practice.
- j) Address areas where the DSAP, DSO, or other relevant sources have identified a failure to learn or improve and robustly test the corrective actions the DBF has taken in response.

Diocesan Safeguarding Advisory Panel (DSAP)

- 4.33 Led by a Chair with three decades of experience in policing, public protection, and carrying out Reviews, the DSAP has successfully transitioned from a historically passive committee into a proactive and engaged body. Under the current leadership, the Panel now actively debates critical operational issues, such as training drop-out rates, while maintaining a strong focus on strategic initiatives. Recently, its core priorities have centred on rolling out the National Case Management System (NCMS), navigating the Victim and survivor-impact in the aftermath of the Makin Report, and developing comprehensive Lone Working policies and risk assessments for clergy.
- 4.34 Despite this growing effectiveness and positive momentum, there are still areas requiring development. The Panel's capacity to provide robust, critical challenge is not yet fully optimised, and strategic risks are not always escalated with the necessary force or urgency.

Recommendation D6: To address these areas, the DSAP should:

- a) Establish clearer communication channels by ensuring the DSAP Chair has direct access to, and formal reporting lines into, the DBF) Trustees.
- b) Engage with the NST to develop and implement governance training for trustees to support their development and an enhanced oversight structure.
- c) Establish a formal annual safeguarding planning meeting led by the DSAP Chair, bringing together the DSO, Archdeacons, and Cathedral leads to coordinate activity and avoid duplication.
- d) Work collaboratively with the DBF to structure a three-year programme of scrutiny and reassurance.
- e) Consider creating targeted subcommittees or task-and-finish groups to focus on specific safeguarding themes.

- f) Develop a comprehensive risk management strategy to ensure strategic risks are escalated with the necessary force and urgency.
- g) Create a dedicated DSAP risk register to track and manage these risks effectively.
- h) Improve current data collection and analysis processes.
- i) Develop a more robust tracking and evaluation system for safeguarding training.

Recommendation D7: The DBF should ensure that all meetings, formal or informal, go beyond capturing actions and provide appropriate minutes that demonstrate the issues discussed and the actions (including rationale) agreed.

Capacity

4.35 The Diocesan Safeguarding Team (DST) is well-led, and its positive impact is widely acknowledged by colleagues across the DBF and the parishes it supports.

4.36 However, operational capacity remains a critical vulnerability. It is important to state clearly that this observation does not reflect on the competence or dedication of the team members; rather, it highlights the reality of a team that is understaffed, overstretched, and under sustained pressure to deliver more.

4.37 Currently, delivery is heavily underwritten by staff goodwill. For example, the safeguarding trainer consistently works more than 30% beyond their contracted hours, and the accumulation of Time Off In Lieu (TOIL) is a systemic feature across the wider team.

4.38 Consequently, this lack of capacity has resulted in several operational deficits: a six-week backlog in training assessment and accreditation; a significant backlog in the transfer of data to MyConcern (though it is noted as good practice that risk and safety plan records are rightly prioritised); incomplete case recording and supervision record-keeping;

insufficient capacity to meaningfully fulfil the Cathedral Service Level Agreement (SLA);
and an inability to fully participate in good practice regarding the oversight of Clergy Files.

Recommendation D8: To consolidate the team, clear current backlogs, and build a sustainable approach, the DBF should:

- a) Establish a Safeguarding Directorate by reconfiguring the current DST into a unified Safeguarding Directorate led by a Director of Safeguarding. This structure must facilitate necessary conversations to ensure compliance with accountability structures while maintaining operationally independent safeguarding provision.
- b) Bring all safeguarding resources under this single, professionally line-managed specialist directorate.
- c) Integrate Cathedral Safeguarding within the Safeguarding Directorate. The CSAs should be physically situated within the Cathedral but professionally line-managed by the Diocesan Safeguarding Officer (DSO) or Case Management Coordinator.
- d) Explore how this integrated approach can provide operational contingency for both the DBF and the Cathedral, creating opportunities for potential cost-sharing.
- e) Appoint a Deputy DSO to bolster operational leadership and case management oversight.
- f) Strengthen team coverage by reviewing the balance of roles. Consider transitioning from dedicated trainers to Assistant DSOs (ADSOs) who hold a training portfolio, supported by a dedicated budget to commission specialist external training as required.
- g) Redesign the current 'Safeguarding Admin' position into a 'Safeguarding Team and Parish Support' role. This will refocus the function to filter calls and increase support for parishes (e.g., Safeguarding Dashboards), Archdeacons (e.g., Visitations), and training evaluations.
- h) Remove all standard DBS administration from the team's remit. In line with expected good practice, the safeguarding team should only engage with DBS disclosures containing blemishes or concerns.
- i) Establish clear career development pathways for all safeguarding professionals to aid retention, progression, and morale.

Recommendation D9: In order to address the immediate remedial needs the DBF should:

- a) Procure two fixed-term contract staff (for six to nine months) to immediately address the operational deficits. Their focus should be strictly on clearing the training backlog, addressing case management delays, and cleansing and updating records.
- b) Conduct a remuneration review benchmarked against current market rates to ensure the Diocese is positioned to attract and retain high-calibre personnel.
- c) Consider piloting the use of approved Artificial Intelligence (AI) tools to streamline general administration and minute-taking, freeing up valuable staff hours for core safeguarding duties.

5 Prevention

- 5.1 The DBF and the wider Diocese demonstrate strong commitment to safer recruitment practices. They adhere to the House of Bishops' guidance (Safer Recruitment and People Management), and processes align with relevant legislation. This framework is supported by a comprehensive suite of measures, including training for key personnel, the establishment of role descriptions, support for and promotion of the Parish Dashboards, reference gathering, and role-specific vetting and barring checks. To ensure continuity of compliance, the Diocese also employs a 'safeguarding passport' system for all incoming clergy. Under this practice, any clergy member entering the Diocese must have at least six months of valid safeguarding training remaining on their record before a license can be formally granted.
- 5.2 The Audit is of the opinion that the current responsibility for DBS administration, held by the DST, would be more appropriately located within the HR team. This should include a clear process for information sharing with the DST, particularly when a DBS check reveals relevant information. This realignment would free up administrative capacity within the DST to offer more proactive outreach and support to parishes.

Recommendation D10: The DBF should transfer DBS administration from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

- 5.3 The DBF provides safeguarding governance and safer recruitment tools to parishes through the Parish Dashboards. While these tools are already available to parishes, the Audit suggests that the DBF could further enhance its support to ensure the system is fully adopted and embedded at a local level. Specifically, the provision of more accessible

guidance, such as concise 'top tips' on the website, frequently asked questions (FAQs), or short explainer videos, would help parishes navigate and utilise the tool more effectively.

Recommendation D11: To ensure the Parish Dashboard is effectively adopted and embedded across the diocese, the DBF should evaluate the most practical ways to support local parishes. This could include curating a suite of accessible resources on the safeguarding webpages, such as frequently asked questions (FAQs) and short explainer videos, to help users navigate and utilise the tool more efficiently. Before developing new content, the DBF should audit existing materials to avoid unnecessary replication and ensure that parishes are simply directed to the best available guidance.

5.4 In addition, the Audit makes the following recommendation to support the transition from the current 'self-assessment' process to a system which facilitates dip sampling and quality assurance.

Recommendation D12: To assure itself of the quality and impact of Parish Dashboard data, the DBF should define and adopt a Parish Dashboard quality assurance process. While it should be built on the principle of 'working with' rather than 'doing to', this process should involve dip sampling to test the veracity of Parish Dashboard data.

5.5 The Diocese conducts regular discussions with safeguarding included across different areas: with its staff and volunteers, within its congregations, and with those who lead Children and Young People. Discussions with Staff and Volunteers are held during regular events such as Staff Briefings, internal DBF team meetings, Enhancing Pastoral Ministry events, and Safeguarding networking/surgery events. For instance, in the last twelve months, the safeguarding team met with the Diocesan Growing Younger Enabler to specifically discuss how to increase and improve the way safeguarding is communicated to young people and those who lead youth groups. Within Congregations, safeguarding is raised at Deanery Synods, PCC meetings, and in particular during Safeguarding Sunday.

Many congregations have participated in this initiative, which provides a dedicated space for discussion; an example of this was when several churches on July 13th used the liturgy for the Parable of The Good Samaritan, drawing direct links to safeguarding during the service.

5.6 The DBF employs different approaches to sharing good practice in safeguarding, helping to ensure continuous learning and consistent application across all levels of its operation. The Diocese actively participates in regional and national safeguarding networks to both share and accrue best practice. The DSO has maintained regular contact with counterparts across the Eastern Region through quarterly online meetings and informal queries since 2019. The recent appointment of a NST Regional Safeguarding Lead is formalising these networks. Furthermore, the DSAP Chair regularly attends NST-run DSAP Chair Days, which provide updates on national initiatives and a networking platform for sharing practices from other dioceses. The DSO and Assistant DSO also attend regular Safeguarding Advisors Networking Days.

5.7 Sharing good practice with parishes is supported through various mechanisms to ensure local safeguarding role holders have the most current information and resources. The safeguarding team distributes resource packs at all events, containing the most recent policies, guidance, and posters from National and Local initiatives. A dedicated Enews is sent out to all safeguarding role holders and clergy, sharing new resources based on parish requests. The team also develops resources directly in response to parish feedback and requests. Resources created in the last 12 months include a Lone Working Policy and tools, guidance for working with and for volunteers under the age of 18, guidance on Healthy Boundaries, and a safeguarding poster suitable for younger children. Additionally, safeguarding officer networking and surgery events facilitate peer-to-peer sharing of practical tools, such as email templates, analogies for explaining training necessity,

conditional formatting spreadsheets for tracking data, and examples of effective noticeboards.

- 5.8 Formal links are established with the Cathedral to ensure aligned safeguarding practice. Members of the DST attend the Cathedral Safeguarding Committee to provide updates and advice on national and local initiatives. Resources are routinely shared between the two bodies; recent examples include the Lone Working Policy and Tools, guidance on boundaries, and guidance for youth leaders. Finally, the Cathedral Chief Operational Officer attends the Diocesan DSAP.
- 5.9 The DBF follows the House of Bishops' Safeguarding Policy, titled 'Promoting a Safer Church'. The Diocese utilises the full suite of National Church policies and practice guidance, which includes the 'Responding Well' policies. All of these resources are publicly accessible through the Church of England's official safeguarding page on their website. Crucially, while the DBF adheres to these national documents, it does not maintain a separate, distinct safeguarding policy of its own. It relies entirely on the comprehensive national framework for its operational guidance.
- 5.10 The DBF employs a comprehensive and layered strategy to enhance safeguarding awareness across its community, utilising both established and emerging communication channels. Digitally, information is disseminated through two main Enews streams: one specifically targeting safeguarding officers and clergy with critical updates, and a general newsletter reaching everyone on the diocesan mailing list. Further online resources, including new policies and guidance, are consistently uploaded and highlighted on the website, which acts as a central repository for all safeguarding information. Safeguarding officers are also alerted to major points of note via notifications on their dedicated Dashboard system. The impact of these initiatives was highlighted during the Audit by a parish volunteer, who noted that the safeguarding team has made "huge strides" in

increasing awareness, adding that the networking events provide a vital sense of support.

- 5.11 Beyond traditional digital communication, the Diocese has found video to be a highly effective tool, with one successful production already proving its ability to raise the profile and importance of safeguarding, marking it as a key future method for interaction. However, the most successful methods involve direct, physical provision of materials. This includes distributing detailed resource packs, containing posters, policies, guidance, and contact information to key personnel such as new incumbents, clergy, and synod representatives. Crucially, in-person meetings, where these physical resources are distributed, have proven to be the most effective and well-received method of communication, followed closely by the highly engaging nature of video in initiating conversations and drawing people into the topic.
- 5.12 Furthermore, the DBF has specifically raised awareness regarding Sexual Abuse through the United in Solace and Grace initiative, utilising both dedicated services and a promotional video. In summary, while digital resources and tailored packs form the foundation, the Diocese finds that in-person meetings and formal presentations are the most effective way to communicate these vital messages.
- 5.13 The Audit observed a positive example of raising awareness regarding domestic abuse and providing practical safety advice. Specifically, the advice highlighted a critical safety concern: for survivors of domestic abuse who maintain a secret or secondary mobile phone, the government's Emergency Alerts system could potentially compromise their location and reveal the device, even if the phone is set to silent. To assist those concerned about their safety, a link to a comprehensive guide from the charity Refuge was provided for both Android and iPhone users. This is good practice.
- 5.14 The diocese effectively addresses diverse accessibility and communication requirements

by providing a range of material copies upon request. This inclusive approach directly tackles various needs, offering Large Print and High Contrast versions essential for those with visual impairments, alongside Coloured Paper for individuals who experience visual stress or fatigue when reading. Furthermore, the inclusion of Dyslexic Print (OpenDyslexic) specifically aids readability for members of the community with dyslexia. For general access and convenience, traditional Physical Copies are also available. Beyond standard communication, the diocese shows a crucial commitment to safeguarding by making Domestic Abuse posters available in various languages via the Suffolk Safeguarding Partnership Board, ensuring that vital, life-saving information is accessible to all, irrespective of their primary language.

5.15 The Diocese of St Edmundsbury & Ipswich ensures that comprehensive safeguarding information is clearly and accessibly displayed across its parishes, confirming that this includes crucial contact details for various statutory and non-statutory support agencies. The materials exhibited are designed to provide immediate access to help and support. Key items in the display include the "Safe Spaces Poster" and a "Domestic Abuse - Tear off poster" which prominently features the DST's contact details. Furthermore, a "Local and National support network poster" provides a wide range of contact information for organisations such as Childline, Leeway, HOPE, the Samaritans, Men's Kind, Gallop, Wellbeing, and Respect.

5.16 While the Audit acknowledges the DBF's efforts to raise the profile of safeguarding via its digital channels, most notably through videos shared by the Bishop and the DSAP, it was noted that social media remains underutilised within the wider communications strategy. The Audit found that safeguarding-related posts currently lack the frequency and thematic breadth required to effectively drive awareness or grow audience engagement. To this end, the Audit makes the following recommendation.

Recommendation D13: The DBF should develop and implement a structured communications plan for safeguarding messages across its digital channels. This plan should include a content calendar outlining timely, considered safeguarding messages for regular inclusion in email newsletters (e.g., a dedicated section or recurring feature) and scheduled posts on relevant social media platforms. Content should be varied, covering topics such as policy updates, training opportunities, real-life examples (anonymised), reminders of reporting mechanisms, and messages promoting a culture of vigilance and support. The DBF should assign responsibility for content creation, approval, and scheduling, ensuring all messages are consistent, accessible, and align with current safeguarding guidelines. Regular review of engagement metrics should inform future content strategy to maximise reach and impact.

5.17 Effective communication is fundamentally a two-way process; therefore, actively seeking and responding to the views of children, young people, and vulnerable adults is essential for robust prevention planning. Within this framework, the DBF utilises its Growing Younger Team to bridge the gap between congregations and local families, empowering parents to act as the primary leads in their children's discipleship.

5.18 The Audit acknowledges the significant progress already made by the Growing Younger Team, specifically highlighting the impact of their e-newsletter. To build on this momentum and further enhance engagement, particularly regarding specific safeguarding matters, the Audit proposes the following recommendation.

Recommendation D14: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, young people and vulnerable adults within safeguarding prevention planning. Such children and youth initiatives could be led by, and build upon the existing work of, the Growing Younger Team

5.19 The Audit observed evidence of appropriate risk assessments for Church activities where

potential safeguarding risks were identified.

- 5.20 In terms of preventing harm to staff and volunteers, the DBF has a Lone Working Policy in place. This policy is designed for practicality, incorporating a user checklist, a clear flowchart, and an example of the "Lone Working: Wise Working Wallet Card" to ensure that the necessary safety protocols are consistently understood and followed.
- 5.21 Guidance on maintaining appropriate boundaries is shared with parishes through the national 'Safer Environment and Activities' framework. To complement this, the DBF has developed and distributed additional local guidance across all parishes. These resources are 'Establishing Healthy and Appropriate Boundaries' and the 'Guidelines for Young Leaders: Safeguarding and Boundaries'. This is good practice.

6 Recognising, Assessing and Managing Risk

- 6.1 The DBF's Risk Register, reviewed in April 2025, addresses several critical areas, including various safeguarding components. However, safeguarding is not currently treated as a standalone priority within the document. To address this, the Audit recommends establishing a dedicated and separate Safeguarding Risk Register. Such a tailored approach would facilitate a more rigorous and granular assessment of risks, ensuring that both high-level strategic concerns and day-to-day operational challenges are managed with the necessary focus.

Recommendation D15: The DBF/DSAP should develop a standalone operational safeguarding Risk Register to allow for more focused scrutiny on the full range of safeguarding concerns, some of which might graduate to the strategic Risk Register held by the DBF. This should be reviewed and updated at a minimum cycle of quarterly.

- 6.2 The Diocese of St Edmundsbury and Ipswich Safeguarding Team operates a structured process for handling concerns, with the DSO and the Assistant Diocesan Safeguarding Officer (ADSO) taking the lead. Referrals and enquiries made to the DST are effectively triaged. All incoming concerns and referrals are initially triaged by either the DSO or ADSO. The crucial first step involves assessing the matter against the statutory definition for safeguarding to determine the appropriate threshold for action. If the concern does not meet this statutory criteria, the case will be risk assessed regarding immediate actions required. For concerns relating to children or vulnerable adults, the DSO ensures the referrer is supported to make the necessary referrals to agencies such as the Multi-Agency Safeguarding Hub (MASH) or related support networks.
- 6.3 In cases which relate to code of conduct disputes within parishes, the area archdeacon will be consulted. The diocese also has in place a mediation scheme which the

safeguarding team can signpost people to. If the referrer feels that the safeguarding team is not responding appropriately they can escalate that to the archdeacons/bishop's office/NST.

- 6.4 Over the last twelve months, the organisation recorded a total of 48 concerns which were formally registered as safeguarding incidents. In addition to these formal incidents, the team also handled 45 contacts which were specifically seeking safeguarding advice. Out of the total concerns that were referred to the Safeguarding Team within the same period, 15 resulted in a formal referral to statutory agencies. These essential referrals were directed to a range of appropriate statutory bodies, including the MASH, Adult Social Care, the Local Authority Designated Officer (LADO), Children's Social Care, the Police, and local Schools. In terms of current workload, the Safeguarding Team maintains a total of 175 open cases on the NSCMS, with 58 of these cases currently recorded as active and requiring ongoing intervention or monitoring.
- 6.5 The allocation of cases remains fluid to ensure operational efficiency. While the ADSO typically leads on matters requiring a church safety plan, the role of case manager for Safeguarding Case Management Groups may be filled by either the DSO or the ADSO. This distribution of tasks is influenced by current workloads, particularly if one officer is occupied with complex cases or significant administrative commitments. Furthermore, given the demanding nature of safeguarding work, case allocation is managed with a strong emphasis on personal wellbeing.
- 6.6 Building on the earlier recommendations regarding increased capacity, an expansion of the DST would necessitate a review of how casework and responsibilities are distributed. To ensure these additional resources are integrated effectively, the Audit makes the following recommendation.

Recommendation D16: If the recommendation to increase safeguarding capacity is adopted (see Part One, the Culture, Leadership, and Capacity section of this report), the DBF should review the DST's internal processes and case allocation methods. This review would ensure that personnel and resources are utilised as effectively as possible throughout the diocese. By adopting a more strategic approach to workload management, the DST can better balance logistical requirements with the specific professional expertise of individual team members.

Central to this activity should be the potential appointment of a dedicated Case Manager and a Deputy Case Manager, roles designed to streamline oversight and ensure clear lines of accountability within the team.

6.7 The National Safeguarding Case Management System (NSCMS) is a centralised and secure database, allowing for safeguarding concerns to be reported and recorded. There is also a facility to attach relevant case reports, quickly retrieve referrals to external agencies and record correspondence and documentation in one place. However, the DBF currently manages a substantial backlog of physical files that have yet to be digitised and integrated into the system. To address this transition gap and ensure data integrity, the following recommendation is proposed.

Recommendation D17: The DBF should commission an external resource to comprehensively review, cleanse, and curate the inputting of existing data into the NSCMS. This activity should operate under terms of reference set by the DSO and adhere to the 'Guiding Principles' for the NSCMS.

6.8 For those cases referred to the DST, outcomes typically involve one or more of the following:

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

- c) The provision / signposting to support
- d) The initiation of disciplinary processes, such as Clergy Disciplinary Measures (CDM)
- e) Initiation of the Safeguarding Case Management procedure (formerly Core Groups)

6.9 At the time of the Audit, there were fifteen respondents categorised as having active Church Safety Plans. The Audit saw effective use of these plans in managing risk. They were well-defined, proportionate to the identified risks, and appropriately authorised. Positively, the practice seen in the more contemporary plans adhere to the national template issued by the CofE, outlining what was working well, identifying risks and detailing the potential consequences of non-compliance. Furthermore, the review process for these safety plans is strong, incorporating representation from statutory agencies such as the Public Protection Unit and the Probation Service.

6.10 The Audit found the DST to be highly regarded for its professionalism and accessibility, with the team being described as "amazingly helpful" and "very, very supportive". Parish Safeguarding Officers reported a low threshold for engagement, noting that the team encourages contact regardless of the scale of the concern. Key members of the team were specifically praised for their ability to handle serious and difficult safeguarding issues with empathy and brilliance. While some administrative delays were noted due to high workloads and staffing pressures, the core safeguarding personnel were described as easy to reach in urgent situations and proactive in their oversight.

6.11 The Audit team met with an individual subject to a safety plan who was accompanied by the incumbent from their setting. The Audit also gathered valuable input from PSOs and other parish volunteers through focus groups and online surveys. The consistent feedback from these channels reinforced the Audit's main assessment; the management of individuals who pose a risk, including those who have sexually harmed, within the CofE presents a high risk. This highlights the critical need for robust oversight and support for

incumbents and reference group members involved in this vital task.

- 6.12 In recognition of the often-complex risks being managed through Safety Plans, and to further strengthen this critical area of practice, targeted training should be delivered for reference groups and the broader cohort of individuals involved in monitoring respondents. It is critically important that such training takes account of the context and complexities of such tasks within a faith-based environment.

Recommendation D18: The Audit recommends implementing targeted training programmes specifically designed for reference groups and the wider personnel responsible for monitoring individuals on safety plans. It is essential that the DBF ensures all training pertaining to risk assessments, safety planning, and broader offender management is contextually appropriate and tailored for use within a faith-based environment.

- 6.13 The Audit saw evidence of the effective use of Safeguarding Case Management Groups (SCMGs) (referred to as Core Groups) in managing complex cases involving church officers. These meetings consistently adhered to a structured agenda, ensuring that crucial elements, such as conflicts of interest and confidentiality, were addressed from the outset.
- 6.14 The DBF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. Support and practice guidance is available at a national level regarding SIR referrals. The Audit was informed that one case had met the threshold for a SIR in the last 12 months. The referral to the Charity Commission aligned with national guidance and the NST was appropriately informed.
- 6.15 The Cathedral has several information sharing agreements (ISAs) in place and follows the National Data Sharing Agreement with the Police. The Audit has identified that the current SLA in place between the Cathedral and DBF presents certain operational challenges regarding safeguarding oversight. As the safeguarding team does not have a regular

physical presence on-site, they are occasionally distanced from day-to-day activity. This can result in a delay in information reaching the team, which may limit their ability to provide timely support or intervention.

- 6.16 There is no defined escalation process to help manage differences of opinion about the decisions and action taken on safeguarding cases. Where such instances occur, the DST has access to guidance from the Safeguarding Regional Lead and / or the NST. Although escalation procedures for the Safeguarding Case Management Group (SCMG) are maintained in accordance with national guidelines, this Audit identifies a need for greater consistency and formal structure.

Recommendation D19: The DBF should implement a defined escalation process that provides a formal structure to managing differences of opinion as they relate to the decisions and actions on safeguarding cases. This process should be applicable to all staff within the DBF and Cathedral (subject to the provisions within the SLA/MoU).

- 6.17 A clear process is in place for assuring the quality of safeguarding cases. The DSO receives regular professional supervision from the NST's Regional Safeguarding Lead (RSL) for East Anglia. Indeed, the Audit highlighted the effective support provided by the RSL, particularly during recent events involving the DBF, the DST, and the Cathedral. To complement this arrangement, the DSO also attends monthly management supervision sessions with both the People Manager and the Diocesan Secretary. Internally, this extends to the wider DST, the DSO conducts monthly supervision sessions for each team member to ensure consistent standards and ongoing support across the department.
- 6.18 Measures are in place to ensure that personal information is stored and shared in compliance with the Data Protection Act 2018 and relevant regulations, including GDPR. To maintain these standards, staff across the DBF and the Bishop's office, including senior

clergy, undergo mandatory annual data protection training. Furthermore, the DBF supports its local communities by providing parishes with direct access to data protection guidance and specialist resources.

7 Victims and Survivors

- 7.1 The experience of abuse can have a deeply traumatic impact on individuals. Disclosing these experiences can be an incredibly vulnerable process, often accompanied by concerns about navigating systems, the possibility of re-traumatisation, or uncertainty about potential outcomes. To address this, it is crucial that Church bodies establish and maintain a safe and supportive environment. This will help to ensure that victims and survivors feel truly heard, supported, and protected, while also creating opportunities for the Church to learn and grow from their experiences.
- 7.2 The Audit evaluated the DBF's safeguarding response by gathering anonymous survey feedback from victims and survivors alongside discussions with key stakeholders and through content analysis of arrangements in place. That said, the Audit team lacked the opportunity for direct, face-to-face engagement with victims and survivors, and the survey response rate was quite low, which is not unusual.
- 7.3 The DST reports low levels of engagement with victims and survivors but recognises the need for increased outreach alongside its current work. To address this, the Audit recommends implementing diocese-wide listening events and additional feedback tools. This would help demonstrate a genuine openness to learning from those with lived experience and facilitate improvements to local support services.

Recommendation D20: The DBF should establish formal mechanisms for ongoing engagement with victims and survivors of abuse and their families. This should include the facilitation of diocese-wide listening events and implementing accessible feedback options, such as surveys.

- 7.4 The 'United in Solace and Grace' initiative is a collaborative outreach program between a

local parish priest and Survivors in Transition. It provides specialised ministry and support to victims and survivors of abuse, as well as their support networks, delivered by a team of ministers experienced in healing, counselling, and Trauma-Informed Practice. Following a successful inaugural service attended by the DST, there is a formal commitment to sustain this work, supported by a new website containing resources for other churches. Fully endorsed by the DSAP, the initiative includes the DSO and ADSO as primary contacts and focuses on establishing safe, church-based environments while enhancing the knowledge of those supporting survivors. Further, the Audit heard of plans to host a service in the Cathedral. This is an excellent initiative which extends beyond the Diocese to provide resources for others.

- 7.5 Building on the success of existing outreach, the Audit identified a desire for a dedicated chaplain for victims and survivors. This proposal should be evaluated in conjunction with the ongoing work of "United in Solace and Grace" to ensure a seamless integration of services. While investing in this role is recommended, care must be taken to prevent the duplication of efforts and avoid overburdening the individuals currently delivering these vital supports.

Recommendation D21: The DBF should invest in a dedicated chaplain for victims and survivors, integrating this role with the 'United in Solace and Grace' initiative. This expansion must formalise ongoing engagement while ensuring that new resources complement existing efforts without duplicating work or overburdening staff.

- 7.6 Survivors in Transition are actively involved in victim and survivor work throughout the Diocese. They have acted as advocates for victims and survivors of sexual abuse, worked to co-develop 'United in Solace and Grace' and are actively involved in DSAP. The Audit has also heard of signposting to a local service for victims and survivors during 'It's Not Okay' week, shared through DSAP. This is good practice.

- 7.7 The DSAP chair, DSO, and Survivors in Transition have co-produced a new strategy to improve engagement with victims and survivors. This approach aligns with past reviews such as the Independent Investigation into Child Sexual Abuse (IICSA) and PCR2, alongside House of Bishops guidance. It offers a high-level vision while providing the practical direction required to meet safeguarding benchmarks effectively. This strategy is located on the Diocesan website, under 'Safeguarding policies and templates'.
- 7.8 The Diocesan website's 'Safeguarding' webpage is a central hub for essential contacts. Contact information is available for the DSO and ADSO, alongside their working hours. Appropriate reporting mechanisms are available on the 'Report a safeguarding concern' webpage, which instructs that immediate concerns must be immediately referred to emergency services. Alternative reporting routes are signposted to, including contacting the local PSO, DSO or Bishop's Office. Contact information is also available for Suffolk County Council and the Police. Those reporting are also signposted to the Diocese's 'Safeguarding support services webpage', recognising the distress reporting can cause. Routes to disclosure are also made prominent through posters, flowcharts, and addressed verbally in local meetings and training.
- 7.9 The Diocesan website features a dedicated 'Safeguarding support services' page providing a comprehensive range of categorised local and national resources. These cover critical areas such as sexual abuse, domestic violence, addiction, and family support. The inclusion of the Dogs Trust 'Freedom Project', a dog fostering service for those leaving their home from domestic abuse, is particularly commendable, as it addresses a significant practical barrier to leaving unsafe environments. While the current directory is strong, adding links to local NHS services and accredited mental health providers would better support the Diocese in managing a prevalent safeguarding theme.

Recommendation D22: The DBF should expand the 'Safeguarding support services' webpage to include local NHS and accredited mental health resources to address prevalent safeguarding themes.

7.10 Overall, the Diocesan website provides valuable information for victims and survivors, supported by a formal commitment to prompt response and care. To strengthen this position, the Diocese should prominently feature the House of Bishops' 'Responding Well to Victims and Survivors of Abuse' guidance and its accompanying co-produced explainer videos. Additionally, the DBF should consider centralising these resources within a single, dedicated 'Victim and Survivor Support' webpage to improve accessibility.

Recommendation D23: To further strengthen its commitment to safeguarding and better serve victims and survivors of abuse, the DBF should enhance its existing 'Safeguarding' webpage by creating a dedicated, visible, and easily accessible sub-page specifically for victims and survivors.

Recommendation D24: The DBF should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

- a) Including a statement of commitment on a newly developed 'Victim and Survivor Support' subpage.
- b) Providing a direct link to the 'Responding Well to Victims and Survivors of Abuse' section of the Safeguarding e-manual.

7.11 The Audit were informed that the Diocesan Safeguarding Trainers recognise that safeguarding training may evoke a trauma response in some individuals. As such, the trainer facilitating the training session communicates that private or open support is available at any time. Furthermore, a consistent follow-up process is mandated for all disclosures made during or after the training.

- 7.12 The DBF demonstrates a commitment to victim and survivor support through innovative partnerships and a clear strategic vision. To further evolve this culture, the Diocese should focus on deepening direct engagement with survivors, formalising dedicated roles like a specialist chaplain, and streamlining digital access to support services. By centralising these resources and establishing consistent listening mechanisms, the DBF will ensure its safeguarding response remains proactive, accessible, and deeply rooted in the lived experiences of those it serves.

8 Learning, Supervision and Support

Safeguarding Learning

- 8.1 Safeguarding learning across the Diocese of St Edmundsbury and Ipswich is delivered in accordance with the Church of England's Safeguarding Learning and Development Framework. Training is provided across the core pathways including Basic Awareness, Foundation and Leadership, alongside additional modules such as Domestic Abuse awareness and Safer Recruitment. Training is delivered through a combination of online and face-to-face sessions, with flexibility around evenings and weekends to enable participation by clergy, staff and volunteers.
- 8.2 The Audit found that safeguarding training across the Diocese continues to be sustained through the commitment of the current training staff and safeguarding leadership. While delivery has been maintained, capacity pressures have limited opportunities for strategic development of safeguarding learning and evaluation of its impact. Training delivery has therefore relied heavily on the goodwill and commitment of a small number of individuals.
- 8.3 These pressures have also resulted in operational challenges. The Audit heard that there is currently a backlog in the assessment and certification of leadership training courses, which has begun to affect clergy licensing and other ministry processes. The current trainer's contracted hours do not provide sufficient capacity to undertake this assessment work at the pace required. Consideration should therefore be given to extending the trainer's hours to ensure that leadership course assessments and certification can be completed in a timely manner.

Recommendation D25: The Diocese should consider extending the safeguarding trainer's contracted hours to include dedicated time for the assessment and accreditation of leadership

training courses in order to address current delays and ensure training requirements for ministry roles are met promptly.

- 8.4 The Diocese has recognised these pressures and has taken positive steps to address them, including recruiting an additional part-time safeguarding trainer. This represents an important step towards strengthening the sustainability of safeguarding learning provision.
- 8.5 However, the Audit considers that further investment and structural support will be required if the Diocese is to develop a more strategic and responsive safeguarding learning culture. One option identified during the Audit is the development of DSAs with defined training portfolios who are able to contribute to training delivery alongside casework responsibilities. This blended model is used in other dioceses and can provide greater flexibility in training delivery while also strengthening the integration between safeguarding learning and safeguarding practice. See recommendation in the Culture, Leadership and Capacity section of Part One in this report.
- 8.6 Additional administrative pressures have also arisen through the migration to the Insight training platform. While the system has the potential to streamline the management of safeguarding training records and reminders, its implementation has generated additional workload due to technical challenges and the need for manual data entry while systems are stabilised. At present, training records are maintained across several systems, including internal spreadsheets and the diocesan contact management system. Because the national online training portal does not automatically integrate with diocesan systems, completion records often require manual updating. This creates additional administrative burden and increases the risk that records fall behind or that oversight of training renewal dates becomes inconsistent.

Recommendation D26: Short-term administrative support should be provided to assist with the migration to the Insight training platform, strengthen the maintenance of safeguarding training records, and address the current backlog in leadership training assessment and certification.

- 8.7 Despite these challenges, the Diocese has demonstrated innovation in its safeguarding learning approach. The development of the ‘Safeguarding & Me; An Introduction’ course provides an accessible safeguarding learning resource designed for young people and individuals who may struggle to engage with more formal safeguarding training pathways. This initiative reflects a thoughtful approach to inclusive safeguarding learning and has the potential to support wider engagement across the diocesan community.
- 8.8 The Diocese has also established a framework for volunteer trainers, creating three levels of involvement so that delivery can be extended to local contexts, especially in rural parishes. This has real potential but is currently limited by the team’s capacity to train and support new volunteers.
- 8.9 Responses to the diocesan workforce survey further indicate strong awareness of safeguarding responsibilities among respondents, with the majority reporting confidence in recognising safeguarding concerns and understanding how to report them appropriately.

Clergy Support

- 8.10 Clergy described generally positive relationships with the DST and reported that safeguarding staff are accessible and responsive when advice is required. During discussions with the Audit team, clergy highlighted that the safeguarding team are approachable and responsive to enquiries, noting that calls are typically returned promptly and that advice is available when safeguarding concerns arise within parish contexts.

- 8.11 Clergy also shared examples of situations in which the Diocese had provided support during challenging safeguarding matters, including circumstances where safeguarding decisions had generated conflict within parish communities. This support was viewed positively and contributed to clergy confidence in responding to safeguarding concerns.
- 8.12 A range of pastoral support mechanisms are available to clergy to help manage the emotional impact of ministry, including informal support from Rural Deans and Archdeacons and access to the Bishop's Advisor for the Pastoral Care of Clergy where additional support is required. Initiatives such as retreat voucher schemes and diocesan discussions on clergy wellbeing further demonstrate an awareness of the pressures clergy may experience in ministry. Those undertaking roles involving safeguarding responsibilities also receive input on managing the impact of disclosures through the Enhancing Pastoral Ministry programme.
- 8.13 At the same time, clergy reflected on the wider pressures associated with parish ministry. Managing safeguarding responsibilities within volunteer-led church environments can present challenges, particularly within rural communities where cultural change around safeguarding expectations may still be developing. While pastoral and line management support is available, some clergy expressed interest in opportunities for further reflective or clinical supervision to support the emotional demands associated with safeguarding work. The Audit understands that work is ongoing within the Diocese to strengthen support in this area.
- 8.14 The Audit also found that safeguarding is not consistently embedded within clergy induction processes. Ensuring that clergy begin their ministry with a clear understanding of safeguarding expectations, procedures and reporting pathways is an important component of safeguarding culture.

Recommendation D27: The Diocese should introduce a short mandatory safeguarding briefing for all incoming incumbents to ensure safeguarding expectations, processes and reporting pathways are clearly understood from the outset of ministry.

8.15 The Audit also considered the role of MDRs in supporting clergy wellbeing and safeguarding reflection. Evidence gathered during the Audit suggests that the MDR process has not been implemented consistently in recent years. Some clergy reported that they had not received an MDR within the expected timeframe, and the Audit found limited evidence of MDR records within clergy files.

8.16 Ensuring that MDRs are delivered consistently and provide a meaningful opportunity to explore safeguarding practice and clergy wellbeing will strengthen support for clergy across the Diocese.

Recommendation D28: The Diocese should ensure that Ministerial Development Reviews are undertaken consistently and within the expected timeframe, with safeguarding practice and clergy wellbeing forming a core component of these discussions.

Supervision and Support of Safeguarding Roles

8.17 The Diocese benefits from a safeguarding team led by an experienced Diocesan Safeguarding Officer with a strong statutory background. The Audit heard positive feedback about the professionalism and approachability of the safeguarding team, who operate within a collaborative working environment and maintain strong professional links with statutory safeguarding partners and wider safeguarding networks. These include the Suffolk Safeguarding Partnership Board Adults, and the Housing Sub-Group, and Area Safeguarding Network Forums (West and South).

8.18 Engagement in these networks supports the safeguarding team in maintaining professional standards and remaining informed about emerging safeguarding practice and

policy developments. Workforce survey responses further indicate that staff generally feel supported in their roles and confident in raising safeguarding concerns where necessary.

9 Conclusion

- 9.1 The St Edmundsbury and Ipswich Diocesan Board of Finance has cultivated a highly positive, resilient, and inclusive safeguarding culture. This commitment to continuous improvement is clearly evidenced by the successful implementation of the vast majority of recommendations from both the 2016 SCIE Audit and the 2022 PCR2 report.
- 9.2 Throughout the diocese, prevailing attitudes reflect an environment where safeguarding is increasingly recognised as a shared community responsibility rather than a siloed administrative function. This strong foundation is underpinned by the dedication of the DST and steady senior leadership during periods of significant episcopal turnover.
- 9.3 The diocese excels in prevention and safer recruitment, demonstrating strict adherence to national frameworks alongside innovative local practices, such as the clergy safeguarding passport system and the highly accessible 'Safeguarding & Me; An Introduction' programme. Crucially, the DBF demonstrates a deep, practical commitment to trauma-informed, survivor-led practice. The 'United in Solace and Grace' initiative, coupled with the active involvement of survivor advocacy groups in co-producing strategy, exemplifies a deeply compassionate approach to victim care.
- 9.4 Additionally, the DST showcases robust capabilities in managing complex risks with empathy and diligence. This is bolstered by structured triage processes, Church Safety Plans, and strong collaborative links with statutory agencies and the Cathedral. To ensure these strengths permeate fully into the wider worshipping community and remain sustainable, the DBF must prioritise recommendations structured around three critical pillars: capacity, safeguarding leadership, and governance.

- 9.5 The most pressing vulnerability identified during the Audit is the DST's current capacity, which operates under unsustainable pressure and relies heavily on staff goodwill. To secure operational viability, the diocese must establish a unified Safeguarding Directorate led by a Director of Safeguarding. This structural change must be paired with immediate, short-term resourcing to clear administrative backlogs. By relocating DBS check administration to Human Resources, commissioning external support to digitise physical files into the NSCMS, and extending the contracted hours of training staff, the diocese can alleviate bottlenecks and empower professionals to focus on proactive case management and parish support.
- 9.6 Alongside these capacity and leadership improvements, diocesan governance should evolve from observational oversight to a rigorous, three-year programme of systematic scrutiny, co-designed by the DBF, the DSAP, and the DSO. Leadership must also fully embed the actionable learning from the recent Cathedral Lessons Learned Review to ensure standardised, improved processes across both the DBF and the Cathedral. Furthermore, structural support for church leaders should be reinforced by introducing mandatory safeguarding briefings during incumbent inductions and ensuring the consistent, timely delivery of Ministerial Development Reviews.
- 9.7 To meet national standards and comprehensively support this governance framework, operational practices require further strengthening. Essential steps include securing Clergy Files in protective cabinets with strict access logs, formalising briefing and debriefing processes for Archdeacons, and establishing a highly trained, impartial (de-conflicted) pool of chairs for Safeguarding Case Management Groups. Risk management should be sharpened by implementing a standalone operational risk register and a formalised escalation process for professional disagreements.
- 9.8 Finally, to build upon its survivor-led initiatives, the diocese should expand continuous

engagement with survivors through formal, diocese-wide listening events, an enhanced digital support directory, and investment in a dedicated, integrated chaplaincy role.

- 9.9 Ultimately, the Diocese of St Edmundsbury and Ipswich has built an impressive, caring, and highly aware safeguarding environment. The fundamental building blocks of a safe church are securely in place, driven by a highly regarded workforce and deeply engaged volunteers. By addressing strategic capacity limitations and refining its governance structures, the diocese is exceptionally well-positioned to build upon its current momentum, ensuring it remains a safer, welcoming, and survivor-focused community for all.

Part Two - St Edmundsbury Cathedral

10 Context

- 10.1 St Edmundsbury Cathedral, a legacy of the historic Abbey of St Edmund, serves as the 'Mother Church' of the Diocese of St Edmundsbury and Ipswich and the seat of the Bishop. Originally a parish church dedicated to St James within the Abbey footprint, it became a cathedral in 1914. The building is renowned for its Gothic revival architecture and modern additions like the Millennium Tower, completed in 2005, which features a vaulted ceiling inspired by the 12th-century Bury Bible. Located in Bury St Edmunds, Suffolk, the Cathedral is a central hub for Christian worship, choral performances, and civic life, while also functioning as a major tourist destination adjacent to the Abbey Gardens and medieval ruins.
- 10.2 Situated in the prosperous market town of Bury St Edmunds, the Cathedral is integrated into the West Suffolk local authority. While not on a direct London main line, the town is well-connected via the East Anglia rail network to Ipswich, Cambridge, and Norwich, and the A14 provides essential road links. The Cathedral is a founding member of the Bury St Edmunds Tourism Partnership, collaborating with local entities like the Theatre Royal and Moyse's Hall Museum to promote town-wide initiatives and heritage events, ensuring its role as both a standalone destination and a key component of the regional tourism offer.
- 10.3 The population of Bury St Edmunds is approximately 45,700. The town and its surrounding areas are characterised by relative affluence and a high rate of employment, supported by the retail, education, healthcare, and tourism sectors. The population is predominantly White British, though it includes a growing number

of residents from other backgrounds, particularly Eastern European communities. The demographic profile features a mix of ages, attracting a significant number of families and retirees due to the area's high quality of life and green spaces.

10.4 In contrast to many urban centres, Bury St Edmunds experiences relatively low levels of deprivation compared to national averages. The Cathedral maintains strong civic and educational ties to address community needs, holding service level agreements with several local institutions. These include an Organ Scholar programme with King Edward VI School, and partnerships with Innov8 and Guildhall Feoffment School to provide outdoor spaces for alternative education and youth engagement.

10.5 In 2024, St Edmundsbury Cathedral recorded 70,741 general visitors. Weekly visitor averages fluctuate seasonally, peaking in the summer with approximately 1,600 visitors per week in July, compared to 1,200 in January and 1,500 in October. These figures represent general tourism and do not include the additional footfall from regular worship services, choral performances, Christmas markets, contemporary concerts, or the various educational programmes hosted on-site.

11 Progress

- 11.1 St Edmundsbury Cathedral was subject to an independent audit by the SCIE and was engaged in the Diocesan PCR2 process. A range of activity to improve safeguarding practice arose following these.
- 11.2 The Cathedral's SCIE report was published in September 2019, resulting in 29 'questions to consider', all of which were accepted. The Cathedral created a dedicated action plan in response, within which all except two considerations were included. While most were integrated into an action plan overseen by the Cathedral Safeguarding Committee, two areas did not feature, but only one of these remains unaddressed. This includes the creation of a formal training strategy. Further, CCTV installation in the main Cathedral was included and considered but subsequently decided against. The Audit recommends that all future recommendations are strictly included in subsequent planning. Notably, while the action plan omitted specific strategies for teaching children about personal safety and healthy boundaries, the Audit observed positive evidence of this being delivered effectively through storytelling and parables. Overall, the Cathedral has demonstrated significant progress in implementing the SCIE improvements.
- 11.3 The Cathedral took part in the Diocesan PCR2. Only one recommendation specifically pertained to the Cathedral which recommended improved recording of safeguarding concerns. In response, the Cathedral implemented a tracking system for recording concerns and even more recently, began to record concerns on the NSCMS. The Audit recognises that its application is more administrative rather than operational and this is addressed further in the *'Recognising, Assessing and Managing Risk'* section of this report.
- 11.4 The Cathedral has taken forward a range of internal reflective lessons learned activity,

resulting in improved practices for future events. The key learning points centre on a shift from general oversight to proactive risk management, focusing on tightening operational protocols and physical boundaries. Ultimately, the lessons highlight that safeguarding is most effective when it is embedded into the initial planning phase and supported by constant vigilance and clear emergency communication protocols.

- 11.5 An internal review was carried out in December 2024 reviewing the Cathedral's practice against the National Safeguarding Standards. Completion of the workbook highlighted several areas where improvement was required, with capacity for safeguarding emerging as a particular concern.
- 11.6 At the time of Audit, the commission of an independent LLR was initiated by the Diocesan Bishop in relation to a formal complaint made in response to the Cathedral's handling of a safeguarding concern. The main learning from this encompasses errors in following safeguarding procedures which ultimately stemmed from capacity and role constraints, whereby actions albeit unintentionally, had an adverse impact. The Audit was cited on this review at an early stage, so cannot comment on the progress of its recommendations.
- 11.7 In summary, St Edmundsbury Cathedral has made significant progress in improving its safeguarding practices. That said, while the Cathedral has demonstrated a transparent commitment to learning from procedural errors, sustained improvement will require embedding these lessons into formal, long-term operational planning.

12 Culture, Leadership and Capacity

- 12.1 When asked to describe the Cathedral's culture, both the workforce and the worshipping community consistently characterised the environment as welcoming, inclusive, supportive, and respectful. Feedback from one-to-one discussions and focus groups reinforced these sentiments, demonstrating a strong drive towards openness and collaboration. This commitment translates into practical action, evidenced by initiatives such as the Dementia-Friendly service, the relaxed 'Together on Tuesday' gatherings, and the promotion and provision of access to the weekly online 'Deaf Church'.
- 12.2 A majority of both groups stated they feel safe within the Cathedral and have observed tangible improvements in safeguarding arrangements. Furthermore, there is a clear consensus that a safeguarding culture is being successfully embedded. This growing confidence suggests safeguarding is increasingly viewed as a collective responsibility, making individuals more likely to reach out for support.
- 12.3 That said, there are notable differences in confidence levels between the workforce and the congregation. While a significant majority of staff reported feeling confident about raising conduct concerns without fear of reprisal, a substantial minority of the worshipping community were unsure or felt less confident. This indicates that the improved safeguarding culture is experienced more acutely by those involved in daily operations than by the wider congregation.
- 12.4 Feedback suggests the Cathedral would benefit from more outward-facing engagement. Although the profile of safeguarding has risen, some congregants noted that related communication can be irregular or less clear compared to internal staff updates.

- 12.5 The survey also reveals a need for further development regarding leadership and active listening. While most of the workforce, but only a minority of the worshipping community, feel leaders listen carefully to expressed opinions and concerns, the majority of the congregation are less confident, frequently reporting feeling neutral or unsure.
- 12.6 This disconnect is particularly pronounced concerning dedicated safeguarding leads. Most of the congregation either did not know or remained neutral when asked if these leads listen carefully to concerns, with only a minority explicitly agreeing. Within the workforce, while agreement was comparatively higher, just under half felt the leads listened carefully, with the remainder stating they were neutral or unsure.

Recommendation C1: To bridge the gap between the workforce and the worshipping community, and to increase confidence in leadership's responsiveness, the Cathedral should instigate an engagement and visibility programme that includes the following:

- a) Integration of a brief safeguarding update into regular congregation communications, such as weekly newsletters, service sheets, or pre-service announcements. This ensures the worshipping community receives information as consistently and clearly as the workforce.
- b) A *'You Said, We Did' Feedback Loop*, by publishing anonymised examples of how leadership and safeguarding leads have listened to and acted upon feedback or concerns. This directly addresses the high volume of 'neutral/unsure' responses regarding whether leaders listen, by demonstrating tangible proof of action.
- c) Introduce informal, regular drop-in sessions with Safeguarding Leads and Cathedral Leaders after services or during community events (e.g., coffee mornings). This personalises the safeguarding team, transitioning them from administrative figures to approachable, listening members of the community.

- d) Visibly display the process for raising concerns on noticeboards and the Cathedral website. These materials must explicitly emphasise the Cathedral's strict policy against reprisals to actively build confidence among the congregation.
- e) Rather than waiting for the next large-scale annual survey, implement short, quarterly 'pulse' surveys consisting of just three to four questions. These should specifically track the identified areas for improvement: confidence in raising concerns without reprisal, and the perception of leaders actively listening.
- f) Establish a dedicated focus group comprising diverse members of the worshipping community to act as a sounding board. This group can provide continuous, qualitative feedback on whether safeguarding communications are effective and if the cultural shift is genuinely reaching beyond the operational staff.

Leadership

12.7 The Dean clearly understands his role as the individual with ultimate oversight and governance accountability for Cathedral safeguarding. Throughout the Audit, there was strong evidence of his reflective and considered approach to this position. Crucially, he maintains a clear distinction between his strategic governance responsibilities and the operational safeguarding functions, which correctly reside with the Cathedral Safeguarding Officer (CSO).

12.8 He is highly respected for his consultative style and the Audit heard from a range of sources that he has successfully rebuilt trust between the Diocese and the Cathedral following historic tensions. This was evident in his excellent working relationships with the Acting Bishop, the Diocesan Secretary, and the Chief Operating Officer (COO), relationships characterised by a mutual desire to align the Cathedral more closely with the DBF.

12.9 The Dean is supported by a senior team operating under significant pressure, with key individuals managing multiple roles. This is most acute from a safeguarding perspective, as the COO currently also serves as the CSO. The Audit deems this an unsustainable arrangement. Whilst the Cathedral's SLT provided assurances that they are aware of the situation and plan to resolve it, the Audit will nonetheless make a formal recommendation in the Capacity section of this report to ensure the matter is addressed.

12.10 Over the past year, alongside preparations for the INEQE Audit, safeguarding has been a regular agenda item at Cathedral executive and operational meetings, including Bishop's Staff meetings. Discussions have covered youth initiatives (Launchpad and Growing Younger), mandatory Senior Leadership Safeguarding training, and complaints protocols. Furthermore, a focus on operational issues have included safer recruitment and DBS tracking, mandatory online listings of Parish Safeguarding Officers (PSO), reviews of drone and photography policies, and improved safety monitoring for choristers. However, whilst action points are reliably recorded, meeting minutes often fail to capture the reasoning behind these decisions. As a result, the Audit makes the following recommendation:

Recommendation C2: The Cathedral should ensure that all meetings, formal or informal, go beyond capturing actions and provide appropriate minutes that demonstrate the issues discussed and the actions (including rationale) agreed.

Governance

12.11 The Cathedral maintains a governance and oversight framework that fully aligns with the expectations of the Church and statutory bodies, including the Charity Commission.

12.12 Since achieving charitable status, St Edmundsbury Cathedral has exhibited a proactive and highly engaged approach to safeguarding governance, characterised by rigorous scrutiny at the Chapter level. The Audit found clear evidence of Trustees providing focused, appropriate challenge, maintaining an active commitment to tracking

recommendations from both national and local reviews, and demonstrating a readiness to commission learning reviews when necessary. Furthermore, the Chapter actively pursued an independent chair for the Safeguarding Committee, confirming the appointment through the NST to ensure objective oversight. This is good practice.

12.13 A review of meeting minutes indicates a culture of transparency and active risk management where concerns are met with appropriate curiosity and robust discussion rather than being minimised. For instance, the Chapter's willingness to debate police advice in favour of higher institutional moral standards demonstrates a highly mature safeguarding culture.

12.14 Leadership dynamics are equally strong, highlighting a constructive working relationship between the Senior Non-Executive Member (SNEM) and the Dean. This is exemplified by the SNEM stepping in to chair agenda items where a perceived conflict of interest could arise.

12.15 Notwithstanding the clear strengths evident at a governance level, the Audit identified several areas where the Chapter's approach could be further strengthened. First, the consideration of potential Serious Incident Reports to the Charity Commission must be fully captured in the minutes. Notably, a recent case lacked minuted evidence demonstrating that Trustees had weighed the necessity of such a submission. Second, the Chapter should formalise the current practice of the SNEM chairing conflict-of-interest items and in doing so include a 'wash-up' session at the end of meetings. Chaired by the SNEM with the Dean recused, this would provide members with a secure forum to raise concerns. Finally, governance capabilities should be enhanced during the next non-executive recruitment cycle by prioritising the appointment of an individual with extensive professional safeguarding experience. To address these issues the Audit makes the following recommendations:

Recommendation C3: To strengthen the Governance framework the Chapter should:

- a) Require clear written evidence in minutes whenever Trustees consider submitting a Serious Incident Report.
- b) Establish a formal agreement for the SNEM to lead conflict-of-interest matters and hold a private review session afterward without the Dean.
- c) Recruit a non-executive member with deep professional safeguarding experience during the next hiring cycle.

The Cathedral Safeguarding Committee

12.16 As a vital sub-committee of Chapter, the Cathedral Safeguarding Committee has demonstrated highly effective leadership. A notable strength within the current framework is the recent appointment of a suitably qualified independent chair, who provides essential objective scrutiny alongside an expanded committee membership. The Cathedral Safeguarding Committee's proactive approach has resulted in updated policies, seamless DBS tracking, and strong diocesan relations. Practical successes overseen by the sub-committee include the secure management of the *Noye's Fludde* production, the delivery of Safeguarding Sunday, and the approval of 'worry boxes' alongside the 'Ask Angela' initiative, with implementation currently being considered by the CSA/O. This commitment to accountability is further demonstrated by the decision to publish survey feedback using a 'You said... We did' format.

12.17 Moving forward, the Cathedral Safeguarding Committee must continue to focus on its approach to complex visitor dynamics. Specifically, it must help Chapter balance its inclusive mission with the overarching duty to protect staff and visitors from aggressive or highly disruptive individuals. Ensuring active oversight of safeguarding compliance by external contractors and event partners should also remain an area of heightened vigilance.

12.18 To maximise the sub-committee's impact, ensure continued oversight, and maintain good practice, a series of targeted recommendations should be implemented.

Recommendation C4: The Cathedral Safeguarding Committee should:

- a) Create a Safeguarding Risk Register to facilitate proactive, safeguarding-focused risk management.
- b) Remunerate the independent chair, aligning this with the process applied to DSAP chairs.
- c) Broaden and diversify the group's perspective by conducting a skills, diversity, and inclusion audit. This will guarantee representation that reflects the community, ensuring external voices are heard and key statutory partners (such as the local police sergeant) are actively engaged.
- d) Establish a framework for managing and reporting on low-level concerns.
- e) Enhance internal auditing processes to ensure alignment with the National Safeguarding Standards.

Capacity:

12.19 Despite strong accountability at the governance level, the Cathedral's operational resilience is severely compromised by capacity constraints. The observation that the Cathedral is most vulnerable when its team of clergy and staff are busy, under-resourced, and overstretched serves as a significant red flag.

12.20 Administrative resourcing is currently highly stretched, reliant on temporary contracts, and operating reactively rather than proactively. The impending INEQE Audit is placing immense pressure on staff, prompting the College of Deans to request emergency funding from the Church Commissioners for part-time administrative support. Crucially, auditor assessments highlight severe 'single point of failure' risks. The heavy reliance on a few key individuals means that staff turnover directly threatens safeguarding continuity, a vulnerability explicitly exposed when key staff departed prior to the 'Flooded' production.

- 12.21 Beyond immediate personnel shortages, several structural and policy gaps are straining operations. First, training capacity is hindered by external dependencies. Notably, Senior Leadership Safeguarding Training faced significant delays due to a lack of moderators at the Diocesan level, an issue that had to be formally logged as a risk.
- 12.22 Additionally, the Cathedral recently navigated complex casework where it was caught between police advice, warning that suspending a volunteer under a historic investigation could be deemed defamation of character and the moral and reputational risks of keeping them active. This friction highlights a critical structural gap in volunteer suspension protocols that requires urgent legal clarification at the National level.
- 12.23 Overall, while the Cathedral's safeguarding health is strong in compliance, its operational resilience requires long-term stabilisation. The vulnerabilities outlined above demonstrate that the current arrangements are unsustainable.
- 12.24 To resolve these systemic risks, it is imperative that the Cathedral moves to a new Safeguarding Directorate model. This approach centres on appointing a dedicated Cathedral Safeguarding Advisor/Officer (CSA/O) who is physically situated within the Cathedral yet formally integrated into the Wider DST.
- 12.25 This structural integration is vital because it ensures the CSA/O is overseen directly by a safeguarding professional, guaranteeing expert guidance, emotional support for complex casework, and strict alignment with broader Diocesan standards. Furthermore, embedding the role within a wider professional network creates automatic operational resilience, providing essential contingency cover for sickness, annual leave, or unforeseen circumstances.
- 12.26 By adopting this model, the Cathedral will permanently eliminate its single points of failure,

reduce its over-reliance on temporary or stretched personnel, and establish the robust, continuous safeguarding culture required to protect both the community and the institution.

Recommendation C5: Adopt a Safeguarding Directorate Model. To eliminate systemic risks and establish a robust safeguarding culture, the Cathedral should appoint a dedicated Cathedral Safeguarding Advisor/Officer (CSA/O) operating under a newly integrated Safeguarding Directorate model. This should ensure:

- a) On-site Presence of the CSA/O within the Cathedral to maintain visibility and immediate access for cathedral worshippers and the workforce.
- b) The CSA/O should be embedded in the Wider DST.
- c) The CSA/O should be supervised and receive support from the DSO/Director of Safeguarding for complex casework and align with broader Diocesan standards.
- d) In a single safeguarding directorate model the relationship with the RSL should primarily be with the DSO, who will be responsible for supervising the wider team.

That said, if the consolidated directorate model is not adopted the supervision could be provided by the RSL.

Chorister Safeguarding

12.27 St Edmundsbury Cathedral maintains an established choral tradition involving children drawn from a number of local schools. Unlike cathedrals with attached choir schools or boarding provision, choristers attend the Cathedral primarily for rehearsals and services and are transported to and from the site by parents or carers.

12.28 The music department is led by the Director of Music and supported by the Assistant Director of Music, scholars and a visiting singing teacher. These staff collectively deliver rehearsals, services and musical development for the choristers.

12.29 The Audit found that safeguarding awareness within the music department is generally

well embedded. Staff spoke confidently about their responsibility to remain vigilant during rehearsals and teaching sessions and demonstrated awareness of reporting procedures should concerns arise.

12.30 While the structure of the chorister programme appears to function effectively, it is delivered by a relatively small group of staff. As with many cathedral music departments, this creates a model that relies on strong relationships and continuity of personnel. This relational culture can be a strength but also requires careful attention to staffing resilience and clarity of safeguarding responsibilities.

Scheduling and Wellbeing

12.31 The chorister programme operates through a structured schedule of rehearsals, services and music theory sessions across the week. Given that choristers attend from a range of schools rather than a single attached school, staff may not always be aware of the wider academic or extracurricular commitments children are managing. As such, maintaining a flexible and responsive approach is particularly important.

12.32 That said, staff demonstrated a clear awareness of the demands that participation in a cathedral choir can place on children. During discussions with the Audit, music staff described remaining attentive to the energy levels, concentration and wellbeing of children during rehearsals and adjusting rehearsal structure where necessary. These adjustments may include modifying rehearsal pacing, balancing practical and theory sessions, or adapting expectations in response to the needs of the group on a particular day.

Parent and Chorister Views

12.33 Parents who participated in the Audit expressed generally positive views about the safeguarding culture surrounding the chorister programme. Parents described staff as attentive and proactive in responding to any issues raised and noted that safeguarding is openly discussed within the Cathedral community.

12.34 Parents highlighted the strong sense of community within the choir and the positive relationships formed between choristers across different age groups. Senior choristers often take on informal mentoring roles for younger members, helping them settle into the choir environment and offering support.

Chaperoning and Staffing

12.35 Choristers are supervised during their time at the Cathedral by music staff and a designated chaperone. The chaperone is present during rehearsals and services, ensuring that there is an adult focused specifically on supervision rather than musical leadership. This is good practice.

12.36 Parents reported that arrangements are in place to ensure an additional adult is present when required, including situations where the regular chaperone is unavailable. In such circumstances, individuals who have been appropriately recruited and hold relevant safeguarding checks may be asked to assist. The Audit also observed sensible decisions being made to ensure an additional adult is present where groups of choristers may require further support.

12.37 While these arrangements appear to function well in practice, the model relies on a relatively small number of individuals. The absence of clear succession or contingency planning could create vulnerability should key personnel be unavailable.

Recommendation C6: The Cathedral should review contingency arrangements for chorister supervision to ensure there is sufficient resilience should key staff or chaperones be unavailable.

12.38 The Audit heard that staff intend to mark Anti-Bullying Week with a reminder to choristers that the same expectations around behaviour and respect that apply in school also apply within the Cathedral. This is a positive initiative.

Physical Environment

12.39 Chorister activities primarily take place within the Cathedral's Song School and associated rehearsal spaces. The Audit heard that individual singing lessons sometimes take place in office spaces or other rooms within the Song School complex. Some of these rooms have visibility through windows or are located in areas with regular footfall from staff and choristers, which helps support safer one-to-one working practices.

12.40 Nevertheless, one-to-one teaching environments require careful management to ensure appropriate visibility and safeguarding assurance for both children and staff. The introduction of CCTV in key chorister areas would add an additional layer of safeguarding oversight and reassurance in this regard. See also recommendation in the Policies subsection of Chorister Safeguarding.

Recommendation C7: The Cathedral should install CCTV coverage in chorister areas, including the Song School and organ loft, to strengthen safeguarding oversight. This would provide additional assurance for both choristers and staff, particularly in areas used for rehearsals and one-to-one teaching.

12.41 The Audit also noted that the staircase leading to the Song School and associated chorister areas can be accessed from public areas of the Cathedral precincts, including the café and public toilets. While some rooms in this area are occasionally used for meetings or organised activities, the wider space is primarily used for chorister activity and should not ordinarily be accessed by members of the public or tourists.

Recommendation C8: The Cathedral should introduce a clear visual deterrent at the entrance to the stairway leading to the chorister areas, such as a rope barrier and signage indicating that the space is not open to public access.

Information Sharing and Recording

12.42 Music staff demonstrated an understanding of safeguarding reporting processes and described escalating concerns to the CSO where required.

12.43 However, the Cathedral's chorister recruitment model, which involves children attending from multiple schools, means that safeguarding oversight depends in part on effective information sharing with those schools. While informal communication appears to take place, the Audit found limited evidence of a consistent framework governing this information exchange.

12.44 Without clear agreements, there is a risk that relevant pastoral or safeguarding information may not always be shared promptly.

Recommendation C9: The Cathedral should ensure that appropriate information sharing arrangements are in place with schools attended by choristers, such as information sharing agreements. These arrangements should clarify expectations for communication relating to safeguarding, pastoral concerns and wellbeing.

Safeguarding Training

12.45 Staff working with choristers report completing Church of England safeguarding training and undergoing DBS checks prior to undertaking their roles. Induction processes include safeguarding expectations alongside other essential training requirements.

Recommendation C10: The Assistant Director of Music should undertake Church of England Leadership Safeguarding Training to support the safeguarding responsibilities associated with the role.

12.46 Given the level of responsibility held within the music department, the Assistant Director of Music would benefit from undertaking CofE Leadership Safeguarding Training.

12.47 Staff have also sought guidance from SEND teachers and other professionals to support inclusivity and accessibility within the choir. Positive steps taken include introducing coloured reading overlays at the start of the year so that all choristers have access to them, rather than individual children needing to request them or be singled out. This is good practice.

Policies

12.48 The Cathedral has safeguarding policies in place which apply to all activity involving children, including the chorister programme. These policies outline expectations for safeguarding practice, reporting procedures and the responsibilities of staff and volunteers working with children. The Cathedral has also produced a Chorister Handbook to serve as additional guidance for choristers and parents.

12.49 While safeguarding expectations are understood by staff, the Audit identified opportunities to strengthen policy guidance within the music department. The Cathedral has a Lone Working Policy in place. However, this does not explicitly address arrangements for one-to-one teaching within the music department, such as individual singing or instrumental lessons with choristers. Clearer guidance within the Chorister Handbook and music department policies would help ensure that expectations around supervision, visibility and safeguards during one-to-one lessons are consistently understood and applied.

Recommendation C11: The Cathedral should review music department policies and the Chorister Handbook to ensure that lone working arrangements relating to one-to-one teaching, including singing and instrumental lessons, are clearly defined and communicated.

12.50 The Audit observed that behaviour management within the choir appears to be handled confidently and appropriately by staff, with clear expectations communicated informally and issues addressed proportionately. However, the absence of a clearly documented

process creates the potential for inconsistency or misunderstanding over time. Formalising expectations would provide additional clarity for choristers, parents and staff, and reduce the risk of error in how behavioural concerns are managed.

Recommendation C12: The Cathedral should develop and document a clear behaviour policy for the choirs, outlining expected behaviours, consequences and escalation routes. This should be shared with choristers and parents to ensure expectations are clearly understood.

12.51 Choir trips and tours appear to be well planned and supervised, with staff describing thoughtful arrangements to ensure choristers are appropriately supported during off-site activities. Given that 'tech-free tours' have been utilised in the past, introducing a simple way for choristers to identify key adult contacts would provide an additional safeguard should a child become separated from the group.

Recommendation C13: The Cathedral should ensure that policies or guidance relating to choir trips include a requirement for each chorister to be provided with visible personal contact information, such as a lanyard or badge, identifying the key adult contact for the trip and relevant emergency contact numbers. This would provide an additional safeguard should a child become separated from the group.

13 Prevention

- 13.1 Recruitment processes are aligned with legislation, relevant policies, and guidance from the CofE. Those in identified roles undergo appropriate training on safer recruitment and have support readily available. Furthermore, job application packs include a clear statement of the Cathedral's 'commitment to safeguarding'. Once appointed, new staff must complete the required level of safeguarding training as a mandatory component of their induction. Arrangements are also in place at the Cathedral to routinely re-check staff DBS certificates every three years. This is good practice. That said, the Audit identified a small number of the workforce where this timescale had lapsed.

Recommendation C14: The Cathedral should review its records for DBS checks to ensure no other staff or volunteers miss the local requirement for three yearly re-checks.

- 13.2 The Cathedral's safeguarding statement is regarded as an effective companion to the organisation's comprehensive safeguarding strategy and its full suite of related policies. The statement is understood to articulate the Cathedral's commitment to safeguarding, clarify the established channels for raising concerns, define the specific responsibilities of the CSO, and incorporate a mandatory safeguarding code of conduct.
- 13.3 Beyond the core statement and strategy, the Cathedral maintains several complementary policies and documents designed to address specific safeguarding issues, manage risk, and provide detailed guidance on responding to concerns. Key examples of this specific guidance include the Safeguarding Complaints Policy, the Music Department Safeguarding Policy and Zoom Safeguarding Policy, and the Young Volunteers and Work Experience Policy. Furthermore, the Cathedral utilises specific direction through its Photographic Policy, Social Media Policy, and a range of privacy notices, such as the

Safeguarding Privacy Notice and the Photography and Filming in Churches Privacy Notice.

- 13.4 The Cathedral adopts a multi-layered approach to sharing good practice, utilising both formal representation and regular communication forums across various organisational levels. One aspect of the vertical integration of safeguarding expertise, is facilitated by the Cathedral Safeguarding Officer's membership of the DSAP. This creates a vital two-way channel: local, practical experiences and lessons learned at the Cathedral are escalated to the Diocese for broader consideration, while the Officer receives immediate policy updates, insights from complex cases, and strategic feedback. Furthermore, peer-to-peer forums are used to disseminate operational good practice across the network. A primary example of this is the bi-monthly meetings held via Microsoft Teams, which bring together Chief Operating Officers (COOs) from all cathedrals to share insights and coordinate efforts.
- 13.5 To ensure the awareness of safeguarding is raised, the Cathedral employs visible and accessible information as a key strategy. This involves the prominent display of safeguarding posters, which include the Cathedral Safeguarding Committee's details, local helpline contacts, and the Cathedral Safeguarding Strategy. These are strategically placed throughout the Cathedral and associated buildings, such as the Noticeboard, Pilgrims' Kitchen, and various meeting rooms, ensuring guidance and support are constantly visible. Furthermore, safeguarding information is integrated into the Cathedral's digital and print communications. This includes a regularly monitored and updated safeguarding page on the official website, a slide show featuring the Safeguarding Committee poster on the TV screens at the Cathedral entrance and Pilgrims' Kitchen, and inclusion in the weekly electronic and paper Bulletins. Moreover, all handbooks for staff, volunteers, choristers and the Pastoral Handbook feature a dedicated safeguarding section.
- 13.6 These measures have addressed a broad spectrum of concerns, ranging from the abuse

of children and vulnerable adults to sexual exploitation and domestic violence. The Cathedral has also extended its focus to include spiritual and discriminatory abuse, alongside contemporary safeguarding priorities such as modern slavery and human trafficking.

- 13.7 Building on these initiatives, the Cathedral has specifically used Safeguarding Sunday, a national awareness campaign, to highlight the importance of safeguarding within its worshipping life. During this dedicated service, the Cathedral addressed the congregation through prayers, sermons, and shared information about the Church's safeguarding responsibilities and procedures, integrating the message into the heart of its mission. Building on the insights gathered by the Cathedral from the previous year, the 2025 Dean's Q&A session was refined to ensure the message was as clear and accessible as possible. This considered approach proved highly effective, resulting in a streamlined delivery that was both warmly received and praised by the congregation.
- 13.8 The Cathedral's website serves as a primary digital hub, clearly outlining the organisation's commitment to safeguarding and providing essential resources for the community. By featuring a dedicated 'Safeguarding' section, prominently positioned within the main navigation menu, the site ensures that users can immediately access policy documents, understand the Cathedral's approach to safer recruitment, and identify key contact personnel. Furthermore, the platform offers explicit guidance on how to report a concern, ensuring that vital information is transparent and easy to find. In line with modern best practices, the website is fully optimised for mobile devices, ensuring that these critical safeguarding tools remain accessible to all users at any time.

Recommendation C15: The Cathedral should update its safeguarding webpage to ensure that reporting guidance is clear and prominent. Specifically, the site must explicitly instruct users to call 999 immediately if they have an urgent concern or believe someone is at risk of imminent

harm. Integrating this information more effectively will ensure that emergency procedures are unmistakable and easy to follow.

13.9 This Audit evaluated the Cathedral's educational offerings, with a particular emphasis on school visits and family engagement. Throughout the assessment, it was evident that there is a commitment to embedding safeguarding practices into every aspect of the Cathedral's operations. The Cathedral offers schools an immersive educational programme, utilising interactive learning and drama to engage students. A prime example is the story of St Edmund, which is brought to life through spirited reenactments involving wooden swords and arrows; this approach successfully blends light-hearted play with historical curriculum. From a logistical and safeguarding perspective, school visits are managed to maintain the required teacher-to-student ratios, along with other protocols in place. However, while the Cathedral proactively requests details regarding children's additional needs, there remains an inconsistency in how thoroughly schools provide this essential information. To address this, the following is recommended.

Recommendation C16: The Cathedral should:

- a) Formalise SEN Queries: Revise the Education Hub booking process to include a more rigorous form. This will ensure schools provide specific details regarding mobility requirements, neurodiversity, and toileting needs well in advance of their visit.
- b) Capture DSL Information: Proactively request the contact details for the school's Designated Safeguarding Lead (DSL) during booking to establish a direct line of communication for any serious concerns.

13.10 The Audit commends the work being done through 'The Yard Project', highlighting it as an example of good practice and innovation. The partnership with Innov8 Workshops provides tailored one-to-one sessions focusing on horticulture, outdoor activities, and crafts to offer crucial support to the most at-risk young people. This is good practice.

13.11 As with all good communication, this needs to be a two-way process. Actively seeking and responding to the views of children, young people and vulnerable adults is a key component to effective prevention planning. The Audit highlights the Cathedral's commitment to safety by facilitating age-appropriate discussions through active engagement with the Junior Church. By developing a culture of open dialogue, leaders have ensured that children and young people clearly understand who to approach if they have any concerns. Furthermore, the Audit noted that insights gained from these sessions have directly shaped the Cathedral's safeguarding strategy, particularly in how materials are displayed and how information is communicated to this younger demographic. The Audit concludes that there is scope to strengthen current practices by adopting a more formalised approach when engaging with children and young people. To address this, the Audit makes the following recommendation.

Recommendation C17: The Cathedral should establish engagement mechanisms to consider the needs, experiences and voices of children, young people within safeguarding prevention planning (see also the relevant recommendation in the DBF's 'Prevention' section in Part One of this report).

13.12 Arrangements are in place to manage safeguarding risks that are associated with the layout of the Cathedral building and its broader working environment. This can be seen in the risk assessments for different activities and the availability of a Lone Working Policy. In addition, guidance is available through the diocese on Establishing Healthy and Appropriate Boundaries and on working with volunteers who are under the age of 18.

13.13 The Audit observed a clear, recently updated pager system is in place with call points at the welcome desk, school, and offices to summon assistance, and protocols in place to mitigate the risks associated with lone working. While CCTV is currently in place, the Audit

notes that this is primarily for monitoring external areas (car park, office entrance), but coverage inside the cathedral floor is limited. To further enhance security and site-wide professional standards, the Audit team also recommended replacing small pin badges with highly visible, identifiable lanyards. This transition would ensure that staff members and their safeguarding credentials are more easily recognisable to both visitors and volunteers. To address these gaps, the following recommendations are made.

Recommendation C18: The Audit recommend the Cathedral replace small pin badges with identifiable lanyards. This would make staff and their safeguarding credentials more clearly visible to visitors and volunteers.

Recommendation C19: The Cathedral should expand CCTV coverage across the site. This should include, but not be limited to, key areas within the Cathedral itself, various entry and exit points, and specific sensitive locations, e.g. the education room and the choristers practice room.

14 Recognising, Assessing and Managing Risk

14.1 The Audit observed a considered approach to safeguarding at the Cathedral aimed at identifying, managing and mitigating risk. This framework includes having the relevant policies, procedures and guidance in place, as well as promoting a culture where everyone is aware of and responsible for safeguarding.

14.2 Safeguarding is included in the Cathedral's Risk Register and the Audit saw evidence of concerns and some control measures being recorded. It was not clear from the documents the Audit reviewed what the formal scrutiny and oversight processes are for this register, or how it is routinely updated. The Audit therefore recommends enhancing the Cathedral's risk register by incorporating more specific safeguarding risks through a dedicated safeguarding risk register. The Audit believes this would involve a more focused approach; for example, explicit reference to the potential risks associated with non-compliance with the DBS re-check process. Furthermore, these specific safeguarding risks should be clearly aligned with and overseen by the appropriate governance bodies, such as the Chapter, Safeguarding Committee, and/or any operational safeguarding sub-groups.

Recommendation C20: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral.

14.3 Safeguarding concerns at the Cathedral may be raised through several accessible channels. For visitors, contact details are clearly displayed on safeguarding posters throughout the Cathedral and on the official website, though individuals may also speak directly to any member of staff or a volunteer. Within the organisation, personnel are encouraged to report issues to the CSO or via a member of the clergy or staff, all of whom ensure such information is immediately passed to the CSO.

14.4 Once a concern is identified, the CSO determines the most appropriate course of action.

Details are recorded securely using the NSCMS. The CSO then triages each case, involving the DST or others as the nature of the situation dictates. The Cathedral operates in close partnership with the DST to ensure that all actions remain aligned with diocesan policy and national safeguarding standards. While the CSO oversees the management of day-to-day reports, the DST provides essential expertise and oversight for more complex matters.

- 14.5 Of the 64 concerns raised over the past three years, 30 were formally recorded as safeguarding incidents. The remaining 34 referrals were categorised as requests for professional advice or guidance. Regarding the activity of the previous 12 months, one specific case escalated to a level that required a formal referral to statutory authorities. Furthermore, there are currently four active safeguarding cases involving the Cathedral that remain open.
- 14.6 The Audit notes that while the Cathedral maintains records within the NSCMS, its current application is predominantly administrative. At present, the system serves as a repository for existing records rather than being utilised as a comprehensive, active case management tool. To address this and enhance operational oversight, the Audit highlights the benefit of appointing a CSO, as previously noted in the Cathedral's 'Culture, Leadership and Capacity' section of this report
- 14.7 The majority of people who responded to the Audit's survey of the Cathedral's workforce and worshipping community said they agreed that they "know who the safeguarding leads are" and are aware of "who to report safeguarding concerns to".
- 14.8 At the time of the Audit, there was one Safety Plan in place relevant to the Cathedral. Given that the Cathedral operates under a formal Working Agreement with the DBF, the DST holds primary responsibility for managing this case and providing the necessary

support. Accordingly, the broader effectiveness of the management of Safety Plans is set out in Part One of this report.

- 14.9 The Audit observed that one Safeguarding Case Management Group (SCMG) meeting had been initiated at the Cathedral in the last year. The broader effectiveness of case management by the DST and the convening of SCMGs is set out in Part One of this report.
- 14.10 The Cathedral is registered as a charity and has a legal requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. Whilst it has yet to make any SIRs, the Cathedral is alert to the need to follow the House of Bishops' guidance set out in 'Safeguarding Serious Incident Reporting to the Charity Commission'.
- 14.11 To facilitate effective information sharing, the Cathedral has several agreements in place. The operational relationship between the St Edmundsbury and Ipswich DBF and St Edmundsbury Cathedral is underpinned by both a formal Working Agreement and a comprehensive Data Sharing Agreement. In addition to these agreements, others are in place. For example, the Cathedral maintains a SLA with Innov8, granting them access to 'The Yard' and 'Old Orchard' for horticultural mentoring and youth holiday programmes.
- 14.12 Feedback from the Cathedral workforce was largely positive, particularly concerning their confidence in escalating concerns. However, this confidence may be undermined by a lack of formal documentation regarding professional disagreements. Although a "Safeguarding Complaints Policy" is in place to manage specific procedural grievances, the Audit found no evidence of a structured process for resolving general safeguarding disputes or the wider escalation of professional differences.

Recommendation C21: Relevant policies and / or procedures should be updated to include details on how safeguarding-related disputes are handled and to outline the appropriate escalation procedures.

14.13 The Cathedral demonstrates a commitment to compliance with UK data protection legislation and the UK General Data Protection Regulations (GDPR) in its security and storage of personal information. Data security is integrated into the workforce from the outset; all staff members with computer access undergo Data Protection training during their first week of induction. To support the secure sharing of information, the Cathedral provides dedicated email addresses to all lead and relevant volunteers, ensuring that sensitive data remains within a protected internal environment. Staff with regular data access must complete this training annually, while lead volunteers with similar access levels are also required to undergo formal training. Members of the Clergy refresh their data protection qualifications every two years. To supplement formal sessions, a "Do's and Don'ts" guide is distributed to all personnel as a practical reference for good practices. Furthermore, data security is a central focus of operations and it is a standing agenda item for the weekly diary and operations.

15 Victims and Survivors

- 15.1 The Audit was informed that the Cathedral follows the House of Bishops' guidance set out in 'Responding Well to Victims and Survivors of Abuse'. The Cathedral seeks advice and support when supporting victims and survivors of abuse through the Chapter's Operational Working Agreement with the DBF.
- 15.2 Aligning with the DBF's commitment, the Cathedral's 'Safeguarding' webpage outlines a prompt and caring response for those reporting concerns or disclosing abuse. The 'Safeguarding Concerns and Support' page provides clear instructions for contacting the police during emergencies. Additionally, both the website and physical posters effectively signpost a wide range of external resources, including advocacy, counselling, and specialised support organisations. Contact information is available for the CSO and the DSO, although presently, this is not as visibly accessible as it could be.
- 15.3 The Cathedral website provides valuable information to those seeking support. To improve support visibility to victims and survivors of abuse, the Cathedral should consider centralising resources within a single, dedicated 'Victim and Survivor Support' webpage to improve accessibility. Further, this webpage should feature the House of Bishops' 'Responding Well to Victims and Survivors of Abuse' guidance and its accompanying co-produced explainer videos.

Recommendation C22: To further strengthen its commitment to safeguarding and better serve victims and survivors of abuse, the Cathedral should enhance its existing 'Safeguarding' webpage by creating a dedicated, visible, and easily accessible sub-page specifically for victims and survivors. This should include key signposts, contact information, and appropriate policies/guidance.

Recommendation C23: The Cathedral should reinforce its commitment to ‘Responding Well to Victims and Survivors of Abuse’ by:

- a) Including a statement of commitment on a newly developed ‘Victim and Survivor Support’ subpage.
- b) Providing a direct link to the ‘Responding Well to Victims and Survivors of Abuse’ section of the Safeguarding e-manual.

15.4 Safeguarding information and contact details for the Safeguarding Team are made available via the Cathedral website and noticeboards in the Cathedral. That said, the Cathedral does not have formal printed or digital materials specifically outlining routes to disclosure and the process to be followed if someone reports abuse. This is an area which could quickly be strengthened.

Recommendation C24: The Cathedral should produce and distribute formal printed and digital resources that clearly map out the disclosure process and subsequent safeguarding procedures. These materials should be integrated into existing website and noticeboard displays to provide a transparent, step-by-step guide for those reporting abuse.

15.5 The Cathedral communicate that staff are available for conversations at any time and they encourage people to reach out in confidence. The Cathedral Safeguarding Committee (CSC) maintains a highly visible profile, notably on Safeguarding Sunday, where the congregation is encouraged to discuss concerns or share experiences with team members in person. This proactive engagement has prompted individuals to disclose both past and current concerns, enabling the Cathedral to provide immediate support, take necessary action, and build trust within the community. The Audit heard that feedback from these interactions has been positive with those who have come forward expressing gratitude for the empathetic, sensitive listening they received and valued having a secure environment for disclosure. These outcomes highlight the vital role of a visible safeguarding presence.

15.6 While the Cathedral maintains a formal and transparent Safeguarding Complaints process for victims and survivors seeking to raise concerns, the Audit identified a specific instance where a complainant was not notified of an outcome. Furthermore, communication errors have caused distress in the past, emphasising the need for greater care and sensitivity in all future correspondence. Although the current process includes defined response timescales, the Audit stresses that the Cathedral must ensure more consistent and reliable follow-up communication.

Recommendation C25: To ensure the safeguarding complaints process is restorative rather than distressing, the Cathedral must implement a mandatory communication protocol. This should include a timeline for regular updates and a formal requirement to notify complainants of all outcomes in writing.

15.7 The Audit heard of an instance whereby someone under investigation was included in Cathedral communications. To protect those who have raised concerns from further harm or distress, the Cathedral must exercise rigorous oversight in its messaging. It is essential to ensure that no individual currently under investigation appears as a public representative in any official Cathedral communications.

Recommendation C26: The Cathedral should establish a process for all official publications and public-facing communications to ensure that any individual currently under investigation is removed from all representative roles. This is essential to maintain public trust and prevent further distress to victims and survivors.

15.8 Frontline staff currently have access to practical guidance for assisting vulnerable adults, specifically regarding requests for financial aid, food, and external referrals. While this provides a good initial foundation, the Audit Team recommends developing support guidance or enhancing the current document with trauma-informed engagement techniques. Other key areas for improvement include more detailed guidance on crisis

management and appropriate handling of safeguarding disclosures.

Recommendation C27: The Cathedral should strengthen existing guidance by integrating:

- a) Practical trauma-informed communication techniques.
- b) Clear, step-by-step procedures for responding to individuals in crisis.
- c) Formal protocols for handling and recording sensitive disclosures.

15.9 Through its active participation in Safeguarding Sunday, the Cathedral has created an environment where individuals feel empowered to disclose both past and recent concerns. The Audit believes there is an opportunity to enhance outreach by partnering with the DBF to co-host listening events. This could promote a more proactive response to victims, survivors and their families, ensuring their voices are heard and inform future practice.

Recommendation C28: The Cathedral should partner with the DBF to co-host listening events, ensuring the voices of survivors and their families are heard and directly influence practice.

15.10 Ultimately, the Cathedral demonstrates a genuine commitment to providing a caring, empathetic response to disclosures of abuse. The Cathedral must now enhance the visibility of its support resources, formalise disclosure processes, and ensure consistent, sensitive communication during safeguarding processes. By integrating trauma-informed guidance and hosting collaborative listening events, the Cathedral can further empower survivors and ensure their voices directly influence future practice.

16 Learning, Supervision and Support

Safeguarding Learning

- 16.1 Safeguarding learning within the Cathedral reflects commitment and creativity, with staff demonstrating a good awareness of safeguarding responsibilities and reporting pathways. Training is delivered through the Diocese in line with the Church of England's Safeguarding Learning and Development Framework, with the Cathedral relying on diocesan trainers through its service level agreement to deliver core safeguarding training.
- 16.2 While this approach ensures alignment with national standards, it has limited flexibility in delivery. The Audit heard that access to diocesan trainers is not always available at the point of need, which can result in delays to refresher training for staff and volunteers. This also reduces opportunities for face-to-face learning, which some staff and volunteers would prefer.
- 16.3 The Cathedral has recognised this and has begun to develop its own internal capacity. The Audit heard that a member of the Safeguarding Committee is undertaking training to support the delivery of safeguarding sessions on-site. This is a positive step, which has the potential to improve accessibility and responsiveness of safeguarding learning.
- 16.4 There are also examples of effective safeguarding awareness and communication across the Cathedral. Safeguarding Sunday services have been used to reinforce key messages, with senior leaders demonstrating responsiveness to feedback by adapting content to ensure it is accessible and meaningful. In addition, safeguarding guidance developed for specific groups, such as bellringers, reflects a thoughtful and context-specific approach, including appropriate consideration of known and potential risks.

- 16.5 Opportunities remain to strengthen the Cathedral's approach to training sustainability and evaluation. As safeguarding capacity develops, consideration should be given to how future safeguarding roles, including any appointed CSO or strengthened diocesan support, could contribute to training delivery and the evaluation of learning to ensure it is having the intended impact on practice.

Recommendation C29: Consideration should be given to how future safeguarding roles can support the evaluation and ongoing development of safeguarding learning.

Clergy Support

- 16.6 Clergy described positive relationships with the DST and reported that safeguarding staff are accessible and responsive when advice is required. The Cathedral benefits from close working relationships with the Diocese, with safeguarding concerns routinely discussed and supported through diocesan structures.
- 16.7 A range of pastoral support mechanisms are available to clergy to help manage the emotional impact of ministry. These include informal support from senior clergy, including the Dean and Archdeacons, as well as access to diocesan support such as the Bishop's Advisor for the Pastoral Care of Clergy. Opportunities for reflection on ministry and wellbeing are also available through programmes such as Enhancing Pastoral Ministry, which includes input on managing the impact of safeguarding disclosures.
- 16.8 At the same time, clergy and staff operate within a context of limited capacity, with key individuals holding multiple roles across the Cathedral. This creates additional pressure and has implications for the time available to engage with safeguarding learning and reflective practice. While support structures are in place, there would be benefit in ensuring that opportunities for reflection and support are consistently embedded and accessible.

Recommendation C30: The Cathedral should ensure that structured opportunities for reflection and support are embedded within clergy and staff practice, including regular time for safeguarding reflection and discussion. This will help mitigate the impact of capacity pressures and ensure that safeguarding learning is consistently applied and supported across roles.

Supervision and Support of Safeguarding Roles

- 16.9 Safeguarding responsibilities within the Cathedral are currently held by a small number of staff, with the COO also undertaking the role of CSO, supported by a Human Resources and Safeguarding Administrator.
- 16.10 The Audit found that, while individuals in these roles are committed and engaged, the structure presents challenges in terms of capacity and role clarity. Holding safeguarding responsibilities alongside senior operational duties limits the time available for safeguarding activity, including oversight, development and engagement with safeguarding learning. These issues are explored further within the Culture, Leadership and Capacity section of Part Two of this report.
- 16.11 The Cathedral benefits from support and advice from the DST, and this relationship is a key strength. However, reliance on diocesan support does not replace the need for a clearly defined and sufficiently resourced safeguarding function within the Cathedral itself.
- 16.12 The Audit also notes that, while informal support is available, there is limited evidence of structured supervision arrangements specifically for those undertaking safeguarding roles within the Cathedral. Given the complexity and sensitivity of safeguarding work, access to structured supervision and opportunities for reflective practice would strengthen safeguarding provision and support those in safeguarding roles. See Culture, Leadership and Capacity section of this report for further detail.

17 Conclusion

- 17.1 St Edmundsbury Cathedral has demonstrated a clear commitment to cultivating a positive and well-embedded safeguarding culture. Following recent audits, the Cathedral has created a welcoming, inclusive, and secure environment underpinned by proactive governance, reflective leadership, and active community engagement. A major milestone in this progression has been the successful implementation of the vast majority of the 2019 SCIE recommendations, representing a strategic shift towards proactive risk management and tighter event protocols.
- 17.2 Leadership has largely rebuilt trust with the Diocese, maintaining appropriate boundaries between strategic oversight and operational safeguarding. The Chapter and the Cathedral Safeguarding Committee, strengthened by the appointment of an independent chair, demonstrate strong scrutiny, transparency, and a strong approach to risk management. Furthermore, the Cathedral enjoys collaborative relationships with the DST and excels in sharing good practice across regional networks.
- 17.3 Operationally, prevention and protection strategies are multi-layered and highly effective. Staff are vigilant, safer recruitment processes are robust, and safeguarding information is prominently visible. Standout initiatives, such as the 'Yard Project' for at-risk youth, immersive educational programmes, and active participation in Safeguarding Sunday, reflect a culture where safety is firmly embedded into the Cathedral's core mission. This is particularly evident within the chorister programme, where thoughtful inclusivity measures, dedicated chaperoning, and dynamic pastoral support have fostered high parental confidence. Additionally, an empathetic approach to disclosures creates a secure, trusted environment for individuals and survivors to come forward. Despite these notable strengths, sustaining this momentum requires a transition from administrative compliance to deeply embedded operational practice.

- 17.4 The most critical risk identified by the Audit is severe capacity constraint, which sits at the root of recent procedural challenges. Operational resilience is currently compromised by a reliance on overstretched key personnel managing multiple demanding roles. This creates structural vulnerabilities and single-point-of-failure risks, which is particularly acute within the small music team where clear contingency planning is urgently required.
- 17.5 Furthermore, while the workforce feels secure in raising concerns, a distinct disconnect exists between operations and the wider worshipping community. Congregants report feeling less informed and remain unsure if their feedback is actively heard by leadership.
- 17.6 To eliminate systemic vulnerabilities and ensure safeguarding remains resilient and sustainable, the Cathedral must address several strategic areas. Chief among these is capacity and structure. The Cathedral should adopt an integrated Safeguarding Directorate Model by appointing a dedicated, on-site CSO. Structurally embedding this role within the wider Diocesan team will alleviate unsustainable pressures on senior staff, clarify role boundaries, and ensure long-term operational stability.
- 17.7 Alongside structural changes, governance and community engagement require further refinement. Implementing a robust community visibility programme, featuring regular updates and active feedback loops, will build congregational confidence. Furthermore, governance practices must be strengthened by formally capturing decision rationales in meeting minutes, establishing strict conflict-of-interest procedures, developing a dedicated safeguarding risk register, and recruiting a non-executive Chapter member with credible professional safeguarding expertise.
- 17.8 From an operational perspective, safeguarding must be integrated into the initial planning stages of all future activities. Administratively, the NSCMS should transition from a purely

static repository into an active, dynamic risk management tool. Compliance and training can be significantly enhanced by enforcing three-yearly DBS re-checks across the workforce, developing a formal training strategy with rigorous evaluation, and embedding structured professional supervision and reflective practice for all staff and clergy.

- 17.9 Victim and survivor support also requires targeted improvements to ensure comprehensive care. The Cathedral should create a dedicated webpage for victims and survivors, produce step-by-step disclosure guides, and institute strict mandatory protocols for complaints to ensure communication remains sensitive and restorative. Partnering with the DBF to co-host collaborative listening events will ensure that survivor voices directly shape future practice.
- 17.10 Security and information sharing must also be upgraded to protect all site users. Expanding CCTV coverage to sensitive areas, including the Song School, organ loft, and Cathedral floor, introducing visual deterrents to restrict public access to chorister spaces, and replacing staff pin badges with highly visible lanyards will strengthen physical safety. Digitally, safeguarding pages must be updated to explicitly direct users to emergency services.
- 17.11 Alongside these immediate physical and digital protections, comprehensive safeguarding requires stronger, structured partnerships with the broader community. To formalise its youth engagement, the Cathedral should establish information-sharing agreements with local schools, proactively capture SEN and DSL details during bookings, and formalise mechanisms to incorporate the lived experiences of young people into prevention planning.
- 17.12 Ultimately, there is no doubt that St Edmundsbury Cathedral has built a strong foundation.

The dedication of its staff, the vigilance of its leadership, and a genuine commitment to the wellbeing of its community have resulted in a safeguarding culture that is both compassionate and highly effective. The vulnerabilities identified during this review do not reflect a lack of resolve, but rather the growing pains of an ambitious cathedral striving for best practice.

Appendices

18 Appendix 1 – DBF Recommendations

Recommendation D1: Administration and Reporting Line of the DSO

- a) To strengthen strategic oversight, escalation pathways, and accountability, the DBF should realign the DSO's reporting line from HR directly to the Diocesan Secretary. This facilitates the administration of sickness and leave, ensuring that capacity, risk, and systemic issues are appropriately escalated without compromising the DSO's operational independence.
- b) If the proposed Director of Safeguarding model is adopted, this post would manage the DST and be formally accountable to both the DBF and the Cathedral Chapter (via agreed reporting and assurance arrangements). This structure ensures a clear separation of strategic accountability from operational delivery, while promoting consistent diocesan-cathedral alignment, clear responsibilities, and robust safeguarding oversight across the diocese.

Recommendation D2: Before visits (formal or informal), the safeguarding team should provide each Archdeacon with a concise briefing pack: local safety plans, recent incidents, relevant national trends (e.g. rising domestic abuse, changing patterns of offending) and dashboard highlights for that Archdeaconry. After visits, Archdeacons should feed back in a short written debrief so that learning, emerging risks and practice gaps are captured and can inform safety planning, serious incident reporting and wider diocesan oversight.

Recommendation D3: To ensure impartial and appropriate chair selection, alongside suitable composition, environment, training, and ongoing support and supervision, the DBF should:

- a) Create a dedicated pool of suitably qualified individuals to act as chairs.

- b) Mandate rigorous conflict of interest checks for all prospective chairs prior to their appointment.
- c) Strictly limit the number of participants in core groups to maintain focus and efficiency.
- d) Ensure that any individuals with a conflict of interest are explicitly excluded from participating in the core group.
- e) Ensure all core groups operate within a neutral, trauma-informed setting.
- f) Implement mandatory foundational training for all core group members.
- g) Provide targeted training for Archdeacons and any others acting as chairs. This programme must cover their specific roles and responsibilities, advanced facilitation skills for highly sensitive meetings, and clear guidance on appropriate escalation pathways.
- h) Provide independent, professional supervision to ensure chairs are fully equipped and supported to manage the complex challenges inherent in these functions.
- i) Clearly establish and embed best practice regarding support and escalation pathways so that chairs are never left isolated when managing difficult situations.

Recommendation D4: To address the issues highlighted in the Audit's examination of Clergy Files, the DBF should:

- a) Introduce a robust access log within each Blue File to capture the signature and rationale for every instance of external access.
- b) Rectify file security by investing in fireproof, lockable cabinets for all active Clergy Files.
- c) Expedite the MDR process within a specific timeframe and ensure the DSO helps to integrate mandatory safeguarding themes into the review format.

Recommendation D5: To move from observational oversight to proactive scrutiny, the DBF should work with the Diocesan Safeguarding Advisory Panel (DSAP) to co-design a three-year programme of work. By aligning the DBF's ultimate accountability with the DSAP's independent assurance, the two bodies can establish a shared schedule of systematic,

thematic deep dives. Together, they should agree on specific DBF oversight questions and expectations of the DSAP, including the testing of policy and practice alongside data-driven impact analysis.

This programme should at a minimum encompass the following key areas:

- a) Mandate assurance from the DSAP, supported by the DSO and external audits, to demonstrate that the diocese is genuinely aligned with the National Safeguarding Standards.
- b) Confirm that DBF leadership is actively enabling a proactive culture of care, rather than a reactive culture of compliance.
- c) Use assessments from the DSAP and direct feedback from the DSO to ensure the DST possesses the necessary capacity, financial backing, and leadership support to deliver safe outcomes.
- d) Tackle issues highlighted by the DSAP, DSO, or other reviews by deploying specific, targeted financial or structural interventions to resolve them.
- e) Mandate the DSAP and DSO to evaluate the effectiveness of these protocols, requiring concrete evidence that they are actively mitigating risk.
- f) Ensure that operational risks identified by the DSAP or DSO are accurately captured and addressed on the DBF's strategic risk register.
- g) Gather input from the DSAP, the DSO, and, where appropriate, victims and survivors themselves, demonstrating that their voices remain central to the design and delivery of the diocese's safeguarding practices.
- h) Resource victim and survivor support structures effectively, and secure confirmation from the DSAP that survivors experience this support as timely, trauma-informed, and compassionate.
- i) Require the DSAP and DSO to confirm that insights from case reviews and audits are not just recorded but are systematically transforming frontline practice.

- j) Address areas where the DSAP, DSO, or other relevant sources have identified a failure to learn or improve and robustly test the corrective actions the DBF has taken in response.

Recommendation D6: To address these areas, the DSAP should:

- a) Establish clearer communication channels by ensuring the DSAP Chair has direct access to, and formal reporting lines into, the DBF) Trustees.
- b) Engage with the NST to develop and implement governance training for trustees to support their development and an enhanced oversight structure.
- c) Establish a formal annual safeguarding planning meeting led by the DSAP Chair, bringing together the DSO, Archdeacons, and Cathedral leads to coordinate activity and avoid duplication.
- d) Work collaboratively with the DBF to structure a three-year programme of scrutiny and reassurance.
- e) Consider creating targeted subcommittees or task-and-finish groups to focus on specific safeguarding themes.
- f) Develop a comprehensive risk management strategy to ensure strategic risks are escalated with the necessary force and urgency.
- g) Create a dedicated DSAP risk register to track and manage these risks effectively.
- h) Improve current data collection and analysis processes.
- i) Develop a more robust tracking and evaluation system for safeguarding training.

Recommendation D7: The DBF should ensure that all meetings, formal or informal, go beyond capturing actions and provide appropriate minutes that demonstrate the issues discussed and the actions (including rationale) agreed.

Recommendation D8: To consolidate the team, clear current backlogs, and build a sustainable approach, the DBF should:

- a) Establish a Safeguarding Directorate by reconfiguring the current DST into a unified Safeguarding Directorate led by a Director of Safeguarding. This structure must facilitate necessary conversations to ensure compliance with accountability structures while maintaining operationally independent safeguarding provision.
- b) Bring all safeguarding resources under this single, professionally line-managed specialist directorate.
- c) Integrate Cathedral Safeguarding within the Safeguarding Directorate. The CSAs should be physically situated within the Cathedral but professionally line-managed by the Diocesan Safeguarding Officer (DSO) or Case Management Coordinator.
- d) Explore how this integrated approach can provide operational contingency for both the DBF and the Cathedral, creating opportunities for potential cost-sharing.
- e) Appoint a Deputy DSO to bolster operational leadership and case management oversight.
- f) Strengthen team coverage by reviewing the balance of roles. Consider transitioning from dedicated trainers to Assistant DSOs (ADSOs) who hold a training portfolio, supported by a dedicated budget to commission specialist external training as required.
- g) Redesign the current 'Safeguarding Admin' position into a 'Safeguarding Team and Parish Support' role. This will refocus the function to filter calls and increase support for parishes (e.g., Safeguarding Dashboards), Archdeacons (e.g., Visitations), and training evaluations.
- h) Remove all standard DBS administration from the team's remit. In line with expected good practice, the safeguarding team should only engage with DBS disclosures containing blemishes or concerns.

- i) Establish clear career development pathways for all safeguarding professionals to aid retention, progression, and morale.

Recommendation D9: In order to address the immediate remedial needs the DBF should:

- a) Procure two fixed-term contract staff (for six to nine months) to immediately address the operational deficits. Their focus should be strictly on clearing the training backlog, addressing case management delays, and cleansing and updating records.
- b) Conduct a remuneration review benchmarked against current market rates to ensure the Diocese is positioned to attract and retain high-calibre personnel.
- c) Consider piloting the use of approved Artificial Intelligence (AI) tools to streamline general administration and minute-taking, freeing up valuable staff hours for core safeguarding duties.

Recommendation D10: The DBF should transfer DBS administration from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

Recommendation D11: To ensure the Parish Dashboard is effectively adopted and embedded across the diocese, the DBF should evaluate the most practical ways to support local parishes. This could include curating a suite of accessible resources on the safeguarding webpages, such as frequently asked questions (FAQs) and short explainer videos, to help users navigate and utilise the tool more efficiently. Before developing new content, the DBF should audit existing materials to avoid unnecessary replication and ensure that parishes are simply directed to the best available guidance.

Recommendation D12: To assure itself of the quality and impact of Parish Dashboard data, the DBF should define and adopt a Parish Dashboard quality assurance process. While it

should be built on the principle of 'working with' rather than 'doing to', this process should involve dip sampling to test the veracity of Parish Dashboard data.

Recommendation D13: The DBF should develop and implement a structured communications plan for safeguarding messages across its digital channels. This plan should include a content calendar outlining timely, considered safeguarding messages for regular inclusion in email newsletters (e.g., a dedicated section or recurring feature) and scheduled posts on relevant social media platforms. Content should be varied, covering topics such as policy updates, training opportunities, real-life examples (anonymised), reminders of reporting mechanisms, and messages promoting a culture of vigilance and support. The DBF should assign responsibility for content creation, approval, and scheduling, ensuring all messages are consistent, accessible, and align with current safeguarding guidelines. Regular review of engagement metrics should inform future content strategy to maximise reach and impact.

Recommendation D14: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, young people and vulnerable adults within safeguarding prevention planning. Such children and youth initiatives could be led by, and build upon the existing work of, the Growing Younger Team

Recommendation D15: The DBF/DSAP should develop a standalone operational safeguarding Risk Register to allow for more focused scrutiny on the full range of safeguarding concerns, some of which might graduate to the strategic Risk Register held by the DBF. This should be reviewed and updated at a minimum cycle of quarterly.

Recommendation D16: If the recommendation to increase safeguarding capacity is adopted (see Part One, the Culture, Leadership, and Capacity section of this report), the DBF should

review the DST's internal processes and case allocation methods. This review would ensure that personnel and resources are utilised as effectively as possible throughout the diocese. By adopting a more strategic approach to workload management, the DST can better balance logistical requirements with the specific professional expertise of individual team members.

Central to this activity should be the potential appointment of a dedicated Case Manager and a Deputy Case Manager, roles designed to streamline oversight and ensure clear lines of accountability within the team.

Recommendation D17: The DBF should commission an external resource to comprehensively review, cleanse, and curate the inputting of existing data into the NSCMS. This activity should operate under terms of reference set by the DSO and adhere to the 'Guiding Principles' for the NSCMS.

Recommendation D18: The Audit recommends implementing targeted training programmes specifically designed for reference groups and the wider personnel responsible for monitoring individuals on safety plans. It is essential that the DBF ensures all training pertaining to risk assessments, safety planning, and broader offender management is contextually appropriate and tailored for use within a faith-based environment.

Recommendation D19: The DBF should implement a defined escalation process that provides a formal structure to managing differences of opinion as they relate to the decisions and actions on safeguarding cases. This process should be applicable to all staff within the DBF and Cathedral (subject to the provisions within the SLA/MoU).

Recommendation D20: The DBF should establish formal mechanisms for ongoing engagement with victims and survivors of abuse and their families. This should include the facilitation of diocese-wide listening events and implementing accessible feedback options, such as surveys.

Recommendation D21: The DBF should invest in a dedicated chaplain for victims and survivors, integrating this role with the 'United in Solace and Grace' initiative. This expansion must formalise ongoing engagement while ensuring that new resources complement existing efforts without duplicating work or overburdening staff.

Recommendation D22: The DBF should expand the 'Safeguarding support services' webpage to include local NHS and accredited mental health resources to address prevalent safeguarding themes.

Recommendation D23: To further strengthen its commitment to safeguarding and better serve victims and survivors of abuse, the DBF should enhance its existing 'Safeguarding' webpage by creating a dedicated, visible, and easily accessible sub-page specifically for victims and survivors.

Recommendation D24: The DBF should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

- a) Including a statement of commitment on a newly developed 'Victim and Survivor Support' subpage.
- b) Providing a direct link to the 'Responding Well to Victims and Survivors of Abuse' section of the Safeguarding e-manual.

Recommendation D25: The Diocese should consider extending the safeguarding trainer's contracted hours to include dedicated time for the assessment and accreditation of leadership training courses in order to address current delays and ensure training requirements for ministry roles are met promptly.

Recommendation D26: Short-term administrative support should be provided to assist with the migration to the Insight training platform, strengthen the maintenance of safeguarding training records, and address the current backlog in leadership training assessment and certification.

Recommendation D27: The Diocese should introduce a short mandatory safeguarding briefing for all incoming incumbents to ensure safeguarding expectations, processes and reporting pathways are clearly understood from the outset of ministry.

Recommendation D28: The Diocese should ensure that Ministerial Development Reviews are undertaken consistently and within the expected timeframe, with safeguarding practice and clergy wellbeing forming a core component of these discussions.

19 Appendix 2 – Cathedral Recommendations

Recommendation C1: To bridge the gap between the workforce and the worshipping community, and to increase confidence in leadership's responsiveness, the Cathedral should instigate an engagement and visibility programme that includes the following:

- a) Integration of a brief safeguarding update into regular congregation communications, such as weekly newsletters, service sheets, or pre-service announcements. This ensures the worshipping community receives information as consistently and clearly as the workforce.
- b) A *'You Said, We Did' Feedback Loop*, by publishing anonymised examples of how leadership and safeguarding leads have listened to and acted upon feedback or concerns. This directly addresses the high volume of 'neutral/unsure' responses regarding whether leaders listen, by demonstrating tangible proof of action.
- c) Introduce informal, regular drop-in sessions with Safeguarding Leads and Cathedral Leaders after services or during community events (e.g., coffee mornings). This personalises the safeguarding team, transitioning them from administrative figures to approachable, listening members of the community.
- d) Visibly display the process for raising concerns on noticeboards and the Cathedral website. These materials must explicitly emphasise the Cathedral's strict policy against reprisals to actively build confidence among the congregation.
- e) Rather than waiting for the next large-scale annual survey, implement short, quarterly 'pulse' surveys consisting of just three to four questions. These should specifically track the identified areas for improvement: confidence in raising concerns without reprisal, and the perception of leaders actively listening.
- f) Establish a dedicated focus group comprising diverse members of the worshipping community to act as a sounding board. This group can provide continuous, qualitative

feedback on whether safeguarding communications are effective and if the cultural shift is genuinely reaching beyond the operational staff.

Recommendation C2: The Cathedral should ensure that all meetings, formal or informal, go beyond capturing actions and provide appropriate minutes that demonstrate the issues discussed and the actions (including rationale) agreed.

Recommendation C3: To strengthen the Governance framework the Chapter should:

- a) Require clear written evidence in minutes whenever Trustees consider submitting a Serious Incident Report.
- b) Establish a formal agreement for the SNEM to lead conflict-of-interest matters and hold a private review session afterward without the Dean.
- c) Recruit a non-executive member with deep professional safeguarding experience during the next hiring cycle.

Recommendation C4: The Cathedral Safeguarding Committee should:

- a) Create a Safeguarding Risk Register to facilitate proactive, safeguarding-focused risk management.
- b) Remunerate the independent chair, aligning this with the process applied to DSAP chairs.
- c) Broaden and diversify the group's perspective by conducting a skills, diversity, and inclusion audit. This will guarantee representation that reflects the community, ensuring external voices are heard and key statutory partners (such as the local police sergeant) are actively engaged.
- d) Establish a framework for managing and reporting on low-level concerns.
- e) Enhance internal auditing processes to ensure alignment with the National Safeguarding Standards.

Recommendation C5: Adopt a Safeguarding Directorate Model. To eliminate systemic risks and establish a robust safeguarding culture, the Cathedral should appoint a dedicated Cathedral Safeguarding Advisor/Officer (CSA/O) operating under a newly integrated Safeguarding Directorate model. This should ensure:

- a) On-site Presence of the CSA/O within the Cathedral to maintain visibility and immediate access for cathedral worshippers and the workforce.
- b) The CSA/O should be embedded in the Wider DST.
- c) The CSA/O should be supervised and receive support from the DSO/Director of Safeguarding for complex casework and align with broader Diocesan standards.
- d) In a single safeguarding directorate model the relationship with the RSL should primarily be with the DSO, who will be responsible for supervising the wider team. That said, if the consolidated directorate model is not adopted the supervision could be provided by the RSL.

Recommendation C6: The Cathedral should review contingency arrangements for chorister supervision to ensure there is sufficient resilience should key staff or chaperones be unavailable.

Recommendation C7: The Cathedral should install CCTV coverage in chorister areas, including the Song School and organ loft, to strengthen safeguarding oversight. This would provide additional assurance for both choristers and staff, particularly in areas used for rehearsals and one-to-one teaching.

Recommendation C8: The Cathedral should introduce a clear visual deterrent at the entrance to the stairway leading to the chorister areas, such as a rope barrier and signage indicating that the space is not open to public access.

Recommendation C9: The Cathedral should ensure that appropriate information sharing arrangements are in place with schools attended by choristers, such as information sharing agreements. These arrangements should clarify expectations for communication relating to safeguarding, pastoral concerns and wellbeing.

Recommendation C10: The Assistant Director of Music should undertake Church of England Leadership Safeguarding Training to support the safeguarding responsibilities associated with the role.

Recommendation C11: The Cathedral should review music department policies and the Chorister Handbook to ensure that lone working arrangements relating to one-to-one teaching, including singing and instrumental lessons, are clearly defined and communicated.

Recommendation C12: The Cathedral should develop and document a clear behaviour policy for the choirs, outlining expected behaviours, consequences and escalation routes. This should be shared with choristers and parents to ensure expectations are clearly understood.

Recommendation C13: The Cathedral should ensure that policies or guidance relating to choir trips include a requirement for each chorister to be provided with visible personal contact information, such as a lanyard or badge, identifying the key adult contact for the trip and relevant emergency contact numbers. This would provide an additional safeguard should a child become separated from the group.

Recommendation C14: The Cathedral should review its records for DBS checks to ensure no other staff or volunteers miss the local requirement for three yearly re-checks.

Recommendation C15: The Cathedral should update its safeguarding webpage to ensure that reporting guidance is clear and prominent. Specifically, the site must explicitly instruct users to call 999 immediately if they have an urgent concern or believe someone is at risk of imminent harm. Integrating this information more effectively will ensure that emergency procedures are unmistakable and easy to follow.

Recommendation C16: The Cathedral should:

- a) Formalise SEN Queries: Revise the Education Hub booking process to include a more rigorous form. This will ensure schools provide specific details regarding mobility requirements, neurodiversity, and toileting needs well in advance of their visit.
- b) Capture DSL Information: Proactively request the contact details for the school's Designated Safeguarding Lead (DSL) during booking to establish a direct line of communication for any serious concerns.

Recommendation C17: The Cathedral should establish engagement mechanisms to consider the needs, experiences and voices of children, young people within safeguarding prevention planning (see also the relevant recommendation in the DBF's 'Prevention' section in Part One of this report).

Recommendation C18: The Audit recommend the Cathedral replace small pin badges with identifiable lanyards. This would make staff and their safeguarding credentials more clearly visible to visitors and volunteers.

Recommendation C19: The Cathedral should expand CCTV coverage across the site. This should include, but not be limited to, key areas within the Cathedral itself, various entry and exit points, and specific sensitive locations, e.g. the education room and the choristers practice room.

Recommendation C20: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral.

Recommendation C21: Relevant policies and / or procedures should be updated to include details on how safeguarding-related disputes are handled and to outline the appropriate escalation procedures.

Recommendation C22: To further strengthen its commitment to safeguarding and better serve victims and survivors of abuse, the Cathedral should enhance its existing 'Safeguarding' webpage by creating a dedicated, visible, and easily accessible sub-page specifically for victims and survivors. This should include key signposts, contact information, and appropriate policies/guidance.

Recommendation C23: The Cathedral should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

- a) Including a statement of commitment on a newly developed 'Victim and Survivor Support' subpage.
- b) Providing a direct link to the 'Responding Well to Victims and Survivors of Abuse' section of the Safeguarding e-manual.

Recommendation C24: The Cathedral should produce and distribute formal printed and digital resources that clearly map out the disclosure process and subsequent safeguarding procedures. These materials should be integrated into existing website and noticeboard displays to provide a transparent, step-by-step guide for those reporting abuse.

Recommendation C25: To ensure the safeguarding complaints process is restorative rather than distressing, the Cathedral must implement a mandatory communication protocol. This should include a timeline for regular updates and a formal requirement to notify complainants of all outcomes in writing.

Recommendation C26: The Cathedral should establish a process for all official publications and public-facing communications to ensure that any individual currently under investigation is removed from all representative roles. This is essential to maintain public trust and prevent further distress to victims and survivors.

Recommendation C27: The Cathedral should strengthen existing guidance by integrating:

- a) Practical trauma-informed communication techniques.
- b) Clear, step-by-step procedures for responding to individuals in crisis.
- c) Formal protocols for handling and recording sensitive disclosures.

Recommendation C28: The Cathedral should partner with the DBF to co-host listening events, ensuring the voices of survivors and their families are heard and directly influence practice.

Recommendation C29: Consideration should be given to how future safeguarding roles can support the evaluation and ongoing development of safeguarding learning.

Recommendation C30: The Cathedral should ensure that structured opportunities for reflection and support are embedded within clergy and staff practice, including regular time for safeguarding reflection and discussion. This will help mitigate the impact of capacity pressures and ensure that safeguarding learning is consistently applied and supported across roles.

20 Appendix 3 – Glossary of Abbreviations

Abbreviation / Acronym	Full Form / Definition
ADSO	Assistant Diocesan Safeguarding Officer
CDM	Clergy Disciplinary Measure
CofE	Church of England
COO	Chief Operating Officer
CSA	Cathedral Safeguarding Advisor
CSA/O	Cathedral Safeguarding Advisor/Officer
CSC	Cathedral Safeguarding Committee
CSO	Cathedral Safeguarding Officer
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSAP	Diocesan Safeguarding Advisory Panel
DSL	Designated Safeguarding Lead
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
FAQ	Frequently Asked Questions
GDPR	General Data Protection Regulation
HR	Human Resources
IICSA	Independent Investigation into Child Sexual Abuse
ISA	Information Sharing Agreement
LADO	Local Authority Designated Officer
LLR	Lessons Learned Review
MASH	Multi-Agency Safeguarding Hub
MDR	Ministerial Development Review
NCMS	National Case Management System
NHS	National Health Service
NST	National Safeguarding Team

PCC	Parochial Church Council
PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
RSL	Regional Safeguarding Lead
SCIE	Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SEN	Special Educational Needs
SIR	Serious Incident Report
SLA	Service Level Agreement
SLT	Senior Leadership Team
SNEM	Senior Non-Executive Member
TOIL	Time Off In Lieu

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