

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

2025

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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 Peterborough DBF and Peterborough Cathedral, this involved the following:

- Over 390 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.
- 788 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, Cathedral and parishes.
- Five focus groups.
- A confidential contact form being made available via a dedicated webpage.
- In total, the Audit undertook 39 separate engagement sessions reaching 70 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, Peterborough DBF and Part Two, Peterborough Cathedral. This has been done to ensure that each audited body is able to focus on their own strengths and areas for identified improvement.
- 1.4 The report has been reviewed for factual accuracy by both the DBF and Cathedral.

Part One - Peterborough Diocesan Board of Finance

2 Context

- 2.1 The Diocese of Peterborough, founded in 1531, covers three counties: all of Northamptonshire, Rutland and the area of Peterborough (Cambridgeshire) north of the River Nene. The Diocese is covered by four local authorities, Rutland, West Northamptonshire, North Northamptonshire and Peterborough City Council.
- 2.2 Each county presents with diverse geographical, demographic, and economic characteristics. Northamptonshire, a historically rich county, faces challenges from local government reorganisation and pressures on public services amidst population growth. While known for its historical shoe industry and expanding logistics sector, the county's road networks can dilute a sense of unified identity. Efforts are underway to strengthen business connectivity and technological development, partly driven by the University of Northampton and various vocational colleges. Additionally, tourism and leisure are vital to the rural economy, leveraging the county's areas of natural beauty and historical importance. In this diverse context, the Diocese plays an important role in connecting communities across the county.
- 2.3 Rutland is England's smallest, rural county, centred on Rutland Water. It has a low population density and an economy based on agriculture and light industry. Peterborough is a fast-growing, diverse city with significant agricultural output and a booming logistics sector. It has benefited from regeneration funding and excellent connectivity, which have helped foster sustainability and high business start-up rates.
- 2.4 The Diocese is geographically organised into two archdeaconries: Oakham in the north and Northampton in the south. Each of these is further subdivided into six, creating a total

of 12 deaneries. The Diocese contains 347 parishes with 380 places of worship, serving a population of 971,000. An estimated 17,600 people participate in regular worshipping activity.

3 Progress

- 3.1 Peterborough Diocesan Board of Finance (DBF) has undergone both a SCIE Safeguarding audit and a PCR2. There were no recommendations from the PCR2, while the SCIE audit, published in April 2016, made 16 ‘considerations’. These considerations covered a range of issues, including capacity, safeguarding resources, the development of a strategic plan, diversifying membership of DSAP and establishing procedures for safeguarding complaints.
- 3.2 The DBF fully accepted the considerations from the SCIE audit and developed an action plan. This Diocesan Safeguarding Advisory Panel (DSAP) oversaw this plan, and all locally achievable actions were initially completed. Other recommendations were superseded by national workstreams. A subsequent review by the current Diocesan Safeguarding Officer (DSO) found that some of the actions had lapsed. The DSO and colleagues have since provided an updated report, highlighting ongoing or pending work. This work is particularly focused on the strategic plan, a review of the training strategy, and updating of complaints policies and procedures.
- 3.3 The 2019 PCR2 for Peterborough concluded without any recommendations, and was cited as *"an example to other Dioceses of Good Practice."* As a result, no action plan was developed. However, this was one of the earlier reviews, and its focus was very narrow, concentrating on file reviews rather than offering insights into policy and practice. After Peterborough’s PCR2, the terms of reference were changed to reinforce expectations regarding the areas for consideration and the need for evidence-based recommendations.
- 3.4 A number of Lessons Learned Reviews (LLRs) have been conducted within the DBF since 2015. However, their effectiveness and scope are uncertain, suggesting that their

completion and monitoring for improvement have been inconsistent. To address this, the DSO is now championing the regular undertaking of LLRs and is partnering with the relatively new DSAP to ensure these reviews lead to practical improvements.

- 3.5 An internal paper by the Diocesan Bishop and DSO, examining past core group practices and learnings, was presented to the Bishop's Management Group (BMG) in December 2024. Following this activity, there is a perception within the DBF that core groups are operating better than before, and this Audit concurs.
- 3.6 The DBF's safeguarding improvement journey is accelerating, despite starting with historical limitations and a false sense of security that arose from an early PCR2. Crucially, the DBF is now on a positive and forward-looking trajectory with a clear commitment to building a robust safeguarding framework.

4 Culture, Leadership and Capacity

- 4.1 The DBF is rebuilding from a low baseline, a position that during focus groups, one to one discussions and survey feedback was largely attributed to past issues. While progress is evident, some stubborn challenges remain. For instance, although 'supportive' and 'respectful' were the top two words used to describe the DBF's working environment, the third most popular reference (used by almost a third of respondents) was 'outdated'.
- 4.2 That said, the Audit clearly showed progress being made and that the culture is in a state of positive transition. There is evidence of active efforts to rebuild trust, improve safeguarding practices, and build a more supportive and inclusive environment. Crucially, the Audit observed a significant shift by the current leadership towards greater transparency and a willingness to learn from past mistakes.
- 4.3 Evidence of this progress is clear: surveys indicated that an overwhelming majority of the DBF workforce, parish workforce, and worshipping community report improvements in respect of the overall safeguarding arrangements. Furthermore, there is growing confidence in the ability to raise concerns.
- 4.4 While a significant majority of the parish workforce and worshipping community believe a safeguarding culture is becoming established in their parishes, confidence is less prevalent across the DBF itself, with just over half of the workforce sharing this sentiment.
- 4.5 To build on their commitment to improve the safeguarding culture, the current leadership will need to continue to invest in the good work already begun. Crucially, they must match their ambition for improvement with the capacity to deliver it. At present, the necessary

skills and capacity to fully embed this positive cultural shift remain underdeveloped. To address these issues and sustain cultural progress, the Audit recommends:

Recommendation D1: Introduce a quarterly DBF-specific safeguarding culture insight survey focused on staff confidence in the established culture, transparency, and effective concern-raising mechanisms. The goal is to achieve a measurable increase in DBF staff confidence (targeting an improvement beyond the current level of 'just over half') that a robust safeguarding culture is embedded within the DBF itself.

Recommendation D2: Formalise the current leadership's commitment to transparency by creating a publicly accessible report (for internal or external audiences as appropriate) that details the specific actions taken to address past issues. The DSAP should, in parallel, monitor the frequency and scope of proactive communication from leadership regarding safeguarding culture updates and actions (e.g., tracking the number of open forums held and the frequency of progress reports issued).

Recommendation D3: The DSAP should investigate and address the perception that the DBF working environment is 'outdated', focusing on any potential impact on effective safeguarding practice. In doing so they should, develop and implement a targeted action plan to improve systems and structures, monitoring the use of 'outdated' as a descriptor in subsequent cultural surveys.

Leadership

Diocesan Bishop

4.6 The new Diocesan Bishop holds ultimate accountability for safeguarding and has

unequivocally accepted this responsibility. Her leadership is central to the required remedial action and has been praised as a key driver in the recent positive change. Along with the DSO, she is credited with pushing the diocese from an unstable and potentially unsafe position to its current improving one. She is supported by an effective Bishop's Chaplain.

The Diocesan Secretary

- 4.7 The Diocesan Secretary² in post during the Audit, was considered to be detached from much of the work concerning investment in and support to the DST. This may be a legacy issue relating to historic working practice, but engagement, focus and a more obvious commitment to these matters will help strengthen the grip and pace of improvement.

Recommendation D4: Clarify and document the safeguarding responsibilities of all senior leaders to ensure that safeguarding activities across the diocese receive appropriate focus and support.

Suffragan Bishop

- 4.8 The Audit found no evidence of a meaningful 'safeguarding footprint' involving the current Suffragan Bishop, who is due to retire. The Audit welcomes the news that, at the time of writing, approval has been given for a replacement appointment.
- 4.9 Moving forward, consideration should be given to developing the Suffragan Bishop's role to better support the Diocesan Bishop. This development would help mitigate capacity and leadership issues and ensure continuity within their area of influence. For

² The Diocesan Secretary that was in post at the time of the Audit has now left the Diocese and an interim Diocesan Secretary is in post whilst a permanent is recruited.

example, the Suffragan Bishop could ensure clergy compliance with training, Disclosure and Barring Service (DBS) requirements, and Dashboard roll-out, as well as providing coordinated support to the Archdeacons in their safeguarding roles and responsibilities.

Recommendation D5: The new Suffragan Bishop should support the Diocesan Bishop in key aspects of the DBF's safeguarding improvement journey, such as issues related to compliance with training and DBS requirements for clergy, Dashboard roll-out and uptake across parishes and support to Archdeacons regarding their safeguarding functions.

Archdeacons

4.10 Archdeacons, (one on was on sabbatical at the time of the Audit), are deeply committed to safeguarding and perform a vital role within the diocesan structure. The Audit confirmed their collaborative approach and their proactive willingness to enhance their safeguarding focus. This was evident during both their formal and informal visits to deaneries and parishes.

However, discussions revealed that the Archdeacons could be better supported. They would significantly benefit from specific training regarding some of the more complex tasks they are asked, or volunteer, to carry out.

4.11 During the Audit's scrutiny, an examination of material linked to a previous core group starkly highlighted the need for improved training and support. The Audit's view is that the health and wellbeing of the victims and survivors impacted in such cases must be the central focus; their experience, and the need to ensure they are heard and supported, is key.

4.12 To achieve this, the approach must also take account of the needs of those who volunteer to chair or participate in such tasks. Therefore, individuals charged with these responsibilities must be properly trained and effectively supported. This support should specifically include access to reflective supervision, and any issues concerning an imbalance of power must be addressed at the earliest possible opportunity.

Recommendation D6: Establish a framework for both formal and informal parish visits to strengthen the safeguarding focus. This framework should require pre-visit briefings from the Diocesan Safeguarding Team (DST) to ensure Archdeacons are well-informed, to guarantee that contextually relevant safeguarding issues are explicitly prioritised as discussion points during all parish engagements, and to mandate post-visit debriefing sessions with the DST to capture key insights and inform broader diocesan strategy.

Recommendation D7: Implement mandatory, specialised training for Archdeacons and all Core Group participants to manage complex safeguarding tasks, including essential skills like trauma-informed practice and clear escalation pathways. Crucially, establish a formal system to ensure the health and wellbeing of those involved by providing guaranteed access to reflective supervision (potentially using an external qualified professional) during these processes. To uphold impartiality, formalise protocols for conflict-of-interest checks for all Chairs and actively address any imbalance of power within core groups at the earliest opportunity.

The Diocesan Safeguarding Officer (DSO)

4.13 The current Diocesan Safeguarding Officer (DSO) is a highly credible professional. They have a background in statutory safeguarding and have been central to establishing

improved safeguarding practice during challenging times. Overall, the DSO is a considerable asset to the DBF and the wider diocese and is key to their ongoing safeguarding improvement journey alongside the new Assistant Diocesan Safeguarding Officer (ADSO), (a former trainer).

4.14 The DSO has undertaken good work, often against the odds. They have carried a workload that is only sustainable because of their considerable goodwill and commitment (working significantly above and beyond). This is addressed in the Capacity section.

4.15 To position the DSO for a senior strategic leadership role, a targeted investment should be implemented. This will elevate the DSO's existing operational expertise into an executive-level influencing capability, fundamentally strengthening the DBF's overall safeguarding framework. This should encompass the following:

Recommendation D8: The Strategic Progression Pathway for the DSO should encompass the following:

- (a. A structured mentorship with an individual in a comparable strategic governance or executive role to impart high-level decision-making and stakeholder management skills.
- (b. Provide focused development in corporate governance and organisational finance to enable the DSO to effectively navigate and influence the executive and financial landscape of the Diocese.
- (c. Fund a relevant post-graduate qualification (e.g., Master's or Executive certification) to formally cement the DSO's strategic leadership capabilities and to equip them for future progression.

Governance

- 4.16 The DBF has faced significant challenges with its governance structures, which have been historically described as weak, outdated, and lacking effective oversight. This assessment is substantiated by a very low overall rating from interviewees, who characterised the governance and organisation as "disconnected, ineffective, and opaque." Crucially, this environment has created a risk where accountability for safeguarding may be compromised, as safeguarding was not a consistent focus of the DBF or other governance meetings until very recently. Furthermore, the DBF's operation of governance and oversight meetings, most notably the DBF itself, has not, until very recently, reflected the expectations of the CofE and external requirements, such as those issued by the Charity Commission. This shortfall is acknowledged as a critical issue.
- 4.17 Despite these historical weaknesses, positive steps are now underway to address the failings. The DBF has commissioned a Diocesan Governance and Leadership Review, which the Audit acknowledges as a commendable and proactive move. Key structural changes are in progress, including the proposed merger of the Bishops' Council and the DBF into a single body to streamline oversight. Additionally, the Diocesan Safeguarding Advisory Panel (DSAP) is undergoing a transition, including the appointment of a new chair with a credible background - signalling a commitment to improved safeguarding leadership.
- 4.18 The DBF's overall direction must now shift its governance focus from a merely observational or curious stance to one that actively exercises challenge, scrutiny, and the collection of evidence of impact.

Recommendation D9: Conduct a skills, inclusion and diversity audit when refreshing board membership. The aim should be to ensure membership at this strategic level reflects the community it serves and has the skills and abilities to ensure effective oversight and challenge. The DSO should be in attendance at all such meetings.

Recommendation D10: Implement a mandatory Trustee Induction and Refresher Training (every 2–3 years), focusing exclusively on the Board's strategic safeguarding governance. This training must distinguish between the Board's ultimate legal accountability and management's operational role.

Recommendation D11: The Board should appoint a Lead Trustee for safeguarding and establish a mechanism for regular, formal reporting to ensure continuous oversight.

Recommendation D12: Trustees must be equipped to approve, resource, and critically review the Safeguarding Policy and associated frameworks. Crucially, they must ensure safeguarding risks are fully integrated into the overall Risk Register, focusing on high-level threats, and clarify the duty for prompt recognition and mandatory reporting of Serious Incidents to regulators.

Recommendation D13: Prioritise a governance culture that actively promotes challenge and scrutiny. Trustees must be equipped to demand and interpret data-driven assurance reports on safeguarding performance, moving beyond anecdotal evidence. Furthermore, the Board must actively model the 'tone from the top' and ensure transparent record-keeping and clear documentation of decisions across all governance bodies to establish an unimpeachable audit trail for accountability.

4.19 A review of meeting minutes, beyond those of the Bishops' Council and DBF, which have only recently begun to fully address their safeguarding responsibilities, reveals little evidence that safeguarding is a standing agenda item or that issues are considered in depth. This is particularly noticeable in key meetings such as the Bishops' Leadership Team (BLT) and the Bishop's Management Group. Furthermore, whilst the DSO has an open invitation to attend (operational requirements permitting) they are not a member of either of these key groups.

Recommendation D14: Safeguarding must become a standing agenda item for all key oversight meetings, including the BLT and the Bishop's Management Group (BMG). This will mandate regular, explicit discussion of safeguarding compliance, strategy, emerging issues and when appropriate operational imperatives.

Recommendation D15: Up to and until the appointment of a Director of Safeguarding, the Diocesan Safeguarding Officer (DSO) should be invited to, and (operational commitments permitting) attend, all key oversight meetings. The DSO's presence is essential, as they are the ultimate authoritative decision-maker on all matters relating to operational safeguarding.

DSAP

4.20 While acknowledging the DSAP is in transition, the Audit notes the credible background of the new Chair who brings considerable experience to this role. His appointment represents a potential reset for the DSAP and this should be capitalised upon to accelerate the DBF's improvement journey. To this end, the Audit makes the following range of recommendations for the DSAP chair to strengthen the existing framework.

Recommendation D16: Formalise and reinforce the independence and demonstrable impact of the DSAP's scrutiny functions. Explore restructuring options or establishing operational subcommittees to strengthen its authoritative and independent role, addressing a key national and local governance concern.

Recommendation D17: Maintain the expansion of the DSAP's membership which includes a representative from a local charity (which covers mental health, foodbanks, homeless support) and continue to improve engagement with all statutory partners to ensure a comprehensive range of viewpoints.

Recommendation D18: Continue to enhance multi-agency relationships through regular one-to-one meetings with key statutory leads. Ensure active DSAP participation in relevant multi-agency forums and establish informal, efficient information-sharing channels.

Recommendation D19: Establish dedicated survivor focus groups or networks and facilitate regular 'listen and learn' events to ensure the direct lived experiences of victims and survivors inform and shape safeguarding practices.

Recommendation D20: Institute a cyclical approach to conduct in-depth reviews of specific safeguarding areas. This activity must be systematically aligned with National Safeguarding Standards to ensure comprehensive scrutiny over time.

Recommendation D21: Develop structured, quantitative frameworks for insight and oversight. These must target the National Safeguarding Standards and agreed areas of risk, need, and development to drive systematic and continuous improvement.

Recommendation D22: Strengthen internal scrutiny by commissioning regular practice audits of safeguarding processes. Further develop and maintain contemporary Risk Registers and develop measurable metrics to assess the actual impact of safeguarding interventions.

Clergy Files - Blue Files

- 4.21 The Bishop's Office effectively manages and secures the Clergy (Blue) Files within the existing system. The Audit noted positive practices are in place, including clear content identification, curation, and the alignment of CDM and other associated sensitive files.
- 4.22 Furthermore, the Bishop's Chaplain and the DSO both review these files upon receipt and before dissemination to another area. This process helps to ensure the accuracy of the Clergy Current Status Letters (CCSLs), which should be constructed to reflect the information held within the Clergy (Blue) File. This is considered good practice.
- 4.23 A log is maintained locally (on a PC) that records external access to the files. This is good practice. This could be further enhanced by the provision of a hard copy access log within the file that captures the signature and rationale for viewing by those who access this

sensitive material.

- 4.24 The current storage of these documents does not utilise secure, fireproof cabinets. To enhance the positive arrangements already identified and provide an added layer of security for these valuable records, this should be rectified.

The Diocesan Safeguarding Team

- 4.25 The Diocesan Safeguarding Team (DST) is well led and their impact acknowledged by those with who they work across the DBF and the parishes they support. The recent investment in the development and growth of the team is a strength as is their reconfiguration to an area-based model.
- 4.26 That said, it has historically been under-resourced, with periods of high turnover and a single person in post for extended periods. This has resulted in a backlog of cases, delayed training, and inconsistent support. It will take time to address these legacy backlogs.
- 4.27 The DBF's financial challenges, marked by its 'asset rich, cash poor' status and significant deficit, contributed to the low baseline from which the new safeguarding team started. Despite this difficult foundation, the team has already made significant progress. Over the last year, the team has expanded and, at the time of the Audit, consisted of three safeguarding professionals supported by administrative staff, including a Safeguarding Support Officer.
- 4.28 Capacity remains a significant challenge, frequently resulting in staff working beyond normal hours and feeling stretched. While recent recruitment has improved the skill

mix within the team, a broader range of expertise, particularly in areas such as adult safeguarding and offender management, would further strengthen their capabilities. Crucially, the DST is still over-reliant on a small number of key individuals, which significantly increases the risk of burnout across the team. Capacity remains a significant challenge, often leading to staff working beyond normal hours and feeling stretched. While recent recruitment has improved the blend of skills within the team, a broader mix of expertise, particularly in areas such as adult safeguarding and offender management would further strengthen their capabilities. Crucially, the DST remains over-reliant on a small number of key individuals, which significantly increases the risk of burnout across the team.

- 4.29 To address these immediate capacity and capability issues in the short-term, the following recommendations are made:

Recommendation D23: Appoint a Deputy DSO.

Recommendation D24: Appoint two fixed term contract staff (six to nine months) to immediately address the deficits in case management, cleansing and updating records and re-launching and supporting an enhanced adoption of Dashboards.

Recommendation D25: Implement a change to the Safeguarding Support Officer's role, renaming it the 'Safeguarding Team and Parish Support Assistant'. The aim is to refocus the function to include filtering calls, providing greater support to parishes (specifically regarding dashboards), assisting archdeacons (with Visitations), and supporting the evaluation of training.

- 4.30 Looking forward, it is important to consider the need for greater resilience and contingency and to address the perception that operational safeguarding is not independent of clergy influence. In order to achieve both objectives, it is crucial to differentiate between independent operational delivery and accountability and to consolidate professional safeguarding resources across the geography of the diocese.
- 4.31 To this end, the Audit proposes a consolidated Safeguarding Directorate. This would merge all professional safeguarding resources across the entire Diocese, and the Cathedral.
- 4.32 This directorate would be headed by an operationally independent Director of Safeguarding (DoS), who would serve as the ultimate authoritative voice on all safeguarding matters, thereby preventing clerical influence on decisions. The DoS would hold the authority to provide robust oversight, expert advice, and direction, enabling them to challenge senior clergy and Church bodies. They would also have a clear escalation pathway for concerns, including directly to the Director of the National Safeguarding Team (NST).
- 4.33 All professional safeguarding resources, including the existing DST and any Cathedral-based professional staff, would report directly to the DoS, clarifying the distinction between operational (casework/early help) and strategic responsibilities.

Recommendation D26: An operationally independent Director of Safeguarding (DoS) should be appointed to lead a new Safeguarding Directorate.

- a) The DoS should be the ultimate authoritative voice on all safeguarding matters, ensuring decisions are not influenced by clergy. They would assume the power and authority vested in the DSO role.
- b) The DoS should be empowered with the authority to provide robust oversight, expert advice, and direction, and the ability to challenge senior clergy and Church bodies when necessary.
- c) The DoS should have a clear pathway to escalate serious concerns directly to higher authorities, including the National Director of Safeguarding (NST).

Recommendation D27: The DBF should carry out a cost benefit analysis of the potential trade off regarding dedicated trainers versus ADSO's with a training portfolio and a budget to bring in specialist external training.

4.34 The Audit welcomes the fact that the most recent addition to the team comes with credible safeguarding experience from a complimentary statutory background. Moving forward, and when the opportunity arises to further strengthen the team (beyond the DSO), consideration should be given to recruiting individuals with a probation/MOSOVA and Adult Safeguarding background.

Recommendation D28: The DBF should consider a job share approach for future recruitment to the DST / Safeguarding Directorate. This would present an opportunity to strengthen the blend of professional safeguarding backgrounds in the DST.

Recommendation D29: The DBF should conduct a review of remuneration for safeguarding roles to ensure it aligns with market rates, thereby offering the best opportunity to engage high-quality personnel.

5 Prevention

- 5.1 Safer Recruitment is a priority for the DBF. The House of Bishops' guidance (Safer Recruitment and People Management) is followed, and processes are aligned to legislation. In general, practice exhibits many strengths. Personnel involved in the recruitment process receive essential training, job descriptions include a statement on the DBF's commitment to safeguarding and relevant information is easily accessible via the DBF's website. Furthermore, specialist advice regarding criminal records checks is available from their contracted Disclosure and Barring Service (DBS) provider.
- 5.2 The DBF is actively working to achieve greater consistency in its approach to DBS eligibility. A draft DBS and Training Eligibility Matrix has been developed and is currently being used to guide decisions. At present, the DBF consistently follows the eligibility criteria provided by a third party. The Peterborough Diocese Guild of Bellringers has also worked with the DBF to produce specific guidance for bellringers. This is good practice.
- 5.3 If a DBS certificate reveals concerning information (referred to as a "blemish"), the DSO or the Assistant DSO (ADSO) conducts a review. The DBF has a dedicated process to thoroughly assess the applicant's suitability for the proposed position, taking into account the information disclosed on their DBS Certificate. This is also good practice.
- 5.4 In the Audit's view, DBS processing falls within the remit of Human Resources. Within this process, safeguarding measures should be triggered if relevant information is disclosed on a confidential declaration form, or if a negative finding is identified during the DBS check itself.

- 5.5 The Parish Dashboard, a tool designed to support parishes with Safer Recruitment practices, is now available for wider use. However, the DBF has yet to put in place a clear, structured, and systematic plan to promote and encourage the adoption of this dashboard.

Recommendation D30: The DBF should implement a clear and systematic plan to encourage parishes to adopt the Parish Dashboard. This could involve actively communicating its benefits, offering user-friendly training and support, demonstrating its value and ease of use, and proactively addressing any concerns.

- 5.6 In addition, the Audit makes the following recommendation to support the 'self-assessment' dashboard tool as a system which facilitates dip sampling and quality assurance.

Recommendation D31: 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.

- 5.7 To ensure a strong preventive culture, safeguarding is a regular topic of discussion at all levels across the Diocese. The DSO provides bi-monthly updates to the Bishops Management Group (BMG). Archdeacons and Rural Deans also encourage discussions among parish staff and volunteers, highlighting a culture of safeguarding through the Archdeacons' Charge to Churchwardens. At the parish level, a 'Safeguarding Hub' group is being piloted in Wellingborough Deanery. This group purpose is to share learning, facilitate information sharing, and serve as a single point of contact with the DST. Clergy and licensed ministers also regularly discuss safeguarding during Safeguarding Sunday events and by making it a standing item at Parochial Church Council (PCC) meetings.

Additionally, the DSO's membership on the Peterborough Safeguarding Children Partnership Board (SCPB) demonstrates a commitment to broader safeguarding best practices and collaboration.

- 5.8 While the DBF does not maintain its own distinct Safeguarding Policy, it adheres to the House of Bishops' Safeguarding Policy, 'Promoting a Safer Church'. This overarching Church of England policy and its associated practice guidance are easily accessible through the safeguarding webpage³.

Recommendation D32: The DBF should develop a safeguarding policy that is specifically tailored to the unique needs and practices of the Peterborough Diocese.

- 5.9 The DST has established arrangements with other dioceses to facilitate the sharing of good practices and mutual learning. One aspect of this is the engagement of the DSO with the NST East Midlands Regional Network, led by the RSL. Since its inception in early 2025, weekly online "drop-in" sessions have been held via Microsoft Teams. The Audit heard that these sessions provide a valuable forum for participants to exchange good practice, pool resources, and support one another through discussions about their work. Feedback gathered throughout the Audit process indicated that opportunities for learning and sharing good practice could be strengthened.

³ <https://www.peterborough-diocese.org.uk/safeguarding>

Recommendation D33: To strengthen opportunities for learning and sharing best practices, the DST should first review its own operations, using the findings from this Audit to identify both strengths and areas for improvement. The team should then identify and learn from other dioceses that have been recognised for their strong practice. Finally, these valuable insights should be integrated into policies and support to enhance existing practices.

Recommendation D34: The DBF should facilitate regular face-to-face or virtual sessions, and/or networking events, for PSOs. These gatherings would provide valuable opportunities for PSOs to learn and share good practice with their peers.

Recommendation D35: The DBF should consider facilitating an annual networking event for PSOs. This event would allow PSOs to connect with peers and hear from leading safeguarding professionals on new and emerging themes relevant to their role. To ensure the success and sustainability of such events, the DBF should also make a provision for a dedicated budget.

5.10 The Diocese of Peterborough website plays a crucial role in communication, particularly evident in the coherent and well-presented "Safeguarding" section. The website's clean design, mobile responsiveness, and intuitive navigation make it user-friendly. The safeguarding webpages act as a central hub for collecting and sharing essential tools, resources, and guidance. For example, the PSO webpage introduces several new resources specifically designed to support individuals in this role. These include a revised PSO role description, an information and welcome pack, and access to the Safeguarding Dashboard with explanatory videos. Importantly, the webpage underscores the significance of the Safeguarding e-manual as a valuable source of information.

5.11 While the PSO webpage⁴ currently provides a wealth of useful information, its overall effectiveness could be improved.

Recommendation D36: The DBF should review the safeguarding and PSO webpages to introduce a clearer hierarchy for content, which would greatly enhance user navigation and the logical flow of information. Furthermore, the text used for hyperlinks should be more explicit, clearly indicating the content or destination that users can expect to find by clicking on them (e.g. the link to access national ‘Templates and resources | The Church of England’ could explain what types of resources are available).

5.12 The DBF manages its communications using a flexible planning tool, allowing for the scheduling of key strategic items while adapting to new needs throughout the year. Over recent years, Diocesan communications have focused on monthly mailings to various internal and external audiences, including specific communications like those from the DST to PSOs, all tracked via a CMS mailing system. However, communication regarding safeguarding has primarily focused on measures such as DBS checks, mandatory training, displaying parish safeguarding posters, and general safeguarding support. The Audit found that the DST has inherited a complex and challenging history. However, with the newly formed team, there is a clear aim for greater stability. Once this new team is fully established, the focus of communication is expected to broaden to more routinely include the sharing of positive safeguarding stories and a more direct approach to addressing specific areas of abuse.

⁴ <https://www.peterborough-diocese.org.uk/safeguarding/safeguarding-noshow/parish-safeguarding-officer-psy-update.php>

Recommendation D37: The DBF should develop a communication plan which embeds key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of the followers, adopting different techniques specific to the platform and utilisation of relevant awareness days, campaigns and events to amplify the message.

5.13 Safeguarding awareness has been promoted through other initiatives. At the Peterborough Diocese Ministers Conference in November 2024, the Diocesan Bishop delivered the opening address to approximately 200 attendees, focusing on the national safeguarding situation and the importance of fostering a healthy culture. Furthermore, the DSO has conducted local outreach, attending Deanery Synods and Chapter Meetings to raise awareness of safeguarding directly within communities. In addition, Safeguarding Sunday has been actively promoted each year, using national resources. This promotion has been carried out through both newsletters and social media channels. In 2024, a new twice-monthly version of the Peterborough Diocesan News (PDN) was introduced. This change has enabled the creation of themed editions focusing on specific issues, one of which was dedicated to safeguarding. Subject matter relating to safeguarding has been integrated into other editions, which includes references to training, Safeguarding Sunday, and the requirements for safer recruitment.

5.14 Across the Audit's surveys of the parish workforce, parish worshipping community, and DBF workforce, most respondents indicated that they had seen improvements in raising awareness about safeguarding.

5.15 As with all good communication, this needs to be a two-way process. Actively seeking and responding to the views of children, young people and vulnerable adults is a key

component to effective prevention planning. The Audit is aware that practice in this area could also be strengthened and makes the following recommendation.

Recommendation D38: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, vulnerable adults, and survivors within safeguarding prevention planning.

- 5.16 The Audit observed evidence of appropriate risk assessments for Church activities where potential safeguarding risks were identified.
- 5.17 In terms of the arrangements to ensure that DBF staff are sufficiently safeguarded and potential risks mitigated, there is a Lone Working Policy in place. Beyond the DBF, these issues are addressed in the Parish Safeguarding Handbook and supported by national guidance.
- 5.18 The CofE's code of safer working practice complements individual parish codes of conduct for volunteers in leadership positions and PCC members.

6 Recognising, Assessing and Managing Risk

- 6.1 At the time of the Audit, the DBF's Risk Register was found to lack clear review dates and contained outdated information, including references to former staff members as 'owners of certain risks'. That said, the DBF was in the process of reviewing the register to align it with an upcoming governance review. While noting this activity and the likely revisions to be made to the DBF's register, the Audit recommends creating a dedicated risk register for safeguarding, developed and overseen by the DSAP (with appropriate escalation to the DBF's risk register as required), this would allow for a more comprehensive and focused assessment of both high-level (strategic) and day-to-day (operational) safeguarding risks.

Recommendation D39: The 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 Following a period of significant flux, the DST is currently in a stabilisation phase with a positive trajectory noted by the Audit. This critical period is focused on developing and formalising the necessary processes and procedures to ensure standardised and reliable practice.
- 6.3 The DST acknowledged significant challenges with its data recording systems, and the figures it provided to the Audit represented the best available results. Over the last 12 months, 110 were concerns recorded on the National Safeguarding Case Management System (NSCMS). Of these, 45 were categorised as primary for 'advice', 55 were marked under other categories and 5 are not known. Of the current cases, there were 68 cases

open to the DST.

- 6.4 The Audit observed some good practice in the use of the NSCMS such as the application of 'Profile Flags' and the completion of summaries. The DST also makes good use of the risk grading function, assigning cases a level of 'high', 'medium' or 'low'. At the time of the Audit, eight concerns were marked as 'high' risk and 65 as 'low' risk. To strengthen this process, the rationale for risk grading and case prioritisation, along with clear timescales for actions and reviews, should be recorded in more detail.

Recommendation D40: As part of the triage process, the DSO should record the rationale for risk grading and the prioritisation of cases, alongside specifying timescales for action and any review of progress.

- 6.5 Despite these positive practices, there are issues with the coding of legacy data within the NSCMS. This, combined with the operational pressures affecting the DST's ability to compile records, has limited the Audit's confidence in the sufficiency of the DBF's arrangements in this area. These deficits need to be addressed urgently. In addition to the recommendations in the 'Culture, Leadership and Capacity' section of this report, the Audit proposes the following to minimise this identified risk.

Recommendation D41: In keeping with Recommendation D24, 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.

- 6.6 It is positive that the Audit's surveys across the Diocese found that most were aware of the safeguarding leads within their settings and how to report a safeguarding concern.

Indeed, the DST was noted as operating a deliberately 'low threshold' that helps to encourage reporting and ongoing communication from those who might be worried. 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)

6.7 Despite finding positive practice in the quality of the responses provided by the DST, the Audit did identify instances where the team failed to respond in an adequately timely manner. Whilst not reflecting good practice, the Audit is clear that capacity constraints have been the cause of such circumstances, as opposed to any other issues. This is addressed in previous recommendations outlined in the 'Part One, Culture, Leadership and Capacity' section of this report.

6.8 In relation to case work allocation, the team is presently trialling a geographical model. The outcomes of this approach will be monitored and regularly reviewed to allow for adjustments to enhance its efficacy.

6.9 The Audit team met with an individual subject to a safety plan, and separately, with a PSO who is managing another individual under a different Safety Plan. 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.

- 6.10 The Audit observed significant challenges in managing individuals who pose a risk in church settings, which stemmed from several factors, including the dynamic nature of the risk itself. The Audit acknowledges the considerable and ongoing efforts by the DST, which has involved restructuring and updating existing Safety Plans and ensuing all have a corresponding risk assessment. The Audit found that the risk assessments in place were appropriate and effectively prioritised the safety of victims, potential victims, and other vulnerable individuals.

Recommendation D42: The DBF should implement a systematic process for the review and updating of all safeguarding risk assessments and safety plans associated to active cases. This process should include assessing new or evolving risks and revising control measures, ensuring continuous alignment with current good practice, integration of lessons learned from incidents (if any), and reflect a contemporary understanding of risks. These updates should adopt the current "Standard risk analysis and risk management" format.

- 6.11 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. Recommendations in this regard are set out in the Learning, Supervision, and Support section of this report.

Recommendation D43: The DBF should ensure that any training related to risk assessments, safety planning and wider offender management is contextually fit for purpose in a faith-based environment.

- 6.12 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.
- 6.13 Since the end of 2024 the NST's East Midlands' Regional Safeguarding Lead has been in post, meaning the DSO now receives consistent supervision and support. This has also introduced a degree of quality assurance activity.
- 6.14 Whilst information sharing between the police and the CofE is governed via a national data sharing agreement, the Audit found limited knowledge about this document or evidence of its use to guide practice.

Recommendation D44: The DBF should raise awareness of the National Data Sharing Agreement between the National Police Chiefs' Council and the Church of England within the Diocese and raise the profile with police forces through the NST.

- 6.15 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, the DSAP, and other safeguarding colleagues (such as statutory partners where appropriate or other Diocese safeguarding teams). If there are differences of opinion about safeguarding cases

with external organisations, the DST can refer to the other organisation's escalation policy. At parish level, issues can be escalated to the DST. Regarding a formal complaints process, the DBF is still developing one, but an interim solution is currently in place.

Recommendation D45: 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.

6.16 The DBF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission for England and Wales. In the last 12 months, one case has met the threshold for a SIR and whilst aligning with the national guidance issued by the Charity Commission, this particular submission was not shared with the NST.

Recommendation D46: To ensure national oversight, facilitate consistent practice and learning across the Church of England, and support strategic policy development, the DBF should share copies of all safeguarding-related Serious Incident Reports (SIRs) with the National Safeguarding Team (NST).

6.17 To ensure that the security and storage of personal information comply with UK data protection legislation and the UK General Data Protection Regulations, staff and clergy (who are in a DBF role), as well as all Archdeacons, receive Data Protection Training funded by the DBF every two years.

6.18 The Audit process revealed that there is a clear need for improved understanding and agreement between Peterborough Cathedral and the DBF regarding the services outlined and provided within their existing Service Level Agreement (SLA).

Recommendation D47: The Dean and Chapter of the Cathedral and the Diocesan Board of Finance (DBF) are advised to work together to review and update their existing Service Level Agreement for safeguarding services. This revision should specifically integrate the conclusions and recommendations from this report, particularly those concerning the capacity of the DST as outlined in the "Culture, Leadership and Capacity" section of Part One. The aim of this collaborative effort is to achieve enhanced clarity, improve efficiency, and strengthen overall safeguarding practices.

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 In evaluating the DBF's response to this vital safeguarding standard, the Audit gathered feedback from victims and survivors via an anonymous online survey. The Audit team also conducted one-to-one discussions with victims and survivors to listen to their individual experiences.
- 7.3 Those in key roles are actively confronting the profound negative impact and harm caused by past safeguarding failures. The current DSO and Diocesan Bishop are diligently working to rebuild trust and cultivate positive relationships with those who have been affected. It is understood that some apologies have been issued for unsatisfactory past experiences. There is a commitment to promoting a culture of openness and kindness within the Diocese, openly acknowledging previous shortcomings and the damage inflicted.
- 7.4 The Diocesan website's 'Safeguarding' webpage is a central hub for essential contacts. It provides contact information for the DSO, Assistant Diocesan Safeguarding Officer (ADSOs), the Safeguarding Support Officer, out-of-hours support (via Thirtyone:eight), and the police. A downloadable list on the 'Support and Useful contacts' subpage

signposts individuals to various survivor support organisations, ensuring a wide range of options are readily available. These include Action on Elder Abuse, Childline, MIND, Rutland Social Services, Samaritans, and the Survivors Trust. However, feedback from some survey participants indicated that they had not received adequate direction to external support. This reinforces the need to ensure signposting is as accessible as possible and includes relevant information covering each local authority area within the Diocese's boundaries.

Recommendation D48: The DBF should include more localised signposts in its contacts information. This should include:

- a) Social Services, Children's Partnership and Adults Board information for West Northamptonshire, North Northamptonshire, Rutland and Peterborough.
- b) Local Domestic Abuse services, e.g. Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership, Freeva and Northamptonshire Domestic Abuse Service.

7.5 To ensure the Diocesan website is a safe and reassuring online space for victims and survivors, it is crucial to maximise the accessibility of information. By creating a dedicated subpage for victims and survivors of abuse, the DBF can enhance visibility and ensure individuals can quickly find the assistance they need, which in turn reinforces confidence in the support provided.

Recommendation D49: 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.

- 7.6 The Diocesan Bishop and DSO have highlighted lessons learned from the Makin review and have sought to raise awareness through reminding congregations that survivors are present in every community. The DBF is actively working to enhance its provision for victims and survivors, demonstrating a strong commitment to fully align with all aspects of national guidance 'Responding Well to Victims and Survivors'. To reinforce this dedication, the DBF could issue a statement of commitment to following 'Responding Well to Victims and Survivors' and signpost directly to this section of the Safeguarding e-manual.

Recommendation D50: 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.

- 7.7 Via the DST, the DBF has demonstrated its commitment to building positive working relationships with Safe Spaces and promoting its services across the Diocese. The Audit found several examples of this effective collaboration. The DST worked closely with Safe Spaces to assist an individual who was seeking information from the Diocese. In another case, the DBF also contributed towards the costs of counselling, allowing the individual to choose their own provider. This is considered good practice, and there are plans to further strengthen this relationship. Once the Redress Scheme is operational, the DST has also offered to support individuals with their applications. Overall, the current DST is having a positive impact on victims and survivors of abuse, helping them to feel validated and supported, regardless of where their abuse occurred.

- 7.8 The DST demonstrates a trauma-informed approach with staff and volunteers by offering training sessions in a one-on-one capacity and in various environments. This flexible, relational approach is a good practice that accommodates the needs of individuals who have experienced abuse.
- 7.9 The DBF is considering several initiatives to improve its support for victims and survivors. Consideration is being given to finding ways to better incorporate survivor feedback and learning into safeguarding practices. The DSO is also exploring the creation of publicly available resources and assessing the availability of Independent Sexual Violence Adviser (ISVA) and Independent Domestic Violence Adviser (IDVA) services throughout the Diocese.
- 7.10 While survey feedback indicated that some felt their voices were not being heard as part of shaping safeguarding practice, the DBF is keen for this to improve and to find better ways of influencing future safeguarding measures. As recognised by the DBF, this needs to be a priority going forward. Recognising the inherent complexities in this area, the Audit recommends that the DBF investigate broader engagement strategies, including listening events at the Diocesan level and beyond.

Recommendation D51: The DBF should consider how it will proactively engage with those who have experienced abuse within the Church and their families, to learn from authentic voices and determine priorities for improvement planning. This should be done through implementing formal feedback mechanisms, such as surveys, feedback forms post engagement, and co-facilitated listening sessions.

8 Learning, Supervision and Support

Safeguarding Learning

- 8.1 The Audit found that safeguarding training across the Diocese has been largely sustained through the dedication of the current ADSO. While this has kept core training provision going, capacity constraints have significantly limited the scope for evaluation, strategy, and innovation. It is positive that the DBF recognises the issues it faces and is actively recruiting a new Safeguarding Learning and Development Officer. However, one appointment alone will not be sufficient to build a resilient and responsive learning culture. Additional capacity will be needed if the DBF is to shift from fire-fighting to forward-planning.
- 8.2 Although capacity issues remain the overriding factor for the DBF, indicators of good practice were apparent to the Audit. The DBF has previously facilitated reasonable adjustments for training including utilising BSL interpreters and support for individuals with lived experience. Additionally, a safeguarding overview session was provided to staff to help them better understand the safeguarding issues that may arise in the context of spiritual direction. The trainer also has taken part in the NST's Trainer Network days to receive national updates, share good practice, and develop confidence and skills in delivering safeguarding training.
- 8.3 That said, much of the current delivery remains reactive. To reduce waiting lists, the ADSO continues to deliver leadership-level training. Whilst this is commendable, it is not a sustainable arrangement. Volunteer trainers offer Basic and Foundation modules in some parishes, including offering on-to-one sessions and ensuring that barriers to completing safeguarding training are lowered. Whilst this is positive, and the DBF are rightly seeking

to nurture this relationship through training events in the summer of 2025, it provides only limited relief to the DST in meeting wider training demands.

- 8.4 In recognition of this, a recent survey was used to explore whether current volunteers would be willing to expand their remit. The Audit supports this direction and considers the expansion of the volunteer trainer network (or the recruitment of additional capacity) as a necessary step toward rebuilding its training offer.

Recommendation D52: The DBF should recruit (short- or long-term) additional training capacity, such as paid part-time trainers or a formalised volunteer delivery team. This would reduce pressure on the ADSO, allow time for strategic oversight, and improve resilience across training delivery.

- 8.5 While training records are in place, gaps in oversight were identified that the DBF are actively working to address. Notably, online training completed via the portal had not been consistently recorded on the DBF's central system. The incoming Learning and Development Officer will need to lead a significant programme of work to raise the overall sufficiency of learning provision to a good standard. The Audit recommends the following approach.

Recommendation D53: The new Learning and Development Officer should implement a more structured and strategic approach to safeguarding learning, including:

- a) Streamlining a centralised, accurate training record system with tracking and follow-ups (including portal learning);
- b) Developing robust feedback and impact evaluation processes, including post-course and longer-term evaluations;
- c) Updating the Safeguarding Training Strategy and Training Programme, informed by a Diocese-wide training needs analysis;
- d) Consider options for introducing contextual learning on topics such as trauma, elder abuse, neurodiversity and working with those who have offended.

Clergy Support and Ministerial Reviews

8.6 The DBF offers a range of pastoral support pathways to clergy, lay leaders, and their families who may be affected by safeguarding-related trauma. This includes immediate advice and debrief support via the DST, pastoral oversight by Archdeacons and Rural Deans, and formal counselling provision through the Pastoral Care and Counselling Adviser. The commitment to resourcing mental, emotional, and spiritual wellbeing is clear and well-embedded within Diocesan culture.

8.7 The role of the Pastoral Care and Counselling Adviser provides an accessible and confidential entry point into therapeutic support, with the DBF funding initial counselling and, where necessary, extending sessions based on ongoing need. In addition, the DBF has demonstrated flexibility by offering support to lay people significantly impacted by safeguarding cases. Collaborative working between the DST, senior clergy, and external professionals (e.g., registered therapists) is a strength. Those who access support have reported positive outcomes.

8.8 While there is a strong infrastructure in place, audit findings indicate that uptake of formalised support (particularly among clergy) is relatively low. There is a risk that some clergy and lay leaders are unaware of the support available or may feel reluctant to engage. Furthermore, support is largely offered on a self-referral basis, with no embedded expectation of reflective practice or regular pastoral supervision for those repeatedly exposed to safeguarding trauma.

8.9 Additionally, existing safeguarding oversight within the MDR process remains limited. Reviews have been sporadic, and references to safeguarding are often reduced to whether training has been completed. However, a positive step is anticipated with the launch of a revised biennial review process and an updated questionnaire later in 2025. This presents a crucial opportunity to more meaningfully embed safeguarding into ministerial reflection and accountability, thereby addressing the current inconsistencies.

Recommendation D54: The DBF should ensure that counselling and pastoral support services are routinely signposted to clergy and lay leaders, with particular emphasis during training, induction, and post-incident responses.

Recommendation D55: The revised Ministerial Development Review process should include structured safeguarding content addressing both training compliance and emotional wellbeing, and be monitored for consistency.

Supervision and Support of Safeguarding Roles

8.10 The DBF has made efforts to embed supervision for safeguarding staff, particularly following periods of instability and change. The DSO receives external and now regional supervision, with a gradual transition plan in place. While arrangements reflect an

emerging culture of care and professionalism, the Audit found that supervision structures are yet to be fully formalised. There are currently no records of previous supervision cycles, and access remains dependent on personal initiative and capacity rather than policy. The anticipated team growth in mid-2025 provides an opportunity to reset expectations, embed the national model, and ensure clinical support is available as appropriate.

Recommendation D56: The DBF should formalise supervision arrangements for all safeguarding staff, including frequency, recording, evaluation, and access to clinical supervision when needed. This should be reviewed annually and aligned with the national supervision framework.

9 Conclusion

- 9.1 Notwithstanding the range of recognised historic challenges it has faced, the findings of this audit paint a comprehensive picture of a Diocesan Board of Finance (DBF) that is resolutely on a path of improvement. The core strengths reflected across the various sections of this report are fundamentally underpinned by the DBF's leadership commitment. Crucially, the influence and impact of the Diocesan Bishop and the Diocesan Safeguarding Officer (DSO) have been key. They are both highly credible professionals who are central to the Audit's optimism that genuine and sustained change can be achieved.
- 9.2 This leadership has already driven tangible progress, evidenced by clear operational strengths in safer recruitment practices, the raised profile of safeguarding across the diocese, and the proactive commitment to engaging with and supporting victims and survivors of abuse.
- 9.3 The progress achieved to date is significant, marked by an overwhelming majority of the worshipping community reporting improvements in the overall safeguarding arrangements and a growing confidence in raising concerns. The DBF has actively moved into a stabilisation phase, demonstrating some good practice in areas like the use of the National Safeguarding Case Management System (NSCMS) and an awareness of safeguarding leads and reporting procedures. Furthermore, the commitment to developing a trauma-informed approach within training and building positive relationships with external support services signals a positive cultural shift. This momentum is vital and must be maintained as the DBF addresses the more persistent structural and capacity issues.

- 9.4 Despite this progress, stubborn challenges remain that must be overcome to embed a truly robust and sustainable safeguarding culture. The primary challenge involves the lack of sufficient capacity within the Diocesan Safeguarding Team (DST), which has historically been under-resourced. This has led to critical backlogs in respect of case management and risk assessments and an unhealthy reliance on staff working beyond their normal hours. This operational pressure limits assurance concerning the full transition to using the NSCMS as the primary case management system. Furthermore, while the culture is improving in parishes, a lack of confidence is more prevalent within the DBF itself, compounded by weaknesses in their governance structures, often-described as ‘outdated’.
- 9.5 In response to these challenges, the recommendations in this report, such as capacity deficits, the need for urgent governance reform, and strategic cultural progression, must be viewed collectively and serve as the roadmap to further expedite the DBF’s improvement journey.

Part Two - Peterborough Cathedral

10 Context

- 10.1 Peterborough Cathedral is widely regarded as one of England's finest Norman cathedrals, with its origins as a monastic community dating back to 654 AD. It later became a medieval abbey, serving as the burial place for two queens and surviving the upheavals of the Civil War. The Cathedral's wider estate encompasses the Precincts and many surrounding listed buildings. Today, it is Peterborough's most prominent landmark, functioning as a tourist attraction and a venue for various exhibitions, cultural events, meetings and receptions. At its heart, however, it remains a central place of Christian prayer, worship, ministry, and mission. It is the 'Mother Church' of the Diocese of Peterborough and the Bishop's seat.
- 10.2 Granted city status in 1541, Peterborough is now a Unitary Authority governed by Peterborough City Council. It is also part of the Cambridgeshire and Peterborough Combined Authority. The city's district includes parts of the historic counties of Northamptonshire and Huntingdonshire, a small section of Cambridgeshire, and 29 civil parishes. Given its location, Peterborough Cathedral is often considered as "my cathedral" by people living in the Diocese of Ely (south of the River Nene) and the Diocese of Lincoln (to the north).
- 10.3 Between 2011 and 2021, Peterborough's population grew by 17.4% to 216,000, making it the third fastest growing city in the East of England after Bedford and Cambridge. Despite recent wage increases, the average gross salary remains below the national average. The city's median age is 36, with 59% of the population being of working-age. The unemployment rate is 4.3% and 46% of residents identify as Christian.

- 10.4 Peterborough is recognised as one of England's most deprived local authorities. Some wards are in the top 10% nationwide for deprivation, which is often deeply entrenched and spans multiple generations. Child poverty is a major concern. In 2020, over a third of Peterborough's children (around 12,000) were living in absolute low-income households. This number is likely to have increased since then.
- 10.5 The Cathedral currently has 241 active members on its Congregational Roll. The average weekly attendance is 782, which includes figures for big festival services and other special services. In 2024 the Cathedral saw an average of 1,826 general visitors per week. An additional 1,365 people per week attended other public events, conferences, meetings, concerts and exhibitions.

11 Progress

- 11.1 Peterborough Cathedral has been subject to an Audit by the Social Case Institute for Excellence (SCIE) and was engaged in the Diocesan Past Cases Review 2 (PCR2). Whilst no recommendations were made by the PCR2, the SCIE Audit (published in January 2022) determined a range of ‘considerations’ for the Cathedral covering its infrastructure, formal procedures, training provision and the measuring of impact.
- 11.2 All 13 SCIE ‘considerations’ were accepted by the Cathedral and collated into an action plan. While initial actions have been met, the plan now forms part of the Cathedral’s broader and dynamic Actions Schedule. This schedule is regularly evaluated and encompasses a range of actions that are overseen every six weeks by the Cathedral Safeguarding Management Group (CSMG). The Cathedral’s Framework, contained within this document, measures how the Cathedral aligns its practice with the National Safeguarding Standards (NSS).
- 11.3 Overall, the Cathedral has made key improvements to its safeguarding arrangements. These include the development of a volunteer handbook with clear references to safeguarding, improved procedures for bellringers and the development of awareness raising materials (with some being made available in different languages). It has also made good progress in addressing a range of significant challenges linked to historic safeguarding issues. Positively, this activity continues to be supported by the strong relationship that exists with the Diocesan Board of Finance (DBF).

12 Culture, Leadership and Capacity

Safeguarding Culture

- 12.1 The overall safeguarding culture at Peterborough Cathedral is perceived positively, with a commitment to embedding it into daily operations. This assessment is supported by findings from both the workforce and worshipping community surveys, where an overwhelming majority reported feeling safe and observing improvements in the Cathedral's safeguarding arrangements. The culture is described as having moved from a "closed, secretive, fragmented" state to one that is now striving for openness, transparency, and integrity.
- 12.2 Whilst this is a work in progress, evidence seen and heard by the Audit supports the view that the organisation is endeavouring to place safeguarding at its core, moving beyond simple compliance to embrace a caring approach that is integrated into daily routines, briefings, and volunteer activities. This ethos aims to ensure that incidents involving vulnerable individuals are handled with dignity and empathy, building an environment where staff and volunteers feel confident and supported in speaking up.
- 12.3 Leadership actively cultivates a low threshold for reporting through encouraging dialogue and comprehensive training, thereby normalising the raising of concerns. Furthermore, the regular promotion of safeguarding awareness through dedicated training on topics like domestic abuse, and the visible presence of updated posters and materials throughout the Cathedral, serve to embed this commitment as a shared, visible, and continuous priority.

- 12.4 Despite this strengthening foundation, some challenges persist. A small number of those who engaged in the survey, focus groups, and one-to-one discussions were less confident that progress was being made at the required pace. A few reflected that entrenched cultural factors such as deference and hierarchy can still create barriers, making it difficult for individuals, including long-standing members of the congregation, to feel empowered to challenge or report concerns. Concurrently, some staff stated that the current financial pressures faced by the Cathedral have raised anxieties about job security.
- 12.5 Whilst these issues need to be addressed, it is important to balance such concerns with the fact that Cathedral survey respondents almost universally described the culture as positive. The workforce and the worshipping community consistently depicted the Cathedral as 'Welcoming', 'Respectful', and 'Inclusive', and a majority of staff members described the environment as 'Supportive'.

Recommendation C1: To ensure the Cathedral's positive safeguarding culture is sustained and its remaining challenges (like deference and pace of change) are addressed, the Chapter should establish a formal, continuous monitoring cycle for cultural health. In order to do so, Chapter should commission 'Pulse Surveys', an anonymous reporting mechanism, and safeguarding culture KPIs to measure performance and progress.

Leadership

- 12.6 The Dean bears the ultimate accountability for safeguarding at the Cathedral, a duty he takes seriously and one he explicitly confirmed during Audit discussions. His sound working relationship with the Diocesan Bishop rests on mutual respect and a willingness to appropriately challenge one another. The Audit saw evidence of this in action, and it is a notable strength.

- 12.7 The Dean has personally and effectively engaged in addressing the significant historic challenges that previously undermined confidence in the Cathedral's leadership, and has demonstrated a reflective and considered approach, as well as a willingness to make difficult decisions when required to do so.
- 12.8 Despite this leadership strength, the senior team is under considerable pressure and in transition, posing a potential risk to continuity and effective safeguarding oversight. Challenges include the upcoming retirement of the capable Chief Operating Officer (COO) and the recent sabbatical of the Cathedral Safeguarding Lead (CSL) / Vice Dean. The CSL (Vice Dean) was clear in his commitment to ensure that safeguarding is always present in everything the Cathedral does. However, they cannot be expected to be in all places at all times and the role of CSL should primarily be focused on strategic oversight.
- 12.9 Furthermore, the temporary handover and execution of the CSL's responsibilities to the interim CSL (the Canon Precentor) was identified by the Audit as an area requiring better management. When tested, this interim arrangement was found to have left gaps in knowledge concerning contemporary safeguarding issues, policies and practice. Given the Canon Precentor's existing capacity constraints, additional responsibilities are neither practical nor sustainable.
- 12.10 Crucially, the current operational safeguarding capacity is a significant concern that requires urgent attention. There is currently no dedicated, operational safeguarding professional (CSA/CSO). This absence leads to an untenable reliance on staff whose primary roles and expertise are not in safeguarding, and/or the voluntary, part-time support of the Designated Safeguarding Lead (DSL) for the Choristers School. While DSL provides substantial and credible support, the Audit considers the overall risk they carry to be "too broad" and "unsustainable." This judgment stems from the inherent time limitations of a

part-time/voluntary role combined with the potential conflict of interest arising from their distinct DSL responsibilities at school.

Recommendation C2: Immediately recruit a dedicated, Part-time Professional Cathedral Safeguarding Officer/Adviser (CSO/CSA) to provide the essential operational resource and support to the Cathedral and professional advice to other staff and volunteers with a safeguarding remit or responsibility.

Recommendation C3: Review and formalise the internal process for the temporary handover of critical roles like CSL to ensure clarity, thoroughness, and effective execution under all circumstances.

Recommendation C4: The Cathedral should engage in discussions with the Diocesan Board of Finance (DBF) to assess the appetite for and viability of establishing a diocesan-wide Safeguarding Directorate, which would be led by a Director of Safeguarding (DoS).

Under this potential structure, the Cathedral's Safeguarding Officer/Adviser (CSO/A) would retain a dedicated and visible presence within the Cathedral. The CSO/A would be accountable, along with the appointed DoS, to the Chapter. However, the CSO/A would also receive professional supervision as an integral part of the wider Diocesan Safeguarding Team.

This structure would achieve several key outcomes:

- It would ensure continuity in safeguarding policy and procedures across the diocese.
- It would reinforce the independence of operational safeguarding decisions.

- It would guarantee the provision of contingency arrangements should the Cathedral require additional support.

(See **Recommendation D26** in Part One of this report.)

Recommendation C5: Clarify roles and responsibilities by:

- a) along with the DBF as soon as the new structures and lines of control and reporting are in place to enhance and formalise external support, and
- b) clearly documenting and communicating the delineated safeguarding responsibilities between the Cathedral and the School.

Governance and Oversight

12.11 The Cathedral's governance and oversight meetings meet the expectations of the CofE and other requirements, such as those from the Charity Commission. Safeguarding is a recurring topic in meetings, briefings, and volunteer induction processes.

Chapter

12.12 It was clear that the Dean values the input of all members of Chapter, not least that provided by the Senior (lay) non-executive member. Their mutual respect and ability to challenge one another (and others) was evident during separate Audit discussion with each. Both shared the view that Chapter is keen to draw on the wisdom of all members and to mitigate any perception that an unmanageable conflict of interest exists through the Dean chairing a group that ultimately holds him to account, to his credit, the Dean acknowledges the potential for such a conflict. The SNEM highlighted the regular approach

to skills audits and largely successful efforts to improve diversity and inclusion.

12.13 There is, however, an identified need to enhance practice to include more proactive scrutiny by Chapter. While there is some evidence of Chapter engaging (appropriately) with staff across the Cathedral, this has not happened for some time and notwithstanding Chapter's non-operational functions, providing a listening ear that better informs and equips them to test the reports that are presented to them (not least on safeguarding culture) would be positive. Furthermore, a review of minutes provided insufficient information to determine the quality of oversight beyond observational briefings.

Recommendation C6: Chapter's oversight practice should be enhanced to include more proactive scrutiny. Minutes should consistently reflect the specific areas of challenge, the quality of information requested, and the ultimate rationale behind Chapter's decisions, moving beyond mere recording of observational briefings.

Recommendation C7: Implement a formal, periodic schedule for non-executive members to engage with various staff groups. This is not for operational involvement but for a 'listening ear' to better understand staff roles, responsibilities, and views on 'what works and what could be improved.'

- a) Ensure the learning gathered from these staff engagements directly informs Chapter's oversight, enabling non-executives to better test reports, particularly those relating to culture, safeguarding, and risk, that are presented to them.

Recommendation C8: To address the potential conflict of interest (the Dean chairing the body that holds him to account), Chapter should ensure its minutes clearly document the Senior Non-Executive Member's (and others') challenge and independent oversight, particularly during sensitive discussions like audits, demonstrating that accountability is robustly maintained.

- a) Chapter should adapt their agenda to ensure that any individual agenda item that may invoke a perception of a conflict of interest for the Dean should, by agreement by Chaired by the SNEM. Furthermore, the washup at the end of meetings that assesses the conduct and management of the meeting should be Chaired by the SNEM.

Safeguarding Management Group (SMG)

12.14 The Safeguarding Management Group (SMG) is chaired by the Vice Dean. While the Vice Dean is undoubtedly dedicated to safeguarding and well-connected throughout the Cathedral, this arrangement could be perceived as diluting the independence of the chair. In the opinion of this Audit, the group's effectiveness would be enhanced by appointing an appropriately safeguarding-qualified Independent Chair.

12.15 Furthermore, the SMG would also benefit from wider external representation. This could include, but not be limited to, individuals operating within the Cathedral's precincts, a representative from the police, members of relevant local charities, and the Chief Executive of a victim-focused charity.

12.16 The focus on safeguarding, at an operational level, could be further reinforced (following the appointment of a Cathedral Safeguarding Officer/Adviser (CSO/A)) by establishing

a Safeguarding Operations Group (SOG). This would function as a more operational, day-to-day safeguarding group, to be chaired by the CSO/A. It would meet more frequently (potentially weekly) to address immediate safeguarding matters, coordinate with vergers and staff, and ensure operational issues are managed proactively.

12.17 Other existing oversight forums, including the Executive and Cathedral Leadership Team meetings, currently consider safeguarding within their remit. The effectiveness of all these forums could be strengthened by harmonising their meeting schedules and agendas to complement and streamline oversight at each appropriate level. For instance, the SMG meeting should consistently take place before each Chapter meeting, and its agenda should primarily focus on matters that support the overarching strategic oversight requirements.

12.18 While each meeting should consider cases, operational matters and Serious Incident Reports (SIRs), depending on their function, their main agenda focus in this area should align with the national safeguarding standards.

Recommendation C9: Appoint an appropriately safeguarding-qualified Independent Chair for the Safeguarding Management Group (SMG) to ensure independence and strengthen governance.

- a) Introduce wider external representation to the SMG, including relevant stakeholders such as police, local charities (especially a victim-focused one), and precinct operators.

Recommendation C10: Constitute a Safeguarding Operations Group (SOG), to be chaired by the Cathedral Safeguarding Officer/Adviser (CSO/A), to focus on operational, day-to-day safeguarding management and coordination. This group should meet more frequently, potentially weekly.

Recommendation C11: Harmonise the meeting schedules and agendas of existing oversight forums (SMG, Executive, Cathedral Leadership Team) to streamline safeguarding oversight.

- a) Ensure the SMG meeting takes place before Chapter and that its agenda is strategically focused on supporting overarching requirements and aligning with national safeguarding standards.

Capacity

12.19 Capacity has been a consistent theme throughout this section, leading to several recommendations aimed at stabilising and strengthening the safeguarding footprint across the Cathedral.

12.20 This includes the recommendation to partner with the DBF by investing in a Safeguarding Directorate and the appointment of a dedicated safeguarding professional to a Cathedral Safeguarding Officer (CSO) / Adviser (CSA) role. This individual would be professionally supervised and supported as part of the DST but would be permanently located within the Cathedral as its own dedicated resource.

12.21 Capacity could be further enhanced if the Cathedral pursued a job-share arrangement when appointing the CSO/CSA. This approach would allow the appointment to capture a wider range of professional skills, significantly improving the Cathedral's ability

to engage with, promote, and manage safeguarding effectively. For instance, a job-share scenario could involve employing one person with a background in safeguarding adults and pairing them with another professional from children's social care or with probation/offender management experience.

Chorister Safeguarding

12.22 Peterborough Cathedral maintains a well-established choral tradition with support from Lay Clerks, Scholars, and a small music department team. Day-to-day safeguarding arrangements fall under the Acting Director of Music and are supported by the CSO, who also serves as a senior leader at the linked school.

12.23 The safeguarding framework surrounding choristers is improving but currently lacks coherence and resilience. This is primarily due to multiple interim staffing arrangements and an over-reliance on goodwill. Staff themselves described a sense of 'ambiguity' resulting from structural flux, with safeguarding sometimes reliant on informal channels.

12.24 The need for improvement in this context has already been recognised by the Cathedral, with the CSO proposing an independent deep dive into the music department's safeguarding arrangements, involving the National Safeguarding Team's RSL. To support this necessary development, the Audit makes the following recommendation.

Recommendation C12: A stand-alone safeguarding review of chorister safeguarding arrangements should be commissioned, jointly led by the CSO and the NST's RSL. Any action plan arising from this activity should be formally reported to Chapter and overseen by the SMG.

Scheduling and Wellbeing

12.25 While most feedback from parents and choristers was positive in relation to scheduling, there were isolated concerns about long days during peak events. A constructive parent suggestion, echoed by the CSO, suggested that younger choristers could be scheduled earlier in services or concerts to allow them to leave sooner. The Audit found that the music department are responding to these concerns by building in flexibility and time for rest. For example, children involved in late events are routinely given the following morning off.

Parent and Chorister Views

12.26 Parents who engaged with the Audit gave generally positive feedback about the care given to choristers and the quality of communication. Several highlighted the strong contribution of the music administrator, who also acts as a parent liaison and is embedded in both the parent and staff community. Parents described open channels of communication with the music team and appreciated the ease of raising minor concerns informally. Several noted improvements in pastoral care over recent years, with one describing the shift as “*less regimented and more understanding of different children’s needs*”.

12.27 While several communication routes exist and are functioning well, the Cathedral could provide more formal opportunities for parents to hear about its safeguarding arrangements and / or share structured feedback.

Recommendation C13: The Cathedral should continue start-of-term parent meetings and an anonymous annual survey to build trust, receive feedback and promote awareness of safeguarding arrangements.

12.28 Children described positive relationships with staff and a strong sense of belonging in the choir. However, one chorister commented that they were “too shy” to raise concerns, highlighting the importance of proactive, child-centred communication, that reinforces the availability of trusted adults, is sensitive to the individual needs of children and encourages children to speak up if they are worried about something. While child-friendly safeguarding posters are used in some areas, these could also be displayed in the rehearsal room and other key spaces, helping to embed visual reminders and normalise help-seeking behaviours.

Recommendation C14: The Cathedral should expand the use of child-friendly safeguarding messaging in the Song School (No. 28) and other relevant areas to ensure all choristers are regularly reminded of how to seek help

Chaperoning

12.29 Parent chaperones play a central role in chorister supervision, particularly around rehearsals, evensong, and transitions. They described a strong team ethos and were clearly committed to safeguarding children.

12.30 However, the dual role chaperones hold (as both parents and staff volunteers) has created ambiguity when it comes to information sharing. It was not always clear to the Audit how details about a child’s behavioural needs or medical conditions were being communicated to those responsible for their care. Feedback from the Audit’s staff and volunteer questionnaire reflected this uncertainty.

12.31 This is not a challenge unique to Peterborough, but it is one that requires clarity. The absence of a formal framework risks inconsistency and avoidable safeguarding failures.

Recommendation C15: The Cathedral should update its chaperone induction process to include a clear confidentiality agreement and guidance on how relevant safeguarding information is shared. Parents should be informed of what might be shared, with whom and why, with consent being sought where appropriate.

Other Safety Provisions

12.32 There are currently no dedicated toilets for choristers to use during services. Instead, they use public facilities, with clear procedures being in place that require chaperones to inspect these beforehand.

12.33 The Song School (No. 28) and organ loft were identified as areas where CCTV coverage is currently limited or unclear. There was no mapped audit of coverage.

Recommendation C16: CCTV coverage in the Song School (No.28) and organ loft should be reviewed and strengthened to improve safeguarding visibility and oversight.

Information Sharing

12.34 Communication between the Cathedral, the school, and parents was described as generally strong. The parent choir administrator was viewed as a key bridge in ensuring smooth coordination. Staff meetings are held weekly and include time for pastoral reflection and safeguarding discussions. These meetings were cited by staff as an important space to raise concerns and review wellbeing.

12.35 A low-level concerns log has been introduced and is used appropriately. The log is

reviewed by the CSO and relevant staff, enabling patterns to be identified and action taken where needed. Additionally, the CSO described a healthy working relationship in which safeguarding concerns are directed to the appropriate setting. However, understanding of thresholds for escalation was inconsistent across the music team, and several staff expressed uncertainty about when to raise concerns.

Recommendation C17: All staff working with choristers should receive a safeguarding refresher covering concern escalation, urgency, and information sharing pathways.

12.36 A gap in monitoring the attendance of choristers was identified by the Audit. Some staff commented that they are sometimes unaware if a child is absent, which creates an inherent risk in situations where a child may be assumed safe, but is in fact unaccounted for.

Recommendation C18: The Cathedral and King's School should establish a joint system for monitoring chorister attendance to ensure consistent oversight and timely safeguarding responses.

Training

12.37 Chorister staff training remains an area for development. At the time of the Audit, no member of the music department had completed Leadership-level safeguarding training, despite holding operational responsibility for children. One member of staff was scheduled to complete this shortly after the Audit.

12.38 Furthermore, not all staff working directly with choristers had received a safeguarding induction. Understanding of lone working procedures also varied. In at least one case, a staff member remained without a Cathedral-issued email address months into post,

creating both personal and organisational risk in terms of data security and professional boundaries. These are not isolated oversights, but part of a broader pattern that suggests safeguarding induction and systems of support are yet to be fully embedded.

Recommendation C19: All music department staff with responsibility for children should urgently complete safeguarding training relevant to their role where this remains outstanding. Lone working, data protection, and professional boundaries should be comprehensively covered with new staff / volunteers during induction, or retrospectively where needed.

12.39 Staff expressed interest in further training around behaviour management, particularly in how best to support neurodiverse choristers. Encouragingly, King's School has offered to support this through targeted training, including opportunities for staff to observe good practice within the school setting.

Recommendation C20: The Cathedral should deliver behaviour management and neurodiversity training for music department staff and volunteers, in collaboration with King's School.

Policies

12.40 The chorister Memorandum of Understanding (MoU) outlines mutual expectations between the Cathedral, choristers, and their families. Whilst generally positive, some phrasing in the MoU would benefit from greater clarity. For example, references to following the "*Choristers' Parent Handbook in force from time to time*" could be made more explicit - making clear that the current version is always applicable, and that parents are expected to read it in full at key points (such as the start of term or when updates are issued).

12.41 The section covering absence also presents an opportunity for refinement. While it rightly seeks to reinforce the importance of attendance and commitment, it could be reworded to better reflect the Cathedral's broader safeguarding responsibility - making clear that children's wellbeing must always take precedence over attendance.

Recommendation C21: The Cathedral should review and clarify the language within the chorister MoU to ensure expectations about handbook compliance and absence are communicated in a way that upholds both commitment and wellbeing.

13 Prevention

- 13.1 Peterborough Cathedral has systems in place to support safer recruitment, with a range of policies and procedures defining practice expectations. As an example, checks are undertaken to ensure the suitability of applicants such as references, Disclosure and Barring Service (DBS) checks and confidential declaration forms. There is also relevant messaging on the Cathedral's website, job descriptions reference the Cathedral's commitment to safeguarding, and there is training for those involved in the recruitment process. All these measures help to create an environment that deters those who might be unsuitable or pose a risk to the young and vulnerable from working in the Cathedral.
- 13.2 During the Audit, it was identified that a member of staff, who held direct responsibilities involving children, had started their position before their DBS check was completed and returned. While it is understood that this individual was never left unsupervised with children, this situation neither aligns with good safer recruitment practices nor a key principle within the House of Bishops' Safer Recruitment and People Management guidance: "Church Officers must not elevate the desire to undertake an activity above the need to do that activity safely."⁵

Recommendation C22: The Cathedral should review and strengthen the onboarding process to ensure that all staff members with direct responsibility for children have a completed and satisfactory DBS check returned before commencing their roles. This should include formalising a "no start" policy until the DBS clearance is confirmed, in line with the House of Bishops' Safer Recruitment and People Management guidance.

⁵ <https://www.churchofengland.org/safeguarding/safeguarding-e-manual/safer-recruitment-and-people-management-guidance/scope-safer-recruitment-and-people-management-guidance-0>

13.3 Establishing clear accountability for safeguarding measures is paramount. To ensure effective oversight and monitoring, the Audit also recommends the following.

Recommendation C23: To ensure effective oversight and monitoring, the Cathedral should report on DBS check and status to Chapter and the SMG. This report should include, for example, the number of DBS checks completed, the number outstanding, and any 'blemishes' returned.

13.4 Safeguarding is a regular topic within the Cathedral, appearing on the agendas of key leadership groups such as the Chapter, the Executive, and the Cathedral Leadership Team (CLT) (for more see Culture, Leadership and Capacity in Part Two of this Report), as well as at music department staff meetings. Broader engagement with safeguarding is also evident. Positively, the Cathedral recently launched a safeguarding questionnaire to its staff and volunteers to ascertain their level of knowledge. The outcomes of this survey were subsequently shared at an All-Staff Forum (including volunteers), via a briefing that included presentations and an interactive Q&A session.

13.5 The Cathedral is committed to safeguarding, following the CofE's 'Promoting a Safer Church' policy alongside its own specific safeguarding guidelines. It provides specific guidance for handling safeguarding concerns, especially over the phone, and integrates safeguarding principles into all handbooks for staff, volunteers, and stewards. Safeguarding is also a vital consideration for social media, engagement with young people, and has a dedicated policy for Cathedral Ringers. Positively, some safeguarding information has been translated into other languages, and the Cathedral's website also features an easily accessible tool to translate its pages. The Audit supports the current work to create a British Sign Language (BSL) version of safeguarding information.

- 13.6 The Cathedral's active membership in the Diocesan Safeguarding Advisory Panel ensures it consistently receives and shares the latest safeguarding updates.
- 13.7 The Cathedral undertakes various activities to highlight wider safeguarding concerns, utilising both email campaigns and visible signage across its physical and digital platforms. The Audit observed excellent visibility of safeguarding signage at the Cathedral, with posters addressing topics such as counter-terrorism, modern-day slavery, Safe Spaces, Promoting a Safer Church, and domestic abuse. The safeguarding poster in the children's area, with its use of Makaton, was identified as a notable strength.
- 13.8 The Cathedral's website also has a strong, clean and modern theme, is mobile responsive and has in-built translation tools. While its safeguarding webpage⁶ currently provides contact information, access to safeguarding documentation, and outlines the Cathedral's commitment, the Audit makes the following recommendation for improvement.

Recommendation C24: The Cathedral should thoroughly review and enhance its [safeguarding webpage](#) layout ensuring that information is prioritised according to user importance. Specifically, a prominent section on 'how to report a safeguarding concern' should be given primary focus, with other frequently accessed sections re-ordered accordingly. The aim is to logically group supporting resources, making them easily discoverable and accessible. Crucially, the website must also include clear guidance instructing users to contact 999 immediately if they have an urgent safeguarding concern.

- 13.9 The Audit found that the Cathedral has robust safeguarding procedures in place for school

⁶ <https://peterborough-cathedral.org.uk/community/safeguarding/>

visits. These comprehensive arrangements include gathering essential information on the booking form, such as the contact details for the school's Designated Safeguarding Lead (DSL), confirmation that the school will adhere to the Cathedral's stipulated student-to-staff ratios, and any relevant information concerning Special Educational Needs and Disabilities (SEND).

13.10 As with all good communication, this needs to be a two-way process. Actively seeking and acting on the views of children, young people and vulnerable adults is a key component to effective prevention planning. The Audit is of the opinion that there is space for similar practice to be strengthened in respect of vulnerable adults and makes the following recommendation.

Recommendation C25: The Cathedral should establish engagement mechanisms to consider the needs, experiences and voices of vulnerable adults and survivors within safeguarding prevention planning.

13.11 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.

13.12 The Audit identified a clear instance of strong authoritative practice in applying appropriate boundaries. This was evident in a case where a staff member had misunderstood these boundaries, prompting decisive action.

13.13 CCTV monitoring plays a crucial role in enhancing the overall security of the Cathedral. Whilst not monitored around the clock, an external company is responsible for the CCTV system covering the Cathedral and its immediate surroundings. To bolster the Cathedral's

arrangements, CCTV coverage could be expanded to several areas identified as vulnerable.

Recommendation C26: The Cathedral should expand CCTV coverage to include key areas, such as the education room and the chorister's practice room.

14 Recognising, Assessing and Managing Risk

- 14.1 The Cathedral's risk register / dashboard addresses a range of corporate issues, including limited reference to safeguarding. It was last updated in April 2024. 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. 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, the SMG, and / or any operational safeguarding sub-groups.

Recommendation C27: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral.

- 14.2 Current safeguarding procedures state that any safeguarding concerns must first be reported to the Cathedral Safeguarding Officer (CSO), whose role is voluntary and part-time and subject to consideration in the Culture, Leadership and Capacity in Part Two of this report. The CSO is then responsible for contacting the Diocesan Safeguarding team. This process is subject to oversight and scrutiny from relevant safeguarding leads and audit trails to secure available evidence and provide an account of decision making.
- 14.3 In 2024, the CSO received 17 referrals specifically for "safeguarding advice". This year, up to the point of the recent audit, there have been six such referrals.

- 14.4 The Audit was advised there have been no Core Groups at the Cathedral over the past 12 months. The findings in relation to Core Groups are outlined in Part One of this report.
- 14.5 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'.
- 14.6 At the time of the Audit, there was one attendance agreement (Safety Plan) in place relevant to the Cathedral. The broader effectiveness of the management of Safety Plans is set out in Part One 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 The Audit gathered positive perceptions from most of the Cathedral's workforce who agreed that they have "*confidence in the escalation processes within the Cathedral*". However, the Audit identified a discrepancy regarding where the processes for handling safeguarding disputes and escalation process are outlined. It was noted that, contrary to what the auditors were told, there was no reference to escalation or disputes within the Safeguarding Policy.

Recommendation C28: The Safeguarding Policy should be updated to include details on how safeguarding-related disputes are handled and to outline the appropriate escalation procedures.

- 14.9 Findings from the Audit's workforce survey also indicated that most were aware of the

privacy notice in respect of data protection. This is positive and reflects the overall sustained efforts to comply with data protection requirements. Staff receive training on data protection via the MeLearning portal and are also required to read and comply with the Cathedral's data policies.

- 14.10 To facilitate effective information sharing, the Cathedral has several agreements in place. The Service Level Agreement with the DBF and the MoU involving the choir are two examples where the arrangements for information sharing are defined.

15 Victims and Survivors

15.1 The Audit was informed that the Cathedral follows the House of Bishops' guidance as set out in 'Responding Well to Victims and Survivors of Abuse'. The Cathedral demonstrates a commitment towards aligning with the CofE's National Safeguarding Standards (NSS) in relation to Victims and Survivors. This is particularly evident in their efforts to create clear disclosure pathways, providing help to those seeking support and ensure ongoing dialogue with the DSO.

15.2 Additionally, as set out within the Cathedral's Safeguarding Policy, pastoral support is available and appropriate signposting to external organisations is clear. That said, the Cathedral recognises the need for improvement in this area, specifically by transitioning from a reactive to a more proactive approach to engagement with victims and survivors of abuse. To facilitate this, the Cathedral should partner with the DBF in hosting listening and learning sessions to capture the voices of victims and survivors of abuse. These should have the aim of better understanding the lived experiences of victims and survivors, and determining how their voices can influence service design and practice improvement.

Recommendation C29: The Cathedral should partner with the DBF to host diocese-wide listening events, providing a platform to hear from a diverse range of voices to inform local practice.

15.3 The Cathedral's Safeguarding Policy sets out the procedures to be followed in the event of a safeguarding concern. The need to 'respond well' to victims and survivors of abuse is emphasised and a range of relevant support services are detailed.

15.4 The Cathedral's safeguarding webpage reflects this information, linking directly to the

Diocesan Safeguarding webpage for information on reporting pathways. Contact details for the CSO, Chapter Safeguarding Lead (CSL) and the DSO are also included. While the webpage is broadly positive, the Audit believes that key information could be made more easily accessible for victims and survivors.

- 15.5 The Cathedral's 'Safeguarding' webpage needs to be highly visible, informative and to a large degree, reassuring to those who might be seeking support. By creating a dedicated sub-section specifically for victims and survivors of abuse, the Cathedral could help ensure that those in need are confident that they have found the right place. This sub-section could clearly detail the Cathedral's unwavering adherence to national guidance on responding to abuse, making its proactive and supportive stance explicit.

Recommendation C30: The Cathedral should enhance its existing 'Safeguarding' webpage by creating a dedicated sub-section for victims and survivors. This new sub-section should:

- a) Clearly detail the Cathedral's adherence to national guidance 'Responding Well to Victims and Survivors of Abuse', explicitly outlining its proactive and supportive stance.
- b) Provide a reassuring and welcoming online space where individuals seeking support can immediately feel at ease and be confident that they have found the appropriate resources.
- c) List appropriate signposting for support (both national and local).

- 15.6 The Cathedral actively participates in Safeguarding Sunday, a dedicated event to highlight safeguarding within the Church. Following the most recent Safeguarding Sunday, two significant disclosures of historic abuse were received. This demonstrates how powerful and effective awareness raising events can be in encouraging survivors to come forward.

15.7 To ensure comprehensive understanding of how to report concerns, the Cathedral utilises a range of materials. These include notices displayed within the Cathedral, sermons delivered during services, information within the staff handbook, the Cathedral's safeguarding policy, and details outlined on the Cathedral website. Furthermore, the Cathedral's internal telephone and email guidance includes specific advice and procedures on how staff should professionally and sensitively handle any disclosures of abuse. Whilst a valuable document, the Audit sees an opportunity to make some small, yet important, improvements to this guidance.

Recommendation C31: The Cathedral should strengthen its safeguarding telephone guidance for those receiving disclosures by explicitly outlining the importance of a trauma-informed approach and providing further guidance on how to respond to safeguarding disclosures. This should include:

- a) Providing a clear explanation of the importance of a trauma-informed approach.
- b) Setting out how disclosures from potential victims and survivors may vary significantly based on their individual experiences.
- c) Further guidance and examples on using empathetic language, active listening techniques, and non-judgmental responses.
- d) Strategies for calming distressed callers and managing sensitive conversations.
- e) Building on the existing protocols for concluding calls in a way that leaves the caller feeling supported and informed of next steps, e.g. forwarding the call to the relevant individual.

15.8 The CSL has undertaken specialised training delivered by the Cambridge and Peterborough Domestic Abuse and Sexual Violence Partnership. This course was conducted in an interfaith context at one of the local Mosques, reflecting a commitment to broader community understanding and collaboration.

- 15.9 The Cathedral frequently interacts with Local Policing Partnerships (LPPs) due to its central location and routine engagement with those who are homeless. The Cathedral refers rough sleepers to LPPs and shares information on challenging behaviours to aid effective case management.
- 15.10 The Cathedral further supports the community by leasing property to Light Project Peterborough, an organisation that helps the homeless. Whilst recognising the limitations of service provision, the Cathedral actively signposts details for out-of-hours homeless services.
- 15.11 At the time of the Audit, the Cathedral's vaults were also being leased to an organisation delivering craft-based activities for vulnerable adults. This organisation is due to vacate the premises in the summer. Additionally, the Cathedral runs a weekly wellbeing café that serves the local community, especially Ukrainian residents, offering drop-in craft and social activities in the afternoon. The Audit recognises the significant benefits of these activities, noting their value in facilitating self-expression, healing, processing trauma, and building confidence and promoting a sense of community.

16 Learning, Supervision and Support

Safeguarding Learning

- 16.1 Peterborough Cathedral's safeguarding training provision is currently sustained through input from Diocesan trainers and the NST. While this approach ensures that staff, clergy, and volunteers can access required training, the current reliance on external providers limits the Cathedral's ability to tailor learning to its unique context.
- 16.2 Although the Cathedral articulates a clear intention to align its safeguarding learning with CofE expectations, there is not yet a contextualised training strategy in place for the Cathedral, nor is there a structured programme outlining the safeguarding training courses available to staff. Furthermore, there is limited evidence of internal evaluation, feedback gathering, or formalised staff guidance on training expectations. Strengthening these areas would help build a more responsive, reflective learning culture. The Cathedral has acknowledged this and has taken initial steps to address the gap through the circulation of a safeguarding questionnaire. This proactive move is welcomed by the Audit and reflects a growing recognition of the need to formalise their learning offer.

Recommendation C32: The Cathedral should develop a contextual safeguarding training strategy, supported by a clear programme of learning that outlines available courses, expectations by role, and methods of delivery. This strategy should be informed by local needs and the CofE's Safeguarding Learning and Development Framework.

- 16.3 Safeguarding records submitted during the Audit appear generally robust and indicate high levels of compliance for training. However, the terminology used in Cathedral records remains inconsistent with the CofE's current Safeguarding Learning and Development

Framework. This may lead to confusion when tracking compliance against national expectations. It suggests that the Cathedral's arrangements are not aligned to current practice.

Recommendation C33: The Cathedral should update its training records to ensure alignment with current national terminology, enabling accurate tracking and compliance monitoring.

16.4 It is positive that formal refresher training is undertaken on a three-year cycle, which is complemented by a broader cultural approach to learning, including informal reminders and safeguarding content embedded into routine staff forums and event briefings. Staff and volunteers are encouraged to complete training more frequently than mandated, with the online national portal used to facilitate access. Additionally, staff input has been sought and, when concerns were raised about emotionally sensitive content within training, the Cathedral acted swiftly by adding appropriate content warnings. This is good practice.

16.5 At present, there is no routine reporting of training data to governance bodies such as the Chapter or the SMG. This limits the ability of leaders to monitor compliance, respond to emerging gaps, or proactively manage renewal cycles. Establishing regular reporting mechanisms would significantly improve safeguarding oversight.

Recommendation C34: To ensure effective oversight and monitoring, the Cathedral should regularly report to the Chapter and SMG on the status of safeguarding training among staff and volunteers, including completion rates and renewal dates.

Clergy Wellbeing and Support

16.6 Clergy affected by safeguarding incidents are offered bespoke support, with interventions

designed around individual need. The Bishop and DSO have engaged directly with clergy affected by previous failings. This was viewed positively and is considered good practice in helping to rebuild trust and address past harm.

- 16.7 Ministerial Development Reviews (MDRs) are undertaken routinely and include safeguarding as a theme, though it was acknowledged during the Audit that further structure is required. The Audit notes positively that safeguarding is considered within the Cathedral's MDR framework and encourages the continuation of this work in tandem with Diocesan developments in this area.

Supervision and Support of Safeguarding Roles

- 16.8 Support structures for those in safeguarding roles are developing but are yet to be formalised. The Cathedral has indicated that staff with safeguarding responsibility will be offered professional support if needed. While arrangements appear to be ad-hoc, they are consistent with the Cathedral's broader commitment to a supportive and relational safeguarding culture.
- 16.9 Survey responses indicated that while most Cathedral staff and volunteers had received an induction, a notable number had either not completed one or could not recall doing so. Among those who did undergo an induction, the majority reported that safeguarding was covered. The Cathedral has reflected constructively on this issue, noting that the inclusion of a dedicated safeguarding meeting within the induction process would strengthen the current approach. The Audit supports this reflection and encourages its implementation.

Recommendation C35: The Cathedral should ensure that all new starters receive a safeguarding-specific component as part of their induction process that goes beyond a recognition of reading the safeguarding policy and completing safeguarding training.

16.10 The Cathedral's safeguarding oversight benefits from its SLA with the DBF and the presence of key staff on the DSAP. These connections provide access to professional safeguarding networks and help to ensure that local practice remains informed by national, regional and local learning. There is evidence that the Cathedral seeks to maintain strong communication with the DST and adheres to Diocesan protocols for support and escalation when needed.

17 Conclusion

- 17.1 The findings of this audit evidence a fundamentally positive and improving safeguarding culture at Peterborough Cathedral, characterised by a genuine movement toward openness, transparency, and integrity. This positive trend is underpinned by strong leadership, where the Dean demonstrates a reflective and considered approach to historic challenges. Furthermore, the mutually respectful relationship with the Senior Non-Executive Member (SNEM) provides a notable strength in governance.
- 17.2 Significant progress is being made across the organisation. The Cathedral continues to encourage a low threshold for raising concerns, has strengthened its preventative measures and has successfully implemented clear reporting pathways that are both understood and trusted. This proactive commitment is further evidenced by the Cathedral's alignment with the CofE's national standards for Victims and Survivors and the frequent, informal embedding of safeguarding into staff forums, which helps integrate it into everyday practice.
- 17.3 To secure this positive foundation and minimise future risk, the audit identified several urgent challenges. The single most critical operational concern is the absence of a dedicated, part-time Cathedral Safeguarding Officer/Adviser (CSO/CSA). This results in an unsustainable reliance on non-safeguarding staff and/or well-qualified but part-time volunteer support. This vulnerability is compounded by a senior leadership team that is currently under transitional pressure.
- 17.4 The safeguarding of choristers is also being undermined by interim staffing arrangements and an over-reliance on informal processes. Furthermore, risk management lacks a

dedicated Safeguarding Risk Register, and CCTV coverage needs to be extended into identified areas of vulnerability. Engagement with victims and survivors also needs to evolve from being a reactive process to one that is characterised by proactive listening.

- 17.5 To minimise future risk, and further strengthen the Cathedral's safeguarding arrangements, key recommendations must be actioned without delay. These include the immediate recruitment of a part-time Professional CSO/CSA to provide dedicated operational capacity and relieve pressure on the senior team.
- 17.6 This must be paired with enhanced oversight, specifically by appointing an Independent Chair for the Safeguarding Management Group (SMG) who is qualified and experienced in the field of safeguarding. Chapter also needs to develop its approach to scrutiny and concentrate on proactive outreach and flexible chairing arrangements for specific agenda items.
- 17.7 Finally, the Cathedral must build resilient, structured systems by creating a more secure framework for those supporting choristers (including updated training on neurodiversity and behaviour management), and formalising a continuous monitoring cycle for cultural health using 'Pulse Surveys.' It must also develop a comprehensive, role-based training programme.
- 17.8 Despite the remaining challenges, the Cathedral's real strength lies in its recognition that there is more work to be done and the absolute commitment from the Dean, staff, and volunteers to build upon the positive safeguarding culture they have already established.

Appendices

18 Appendix 1 – DBF Recommendations

Recommendation D1: Introduce a quarterly DBF-specific safeguarding culture insight survey focused on staff confidence in the established culture, transparency, and effective concern-raising mechanisms. The goal is to achieve a measurable increase in DBF staff confidence (targeting an improvement beyond the current level of 'just over half') that a robust safeguarding culture is embedded within the DBF itself.

Recommendation D2: Formalise the current leadership's commitment to transparency by creating a publicly accessible report (for internal or external audiences as appropriate) that details the specific actions taken to address past issues. The DSAP should, in parallel, monitor the frequency and scope of proactive communication from leadership regarding safeguarding culture updates and actions (e.g., tracking the number of open forums held and the frequency of progress reports issued).

Recommendation D3: The DSAP should investigate and address the perception that the DBF working environment is 'outdated', focusing on any potential impact on effective safeguarding practice. In doing so they should, develop and implement a targeted action plan to improve systems and structures, monitoring the use of 'outdated' as a descriptor in subsequent cultural surveys.

Recommendation D4: Clarify and document the safeguarding responsibilities of all senior leaders to ensure that safeguarding activities across the diocese receive appropriate focus and support.

Recommendation D5: The new Suffragan Bishop should support the Diocesan Bishop in key aspects of the DBF's safeguarding improvement journey, such as issues related to compliance with training and DBS requirements for clergy, Dashboard roll-out and uptake across parishes and support to Archdeacons regarding their safeguarding functions.

Recommendation D6: Establish a framework for both formal and informal parish visits to strengthen the safeguarding focus. This framework should require pre-visit briefings from the Diocesan Safeguarding Team (DST) to ensure Archdeacons are well-informed, to guarantee that contextually relevant safeguarding issues are explicitly prioritised as discussion points during all parish engagements, and to mandate post-visit debriefing sessions with the DST to capture key insights and inform broader diocesan strategy.

Recommendation D7: Implement mandatory, specialised training for Archdeacons and all Core Group participants to manage complex safeguarding tasks, including essential skills like trauma-informed practice and clear escalation pathways. Crucially, establish a formal system to ensure the health and wellbeing of those involved by providing guaranteed access to reflective supervision (potentially using an external qualified professional) during these processes. To uphold impartiality, formalise protocols for conflict-of-interest checks for all Chairs and actively address any imbalance of power within core groups at the earliest opportunity.

Recommendation D8: The Strategic Progression Pathway for the DSO should encompass the following:

- (d. A structured mentorship with an individual in a comparable strategic governance or executive role to impart high-level decision-making and stakeholder management skills.
- (e. Provide focused development in corporate governance and organisational finance to enable the DSO to effectively navigate and influence the executive and financial landscape of the Diocese.
- (f. Fund a relevant post-graduate qualification (e.g., Master's or Executive certification) to formally cement the DSO's strategic leadership capabilities and to equip them for future progression.

Recommendation D9: Conduct a skills, inclusion and diversity audit when refreshing board membership. The aim should be to ensure membership at this strategic level reflects the community it serves and has the skills and abilities to ensure effective oversight and challenge. The DSO should be in attendance at all such meetings.

Recommendation D10: Implement a mandatory Trustee Induction and Refresher Training (every 2–3 years), focusing exclusively on the Board's strategic safeguarding governance. This training must distinguish between the Board's ultimate legal accountability and management's operational role.

Recommendation D11: The Board should appoint a Lead Trustee for safeguarding and establish a mechanism for regular, formal reporting to ensure continuous oversight.

Recommendation D12: Trustees must be equipped to approve, resource, and critically review the Safeguarding Policy and associated frameworks. Crucially, they must ensure safeguarding risks are fully integrated into the overall Risk Register, focusing on high-level threats, and clarify the duty for prompt recognition and mandatory reporting of Serious Incidents to regulators.

Recommendation D13: Prioritise a governance culture that actively promotes challenge and scrutiny. Trustees must be equipped to demand and interpret data-driven assurance reports on safeguarding performance, moving beyond anecdotal evidence. Furthermore, the Board must actively model the 'tone from the top' and ensure transparent record-keeping and clear documentation of decisions across all governance bodies to establish an unimpeachable audit trail for accountability.

Recommendation D14: Safeguarding must become a standing agenda item for all key oversight meetings, including the BLT and the Bishop's Management Group (BMG). This will mandate regular, explicit discussion of safeguarding compliance, strategy, emerging issues and when appropriate operational imperatives.

Recommendation D15: Up to and until the appointment of a Director of Safeguarding, the Diocesan Safeguarding Officer (DSO) should be invited to, and (operational commitments permitting) attend, all key oversight meetings. The DSO's presence is essential, as they are the ultimate authoritative decision-maker on all matters relating to operational safeguarding.

Recommendation D16: Formalise and reinforce the independence and demonstrable impact of the DSAP's scrutiny functions. Explore restructuring options or establishing operational subcommittees to strengthen its authoritative and independent role, addressing a key national and local governance concern.

Recommendation D17: Maintain the expansion of the DSAP's membership which includes a representative from a local charity (which covers mental health, foodbanks, homeless support) and continue to improve engagement with all statutory partners to ensure a comprehensive range of viewpoints.

Recommendation D18: Continue to enhance multi-agency relationships through regular one-to-one meetings with key statutory leads. Ensure active DSAP participation in relevant multi-agency forums and establish informal, efficient information-sharing channels.

Recommendation D19: Establish dedicated survivor focus groups or networks and facilitate regular 'listen and learn' events to ensure the direct lived experiences of victims and survivors inform and shape safeguarding practices.

Recommendation D20: Institute a cyclical approach to conduct in-depth reviews of specific safeguarding areas. This activity must be systematically aligned with National Safeguarding Standards to ensure comprehensive scrutiny over time.

Recommendation D21: Develop structured, quantitative frameworks for insight and oversight.

These must target the National Safeguarding Standards and agreed areas of risk, need, and development to drive systematic and continuous improvement.

Recommendation D22: Strengthen internal scrutiny by commissioning regular practice audits of safeguarding processes. Further develop and maintain contemporary Risk Registers and develop measurable metrics to assess the actual impact of safeguarding interventions.

Recommendation D23: Appoint a Deputy DSO.

Recommendation D24: Appoint two fixed term contract staff (six to nine months) to immediately address the deficits in case management, cleansing and updating records and re-launching and supporting an enhanced adoption of Dashboards.

Recommendation D25: Implement a change to the Safeguarding Support Officer's role, renaming it the 'Safeguarding Team and Parish Support Assistant'. The aim is to refocus the function to include filtering calls, providing greater support to parishes (specifically regarding dashboards), assisting archdeacons (with Visitations), and supporting the evaluation of training.

Recommendation D26: An operationally independent Director of Safeguarding (DoS) should be appointed to lead a new Safeguarding Directorate.

- d) The DoS should be the ultimate authoritative voice on all safeguarding matters, ensuring decisions are not influenced by clergy. They would assume the power and authority vested in the DSO role.
- e) The DoS should be empowered with the authority to provide robust oversight, expert advice, and direction, and the ability to challenge senior clergy and Church bodies when necessary.
- f) The DoS should have a clear pathway to escalate serious concerns directly to higher authorities, including the National Director of Safeguarding (NST).

Recommendation D27: The DBF should carry out a cost benefit analysis of the potential trade off regarding dedicated trainers versus ADSO's with a training portfolio and a budget to bring in specialist external training.

Recommendation D28: The DBF should consider a job share approach for future recruitment to the DST / Safeguarding Directorate. This would present an opportunity to strengthen the blend of professional safeguarding backgrounds in the DST.

Recommendation D29: The DBF should conduct a review of remuneration for safeguarding roles to ensure it aligns with market rates, thereby offering the best opportunity to engage high-quality personnel.

Recommendation D30: The DBF should implement a clear and systematic plan to encourage parishes to adopt the Parish Dashboard. This could involve actively communicating its benefits, offering user-friendly training and support, demonstrating its value and ease of use, and proactively addressing any concerns.

Recommendation D31: 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 D32: The DBF should develop a safeguarding policy that is specifically tailored to the unique needs and practices of the Peterborough Diocese.

Recommendation D33: To strengthen opportunities for learning and sharing best practices, the DST should first review its own operations, using the findings from this Audit to identify both strengths and areas for improvement. The team should then identify and learn from other dioceses that have been recognised for their strong practice. Finally, these valuable insights should be integrated into policies and support to enhance existing practices.

Recommendation D34: The DBF should facilitate regular face-to-face or virtual sessions, and/or networking events, for PSOs. These gatherings would provide valuable opportunities for PSOs to learn and share good practice with their peers.

Recommendation D35: The DBF should consider facilitating an annual networking event for PSOs. This event would allow PSOs to connect with peers and hear from leading safeguarding professionals on new and emerging themes relevant to their role. To ensure the success and sustainability of such events, the DBF should also make a provision for a dedicated budget.

Recommendation D36: The DBF should review the safeguarding and PSO webpages to introduce a clearer hierarchy for content, which would greatly enhance user navigation and the logical flow of information. Furthermore, the text used for hyperlinks should be more explicit, clearly indicating the content or destination that users can expect to find by clicking on them (e.g. the link to access national 'Templates and resources | The Church of England' could explain what types of resources are available).

Recommendation D37: The DBF should develop a communication plan which embeds key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of the followers, adopting different techniques specific to the platform and utilisation of relevant awareness days, campaigns and events to amplify the message.

Recommendation D38: The DBF should develop engagement mechanisms to consider the needs, experiences and voices of children, vulnerable adults, and survivors within safeguarding prevention planning.

Recommendation D39: The 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 D40: As part of the triage process, the DSO should record the rationale for risk grading and the prioritisation of cases, alongside specifying timescales for action and any review of progress.

Recommendation D41: In keeping with Recommendation D24, 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 D42: The DBF should implement a systematic process for the review and updating of all safeguarding risk assessments and safety plans associated to active cases. This process should include assessing new or evolving risks and revising control measures, ensuring continuous alignment with current good practice, integration of lessons learned from incidents (if any), and reflect a contemporary understanding of risks. These updates should adopt the current "Standard risk analysis and risk management" format.

Recommendation D43: The DBF should ensure that any training related to risk assessments, safety planning and wider offender management is contextually fit for purpose in a faith-based environment.

Recommendation D44: The DBF should raise awareness of the National Data Sharing Agreement between the National Police Chiefs' Council and the Church of England within the Diocese and raise the profile with police forces through the NST.

Recommendation D45: 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.

Recommendation D46: To ensure national oversight, facilitate consistent practice and learning across the Church of England, and support strategic policy development, the DBF should share copies of all safeguarding-related Serious Incident Reports (SIRs) with the National Safeguarding Team (NST).

Recommendation D47: The Dean and Chapter of the Cathedral and the Diocesan Board of Finance (DBF) are advised to work together to review and update their existing Service Level Agreement for safeguarding services. This revision should specifically integrate the conclusions and recommendations from this report, particularly those concerning the capacity of the DST as outlined in the "Culture, Leadership and Capacity" section of Part One. The aim of this collaborative effort is to achieve enhanced clarity, improve efficiency, and strengthen overall safeguarding practices.

Recommendation D48: The DBF should include more localised signposts in its contacts information. This should include:

- c) Social Services, Children's Partnership and Adults Board information for West Northamptonshire, North Northamptonshire, Rutland and Peterborough.
- d) Local Domestic Abuse services, e.g. Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership, Freeva and Northamptonshire Domestic Abuse Service.

Recommendation D49: 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 D50: The DBF should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

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

Recommendation D51: The DBF should consider how it will proactively engage with those who have experienced abuse within the Church and their families, to learn from authentic voices and determine priorities for improvement planning. This should be done through implementing formal feedback mechanisms, such as surveys, feedback forms post engagement, and co-facilitated listening sessions.

Recommendation D52: The DBF should recruit (short- or long-term) additional training capacity, such as paid part-time trainers or a formalised volunteer delivery team. This would reduce pressure on the ADSO, allow time for strategic oversight, and improve resilience across training delivery.

Recommendation D53: The new Learning and Development Officer should implement a more structured and strategic approach to safeguarding learning, including:

- e) Streamlining a centralised, accurate training record system with tracking and follow-ups (including portal learning);
- f) Developing robust feedback and impact evaluation processes, including post-course and longer-term evaluations;
- g) Updating the Safeguarding Training Strategy and Training Programme, informed by a Diocese-wide training needs analysis;
- h) Consider options for introducing contextual learning on topics such as trauma, elder abuse, neurodiversity and working with those who have offended.

Recommendation D54: The DBF should ensure that counselling and pastoral support services are routinely signposted to clergy and lay leaders, with particular emphasis during training, induction, and post-incident responses.

Recommendation D55: The revised Ministerial Development Review process should include structured safeguarding content addressing both training compliance and emotional wellbeing, and be monitored for consistency.

Recommendation D56: The DBF should formalise supervision arrangements for all safeguarding staff, including frequency, recording, evaluation, and access to clinical supervision when needed. This should be reviewed annually and aligned with the national supervision framework.

19 Appendix 2 – Cathedral Recommendations

Recommendation C1: To ensure the Cathedral's positive safeguarding culture is sustained and its remaining challenges (like deference and pace of change) are addressed, the Chapter should establish a formal, continuous monitoring cycle for cultural health. In order to do so, Chapter should commission 'Pulse Surveys', an anonymous reporting mechanism, and safeguarding culture KPIs to measure performance and progress.

Recommendation C2: Immediately recruit a dedicated, Part-time Professional Cathedral Safeguarding Officer/Adviser (CSO/CSA) to provide the essential operational resource and support to the Cathedral and professional advice to other staff and volunteers with a safeguarding remit or responsibility.

Recommendation C3: Review and formalise the internal process for the temporary handover of critical roles like CSL to ensure clarity, thoroughness, and effective execution under all circumstances.

Recommendation C4: The Cathedral should engage in discussions with the Diocesan Board of Finance (DBF) to assess the appetite for and viability of establishing a diocesan-wide Safeguarding Directorate, which would be led by a Director of Safeguarding (DoS).

Under this potential structure, the Cathedral's Safeguarding Officer/Adviser (CSO/A) would retain a dedicated and visible presence within the Cathedral. The CSO/A would be accountable, along with the appointed DoS, to the Chapter. However, the CSO/A would also receive professional supervision as an integral part of the wider Diocesan Safeguarding Team.

This structure would achieve several key outcomes:

- It would ensure continuity in safeguarding policy and procedures across the diocese.
- It would reinforce the independence of operational safeguarding decisions.
- It would guarantee the provision of contingency arrangements should the Cathedral require additional support.

(See **Recommendation D26** in Part One of this report.)

Recommendation C5: Clarify roles and responsibilities by:

- a) along with the DBF as soon as the new structures and lines of control and reporting are in place to enhance and formalise external support, and
- b) clearly documenting and communicating the delineated safeguarding responsibilities between the Cathedral and the School.

Recommendation C6: Chapter's oversight practice should be enhanced to include more proactive scrutiny. Minutes should consistently reflect the specific areas of challenge, the quality of information requested, and the ultimate rationale behind Chapter's decisions, moving beyond mere recording of observational briefings.

Recommendation C7: Implement a formal, periodic schedule for non-executive members to engage with various staff groups. This is not for operational involvement but for a 'listening ear' to better understand staff roles, responsibilities, and views on 'what works and what could be improved.'

- b) Ensure the learning gathered from these staff engagements directly informs Chapter's oversight, enabling non-executives to better test reports, particularly those relating to culture, safeguarding, and risk, that are presented to them.

Recommendation C8: To address the potential conflict of interest (the Dean chairing the body that holds him to account), Chapter should ensure its minutes clearly document the Senior Non-Executive Member's (and others') challenge and independent oversight, particularly during sensitive discussions like audits, demonstrating that accountability is robustly maintained.

- b) Chapter should adapt their agenda to ensure that any individual agenda item that may invoke a perception of a conflict of interest for the Dean should, by agreement be Chaired by the SNEM. Furthermore, the washup at the end of meetings that assesses the conduct and management of the meeting should be Chaired by the SNEM.

Recommendation C9: Appoint an appropriately safeguarding-qualified Independent Chair for the Safeguarding Management Group (SMG) to ensure independence and strengthen governance.

- b) Introduce wider external representation to the SMG, including relevant stakeholders such as police, local charities (especially a victim-focused one), and precinct operators.

Recommendation C10: Constitute a Safeguarding Operations Group (SOG), to be chaired by the Cathedral Safeguarding Officer/Adviser (CSO/A), to focus on operational, day-to-day safeguarding management and coordination. This group should meet more frequently, potentially weekly.

Recommendation C11: Harmonise the meeting schedules and agendas of existing oversight forums (SMG, Executive, Cathedral Leadership Team) to streamline safeguarding oversight.

- b) Ensure the SMG meeting takes place before Chapter and that its agenda is strategically focused on supporting overarching requirements and aligning with national safeguarding standards.

Recommendation C12: A stand-alone safeguarding review of chorister safeguarding arrangements should be commissioned, jointly led by the CSO and the NST's RSL. Any action plan arising from this activity should be formally reported to Chapter and overseen by the SMG.

Recommendation C13: The Cathedral should continue start-of-term parent meetings and an anonymous annual survey to build trust, receive feedback and promote awareness of safeguarding arrangements.

Recommendation C14: The Cathedral should expand the use of child-friendly safeguarding messaging in the Song School (No. 28) and other relevant areas to ensure all choristers are regularly reminded of how to seek help

Recommendation C15: The Cathedral should update its chaperone induction process to include a clear confidentiality agreement and guidance on how relevant safeguarding information is shared. Parents should be informed of what might be shared, with whom and why, with consent being sought where appropriate.

Recommendation C16: CCTV coverage in the Song School (No.28) and organ loft should be reviewed and strengthened to improve safeguarding visibility and oversight.

Recommendation C17: All staff working with choristers should receive a safeguarding refresher covering concern escalation, urgency, and information sharing pathways.

Recommendation C18: The Cathedral and King's School should establish a joint system for monitoring chorister attendance to ensure consistent oversight and timely safeguarding responses.

Recommendation C19: All music department staff with responsibility for children should urgently complete safeguarding training relevant to their role where this remains outstanding. Lone working, data protection, and professional boundaries should be comprehensively covered with new staff / volunteers during induction, or retrospectively where needed.

Recommendation C20: The Cathedral should deliver behaviour management and neurodiversity training for music department staff and volunteers, in collaboration with King's School.

Recommendation C21: The Cathedral should review and clarify the language within the chorister MoU to ensure expectations about handbook compliance and absence are communicated in a way that upholds both commitment and wellbeing.

Recommendation C22: The Cathedral should review and strengthen the onboarding process to ensure that all staff members with direct responsibility for children have a completed and satisfactory DBS check returned before commencing their roles. This should include formalising a "no start" policy until the DBS clearance is confirmed, in line with the House of Bishops' Safer Recruitment and People Management guidance.

Recommendation C23: To ensure effective oversight and monitoring, the Cathedral should report on DBS check and status to Chapter and the SMG. This report should include, for example, the number of DBS checks completed, the number outstanding, and any 'blemishes' returned.

Recommendation C24: The Cathedral should thoroughly review and enhance its [safeguarding webpage](#) layout ensuring that information is prioritised according to user importance. Specifically, a prominent section on 'how to report a safeguarding concern' should be given primary focus, with other frequently accessed sections re-ordered accordingly. The aim is to logically group supporting resources, making them easily discoverable and accessible. Crucially, the website must also include clear guidance instructing users to contact 999 immediately if they have an urgent safeguarding concern.

Recommendation C25: The Cathedral should establish engagement mechanisms to consider the needs, experiences and voices of vulnerable adults and survivors within safeguarding prevention planning.

Recommendation C26: The Cathedral should expand CCTV coverage to include key areas, such as the education room and the chorister's practice room.

Recommendation C27: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral.

Recommendation C28: The Safeguarding Policy should be updated to include details on how safeguarding-related disputes are handled and to outline the appropriate escalation procedures.

Recommendation C29: The Cathedral should partner with the DBF to host diocese-wide listening events, providing a platform to hear from a diverse range of voices to inform local practice.

Recommendation C30: The Cathedral should enhance its existing ‘Safeguarding’ webpage by creating a dedicated sub-section for victims and survivors. This new sub-section should:

- d) Clearly detail the Cathedral's adherence to national guidance ‘Responding Well to Victims and Survivors of Abuse’, explicitly outlining its proactive and supportive stance.
- e) Provide a reassuring and welcoming online space where individuals seeking support can immediately feel at ease and be confident that they have found the appropriate resources.
- f) List appropriate signposting for support (both national and local).

Recommendation C31: The Cathedral should strengthen its safeguarding telephone guidance for those receiving disclosures by explicitly outlining the importance of a trauma-informed approach and providing further guidance on how to respond to safeguarding disclosures. This should include:

- f) Providing a clear explanation of the importance of a trauma-informed approach.
- g) Setting out how disclosures from potential victims and survivors may vary significantly based on their individual experiences.
- h) Further guidance and examples on using empathetic language, active listening techniques, and non-judgmental responses.
- i) Strategies for calming distressed callers and managing sensitive conversations.

- j) Building on the existing protocols for concluding calls in a way that leaves the caller feeling supported and informed of next steps, e.g. forwarding the call to the relevant individual.

Recommendation C32: The Cathedral should develop a contextual safeguarding training strategy, supported by a clear programme of learning that outlines available courses, expectations by role, and methods of delivery. This strategy should be informed by local needs and the CofE's Safeguarding Learning and Development Framework.

Recommendation C33: The Cathedral should update its training records to ensure alignment with current national terminology, enabling accurate tracking and compliance monitoring.

Recommendation C34: To ensure effective oversight and monitoring, the Cathedral should regularly report to the Chapter and SMG on the status of safeguarding training among staff and volunteers, including completion rates and renewal dates.

Recommendation C35: The Cathedral should ensure that all new starters receive a safeguarding-specific component as part of their induction process that goes beyond a recognition of reading the safeguarding policy and completing safeguarding training.

20 Appendix 3 – Glossary of Abbreviations

BST	Bishop's Staff Team
CCSL	Clergy Current Status Letter
CCTV	Closed-circuit TV
CDM	Clergy Discipline Measure
CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
CPS	Crown Prosecution Service
CSA	Cathedral Safeguarding Advisor
CSC	Children's Social Care
CSG	Casework Scrutiny Group
CSL	Chapter Safeguarding Lead
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
GDPR	General Data Protection Regulation
HR	Human Resources
IICSA	The Independent Inquiry into Child Sexual Abuse
ISA	Information Sharing Agreement
IT	Information Technology
LADO	Local Authority Designated Officer
LLR	Learning Lessons Reviews
MAPPA	Multi-Agency Public Protection Arrangements

MDR	Ministerial Development Review
MOSOVO	Management of Sexual Offenders and Violent Offenders
MoU	Memorandum of Understanding
NAPAC	National Association for People Abused in Childhood
NHS	National Health Service
NPCC	National Police Chiefs' Council
NSCMS	National Safeguarding Case Management System
NSS	National Safeguarding Standards
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
PTO	Permission to Officiate
RSL	Regional Safeguarding Lead
SARC	Sexual Assault Referral Centre
SCIE	The Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SIR	Serious Incident Report
SLA	Service Level Agreement
SLT	Senior Leadership Team
SMG	Safeguarding Management Group

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