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

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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 Diocesan 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 Blackburn DBF and Blackburn Cathedral, this involved the following:

- Over 470 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.
- 423 anonymous survey responses were received, which gathered input from key communities connected to the Church. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the DBF, the Cathedral and parishes.
- Seven focus groups.
- A confidential contact form being made available via a dedicated webpage.
- In total, the Audit undertook 41 separate engagement sessions reaching 84 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, Blackburn DBF and Part Two, Blackburn 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 the Cathedral.

Part One - Blackburn Diocesan Board of Finance

2 Context

2.1 The Diocese of Blackburn, established in 1926, covers approximately 930 square miles, encompassing most of Lancashire, along with Standish (Greater Manchester) and Tosside (North Yorkshire). Comprising two archdeaconries and 14 rural deaneries, it includes 227 parishes with 287 places of worship. This diverse region spans urban and rural landscapes, from the Trough of Bowland to industrial East Lancashire, university cities like Preston and Lancaster, coastal resorts such as Blackpool and Morecambe, and communities ranging from affluent villages to multicultural urban centres.

2.2 Its boundaries intersect with Lancashire County Council, Blackburn with Darwen, Blackpool, Greater Manchester, and North Yorkshire. Consequently, it falls under the jurisdiction of Lancashire, Greater Manchester, and North Yorkshire Constabularies, and is served by the Lancashire and South Cumbria, Greater Manchester, and Humber and North Yorkshire Integrated Care Boards.

2.3 Following 20th-century economic decline, Lancashire now focuses on light industry, agriculture, engineering, and services like education, healthcare, and digital innovation. Resilience is evident in transitions from declining industries (e.g., textiles and mining) to BAE Systems and entrepreneurial start-ups emerging from universities, showcasing adaptability. However, significant socioeconomic disparities persist, with some parishes among the nation's most deprived, while others are highly affluent.

2.4 Blackburn Diocese has an estimated population of around 1.7 million. Data collected locally indicates that average weekly church attendance in 2023 was 11,927 adults and 2,846 children and young people (under 18). The region offers numerous church primary and secondary schools, along with sixth form colleges in major towns and universities in

two cities. The diocese is mainly Christian or non-religious, with small populations adhering to other faiths.

3 Progress

3.1 Overall, the SCIE Safeguarding audit and PCR2 made 58 considerations / recommendations for the DBF in Blackburn. These covered a range of issues, including capacity, safer recruitment, case management and supporting and engaging with victims and survivors. The Audit has been reassured that initial actions were met, with several being subsumed into annual iterations of the Diocesan Business Plan or superseded by national developments, such as implementation of parish dashboards and adoption of the National Safeguarding Case Management System (NSCMS). This overarching business plan is aligned with the National Safeguarding Standards and is overseen at each Diocesan Safeguarding Advisory Panel (DSAP) meeting.

3.2 The Audit heard that upon commencement of the current Diocesan Safeguarding Officer's (DSO) arrival in post, outstanding SCIE and PCR2 actions from previous business plans were reviewed and incorporated into a new one. The Audit heard that initial local supervision from the previous Diocesan Safeguarding Advisor (DSA) facilitated a smooth transition for the current DSO before regional supervision.

3.3 The SCIE audit was published in January 2016 and resulted in eight considerations, all of which were accepted. The PCR2 was published in February 2021, resulting in 50 recommendations, grouped by theme. The Audit heard of the activity undertaken in response to PCR2 and was reassured of the progress that had been made. The Audit acknowledged that some areas remain continual and will remain subject to ongoing assessment.

3.4 In response to these findings, the DBF has implemented a series of improvement measures. These include the creation of a Survivor Consultative Group, better

relationships with external agencies - including wider representation on DSAP - and working collaboratively with other dioceses to share good practice.

3.5 The DBF demonstrates a commitment to continuous improvement by integrating actions from Lessons Learned Reviews (LLRs) into its business plan. The Audit saw tangible evidence of lessons being applied from both LLRs and core group reflections.

4 Culture, Leadership and Capacity

Culture

4.1 Feedback gathered through the Audit's surveys, focus groups and interviews indicated a positive shift in how safeguarding is approached within the Diocese of Blackburn, with a majority from within the DBF and parishes acknowledging significant progress. Responses concerning the culture within the DBF and across the diocese were most often characterised by words like 'welcoming', 'collaborative', 'inclusive', and 'forward-thinking.' Good interpersonal connections, open dialogue among those in leadership, and a readiness to review and adapt internal practices were similarly emphasised. Overall, the Audit was reassured that the current leadership actively seeks to understand the range of varied and different perspectives within and across the diocese.

4.2 Moving forward, the DBF is focused on fully integrating safeguarding into its fundamental principles. The commitment to strengthen existing good relationships and encourage a culture of open communication and continuous learning was evident in the Audit's findings, with most of the DBF's workforce and the wider parish community feeling able to speak truth to power.

4.3 That said, although still the majority, slightly fewer expressed the same level of confidence regarding the handling of concerns and whether the views of children and adults within the community were always heard. Given the current positive trajectory, alongside feedback from those engaged by the Audit, approachability, pace and consistency will be key to effectively addressing these legacy issues.

4.4 Most participants in the Audit spoke of the Diocesan Bishop leading by example through actively cultivating an environment where safeguarding is prioritised and both challenge and reflection are encouraged.

Leadership

4.5 The Diocesan Bishop clearly understands and accepts his overall accountability for safeguarding and does not delegate his strategic responsibilities in this regard. In the opinion of the Audit this is good practice.

4.6 The Audit also found substantial evidence of his collaborative approach, working closely with his senior team, the DSO and Diocesan Safeguarding Team (DST). His relational leadership style prioritises the building of trusting and honest relationships with clergy and staff, further reinforcing what appears to be a highly collegiate environment.

4.7 The Diocesan Bishop was found to apply a 'safeguarding first' approach to his decision making. This was evident in the examples of authoritative practice observed by the Audit, which found evidence of appropriate and unambiguous challenge at all levels. This included making difficult decisions that put safeguarding before reputation, personal or professional relationships. This is exemplified in his approach to concerns raised with him regarding perceived leadership challenges at the Cathedral and their potential impact on safeguarding. The Audit found that despite the autonomy of the Cathedral and its leadership and governance, he did not shy away from addressing the issues, seeking reassurance and instigating appropriate enquiries. Critically, the Audit also saw evidence of his ability to constructively reflect on his own actions.

4.8 Supporting the Diocesan Bishop are a highly effective Diocesan Secretary, two Suffragan Bishops who provides both strategic support and pastoral care, and the active Archdeacons. Each brings complementary skills, an appetite to learn and strengthen safeguarding practices, as well as the capacity for both individual and collective challenge.

Archdeacons

4.9 The Archdeacons play an important role in safeguarding, particularly through their formal and informal visits and annual clergy conversations, which emphasise holistic development for clergy. Consistent with the prevailing leadership ethos, their strengths lie in their relational approach, prioritising trust and support. They chair core groups, monitor parish safeguarding dashboards, and guide parishes in recruiting Parish Safeguarding Officers (PSOs). They consider safeguarding as integral to ensuring 'healthy churches' and provide valuable insights into local church dynamics, enabling contextually relevant support. To further enhance their effectiveness, the following recommendations are made:

Recommendation D1: **Enhanced Communication and Oversight**

The Archdeacons should establish quarterly meetings with the DSO to ensure structured information sharing, enabling them to maximise the safeguarding impact of their formal and informal visits. These meetings should be underpinned by enhanced safeguarding briefs, debriefs, and record-keeping regarding outcomes and any necessary remedial actions.

Recommendation D2: **Strengthened Ministerial Development Reviews**

The current positive practice of Ministerial Development Reviews (MDRs), specifically the annual conversations, should be strengthened by consistently embedding a structured safeguarding development section in each record. This section should include practical reflections on an individual's safeguarding experience (in past and current roles) and identify future development areas. Development opportunities, both internal and external, should be provided, such as mentoring from external safeguarding experts, visits to statutory partners and access to relevant courses beyond the Church of England's national curriculum.

Recommendation D3: **Refreshed Core Group Training**

Core group training should be refreshed, with an invitation to neighbouring Archdeacons to attend a best practice workshop. This workshop should explore different approaches and outcomes, aiming to identify and establish consistently good practice.

During Audit discussion, the Archdeacons reinforced their desire to create an environment within which clergy would feel safe when admitting honest mistakes without fear of blame or punishment, similar to the approach taken in Local Child Safeguarding Practice Reviews. The Audit supports this idea in principal and will develop a balanced recommendation for the NST.

Clergy (Blue) Files

4.10 Clergy (Blue) files are efficiently administered and securely stored within the Bishop's office in fireproof cabinets. This is considered good practice. Further good practice was noted in the approach to ensuring content was easily identifiable and curated to remove duplicate documents.

4.11 The scrutiny and production of Clergy Current Status Letter (CCSL) documentation was of a very high standard, including the follow-up of delayed incoming Clergy Files, and the approach to both incoming and outgoing CCSLs. This good practice was evidenced by the material being found to be unvarnished, proportionate and balanced, achieving a clarity that would enable others to make informed decisions.

Governance

4.12 The DBF operates a range of appropriate governance and oversight meetings, reflecting CofE expectations and relevant requirements, such as those issued by the Charity Commission. Safeguarding is routinely addressed at these meetings, and the DSO attends by invitation.

4.13 Notwithstanding capacity challenges for the DST, discussions with members of the Senior Leadership Team and DSO highlighted a growing recognition of the need to embed safeguarding representation more deeply into the DBF's strategic planning and governance arrangements. If capacity can be addressed (recommendations regarding safeguarding structure and capacity are detailed elsewhere in this report), the Audit welcomes the Diocesan Bishop's openness to ensuring that the DSO (or Director of Safeguarding) can attend appropriate meetings including the DBF, Vision and Strategy and Bishop's Appointments Team meetings.

The Diocesan Safeguarding Advisory Panel (DSAP)

4.14 The Diocesan Safeguarding Advisory Panel (DSAP) has several key strengths, notably its leadership under the current Chair. Her extensive safeguarding background brings significant value and yields benefits for the wider Diocese.

4.15 The DSAP has successfully diversified its membership, incorporating voices from the police, local authorities, and health, leading to richer and more insightful discussions. Crucially, the Chair effectively challenges members, including senior clergy, thereby promoting overarching accountability. The DSAP's ability to convene extra meetings for focused discussions further highlights its agility.

4.16 However, whilst victim and survivor representation exists, it could be strengthened to ensure their voices are heard more fully. Achieving full safeguarding training compliance across clergy and church officers remains a challenge that must be effectively addressed. Furthermore, a more structured approach to oversight and accountability, such as developing and monitoring a comprehensive action tracker for reviews and audits, and a three-year themed scrutiny approach focusing on in-depth examinations of performance against the National Safeguarding Standards, could further enhance the DSAP's effectiveness.

4.17 The following recommendations aim to strengthen the DSAP's effectiveness as it relates to oversight and accountability:

Recommendation D4: **Enhanced Victim and Survivor Engagement:**

a) The DSAP should implement a strategy for proactive outreach to local and national victim and survivor support groups. This should involve designated DSAP members or representatives visiting their meetings as listeners to gain a deeper understanding of their experiences and needs.

b) The DSAP should extend invitations and provide appropriate facilities for a range of victim and survivor support groups to present their perspectives, insights, and recommendations directly to the DSAP members. This may foster a more direct and informed dialogue.

Recommendation D5: **Comprehensive Action Plan and Accountability:**

a) The DSAP should develop a comprehensive action plan that meticulously captures all current outstanding safeguarding actions identified from audits, reviews, and other relevant sources. This plan should be a central, living document.

b) For each action within the plan, the DSAP should clearly designate a specific individual or role responsible for its completion ('Action Owner').

c) The DSAP should establish clear and measurable key milestones for each action, outlining expected completion dates and interim update requirements. This will facilitate effective monitoring of progress.

d) A robust mechanism should be implemented requiring Action Owners to provide regular updates to the DSAP on their assigned actions. These updates should be formally reviewed during DSAP meetings.

Recommendation D6: **Three-Year Themed Scrutiny Programme:**

a) The DSAP should hold a dedicated workshop for its members and relevant safeguarding professionals to identify key National Safeguarding Standards for in-depth scrutiny over a three-year period.

b) As an initial phase, the 'Year One DSAP Audit Programme' could focus on the following key National Safeguarding Standards through deep dives:

   i. Examining the effectiveness of learning mechanisms from safeguarding incidents and the quality of supervision provided to safeguarding professionals and other relevant roles.

   ii. Reviewing the sufficiency of safer recruitment practices across all relevant roles in the DBF and across the wider Diocese.

   iii. Assessing the effectiveness of risk assessment processes, the development and implementation of safety plans, and their impact on safeguarding vulnerable individuals.

c) The themed scrutiny programme for subsequent years should capture further key National Safeguarding Standards for deep dive audits, ensuring a comprehensive and systematic review over the three-year cycle.

Recommendation D7: **Enhanced Escalation Process for Non-Completion of Safeguarding Training:**

a) The DSAP should establish a clear process whereby, after set deadlines for mandatory safeguarding training completion have passed, the DSAP will formally write to those with oversight responsibility for individuals who remain non-compliant (e.g., Archdeacons for clergy, PCC Secretaries for church officers). This notification will explicitly state the outstanding training requirements and the potential consequences of continued non-compliance.

b) The DSAP should implement a system to restrict the role and function of individuals who fail to complete the required safeguarding training within a reasonable timeframe after formal notification. This system should be clearly defined and communicated, and could include temporary suspension from specific duties involving contact with vulnerable individuals or leadership responsibilities until the training is completed. The DSAP should oversee this system and monitor its consistent application.

c) The DSO should provide regular reports to the DSAP on safeguarding training compliance and any instances requiring escalation and role limitation. This will enable the DSAP to monitor the effectiveness of the training programme and the escalation process.

Capacity DST

4.18 The DST benefits from strong leadership and its members possess credible and complementary skill sets. The team comprises a fulltime DSO, Assistant Diocesan Safeguarding Officer (the ADSO works four days per week), a full time Administrator and a Trainer who works three days per week. The team has a good balance of technical expertise, interpersonal skills, and an appetite to learn.

4.19 The DSO brings a wealth of experience drawn from social work, the charity sector, housing, homelessness, substance misuse, and sexual assault support, augmented by the ADSO's professional background in probation. Together, they possess complementary skillsets and a proven ability to effectively engage with vulnerable people. Feedback from the Local Authority Designated Officer (LADO) underscored confidence in the DST's competence, highlighting their approachability and professionalism. That said, the team is simply too small to deliver all of the functions expected of them and lacks the capacity to develop a meaningful strategic capability.

4.20 In the opinion of the Audit, consideration should be given to restructuring the safeguarding functions within the DBF. This could be achieved through the establishment of a dedicated Safeguarding Directorate, led by a suitably qualified Director of Safeguarding. This would provide an autonomous safeguarding team responsible for the delivery of safeguarding, with the Director of Safeguarding holding the ultimate authoritative decision-making power on operational matters. This arrangement would ensure independence from clergy-based decision-making, without impeding the role and accountability function of trustees at a governance level.

4.21 The following recommendations aim to build capacity, enhance professional skills, and create a more robust safeguarding system.

Recommendation D8: **Establish an Independent Safeguarding Directorate**

To significantly strengthen safeguarding across the Diocese, the DBF should establish an operationally independent Safeguarding Directorate, led by a Director of Safeguarding. This Directorate would consolidate all safeguarding resources and provide comprehensive and consistent support to the DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the authority and autonomy to:

a) Provide expert advice and robust oversight on all safeguarding matters.
b) Challenge senior clergy and church bodies when necessary, ensuring accountability.
c) Escalate concerns directly to higher authorities, including the NST, without undue influence.

To ensure the effectiveness and significance of this structure, the following is required:

a) The Director should be a member of and report directly to key decision-making bodies, including the DBF, Bishop's Council, Chapter, and BLT / SLT.
b) A comprehensive Service Level Agreement (SLA) between the DBF, Parish PCCs, and the Cathedral should clearly define the Director's authority and responsibility to provide safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the Diocese.
c) The Directorate should be equipped with sufficient resources and staffing, including the consolidation of all professional safeguarding staff (including those currently at the

Cathedral), and the creation of at least two new positions: one to backfill the existing DSO role and at least one new Assistant DSO (ADSO) position.

Note: This recommendation should be read in conjunction with the section on a Safeguarding Directorate within the Independent Safeguarding Audits Annual Report (2024/2025).[2]

4.22 Regardless of whether the above recommendation is accepted, the current capacity of the DST needs to be addressed, and the following is recommended.

Recommendation D9: **Phased Recruitment of Additional Assistant Safeguarding Advisors / Caseworkers**

To enhance the DST's capacity and resilience, a staged recruitment of additional caseworkers is recommended, incorporating complementary skill sets and training responsibilities.

Phase 1: Recruitment of an Assistant Diocesan Safeguarding Officer (ADSO) / Case worker (CW) with Specialist Skills:

a) The DBF should recruit an additional ADSO / CW with a complementary professional background, such as experience in the police or social care sectors, and a specific and demonstrable safeguarding skill set (e.g., child protection, adult safeguarding, risk assessment). This additional role should work in conjunction with the Safeguarding Support Coordinator (currently the Administrator role) to enhance and expand early help provision to parishes.

Phase 2: Recruitment of a Caseworker / Assistant Diocesan Safeguarding Advisor with Training Portfolio Responsibility:

a) The DBF should recruit an additional caseworker, with the potential for development into an ADSO role, whose remit will include a significant focus on enhancing the current safeguarding training provision across the Diocese.

Structure, Role and Expectations for ASDOs / CWs:

a) The additional caseworkers will primarily assist with casework management, providing vital support to the existing team.

[2] https://ineqe.com/churchofengland/

b) One caseworker will specifically contribute to the development and delivery of the training portfolio.
c) Both roles will provide essential backup and cover for existing team members, increasing the team's resilience and flexibility.
d) Consideration should be given to aligning caseworker responsibilities with archdeaconry areas, mirroring successful models in other dioceses for localised support.
e) Explore the potential incorporation of the Cathedral Safeguarding Advisor role within the DST's professional line management structure. Whilst dedicated to the Cathedral, this integration would allow for professional oversight, enhanced training opportunities, and the ability to reinforce the wider DST during periods of high demand or contingency.

4.23 The current Administrative support should be transformed from a purely supportive function to a more safeguarding focused, skills-based position that contributes directly to the team's effectiveness.

Recommendation D10: **Evolve the Administrator Role to Support the DST**

To enhance the operational capacity and effectiveness of the DST, the current administration function should be expanded. This enhanced role should encompass the development of a professional portfolio (in support of the Administrator) and the acquisition of skills extending beyond traditional administrative duties. Specifically, the administrator's naming convention should be changed to Safeguarding Support Co-ordinator and their duties (once trained) should include:

- The initial triage of incoming safeguarding calls, mirroring a social care model for preliminary screening and information gathering.
- Expanded responsibilities to manage and filter incoming calls and communications, thereby alleviating pressure on the DST and ensuring the efficient allocation of resources.
- A training evaluation support function, involving follow-up contact with participants to gather valuable feedback on their learning experience, how any new skills are being practically applied, and the overall impact of the training.
- Supporting PSOs and being responsible for assisting with the management and regular updating of the Parish Safeguarding Dashboard, contributing to the effective tracking and documentation of safeguarding activities and outcomes.

Memorandum of Understanding – Cathedral and DBF

4.24 To establish a more robust and collaborative safeguarding framework, a refreshed Memorandum of Understanding (MoU) or Service Level Agreement (SLA) between the Cathedral and DBF is crucial. This MoU / SLA should comprehensively address structural elements, operational components, and key principles to ensure a unified and effective approach.

Recommendation D11: An effective MoU / SLA between the Cathedral and DBF should contain the following:

Key Principles

a) Operational independence of safeguarding

b) Professional collaboration

c) Consistent safeguarding standards

d) Mutual accountability

Structural Elements:

e) Clear definition of roles and responsibilities

f) Explicit lines of professional accountability

g) Mechanisms for consistent communication

h) Shared commitment to the CofE's National Safeguarding Standards

Operational Components:

i) Case Management
   i. Shared access to a case management system
   ii. Clear protocols for case allocation
   iii. Consistent record-keeping standards
   iv. Mechanisms for cross-organisational case review

j) Professional Supervision

i. Clear supervision frameworks

ii. Defined escalation processes

iii. Mutual commitment to professional development

iv. Transparency in decision-making

k) Resource Sharing

i. Clarity on resource allocation

ii. Defined capacity expectations

iii. Mechanisms for collaborative resource deployment

iv. Contingency planning

l) Quality Assurance

i. Agreed quality assurance frameworks

ii. Regular performance reviews

iii. Shared metrics for evaluating performance and safeguarding effectiveness

iv. Commitment to continuous improvement

m) Information Sharing

i. Protocols for timely and comprehensive information exchange

ii. Confidentiality guidelines

iii. Mechanisms for joint risk assessment

iv. Clear communication channels

Collaboration

4.25 Given the financial pressures facing both the DBF and the Cathedral, which may limit their ability to invest in additional safeguarding resources, the DBF and the Cathedral should consider jointly exploring opportunities for greater collaboration, specifically focused on identifying potential cost savings.

Recommendation D12: A formal review should be undertaken by the DBF and Cathedral to assess the feasibility and benefits of shared support services, such as HR, finance, or IT, with the explicit aim of streamlining operations and generating cost efficiencies that can be reinvested into bolstering safeguarding resources across both organisations.

5 Prevention

5.1 One way in which the DBF demonstrates its prioritisation of safeguarding is through its arrangements for safer recruitment. The DBF follows the House of Bishops' Safer Recruitment and People Management guidelines, ensuring processes are aligned to legislation. Local practice is effective, including comprehensive training for recruitment personnel, accessible online resources, and expert support for Disclosure and Barring (DBS) checks through a contracted provider. The discernment journey provides a strong example of proactive safer recruitment. Candidates are required to complete DBS checks and safeguarding training early in the process, ensuring these measures are in place from the beginning. This is good practice.

5.2 As part of the Audit, a case was identified involving an individual who had failed to disclose pertinent information on their Confidential Declaration Form and throughout the recruitment process. This non-disclosure raised serious concerns and in accordance with the House of Bishops guidance[3], and it is noteworthy that the Audit found evidence of effective management practices in place for addressing such issues once identified.

Recommendation D13: The DBF should ensure that all staff and volunteers are up to date with DBS checks and are within the three-year cycle.

5.3 The Audit is of the opinion that the current responsibility for DBS administration, held by

[3] See Section 10, House of Bishops' Guidance Safer Recruitment and People Management which states "If the DBS Certificate identifies information that the individual has not disclosed on his/her Confidential Declaration form or at any other time during the proceedings to date, then serious consideration must be given as to whether this candidate can be appointed after such a potential breach of trust. In all cases, the applicant should be given the opportunity to explain the discrepancy before a final decision on their suitability for the position is made." https://www.churchofengland.org/safeguarding/safeguarding-e-manual/safer-recruitment-and-people-management-guidance/section-10

the DST, would be more appropriately located within the HR team. This should include a clear process for information sharing with the DST, particularly when a DBS check reveals relevant information. This realignment would free up administrative capacity within the DST to offer more proactive outreach and support to parishes.

Recommendation D14: The DBF should transfer DBS administration from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

5.4 Safeguarding is a clear priority at all levels within the DBF and there is evidence that this is being routinely considered in key forums. Safeguarding is an agenda item at leadership meetings, within induction and recruitment processes for clergy and leadership, and in events such as the Staff Away Day, where safeguarding materials are presented.

5.5 The DBF demonstrates its commitment to embedding safeguarding through various activities across different levels. This includes direct engagement with youth leaders, such as safeguarding sessions delivered by the DSO in a city centre church in Blackpool. At the parish level, the DBF actively promotes safeguarding awareness, encouraging each parish to observe Safeguarding Sunday, during which clergy and local leaders engage their congregations in discussions about safeguarding. Following key events, the Bishop of Blackburn and the DSO have communicated relevant messaging with parishes and continue to support their safeguarding activities. To further strengthen these efforts, the DBF facilitates monthly online drop-in sessions with Parish Safeguarding Officers (PSOs) and holds face-to-face meetings with PSOs three times a year, enabling peer support and the sharing of knowledge and ideas.

5.6 The Audit observed several mechanisms used by the DBF to develop, adopt, and share

good safeguarding practice. These include informal networking among northern dioceses, monthly NST drop-in attendance by the DSO and ADSO, and the DSO's participation in Cathedral safeguarding meetings to share practice and experience. The DSO has also engaged with Regional Safeguarding Leads (RSL) through the pilot process and attended the Lancashire Safeguarding Adults Board (LSAB) as a guest. Operationally, the DSO and ADSO participate in allegations meetings with the LADO and professional meetings with partner agencies such as Management of Sexual Offenders and Violent Offenders (MOSOVO) and probation, where case discussions occur.

5.7 The Audit acknowledges the critical importance of effective communication in safeguarding, recognising that individuals require information at various stages, in diverse formats, and across different locations.

5.8 Most respondents to the Audit's survey in parishes indicated that they had observed improvements in how awareness about safeguarding was being raised. The DBF engages a variety of materials and methods to promote safeguarding with different audiences. Clear contact details and service descriptions are provided on the Diocesan website, ensuring individuals can easily access the appropriate support. The DBF provides parishes with 'model safeguarding wording' for them to copy and use on their own websites. This is good practice.

5.9 The Safeguarding Matters E-Bulletin keeps key parish personnel informed with vital updates and information. Recent communications have included the release of the new CofE Safeguarding Records Retention form, along with promotional materials for a workshop on Safeguarding Hubs, Modern Slavery Training, and access to the Safeguarding Standards and Quality Assurance Framework. The E-Bulletin also provides regular reminders about reporting concerns and safer recruitment processes. Furthermore, it highlights external resources, such as a Charity Commission video and

guide on trustee safeguarding responsibilities and encourages everyone to read the Lancashire Safeguarding Partnership newsletter.

5.10 Key safeguarding information is disseminated broadly, with the distribution method tailored to the specific topic and its relevance. For instance, national guidance on 'Children's and Youth Ministry in Personal Homes' was shared widely through the parish update newsletter to ensure it reached the individuals most likely to be involved in such activities.

5.11 The Diocese's website has a strong, clean and modern theme and is mobile responsive. It is positive that the 'Safeguarding' section has prominence and strong visibility. Within the Diocesan safeguarding webpages, there is clear and consistent signposting to internal help and external support, the ability to access online safeguarding training, and DBS guides, tools and diocesan and national policies.

5.12 With regards to the messages communicated, the DBF has appointed a new digital officer tasked with integrating safeguarding messages across online and social media platforms. This initiative is also planned to promote Safeguarding Sunday and showcase examples of best practices.

Recommendation D15: The DBF should adjust its communication plan to include key safeguarding messages via its digital channels. In order to enhance this engagement, it should:

a) Tailor content to resonate with the specific interests and preferences of followers on each platform.

b) Employ diverse communication strategies suited to each platform's unique features and user expectations.

c) Capitalise on relevant awareness days, campaigns, and events to amplify key messages and expand audience engagement.

5.13 Communication is adapted to meet the specific needs of the audience. The Audit found an example of this in practice, where key safeguarding information was translated from English to Farsi to effectively communicate with an individual.

5.14 Diocesan Synod has established a Youth Forum working with The Diocesan Board of Education and the Bishop of Blackburn to gather direct feedback from young people and use such input to shape its activities. As part of the Audit, discussions were held with members of this forum, providing a platform for young people to express their views about safeguarding within the Church. The forum itself fosters a safe environment for young people to share their opinions and contribute to positive change, aligning with good practice in youth participation and empowerment. The young people put forward ideas for improvement, such as lowering posters to enhance visibility for younger children and increasing the number of safeguarding activities available to them. They received a prompt response from the youth forum facilitators and the Diocesan Bishop, demonstrating how these ideas were disseminated across parishes. When the group participates in trips, clear rules are established that are understood by the young people, and effectively supervised by adults.

5.15 Reflecting a thorough approach to its prevention activity, the Audit also saw evidence of template risk assessments that are completed for a range of Church activities. These templates cover areas such as home risk assessments, blemishes arising from DBS checks, standard risk assessments for safety plans, and risk assessments for Youth Forum events.

5.16 In terms of preventing harm to staff and volunteers, the DBF has a Lone Working Policy in place. For others within the diocese, guidance is provided through the national CofE Safer Environment and Activities which also outlines good practice in respect of maintaining clear boundaries. Furthermore, in respect of deliverance ministry within the DBF, the Audit

revealed a systematic and considered approach where safeguarding was integrated within guidelines and operating protocols.

5.17 The Audit saw evidence of safeguarding being considered in a broader sense within the physical spaces being occupied. For example, a recent online article on the Diocesan website 'Filming and photography including asking for consent', highlights the importance of seeking consent, including parental consent, when publishing images of adults and children.

6 Recognising, Assessing and Managing Risk

6.1 The DBF risk register covers key corporate issues. There is a specific 'safeguarding' section within the risk register, with concerns and control measures well documented. This allows for a specific focus on safeguarding and as an approach, is considered to reflect good practice. Whilst it is clear that reviews take place, the Audit believe this process could be strengthened. Firstly, by clearly recording the next scheduled review dates and, secondly, by implementing a process whereby risk owners assess cross organisational risk on a quarterly basis.

Recommendation D16: The DBF should include the review dates on Risk Registers. Risks should be reviewed on a quarterly basis to assess cross organisational risk particularly in the event of significant changes to workplace processes.

6.2 The DST operates on a low-threshold model of practice. This promotes a culture that encourages reporting and dialogue with the DST when someone has concerns. This is good practice. Defined processes are in place for receiving and triaging new concerns, assessing risk, and allocating cases.

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

- Onward referrals to statutory authorities
- The management of individuals within the worshipping community
- The provision / signposting to support
- The initiation of disciplinary processes, such as Clergy Disciplinary Measures (CDM)
- Initiation of the Safeguarding Case Management Group (SCMG) procedure (formerly Core Groups)

6.4 There is good awareness about how and to whom concerns can be reported, supported

by website signposting, published email addresses, and a central phone number. Phone call enquiries are aided by a central phone system to route calls to available team members. The DSO retains oversight and knowledge of all cases.

6.5 The DST makes good use of the risk grading function on the NSCMS. Cases are allocated a risk level of 'high', 'medium' or 'low'. This could be strengthened by detailed recording of the rationale for the risk grading and the prioritisation of cases, alongside there being clear timescales for actions and the review of these.

Recommendation D17: 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.

6.6 At the time of the Audit, there were 169 open cases recorded on the NSCMS. Each case had been assigned a risk level, with 116 graded as 'low' risk, 40 as 'medium' and 13 as 'high.' 862 cases had been filed and closed on the system.

6.7 Of the open cases, 12 were not allocated to a named individual on the NSCMS but to an 'owning group', namely the DST. The absence of an identified worker on this dashboard has the potential to confuse accountability and responsibility for case management. Designating an allocated case owner will also allow for the more effective monitoring of workloads allocated to DST members.

6.8 The Audit observed some inconsistency with the use of concern summaries in the NSCMS. To improve practice in this context, the Audit recommends implementing a standardised and mandatory approach to this aspect of case recording.

Recommendation D18: The DBF should ensure that 'Concern Summaries' are recorded in all cases.

6.9 At the time of the Audit, there were 36 respondents categorised as having active safety plans on the NSCMS. The Audit saw good use of these plans in managing risk. This included a multi-agency approach, the setting of explicit prohibitions / expectations and regular reviews which were documented and signed by relevant parties.

6.10 Safety plans adhered to the national template issued by the CofE, although the Audit noted here (as it has in previous Audits) the limitations of the template not taking account of respondents attending other churches or church establishments. The Audit has raised this with the NST.

6.11 With regards to the core processes engaged by the DST, the Audit saw evidence of a multi-agency approach with statutory agencies, the convening of Safeguarding Case Management Groups (SCMG) (formerly referred to as Core Groups), engagement in strategy meetings, risk assessments and support being provided for relevant parties.

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

6.13 The DBF, as a registered charity, is required to submit Safeguarding Serious Incident Reports (SIRs) to the Charity Commission. The Audit was informed that there is adherence to the House of Bishop's guidance on this issue. The DBF has submitted three SIRs, and the Audit was advised that all cases had been shared with the NST.

6.14 The DBF has several information sharing agreements (ISAs) in place. These include agreements with DBE Services, the Blackburn Diocesan Board of Education, Blackburn Cathedral, the Bishop of Blackburn, Lifeline Translation Services Ltd, the National Police Chiefs' Council (NPCC), and the Probation Service.

6.15 The challenges of handling safeguarding issues can lead to differences of opinions among decision makers. The DBF has sensibly addressed this by establishing a clear escalation process within their Complaints Handling Procedure.

6.16 The DSO receives structured safeguarding supervision from the Regional Safeguarding Lead (RSL) every six to eight weeks. Supervision records provided to the Audit highlight the welfare support being provided to the DSO, as well as discussions about organisational issues, working relationships and succession planning. Team members receive line management and supervision from the DSO through monthly one-to-one meetings. In addition, the DSO holds an individual monthly meeting with the ADSO that covers casework supervision.

6.17 The DBF maintains protocols and measures to ensure the secure storage and handling of personal information. These measures include secure email utilising Microsoft 365 features, Egress for communication with local authorities, My Concern as the NSCMS, and the Criminal Justice Secure Mail (CJSM) system for communication with probation and police. Furthermore, information for DBF and DBE staff on Data Protection and the handling of confidential information is contained within the Staff Handbook.

6.18 There is a Memorandum of Understanding (MoU) between the DBF and the Cathedral which aims to foster collaboration, improve information sharing and ensure consistent practice. However, the Audit revealed a gap between the intended outcomes and actual

implementation. Specifically, there was a lack of clarity regarding how safeguarding matters at the Cathedral are overseen. Furthermore, the Audit highlighted the necessity for stronger working relationships and improved collaboration between the two entities.

Recommendation D19: The accountability and responsibilities of the DST outlined in the MoU for safeguarding services and support between the Cathedral and DBF should be clearly communicated. Furthermore, the MoU itself requires effective implementation, consistent application, and regular review to maintain its relevance and effectiveness.

A further recommendation regarding the MoU is made in Part One, *Culture, Leadership and Capacity* section of this report.

7 Victims and Survivors

7.1 For many victims and survivors, living with the abuse they have suffered can be deeply traumatic. Disclosing this to others can be incredibly difficult. Victims and survivors may feel overwhelmed by the processes, the potential for re-traumatisation or anxieties about the outcome. In this context, it is crucial for Church bodies to create and maintain a nurturing environment that enables victims and survivors to feel heard, supported and protected, whilst also learning from their experiences.

7.2 In evaluating the DBF's response to this key standard of safeguarding practice, the Audit obtained feedback from victims and survivors from across the diocese through an anonymous online survey. In addition, the Audit had the opportunity to listen to the authentic voice of a survivor through a face-to-face virtual discussion.

7.3 The DBF follows the House of Bishop's policy, 'Responding Well to Victims and Survivors of Abuse'. That said, most respondents to the Audit's victim / survivor survey were not aware of this guidance and there was uncertainty about whether it would have made a difference had it been in place at the time of reporting their abuse. In this respect, the Audit makes the following recommendation.

Recommendation D20: The DBF should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

a) Including a statement of commitment on its 'Reporting Abuse and Finding Support' webpage.

b) Linking to 'Responding Well to Victims and Survivors of Abuse' guidance.

7.4 Overall, the Diocesan website serves as a central hub for anyone seeking assistance. Individuals can readily find contact information for the DST, including their phone numbers and email addresses. The Safeguarding page also instructs visitors to contact appropriate contacts within their local parish in the first instance. A comprehensive list of external support helps to ensure that individuals have access to a wide range of support options. These include the Suzy Lamplugh Trust, Sexual Assault Referral Centres (SARCs), National Association for People Abused in Childhood (NAPAC), Mind, and Rethink Mental Illness. There are concerns about waiting lists at local specialist charities, so the DBF encourages access to BACP registered therapists who undertake private work. The DBF's safeguarding budget assists in providing immediate access to therapy when required.

7.5 A variety of resources are utilised to promote the disclosure of abuse, including training, posters, and organised talks. The DBF is continuously auditing parish websites to confirm they offer accessible support and clear guidance on disclosure procedures. The DST's recent trauma-informed care training, coupled with the DSO's established expertise in this area, ensures a consistent and supportive approach. This training opportunity was also extended to licensed clergy and PSOs, of whom a number attended. This is positive. That said, some of those who engaged with the Audit did not feel they had experienced a person-centric and trauma-informed approach to their disclosures. This underpins the importance of ensuring such principles are well understood across the diocese.

7.6 The DST maintains a budget for immediate responses, ensuring survivors are promptly connected with specialised counselling and support following a disclosure. The approach of the team is survivor-centred, recognising individual needs and empowering survivors to direct their own care. The DST helps facilitate this process by providing information and attentively listening to each survivor's specific requirements. The Audit was told of the importance of transparency with victims / survivors who should be kept fully informed about

what is happening with regards to safeguarding investigations and the provision of support. This relational approach to practice is described in some helpful guidance currently being drafted in collaboration with the Diocese's Survivor's Consultative Group. This covers issues such as the creation and implementation of a clear care plan and communication. This is positive, although feedback to the Audit suggests such practice is yet to be fully embedded, with participants detailing uncertainty as to whether ongoing and timely updates were being received. The Audit believes there is an opportunity here to strengthen the DBF's Survivor Support Information.

Recommendation D21: The DST should formally incorporate the following communication standards within its survivor support information and ensure they are consistently upheld in practice:

a) Clearly state the DST's commitment to providing regular and timely updates to survivors throughout the safeguarding process. This should include specific assurances about the frequency and format of updates.

b) Clearly identify the role of the Designated Safeguarding Officer (or other designated individual(s)) as the primary point of contact for survivors, responsible for ensuring consistent and timely communication.

c) Outline a process for gathering and respecting survivors' preferred method of communication (e.g., phone, email, in-person meetings).

7.7 Pastoral support is always offered, and victims / survivors have access to the DST as required. At present, the DBF currently has no persons engaged in the Support Person role and is struggling to recruit to this position. However, through networking with other dioceses in the Northern area, discussions about sharing support and link persons are underway. One survivor told us about how the Church had offered support, which the

individual declined due to their distrust. Over time, the individual's perspective shifted, leading to their involvement in the Survivors' Consultative Group and national-level safeguarding work.

7.8 The establishment of the Survivors' Consultative Group has been a valuable asset to the DBF since PCR2. Meetings are strategically scheduled before DSAP and are facilitated by an independent chair who fosters a positive rapport with the DSO. The DBF also benefits from a dedicated survivor advocate who participates in DSAP as an independent member, bringing personal experience (whilst acknowledging the diversity of survivor perspectives). To stay informed, group members receive national safeguarding updates on a weekly basis, supporting their engagement and contribution at both local and national levels.

7.9 Whilst the group provides a passionate and articulate voice, its small size could be expanded to include additional perspectives. From a systemic approach, including families impacted by abuse would create a more robust feedback mechanism to help drive change. Recognising the inherent complexities in this area, the Audit also recommends that the DBF investigate broader engagement strategies, including listening events at the diocesan level and beyond. The Survivors' Consultative Group should be a part of this approach to listen to other victims and survivors to drive change within the Church. This complements the previous recommendation for DSAP outlined in Part One, *Culture, Leadership and Capacity* section of this report.

Recommendation D22: The DBF should continue to expand membership of its Survivor's Consultative Group. This should include family members of those impacted by church-related abuse.

7.10 The Audit heard of the DST's plans to collaborate with the Survivor Consultative Group to develop a 'Healthy Cultures Survey' that is specifically tailored to individuals who have experienced abuse. This initiative aims to strengthen the way in which feedback from survivors directly influences learning and improvement.

7.11 The DBF is working to improve its safeguarding culture following past failures. With the recent publication of the Makin Report, this is a difficult task. Appropriate communications from the DSO and the Diocesan Bishop were issued to offer support to parishes and encourage them to focus on victims / survivors during their Safeguarding Sunday service in response to the publication of the Makin Report. The Audit has seen evidence of the Bishop of Blackburn advocating for victims and survivors and offering apologies. The Bishop actively participates in the House of Bishops, recently proposing two motions informed by engagement with victims and survivors.

7.12 The positive impact of the Bishop's approach, and the work of the DSO, was recognised and acknowledged by a survivor who shared their personal experience with the Audit. This renewed focus on prioritising the needs and experiences of victims / survivors represents a significant step forward in fostering a safer and more supportive environment.

8 Learning, Supervision and Support

Safeguarding Learning

8.1 The provision of safeguarding training is led by an experienced trainer who is supported by several volunteer trainers. A well-structured strategy is in place and the local training programme aligns with the CofE's national framework.

8.2 For a period of time, training relied on external consultants, which limited capacity for evaluation and the development of bespoke training. Since then, the Training Officer position has been filled and the DBF has prioritised tailored courses, particularly those designed to meet the needs of specific cohorts and specific contexts. One example can be seen in the training developed for Whalley Abbey, where safeguarding materials were adapted to reflect its setting as a retreat with a B&B.

8.3 In addition, the DBF has engaged specialist training delivered by external experts, including Neglect Awareness through Darwen Borough Council and Modern Slavery and Human Trafficking through organisations such as the Clewer Initiative and the Pan Lancashire Anti-Slavery Partnership. Recognising the importance of sustainability, a 'train the trainer' programme helps to ensure that all trainers are fully equipped and capable of effective delivery.

8.4 Plans are in place to expand bespoke training to cover grooming, elder abuse, stalking, and digital safeguarding for youth groups. Whilst these are positive steps, progress has been delayed due to capacity constraints within the team. Ensuring space for this work, alongside improvements in the overall evaluation process is addressed under Part One, *Culture, Leadership, and Capacity* section of this report.

8.5 Other positive observations made by the Audit include authoritative decision making around training for churchwardens. The DBF requires all churchwardens to complete safeguarding leadership training, despite this not being a national requirement.

8.6 It is also positive that exemptions are made for those with lived experience of abuse or additional needs, ensuring they receive essential safeguarding information in an accessible way.

8.7 Record-keeping was found to be robust, with timely follow-up ensuring that the very few outstanding training requirements are addressed efficiently.

Clergy Support

8.8 Clergy are provided with structured support to help them manage the emotional and psychological impact of their roles, particularly in relation to safeguarding. The DST maintains regular communication with clergy involved in safeguarding cases, ensuring their wellbeing is monitored and appropriate support is signposted. In 2024, an Assistant Archdeacon for Clergy Wellbeing was appointed to lead on this area, with responsibilities including the development of a coherent strategy for clergy wellbeing, regular engagement with clergy, and identifying gaps in existing support. This is good practice.

8.9 Clergy who have been victims of abuse have access to therapy through the DST's budget and wellbeing is further supported through access to retreat programmes and external partnerships such as Bridge Builders, Clergy Support Trust, St Luke's and the Sheldon Hub.

8.10 To prepare curates for the safeguarding challenges they may face in ministry, safeguarding training is integrated into the start of the Ministry Programme, enabling new clergy to reflect on issues concerning their own wellbeing and the responsibilities they

hold. MDRs / Annual Conversations take place regularly and are subject to a recommendation in Part One, *Culture, Leadership and Capacity* section of this report.

Supervision and Support of Safeguarding Roles

8.11 Those in safeguarding roles undergo a structured induction programme designed to equip them with the knowledge and confidence needed for their responsibilities. The induction process includes pre-read materials, targeted one-to-one meetings with key personnel, and a phased introduction to their role. Safeguarding content is routinely reviewed and updated, ensuring new staff are well-prepared before engaging directly with children, young people, or vulnerable adults. Whilst over half of respondents to the Audit survey reported that their induction covered what they needed to know about safeguarding, a significant number either felt it did not or were unsure. This suggests inconsistencies in how safeguarding information is delivered and retained.

Recommendation D23: All staff and volunteers working at the DBF (and key safeguarding roles within parishes) who were not given an induction at the commencement of their role should be required to undertake one. This retrospective induction session should be mandatory regardless of a person's length of service.

8.12 Staff in safeguarding roles report feeling well-supported, with regular one-to-one sessions with the DSO and independent supervision in place. Wellbeing is a key focus, discussed at team meetings and supported through various measures, including team meals, retreat opportunities at Whalley Abbey, Medicash provision for health and stress support and flexible working policies.

8.13 The DSO and other safeguarding staff receive regular supervision from appropriately trained and experienced supervisors. The DSO receives supervision from the NST's Regional Lead for the North West, following a nationally agreed supervision model.

8.14 Although monthly supervision from the DSO is in place for some staff, others receive support on a more ad-hoc basis. A more structured approach, incorporating regular check-ins alongside formal monthly supervision, would provide greater consistency and ensure staff feel adequately supported. These shorter, routine check-ins would create more opportunities to discuss challenges while maintaining structured oversight.

Recommendation D24: To enhance consistency and ensure all safeguarding staff receive the level of support they need, regular, structured supervision sessions should be available for all team members, supported by routine check-ins.

8.15 Training opportunities for continuous professional development include e-learning modules, shadowing opportunities, cross-diocesan training with York and Liverpool, attendance at NST Conferences, and participation in webinars on child sexual exploitation and modern slavery.

9 Conclusion

9.1 The Audit found a strong commitment to safeguarding in Blackburn. This commitment is driven and supported by the Diocesan Safeguarding Team (DST), which provides daily support to frontline Parish Safeguarding Officers (PSOs) and those they work with to help keep people safer.

9.2 The leadership upon which their approach is built was found to be strong. The Diocesan Bishop leads by example and demonstrates a deep understanding of his role, accountability, and the influence he has. He, and his highly collegiate and effective team, operate with a 'safeguarding first' approach, prioritising the safety of people and not hesitating, when appropriate, to make difficult decisions.

9.3 There's a genuine willingness to listen and learn, evident in the participation of almost everyone involved in the audit, from parish level to the Diocesan Board of Finance. The safeguarding training is well-structured, tailored to specific needs, and includes specialist opportunities for advanced learning.

9.4 Clergy are provided with structured support, and there's a strong emphasis on the wellbeing of staff in safeguarding roles. All of this is reflected in the positive cultural shift evidenced in surveys, focus groups, and interviews, as well as in an environment built on strong interpersonal connections and open dialogue.

9.5 Meetings are well attended, effectively structured, and led. For example, the Diocesan Safeguarding Advisory Panel (DSAP) is effective, has diversified its membership, and the Survivors' Consultative Group provides a valuable platform to build upon to ensure that victim and survivors' voices are heard.

9.6 In order to build upon these strengths and continue with the positive trajectory they are now on, the diocese will need to focus on the recommendations that will enable them to further enhance their approach. These include addressing capacity constraints within the Diocesan Safeguarding Team (DST), and in doing so, considering how they might reconfigure their safeguarding arrangements to deliver clearly autonomous and operationally independent safeguarding, including deepening safeguarding's integration and independent authoritative voice in governance.

Part Two - Blackburn Cathedral

10 Context

10.1 Blackburn Cathedral, formerly St Mary the Virgin Parish Church, became a cathedral in 1926 when the Diocese of Blackburn was created. While the site's religious history is believed to stretch back to 596, the current building, designed in Georgian style by John Palmer, was consecrated in 1826. Significant renovations have transformed its original Gothic Revival appearance into a 20th-century post-war modern style. Inside, the cathedral boasts a remarkable collection of 20th-century art and one of the UK's most exceptional organs. In 2016, Clergy Court, a new development providing housing, offices, and commercial spaces, was inaugurated.

10.2 The Cathedral is situated in Blackburn town centre, serving a total population of 154,922. Blackburn with Darwen, a unitary authority, encompasses one of the UK's most economically disadvantaged regions. The town's industrial past forms the context for several ongoing cultural regeneration initiatives.

10.3 The Cathedral receives an average of 278 visitors each week. Three choral evensongs take place mid-week alongside a Eucharist and Evensong on Sundays. Blackburn Cathedral also hosts a suite of events throughout the year including exhibitions, concerts, recitals, special events and talks.

11 Progress

11.1 The Social Care Institute for Excellence (SCIE) audit of the Cathedral was published in March 2020 and resulted in 33 ‘considerations’. The Cathedral was also involved in the Diocesan Past Cases Review 2 (PCR2) process and whilst there were no formal recommendations for the Cathedral itself, themes identified were incorporated into a joint action plan. It is noted within PCR2 that an overarching theme was to ensure that all diocesan offices should ensure their recording systems are robust and cross referenced with the electronic case management system. This remains an ongoing area of activity within the Cathedral, with the intent to onboard and use of the National Safeguarding Case Management System (NSCMS).

11.2 The Cathedral accepted all the SCIE audit considerations, with its responses being coordinated via a defined action plan owned by Chapter and led by the Cathedral Safeguarding Advisor (CSA) along with the previous Chapter Safeguarding Lead (CSL). The Audit heard this plan was periodically discussed at the Cathedral Safeguarding Management Group (CSMG). The Cathedral now uses the Cathedral Safeguarding Standards Workbook as their core action plan and has subsumed areas of work into its new Safeguarding Strategy. In developing this strategy, which aligns with National Safeguarding Standards, the Cathedral took account of both outstanding and ongoing SCIE actions and themes emerging from PCR2.

11.3 In terms of evidenced progress, the improvement activity that followed the SCIE audit has resulted in many recommendations being met. Areas of note include the development of a policy for missing children, a staff register and a low-level concerns policy. Areas identified as requiring ongoing attention include record keeping, case management and safeguarding arrangements being strengthened for bellringers and visiting bellringers.

11.4 In October 2023, following representation from Chapter, the Cathedral published its response to a Lessons Learned Review (LLR), which had been commissioned by the Bishop of Blackburn. This outlined the Cathedral's commitment to improve its communications with whistleblowers and survivors, strengthen governance, change culture and work with the wider church and external agencies. That said, progression of internal learning relating to LLR recommendations has been somewhat hindered by relational and communication issues. This should be addressed to ensure the Cathedral is prioritising and maximising the potential for improvement.

12 Culture, Leadership and Capacity

Culture

12.1 Feedback from surveys, discussions and focus groups, alongside other material reviewed by the Audit, revealed mixed views on the Cathedral's culture. While a majority of the workforce agreed that the overall safeguarding arrangements had improved, with most stating they could speak truth to power, this confidence was shared by only half the worshipping community. Both legacy and contemporary issues continue to hinder the Cathedral's potential to consolidate the confidence expressed by many and develop a more positive culture for everyone.

12.2 Some participants in the Audit frequently mentioned internal conflict during discussions. They stated a desire to move away from the 'rigid, silenced approaches of the past'. Although some participants spoke about the emergence of a more 'can-do culture', the same group also pointed out how the behaviour of certain individuals at the Cathedral illustrates 'a culture that appears collaborative on the surface but has underlying tensions'.

12.3 Indeed, the Audit encountered evidence of these tensions from a range of individuals and groups. The anxiety following the recent exposé of the Hindley case persists and has impacted many staff, volunteers and leaders. While the mixed sentiments being expressed cannot be attributed to a single cause or person, the Audit is in no doubt that recent disagreements between senior clergy at the Cathedral and elsewhere, and the perceptions of those who have witnessed or heard about these events, have not been helpful.

Cathedral Leadership

12.4 The Dean unambiguously accepts overall accountability for safeguarding, and it is fair to say that he has faced some significant contemporary and historical challenges in his role, particularly in the aftermath of the Hindley case. These challenges need to be quickly

resolved, as there is a significant risk of division that could prevent or further undermine the urgently required improvements in safeguarding at the Cathedral.

12.5 The Audit was informed that the Dean currently acts as the Designated Safeguarding Lead, (something he accepted) and consequently, he is involved in a considerable level of day-to-day safeguarding work, directing and influencing operational activity. In the opinion of the Audit, this arrangement is neither appropriate nor sustainable.

12.6 To his credit, the Dean acknowledged that the safeguarding arrangements and framework across the Cathedral are far from optimal. Currently, professional advice relies on a Cathedral Safeguarding Advisor (CSA) based outside the Diocese, providing only two days of support per month. Given that one of these days would typically be allocated for supervision from the NST's Regional Safeguarding Lead (RSL), there has been limited opportunity for the CSA to make an impact. The Audit found little evidence of their footprint, influence, or authority being applied within the Cathedral. Furthermore, despite the previous RSL having raised concerns with the Chief Operating Officer (COO), there was no indication that any action was taken to address these issues. This lack of response subsequently led to the new RSL triggering a further escalation process.

12.7 The Audit noted poor communication and visibility regarding the CSA. Notwithstanding the presence of posters displaying their information, staff were often unaware of the identity of the CSA. Some of those who engaged with the Audit suggested that tensions between the Cathedral and the Diocese exacerbated this situation, creating additional barriers to effective communication. The Audit concurs with this assessment.

12.8 These circumstances have been compounded by the absence of a CSL for Chapter and the fact that two other key safeguarding posts are held by volunteers. While the support of experienced volunteers is commendable, they do not operate within an HR framework that

would provide the level of assurance for the significant responsibilities they hold. Additionally, many staff displayed a lack of awareness as to their identify, role and how to communicate with them.

12.9 Interviews and a review of other material revealed that neither the part-time CSA, nor the DSO appeared able to effectively challenge the Dean on safeguarding cases. The Audit found that risk assessment and management lacked appropriate structure and implementation, record-keeping is poor, and HR processes are in need of urgent improvement. The Audit therefore concludes that safeguarding arrangements at the Cathedral are currently inadequate and require immediate action.

Recommendation C1: **Implement a Formal Escalation and Challenge Process for Systemic Safeguarding Weaknesses**

a) To ensure robust oversight and address systemic safeguarding weaknesses effectively, a clear and accessible formal escalation process should be urgently established and actively promoted within the Cathedral.

b) This process should empower all individuals, including safeguarding professionals (such as the CSA), staff, and volunteers, to escalate concerns regarding inadequate safeguarding arrangements, lack of influence, or any other systemic issues without fear of reprisal.

c) The process should outline clear steps for escalation to higher authorities within the Cathedral structure and, if necessary, to external bodies such as the Diocesan Safeguarding Team (DST) or the National Safeguarding Team (NST).

d) Furthermore, training should be provided to ensure a culture of professional curiosity and respectful challenge at all levels, encouraging individuals to proactively identify and address potential safeguarding risks and weaknesses.

12.10 Despite the deficits identified above, there is good support from an effective and professional Chief Operating Officer (COO) who has begun the process of rehabilitating their HR functions alongside record keeping practices, all of which require immediate remedial action. There is also potential within the Cathedral Safeguarding Management Group (SMG) to help drive and scrutinise a safeguarding improvement plan.

Governance

12.11 The Cathedral operates a range of governance and oversight meetings, reflecting the expectations of the CofE and relevant requirements, such as those issued by the Charity Commission. However, an examination of Chapter minutes revealed little evidence that members have been sufficiently inquisitive or challenging about their limited safeguarding framework. Chapter minutes from January to September 2024 indicate a light-touch approach to safeguarding, lacking evidence of challenge or curiosity. Only one delayed SMG report was presented, and meeting notes were largely factual, showing no real scrutiny. The agenda items and how they were addressed at the September 2024 meeting further suggest a passive engagement with safeguarding. None of the minutes seen by the Audit showed any attempts by Chapter to seek reassurance about safeguarding capacity and capability.

12.12 To facilitate appropriate oversight of the Cathedral's improvement journey moving forward, the Audit makes the following recommendations.

Recommendation C2: **Governance and Leadership Oversight of the Cathedral's Safeguarding Improvement Journey:** Chapter should develop a detailed action plan with clear timelines and responsibilities to address all identified concerns. This plan should include, but not be limited to, the following actions:

1. Leadership and Separation of Responsibilities:

a) The Dean should step back from involvement in day-to-day safeguarding activity to ensure the appropriate separation of leadership and governance from operational safeguarding activities.

b) Chapter should urgently appoint a suitably qualified and experienced individual as its Cathedral Safeguarding Lead (CSL).

2. Strengthening Safeguarding Expertise:

a) Chapter should urgently recruit and appoint a suitably qualified and experienced individual as its full-time Cathedral Safeguarding Advisor (CSA). This role should be based at the Cathedral for three days per week and be professionally line managed and supervised by the DSO.

- If it is anticipated that this recruitment will take time, they should immediately appoint a suitably qualified interim (using an accredited agency if necessary).
- To this end, Chapter should involve an NST representative (the RSL) and the DSO on the interview panel.

3. Enhancing Governance Oversight:

a) The Chair of the Safeguarding Management Group (SMG) should be invited to attend the Cathedral Chapter. This will ensure direct safeguarding representation at the highest governance level, facilitating informed decision-making and robust challenge.

b) A temporary 'Cathedral Safeguarding Improvement Board' should be created. This Board should involve appropriate Cathedral, Diocese, and NST (RSL) representatives to record, monitor, and report on progress and improvement to Chapter. The Board should be independently chaired by a professionally qualified individual with substantial safeguarding experience. This interim measure would terminate once the

improvements had been made and the safeguarding arrangements at the Cathedral were considered sufficiently embedded.

4. Operational Safeguarding Framework:

a) The Cathedral should develop and implement a structured framework in line with national standards for risk assessment, management (safety planning), and mitigation, ensuring consistent and appropriate application across all Cathedral activities and with clear lines of responsibility.

b) The Cathedral should implement a robust and auditable record-keeping system for all safeguarding matters, ensuring records are easily locatable, complete, and securely stored. It should ensure that safeguarding training is provided to all relevant staff and volunteers on proper record-keeping procedures.

c) The Cathedral should conduct an immediate review of the safeguarding roles currently held by volunteers to assess the sustainability and appropriateness of these arrangements. It should develop a plan to transition these responsibilities to appropriately employed and professionally supported staff.

5. Comprehensive Action Plan Integration:

The detailed action plan developed by Chapter should incorporate all recommendations outlined within this report, alongside any other relevant internal or external safeguarding improvement recommendations identified in previous reports or reviews. This integrated approach will ensure a holistic and coordinated strategy for enhancing safeguarding across the Cathedral.

6. Monitoring and Accountability:

The Cathedral should implement a robust monitoring process to track progress against the detailed action plan and ensure accountability for remedial action.

Safeguarding Management Group (SMG)

12.13 The Safeguarding Management Group (SMG) currently provides a robust foundation for safeguarding efforts, characterised by a well-qualified chair, expert membership, structured meetings, and a clear strategic focus. However, to further enhance its oversight and effectiveness, several key areas require development.

Recommendation C3: **Strengthening the Safeguarding Management Group (SMG):**

a) The SMG's membership should be broadened to include representatives from diverse community organisations relevant to safeguarding, such as local charities supporting vulnerable adults, children, or those affected by domestic abuse or homelessness.

b) The SMG should conduct regular skills, diversity, and inclusion audits of its membership to identify gaps and ensure a balanced and effective committee.

c) Once appointed, the on-site Cathedral Safeguarding Advisor (CSA) should become a member of the SMG.

d) Once appointed, the Chapter Cathedral Safeguarding Lead (CSL) should become a member of the SMG.

e) The SMG should develop a comprehensive three-year strategic safeguarding plan for the Cathedral, outlining key priorities, objectives, and measurable outcomes. This plan should be regularly reviewed, updated, and agreed upon by Chapter.

f) Dedicated and robust challenge sessions should be introduced at SMG meetings. These sessions should specifically focus on in-depth reviews of safeguarding incidents, lessons learned reports, and the implementation of recommendations, encouraging critical analysis and constructive scrutiny.

g) The SMG should work with the CSA (once established) and the DSO to evaluate the benefits of creating a Safeguarding Operational Group (SOG) as a sub-committee to the SMG.

Safeguarding Capacity

12.14 Ambiguity regarding operational safeguarding responsibilities, inadequate allocation of time, and a lack of challenge, ability, or willingness to listen to advice has compounded the difficulties currently faced by the Cathedral.

12.15 Recommendations earlier in this report address the urgent need to appoint a permanent appropriately qualified CSA, preferably from a statutory background with safeguarding experience that complements (as opposed to duplicates) that available within the DST. They should be employed for a minimum of three days a week and work closely with the CSL (covered in an earlier recommendation). Beyond new appointments a range of actions are outlined in recommendations throughout this report to help rehabilitate the Cathedral's safeguarding framework.

Memorandum of Understanding – Cathedral and DBF

12.16 To establish a more robust and collaborative safeguarding framework, a refreshed Memorandum of Understanding (MoU) between the Cathedral and DBF is crucial. This MoU should comprehensively address structural elements, operational components, and key principles to ensure a unified and effective approach.

Recommendation C4: An effective MoU between the Cathedral and DBF should contain the following:

Key Principles

a) Operational independence of safeguarding
b) Professional collaboration
c) Consistent safeguarding standards
d) Mutual accountability

Structural Elements:

a) Clear definition of roles and responsibilities
b) Explicit lines of professional accountability
c) Mechanisms for consistent communication

d) Shared commitment to the CofE's National Safeguarding Standards

Operational Components:

a) Case Management

i. Shared access to a case management system

ii. Clear protocols for case allocation

iii. Consistent record-keeping standards

iv. Mechanisms for cross-organisational case review

b) Professional Supervision

i. Clear supervision frameworks

ii. Defined escalation processes

iii. Mutual commitment to professional development

iv. Transparency in decision-making

c) Resource Sharing

i. Clarity on resource allocation

ii. Defined capacity expectations

iii. Mechanisms for collaborative resource deployment

iv. Contingency planning

d) Quality Assurance

i. Agreed quality assurance frameworks

ii. Regular performance reviews

iii. Shared metrics for evaluating performance and safeguarding effectiveness

iv. Commitment to continuous improvement

e) Information Sharing

i. Protocols for timely and comprehensive information exchange

ii. Confidentiality guidelines

iii. Mechanisms for joint risk assessment

iv. Clear communication channels

Collaboration

12.17 Given the financial pressures facing both the Cathedral and the DBF, which may limit their ability to invest in additional safeguarding resources, the Cathedral and the DBF should consider jointly exploring opportunities for greater collaboration, specifically focused on identifying potential cost savings.

Recommendation C5: A formal review should be undertaken by the Cathedral and DBF to assess the feasibility and benefits of shared support services, such as HR, finance, or IT, with the explicit aim of streamlining operations and generating cost efficiencies that can be reinvested into bolstering safeguarding resources across both organisations.

Safeguarding Directorate and Director of Safeguarding

12.18 In the opinion of the Audit, consideration should be given to restructuring the safeguarding functions across the Diocese, including those involving the Cathedral. This could be achieved through the establishment of a dedicated Safeguarding Directorate led by a suitably qualified Director of Safeguarding. This would provide an autonomous safeguarding team responsible for the delivery of safeguarding across the DBF, the Cathedral and the wider Diocese, with the Director of Safeguarding holding the ultimate authoritative decision-making power on operational matters. This arrangement would ensure independence from clergy-based decision-making, without impeding the role and accountability function of trustees at a governance level.

12.19 The following recommendations aim to build capacity, enhance professional skills, and create a more robust safeguarding system.

Recommendation C6: **Establish an Operationally Autonomous Safeguarding Directorate**

To significantly strengthen safeguarding across the Diocese, the DBF should establish an operationally independent Safeguarding Directorate, led by a Director of Safeguarding. This

Directorate would consolidate all safeguarding resources and provide comprehensive and consistent support to the DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the authority and autonomy to:

a) Provide expert advice and robust oversight on all safeguarding matters.

b) Challenge senior clergy and church bodies when necessary, ensuring accountability.

c) Escalate concerns directly to higher authorities, including the NST, without undue influence.

To ensure the effectiveness and significance of this structure, the following is required:

a) The Director should attend or be a member of and report directly to key decision-making bodies, including the DBF, Bishop's Council, Chapter, and Vision and Strategy / Bishop's Appointments Team.

b) A comprehensive Memorandum of Understanding (MoU) between the DBF, Parish PCCs, and the Cathedral should clearly define the Director's authority and responsibility to provide safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the Diocese.

c) The Directorate should be equipped with sufficient resources and staffing, including the consolidation of all professional safeguarding staff (including those currently at the Cathedral), and the creation of at least two new positions: one to backfill the existing DSO role and at least one new Assistant DSO (ADSO) position.

Note: This recommendation should be read in conjunction with the section on a Safeguarding Directorate within the Independent Safeguarding Audits Annual Report (2024 / 2025).

Chorister Safeguarding

Context

12.20 The Audit team engaged with chorister parents, the staff surrounding the choristers and the choristers themselves, who all described positive safeguarding arrangements and a strong safeguarding culture. Choristers expressed high levels of trust and confidence in knowing who to approach if they had concerns.

Scheduling and Wellbeing

12.21 Due to the voluntary nature of the chorister role at Blackburn, a level of flexibility on their commitments is unavoidable. However, the management of their schedule stands out as a significant strength. An initiative to support this is the 'Super Weekend,' where choristers are allowed to take a weekend off without needing to provide justification. This is good practice. Additional flexibility is also given for exams, illness or other reasonable causes.

Physical Safety

12.22 The physical safeguarding arrangements for choristers are robust**,** with key-coded access to the Song Room area, dedicated chorister-only toilets, and CCTV coverage in all chorister areas. Child-friendly signposting within the Song Room and toilets directs children to sources of help and support and is another example of good practice.

12.23 In addition, the Audit noted how safeguarding is considered during broadcasted services. When the Dean presented awards to choristers, care was taken to ensure this was carried out before the service started so that chorister names were not broadcast on the livestream.

Information Sharing

12.24 Within the music department, low level concerns are recorded digitally and are filtered through the Director of Music or Canon Precentor. The introduction of the low-level

concerns policy is good practice. However, pathways for sharing relevant safeguarding information with corresponding schools are lacking. Recorded patterns of behaviour at the Cathedral could potentially provide crucial context for schools, and vice versa.

Recommendation C7: The Cathedral should implement a low-level concerns log to ensure that handover observations, low-level concerns and patterns of behaviours are recorded by key staff.

12.25 The Audit identified a need for improved information-sharing and oversight in relation to safeguarding arrangements for staff working with choristers. In particular, there needs to be much clearer communication about safeguarding expectations, risk management and safety plan processes to ensure that all relevant staff are appropriately informed and risks managed. This issue has been raised at a management level and is being addressed through internal safeguarding procedures.

Communication

12.26 Current arrangements for communicating with parents do not provide sufficient protection for staff, with communication relying on personal numbers and social media accounts. This could lead to a gap in oversight from an organisational level. There is a concern that changing these methods could frustrate parents and risk disengagement, however, the Audit believes there are ways to merge both safeguarding, and preference of communication methods for parents.

Recommendation C8: The Cathedral should introduce a dedicated chorister phone, managed by key members of staff to allow for secure and structured communication through approved and preferred platforms such as email, text message and WhatsApp.

Chaperoning

12.27 It is positive to note the large number of chaperones available for chorister duties, many of whom bring good experience in working with children and / or professional safeguarding expertise**.** That said, some would benefit from a refresher on safeguarding expectations to ensure they feel empowered to make decisions effectively.

Recommendation C9: The Cathedral should undertake a review of its chorister staff to ensure that all are confident in making relevant safeguarding decisions appropriately, including who to report to and when. This could take the form of a staff survey or refresher safeguarding session.

Policies

12.28 The Audit notes the robustness of the package of information provided to visiting choirs. This includes health and safety guidelines and a visiting choirs pack and form - all of which include a reference to safeguarding. The visiting form asks individuals to confirm they have read Blackburn Cathedral's Safeguarding policy. However, the guidance provided to visiting organists misses an opportunity to check that they are also aware of safeguarding processes and have read the policy before attending the Cathedral.

Recommendation C10: Additional reference to safeguarding should be made in the 'Visiting Organists' package to ensure they are aware of arrangements and have read and signed the safeguarding policy before visiting.

13 Prevention

13.1 Safer recruitment policies and practices are a vital part of creating safer environments, discouraging unsuitable individuals from joining an organisation and preventing harm. The Cathedral has measures in place to ensure the safer recruitment of individuals to various roles. Such measures include reference gathering, confidential declarations for eligible roles, the Cathedral's safeguarding commitment being specified in application packs, and criminal record checks for certain roles.

13.2 The Audit has identified a case where an individual failed to disclose pertinent information on their Confidential Declaration form and throughout the recruitment process. This non-disclosure raises serious concerns, as it potentially breaches trust, and in accordance with the House of Bishops guidance[4], requires careful consideration. The Audit is addressing this through a separate process, directly with the cathedral.

Recommendation C11: The Cathedral should ensure that all relevant staff and volunteers have up to date DBS checks and are within the three-year cycle.

13.3 The Audit is of the opinion that the Cathedral would also benefit from improved clarity about what level of DBS check and training is required for each of its roles. The Audit found that current procedures within the Cathedral do not require DBS checks (at any level) for education volunteers involved in school visits. However, Government guidance for DBS checks for working with children in places of worship states the following:

[4] See Section 10, House of Bishops' Guidance Safer Recruitment and People Management which states "If the DBS Certificate identifies information that the individual has not disclosed on his/her Confidential Declaration form or at any other time during the proceedings to date, then serious consideration must be given as to whether this candidate can be appointed after such a potential breach of trust. In all cases, the applicant should be given the opportunity to explain the discrepancy before a final decision on their suitability for the position is made." https://www.churchofengland.org/safeguarding/safeguarding-e-manual/safer-recruitment-and-people-management-guidance/section-10

"If an individual does not teach the children but is responsible for their care or supervision on more than 3 days in a 30-day period [they] can get an Enhanced DBS check with a Children's Barred List check. If they do it less often, they can get an Enhanced DBS check without a Children's Barred List check."[5]

13.4 Given this guidance, the Audit makes the following recommendation.

Recommendation C12: The Cathedral should review the functions of volunteers and other roles where a DBS check is currently not undertaken, including Education Volunteers, to ensure they follow contemporary Government guidance. For each role, the Cathedral should establish whether a check is necessary and at what level. To note, a basic check can be undertaken for any position or purpose.

13.5 Feedback about the quality and effectiveness of safeguarding practice was collected from staff and volunteers across all levels and groups within the Cathedral. Current measures include a Memorandum of Understanding (MOU) stipulating that the DSO attends the Cathedral Safeguarding Management Group, and the Dean attends the Diocesan Safeguarding Advisory Panel (DSAP). Weekly management meetings, which involve all staff, include safeguarding as a standing item. Safeguarding issues are regularly raised in forums engaging the Chief Operating Officers (COOs) and other staff. The Cathedral maintains memberships with the Association of English Cathedrals (AEC) and the Cathedrals Administration and Finance Association (CAFA). Safeguarding information is disseminated through various channels, including posters displayed within the Cathedral (featuring Safer Church, Safe Spaces, and Mothers' Union), website information, visitor information, and social media presence.

[5] https://www.gov.uk/government/publications/dbs-checks-for-working-with-children-in-places-of-worship/dbs-checks-for-working-with-children-in-places-of-worship#

13.6 The Cathedral has established a protocol which requires all new staff and volunteers to wear ID cards. A colour-coded lanyard and card holder system allows for quick identification of individuals and their respective areas within the Cathedral.

13.7 Regarding safeguarding awareness initiatives, the Cathedral utilises several methods, including displaying posters, providing website and visitor information, using local notice boards, and observing 'Safeguarding Sunday'. The Audit recognises these as foundational steps and, therefore, recommends the following to further develop its safeguarding awareness programme.

Recommendation C13: The Cathedral should develop a communication plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of followers, adopting different techniques specific to the platform in use and utilisation of relevant awareness days, campaigns and events to amplify the message.

13.8 The Cathedral's website presents a strong, modern theme that loads quickly, performs well with search engine optimisation (SEO) and is mobile-responsive. It is positive that the 'safeguarding' section is prominently featured within the navigation and is easily accessible. There are areas of the safeguarding webpage that could be strengthened, and the Audit makes recommendations to this effect.

Recommendation C14: The Cathedral should provide visitors to the safeguarding webpage the ability to access relevant material on the Diocesan website. This could include, for example, an ability to subscribe to the DBF's Safeguarding Matters newsletter and hyperlinks to the Safeguarding Resource Hub.[6]

[6] https://www.blackburn.anglican.org/safeguarding-resource-hub

13.9 Actively seeking and acting on the views of children, young people and vulnerable adults is a key component to effective prevention planning. Whilst there are opportunities for the Cathedral to gather such feedback, these can be ad-hoc and infrequent. In this respect, the Audit believes there is the potential to introduce more defined mechanisms that help to facilitate this happening in a more structured manner.

13.10 Although the Cathedral has limited opportunities to directly engage with children and young people to gather their views, feedback has been collected through other channels. For instance, the Education Department's feedback forms have yielded positive responses from schools following a visit to the Cathedral. Whilst not specifically related to safeguarding, this qualitative feedback indicates positive and beneficial experiences for schools and their students.

13.11 Importantly, the Cathedral recognises the needs of vulnerable adults and survivors of abuse, ensuring their experiences inform its safeguarding arrangements. This is addressed further in the *Victims and Survivors* section of this report.

Recommendation C15: The Cathedral should review the mechanisms it has in place to capture the voices and experiences of children, vulnerable adults and victims and survivors. It should develop a defined 'engagement' plan that ensures stakeholders are identified, spoken to frequently, and that their views are routinely reported to Chapter and relevant committees. The plan should also include arrangements for how such voices influence contemporary practice and new initiatives.

13.12 The Cathedral maintains a comprehensive range of risk assessments to effectively manage potential risks across various activities. This includes specific documents such as the 'Risk Assessment for Educational Visits' and a general 'Cathedral Risk Assessment', covering a wide range of activities. Furthermore, a 'Risk Assessment Policy' is in place,

which is subject to annual review by the Finance, Audit and Risk Committee.

13.13 The Cathedral's unique environment creates specific needs for lone working arrangements, with some good guidance being available through the Cathedral's Lone Working Policy. That said, the Audit is of the opinion that reinforcing lone working procedures and providing training on associated measures, such as using 'walkie-talkies' for assistance, would be beneficial.

Recommendation C16: The Cathedral should review and take steps to raise awareness and further embed the Lone Working Policy and associated protocols such as use of two-way radios throughout the Cathedral.

13.14 CCTV monitoring plays a crucial role in enhancing the overall security of the Cathedral. Whilst not monitored around the clock, the Cathedral's Verger Team oversees the footage, ensuring a vigilant eye on critical areas. CCTV coverage could be expanded to several areas identified as vulnerable.

Recommendation C17: CCTV coverage should be expanded to include the area towards the back of the Cathedral

14 Recognising, Assessing and Managing Risk

14.1 The Cathedral has in place a stand-alone risk register focused on safeguarding, with concerns and control measures documented. This was last reviewed in August 2024. The Audit's recommendations for the DBF risk register are set out in Part One of this report and have equal relevance to the context of safeguarding at the Cathedral.

14.2 Following a concern being identified or raised with a member of staff or volunteer in the Cathedral, the CSA is ordinarily engaged. The CSA will determine next steps, such as engaging key Cathedral staff and contacting statutory agencies as appropriate. Thresholds are determined by the Cathedral's Low Level Concern policy, with staff / volunteers assessing if a situation meets this threshold or requires external input. Allegations against staff or volunteers follow NST Practice Guidance.

14.3 Whilst policy and procedure is defined, the Audit identified inconsistencies in the application of practice. For example, on-the-ground testing by the Audit team demonstrated a lack of clarity regarding reporting procedures. Specifically, some individuals were unsure who to contact with a safeguarding concern, and the CSA was largely unknown to those directly involved in daily activities.

14.4 To strengthen arrangements in this context, the Audit recommends the following:

Recommendation C18: The Cathedral should take immediate action to ensure all of its staff and volunteers are alert to the process for escalating a safeguarding concern and to whom this should be made (the CSA).

14.5 Although the Cathedral currently handles a relatively low volume of safeguarding cases,

demand is showing a trajectory of growth, with cases being varied and presenting a range of different challenges. These have involved both contemporary issues and non-recent allegations of abuse. One case has triggered onward referrals to statutory authorities in the last 12 months.

14.6 The Audit also found inconsistencies in case management and record keeping. Although systems are in place, these are largely insufficient, with case records for safeguarding concerns being kept in hard copy and low-level concerns being stored electronically on a 'SharePoint' site. Overall, the Audit noted a lack of a systematic and consistent approach to the recording and storage of safeguarding information resulting in a lack of confidence that all matters are properly recorded and stored.

14.7 The Cathedral's plan to transition to the NSCMS through a shared access arrangement with the DBF is likely to help in this respect. Recognising that this is contingent upon the signing of a data sharing agreement, the Audit makes the following recommendation.

Recommendation C19: The Cathedral should rapidly engage the DBF to expedite the signing of the data sharing agreement and adopting the NSCMS.

14.8 The Audit examined a number of cases regarding the Cathedral's risk assessment, management, and safety planning processes. Feedback from key personnel responsible for one particular respondent indicated that day-to-day oversight works well and confidentiality is maintained. However, the Audit is aware of another case where a risk assessment had been completed but it had not been transposed into an appropriate safety plan. This undermined the Audit's confidence in the consistency of the Cathedral's approach regarding these critically important processes. To ensure this vulnerability is appropriately addressed, the Audit makes the following recommendation.

Recommendation C20: In collaboration with the DBF and DSO, the ADSO (who has prior statutory experience in this field) should review the existing Cathedral risk assessments and safety plans. The findings of this review should serve to strengthen identified vulnerabilities and oversee the improvement of these processes within the Cathedral.

Updates confirming the accuracy and effectiveness of the Cathedral's risk assessments and safety plans should be shared with the NST RSL and provided to the SMG for their scrutiny and assurance on a quarterly basis for the next 12 months.

14.9 At the time of the Audit, one Safeguarding Case Management Group (SCMG) led by the Cathedral had been convened in the last year. The records reviewed by the Audit demonstrate an approach that included agreed actions to support the victim / survivor, consideration of police involvement, and assessment of potential risk.

14.10 The Cathedral has recently been registered as a charity and as such has a legal requirement to submit Serious Incident Reports to the Charity Commission. The Audit was informed that one case had met the threshold for a safeguarding SIR in the last 12 months. The referral to the Charity Commission aligned with national guidance.

14.11 The DBF and Cathedral have a Memorandum of Understanding (MoU) and a Data Sharing Agreement in place. The MoU sets out the collaborative relationship of the DBF and the Cathedral in ensuring a safer environment for everyone. This includes sharing information about safeguarding concerns, working together to manage risks and defining the applicable complaints procedure. The Audit's recommendations for the MoU are set out in Part One of this report and have equal relevance to the context of safeguarding at the Cathedral.

14.12 The Cathedral advised the Audit that all personal information is stored and shared in ways which are compliant with data protection legislation and the General Data Protection Regulations (GDPR). That said, at the time of the site visit, the Audit was informed that a number of files could not be found. Post-audit, information was provided to suggest the files had not been deleted, but rather had been misplaced within the system. As such, the Audit makes the following recommendation.

Recommendation C21: The Cathedral should take steps to identify the root cause of files being incorrectly posted, enabling the implementation of preventative measures. These measures include strengthening backup and recovery procedures, refining user permissions, providing comprehensive user training, and consideration of implementing Data Loss Prevention policies.

If this incident resulted in the loss or mismanagement of personal data, Chapter should satisfy itself that it has followed any relevant reporting / compliance requirements.

15 Victims and Survivors

15.1 For some within Blackburn's community, the impact of past safeguarding failures by the Church has been profound. The legacy of trauma and pain continues to be felt, with the recent publication of the Makin review bringing this into stark focus. In this context, there is an absolute need to maintain an unswerving focus on victims and survivors, ensuring they are protected from future harm, that they have opportunities to heal and that their authentic voices help to shape the Church's safeguarding arrangements going forward.

15.2 At the Cathedral, Chapter has published its response to an LLR which outlines its commitment to *'being more proactive and transparent'* in communications with whistleblowers and survivors. This included the improvement of whistleblowing and survivor support, governance, cultural change, and collaboration with the wider Church and external bodies. The Dean has publicly apologised for past failures, acknowledged lessons that need to be learned and advocated for victims and survivors' voices to be listened to.

15.3 That said, at the time of writing, the Audit has seen limited evidence of the application of this aspiration in practice. The Audit believes more can be done. For example, there is an opportunity to use the locale of the Cathedral to develop an open space to listen to the voice of victims and survivors in driving forward change. The Cathedral could work with the DST to organise such events, utilising the existing Survivor's Consultative Group's voice as a starting point. Obtaining feedback could be undertaken in a variety of ways and as such the Audit makes the following recommendations.

Recommendation C22: The Cathedral should consider implementing a formal feedback mechanism to determine priorities for improvement planning to victims and survivors' provision. This could include surveys, feedback forms, or co-facilitated listening sessions.

15.4 The Audit was told that the Cathedral follows the House of Bishops' guidance as set out in 'Responding Well to Victims and Survivors of Abuse'. The Audit also recognises that the Cathedral has its MoU with the DBF, within which it is set out that the Cathedral will provide pastoral support and access to independent services to those affected by safeguarding issues. Whilst the Cathedral has access to support and link services from the DBF when required, the Audit saw evidence of poor practice regarding ensuring that complainants are kept up to date. In part, this has been due to the unavailability of link and support persons. The Audit has heard that this is being progressed by the DBF at a regional level.

15.5 Demonstrating its commitment to addressing domestic abuse, over the last two years, the Cathedral has engaged with the 'Red Chair Project' by Restored UK during the 16 Days of Activism Against Gender-Based Violence. This year, the 'chair's' strategic placement in a visibly impactful setting sought to stimulate reflection and increase awareness. The Cathedral also marks Safeguarding Sunday through a special service.

15.6 Routes for disclosure are evident at the Cathedral, with signage on posters for Safe Spaces and Promoting a Safe Church all being clear. Up-to-date contact details for key safeguarding personnel are also included as they are on the Cathedral's website. The Cathedral could benefit from making these contact details consistent across its resources. In terms of reporting pathways, there are also two separate forms located on the Cathedral's website: one for children and one for adults at risk. The Cathedral appropriately instruct those with immediate concerns to always call 999.

Recommendation C23: To enhance safeguarding practices, the Cathedral should standardise contact information for safeguarding personnel across all resources, ensuring consistency between physical signage and the website.

15.7 The Cathedral's open access has led to an increased number of individuals seeking support for mental health and substance abuse issues. The Audit also recognised the Cathedral's role in connecting homeless congregants with local support services. To improve these efforts, the Audit recommends developing clear and accessible signposting resources for these issues via the Cathedral’s posters, noticeboards and online platforms. Furthermore, establishing formal partnerships with local charities such as Nightsafe and Lancashire Mind (possibly by invitation to the SMG/DSAP) would help to build closer relationships and facilitate more timely access to vital support.

Recommendation C24: The Cathedral should implement clear and accessible signposting resources for local support services (posters, noticeboards, online information) and establish formal partnerships with local charities like Nightsafe and Lancashire Mind (possibly by invitation to the SMG/DSAP) as this would help to build closer relationships and facilitate more timely access to vital support.

16 Learning, Supervision and Support

Safeguarding Learning

16.1 A key challenge for Blackburn Cathedral is its limited capacity to effectively manage and promote safeguarding training across its staff and volunteers. This has affected the range of training that is available, its evaluation and the consistency of record-keeping. Recommendations addressing the issues of capacity within the Cathedral are proposed in the *Culture, Leadership and Capacity* section of this report.

16.2 That said, most respondents to the Audit's survey reported seeing improvements in the Cathedral's training provision. Currently, safeguarding training is predominantly delivered through the CofE's training portal, with additional input from the DST. The Cathedral follows the nationally defined learning pathways, but a structured training programme is needed to ensure consistency and oversight. A training programme, developed through engagement with individual staff teams, would help to ensure that staff routinely receive the appropriate level of training and take advantage of the best learning opportunities available.

Recommendation C25: The Cathedral should implement a yearly training programme after consulting with staff to gain an understanding of their training needs.

16.3 Whilst training records for Cathedral staff are maintained, the Audit was not assured that these are being held in a centralised system to support the tracking of compliance and overall performance. A more streamlined approach would improve accessibility, oversight, and long-term planning. The Audit heard that the Director of Music will attend safer recruitment training, and this is a positive step that should be actioned soon.

Recommendation C26: The Cathedral should consolidate staff training records into a single centralised system, ensuring that training completion, renewal dates, and scheduling are easily tracked and managed.

Clergy Support

16.4 To help clergy members manage the emotional and psychological impact of their roles, particularly in relation to safeguarding, diocesan resources are available. The DST maintains regular communication with clergy involved in safeguarding cases, ensuring their wellbeing is monitored and appropriate support is signposted. In 2024, an Assistant Archdeacon for Clergy Wellbeing was appointed to lead on this area, with responsibilities including the development of a coherent strategy for clergy wellbeing, regular engagement with clergy, and identifying gaps in existing support. This is good practice.

16.5 Clergy who have been victims of abuse have access to therapy through the DST's budget and wellbeing is further supported through access to retreat programmes and external partnerships involving Bridge Builders, Clergy Support Trust, St Luke's and the Sheldon Hub.

16.6 There is a lack of resources to fully support Church Officers when an allegation of abuse or complaint is made against them. Adequate capacity is required to ensure that Church Officers subject to allegations receive appropriate support.

Recommendation C27: The Cathedral should consider options to increase resourcing and capacity for support of Church Officers facing allegations or complaints.

Supervision and Support of Safeguarding Roles

16.7 The CSA receives supervision from the NST Regional Safeguarding Lead (RSL).

16.8 The induction process positively includes safeguarding training, with pre-read materials provided either online or in hard copy, alongside targeted one-to-one meetings with key personnel. Induction is completed before engagement with children and young people and is reviewed through line management as part of the appraisal process.

16.9 The safeguarding team does not currently participate in any multi-agency safeguarding forums or groups that support learning. Expanding their membership into these networks would help strengthen safeguarding practice and collaboration.

Recommendation C28: Cathedral staff with a core safeguarding function should seek to engage with local multi-agency safeguarding forums or groups (independent to the DBF).

17 Conclusion

17.1 This Audit has identified some positive aspects within the Cathedral's approach to safeguarding, including some committed leaders, staff, and volunteers, the potential of the Safeguarding Management Group, and good practices in chorister safeguarding and the general approach to safer recruitment. However, these strengths are significantly undermined by critical vulnerabilities that demand urgent and comprehensive attention.

17.2 There is a view that safeguarding is not being driven or influenced by a safeguarding professional but by the opinion of senior leadership. Whilst senior leaders are rightly accountable, they are not equipped with the skillset to deliver operational safeguarding. Interviews and a review of other material revealed that neither the part-time CSA nor the DSO appears able to effectively challenge the Dean on safeguarding matters. This may be a result of a lack of mutual confidence in one another's abilities. That said, regardless of the reason, it has resulted in an absence of effective safeguarding leadership, questionable decision-making, inadequate safeguarding capacity and expertise, poor communication, inconsistencies in practice, and a failure to embed robust governance, oversight, and accountability.

17.3 The Audit found that risk assessment and management lacked appropriate structure and implementation. Record-keeping is poor, and HR processes are in need of urgent improvement. These systemic issues necessitate immediate remedial action to ensure the safety and wellbeing of all within the Cathedral community.

17.4 Guided by the recommendations in this Audit report, the Cathedral must now prioritise a properly constructed and independently overseen safeguarding improvement plan. This plan must encompass significant structural, operational, and leadership improvements to

ensure that safeguarding is professionally led and embedded as a demonstrable priority at all levels, including governance, leadership, oversight, and operations.

Appendices

18 Appendix 1 – DBF Recommendations

Recommendation D1: **Enhanced Communication and Oversight**

The Archdeacons should establish quarterly meetings with the DSO to ensure structured information sharing, enabling them to maximise the safeguarding impact of their formal and informal visits. These meetings should be underpinned by enhanced safeguarding briefs, debriefs, and record-keeping regarding outcomes and any necessary remedial actions.

Recommendation D2: **Strengthened Ministerial Development Reviews**

The current positive practice of Ministerial Development Reviews (MDRs), specifically the annual conversations, should be strengthened by consistently embedding a structured safeguarding development section in each record. This section should include practical reflections on an individual's safeguarding experience (in past and current roles) and identify future development areas. Development opportunities, both internal and external, should be provided, such as mentoring from external safeguarding experts, visits to statutory partners and access to relevant courses beyond the Church of England's national curriculum.

Recommendation D3: **Refreshed Core Group Training**

Core group training should be refreshed, with an invitation to neighbouring Archdeacons to attend a best practice workshop. This workshop should explore different approaches and outcomes, aiming to identify and establish consistently good practice.

During Audit discussion, the Archdeacons reinforced their desire to create an environment within which clergy would feel safe when admitting honest mistakes without fear of blame or punishment, similar to the approach taken in Local Child Safeguarding Practice Reviews. The Audit supports this idea in principal and will develop a balanced recommendation for the NST.

Recommendation D4: **Enhanced Victim and Survivor Engagement:**

c) The DSAP should implement a strategy for proactive outreach to local and national victim and survivor support groups. This should involve designated DSAP members or representatives visiting their meetings as listeners to gain a deeper understanding of their experiences and needs.

d) The DSAP should extend invitations and provide appropriate facilities for a range of victim and survivor support groups to present their perspectives, insights, and recommendations directly to the DSAP members. This may foster a more direct and informed dialogue.

Recommendation D5: **Comprehensive Action Plan and Accountability:**

e) The DSAP should develop a comprehensive action plan that meticulously captures all current outstanding safeguarding actions identified from audits, reviews, and other relevant sources. This plan should be a central, living document.

f) For each action within the plan, the DSAP should clearly designate a specific individual or role responsible for its completion ('Action Owner').

g) The DSAP should establish clear and measurable key milestones for each action, outlining expected completion dates and interim update requirements. This will facilitate effective monitoring of progress.

h) A robust mechanism should be implemented requiring Action Owners to provide regular updates to the DSAP on their assigned actions. These updates should be formally reviewed during DSAP meetings.

Recommendation D6: **Three-Year Themed Scrutiny Programme:**

d) The DSAP should hold a dedicated workshop for its members and relevant safeguarding professionals to identify key National Safeguarding Standards for in-depth scrutiny over a three-year period.

e) As an initial phase, the 'Year One DSAP Audit Programme' could focus on the following key National Safeguarding Standards through deep dives:

   iv. Examining the effectiveness of learning mechanisms from safeguarding incidents and the quality of supervision provided to safeguarding professionals and other relevant roles.

   v. Reviewing the sufficiency of safer recruitment practices across all relevant roles in the DBF and across the wider Diocese.

   vi. Assessing the effectiveness of risk assessment processes, the development and implementation of safety plans, and their impact on safeguarding vulnerable individuals.

f) The themed scrutiny programme for subsequent years should capture further key National Safeguarding Standards for deep dive audits, ensuring a comprehensive and systematic review over the three-year cycle.

Recommendation D7: **Enhanced Escalation Process for Non-Completion of Safeguarding Training:**

d) The DSAP should establish a clear process whereby, after set deadlines for mandatory safeguarding training completion have passed, the DSAP will formally write to those with oversight responsibility for individuals who remain non-compliant (e.g., Archdeacons for clergy, PCC Secretaries for church officers). This notification will

explicitly state the outstanding training requirements and the potential consequences of continued non-compliance.

e) The DSAP should implement a system to restrict the role and function of individuals who fail to complete the required safeguarding training within a reasonable timeframe after formal notification. This system should be clearly defined and communicated, and could include temporary suspension from specific duties involving contact with vulnerable individuals or leadership responsibilities until the training is completed. The DSAP should oversee this system and monitor its consistent application.

f) The DSO should provide regular reports to the DSAP on safeguarding training compliance and any instances requiring escalation and role limitation. This will enable the DSAP to monitor the effectiveness of the training programme and the escalation process.

Recommendation D8: **Establish an Independent Safeguarding Directorate**

To significantly strengthen safeguarding across the Diocese, the DBF should establish an operationally independent Safeguarding Directorate, led by a Director of Safeguarding. This Directorate would consolidate all safeguarding resources and provide comprehensive and consistent support to the DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the authority and autonomy to:

d) Provide expert advice and robust oversight on all safeguarding matters.

e) Challenge senior clergy and church bodies when necessary, ensuring accountability.

f) Escalate concerns directly to higher authorities, including the NST, without undue influence.

To ensure the effectiveness and significance of this structure, the following is required:

d) The Director should be a member of and report directly to key decision-making bodies, including the DBF, Bishop's Council, Chapter, and BLT / SLT.

e) A comprehensive Service Level Agreement (SLA) between the DBF, Parish PCCs, and the Cathedral should clearly define the Director's authority and responsibility to provide safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the Diocese.

f) The Directorate should be equipped with sufficient resources and staffing, including the consolidation of all professional safeguarding staff (including those currently at the Cathedral), and the creation of at least two new positions: one to backfill the existing DSO role and at least one new Assistant DSO (ADSO) position.

Note: This recommendation should be read in conjunction with the section on a Safeguarding Directorate within the Independent Safeguarding Audits Annual Report (2024/2025).[7]

Recommendation D9: **Phased Recruitment of Additional Assistant Safeguarding Advisors / Caseworkers**

To enhance the DST's capacity and resilience, a staged recruitment of additional caseworkers is recommended, incorporating complementary skill sets and training responsibilities.

Phase 1: Recruitment of an Assistant Diocesan Safeguarding Officer (ADSO) / Case worker (CW) with Specialist Skills:

b) The DBF should recruit an additional ADSO / CW with a complementary professional background, such as experience in the police or social care sectors, and a specific and demonstrable safeguarding skill set (e.g., child protection, adult safeguarding, risk assessment). This additional role should work in conjunction with the Safeguarding Support Coordinator (currently the Administrator role) to enhance and expand early help provision to parishes.

Phase 2: Recruitment of a Caseworker / Assistant Diocesan Safeguarding Advisor with Training Portfolio Responsibility:

b) The DBF should recruit an additional caseworker, with the potential for development into an ADSO role, whose remit will include a significant focus on enhancing the current safeguarding training provision across the Diocese.

Structure, Role and Expectations for ASDOs / CWs:

f) The additional caseworkers will primarily assist with casework management, providing vital support to the existing team.

[7] https://ineqe.com/churchofengland/

g) One caseworker will specifically contribute to the development and delivery of the training portfolio.

h) Both roles will provide essential backup and cover for existing team members, increasing the team's resilience and flexibility.

i) Consideration should be given to aligning caseworker responsibilities with archdeaconry areas, mirroring successful models in other dioceses for localised support.

j) Explore the potential incorporation of the Cathedral Safeguarding Advisor role within the DST's professional line management structure. Whilst dedicated to the Cathedral, this integration would allow for professional oversight, enhanced training opportunities, and the ability to reinforce the wider DST during periods of high demand or contingency.

Recommendation D10: **Evolve the Administrator Role to Support the DST**

To enhance the operational capacity and effectiveness of the DST, the current administration function should be expanded. This enhanced role should encompass the development of a professional portfolio (in support of the Administrator) and the acquisition of skills extending beyond traditional administrative duties. Specifically, the administrator's naming convention should be changed to Safeguarding Support Co-ordinator and their duties (once trained) should include:

- The initial triage of incoming safeguarding calls, mirroring a social care model for preliminary screening and information gathering.
- Expanded responsibilities to manage and filter incoming calls and communications, thereby alleviating pressure on the DST and ensuring the efficient allocation of resources.
- A training evaluation support function, involving follow-up contact with participants to gather valuable feedback on their learning experience, how any new skills are being practically applied, and the overall impact of the training.
- Supporting PSOs and being responsible for assisting with the management and regular updating of the Parish Safeguarding Dashboard, contributing to the effective tracking and documentation of safeguarding activities and outcomes.

Recommendation D11: An effective MoU / SLA between the Cathedral and DBF should contain the following:

Key Principles

n) Operational independence of safeguarding

o) Professional collaboration

p) Consistent safeguarding standards

q) Mutual accountability

Structural Elements:

r) Clear definition of roles and responsibilities

s) Explicit lines of professional accountability

t) Mechanisms for consistent communication

u) Shared commitment to the CofE's National Safeguarding Standards

Operational Components:

v) Case Management
   v. Shared access to a case management system
   vi. Clear protocols for case allocation
   vii. Consistent record-keeping standards
   viii. Mechanisms for cross-organisational case review

w) Professional Supervision
   v. Clear supervision frameworks
   vi. Defined escalation processes
   vii. Mutual commitment to professional development
   viii. Transparency in decision-making

x) Resource Sharing

v. Clarity on resource allocation

vi. Defined capacity expectations

vii. Mechanisms for collaborative resource deployment

viii. Contingency planning

y) Quality Assurance

v. Agreed quality assurance frameworks

vi. Regular performance reviews

vii. Shared metrics for evaluating performance and safeguarding effectiveness

viii. Commitment to continuous improvement

z) Information Sharing

v. Protocols for timely and comprehensive information exchange

vi. Confidentiality guidelines

vii. Mechanisms for joint risk assessment

viii. Clear communication channels

Recommendation D12: A formal review should be undertaken by the DBF and Cathedral to assess the feasibility and benefits of shared support services, such as HR, finance, or IT, with the explicit aim of streamlining operations and generating cost efficiencies that can be reinvested into bolstering safeguarding resources across both organisations.

Recommendation D13: The DBF should ensure that all staff and volunteers are up to date with DBS checks and are within the three-year cycle.

Recommendation D14: The DBF should transfer DBS administration from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

Recommendation D15: The DBF should adjust its communication plan to include key safeguarding messages via its digital channels. In order to enhance this engagement, it should:

d) Tailor content to resonate with the specific interests and preferences of followers on each platform.

e) Employ diverse communication strategies suited to each platform's unique features and user expectations.

f) Capitalise on relevant awareness days, campaigns, and events to amplify key messages and expand audience engagement.

Recommendation D16: The DBF should include the review dates on Risk Registers. Risks should be reviewed on a quarterly basis to assess cross organisational risk particularly in the event of significant changes to workplace processes.

Recommendation D17: 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 D18: The DBF should ensure that 'Concern Summaries' are recorded in all cases.

Recommendation D19: The accountability and responsibilities of the DST outlined in the MoU for safeguarding services and support between the Cathedral and DBF should be clearly communicated. Furthermore, the MoU itself requires effective implementation, consistent application, and regular review to maintain its relevance and effectiveness.

A further recommendation regarding the MoU is made in Part One, *Culture, Leadership and Capacity* section of this report.

Recommendation D20: The DBF should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

c) Including a statement of commitment on its 'Reporting Abuse and Finding Support' webpage.

d) Linking to 'Responding Well to Victims and Survivors of Abuse' guidance.

Recommendation D21: The DST should formally incorporate the following communication standards within its survivor support information and ensure they are consistently upheld in practice:

d) Clearly state the DST's commitment to providing regular and timely updates to survivors throughout the safeguarding process. This should include specific assurances about the frequency and format of updates.

e) Clearly identify the role of the Designated Safeguarding Officer (or other designated individual(s)) as the primary point of contact for survivors, responsible for ensuring consistent and timely communication.

f) Outline a process for gathering and respecting survivors' preferred method of communication (e.g., phone, email, in-person meetings).

Recommendation D22: The DBF should continue to expand membership of its Survivor's Consultative Group. This should include family members of those impacted by church-related abuse.

Recommendation D23: All staff and volunteers working at the DBF (and key safeguarding roles within parishes) who were not given an induction at the commencement of their role should be required to undertake one. This retrospective induction session should be mandatory regardless of a person's length of service.

Recommendation D24: To enhance consistency and ensure all safeguarding staff receive the level of support they need, regular, structured supervision sessions should be available for all team members, supported by routine check-ins.

19 Appendix 2 – Cathedral Recommendations

Recommendation C1: **Implement a Formal Escalation and Challenge Process for Systemic Safeguarding Weaknesses**

e) To ensure robust oversight and address systemic safeguarding weaknesses effectively, a clear and accessible formal escalation process should be urgently established and actively promoted within the Cathedral.

f) This process should empower all individuals, including safeguarding professionals (such as the CSA), staff, and volunteers, to escalate concerns regarding inadequate safeguarding arrangements, lack of influence, or any other systemic issues without fear of reprisal.

g) The process should outline clear steps for escalation to higher authorities within the Cathedral structure and, if necessary, to external bodies such as the Diocesan Safeguarding Team (DST) or the National Safeguarding Team (NST).

h) Furthermore, training should be provided to ensure a culture of professional curiosity and respectful challenge at all levels, encouraging individuals to proactively identify and address potential safeguarding risks and weaknesses.

Recommendation C2: **Governance and Leadership Oversight of the Cathedral's Safeguarding Improvement Journey:** Chapter should develop a detailed action plan with clear timelines and responsibilities to address all identified concerns. This plan should include, but not be limited to, the following actions:

1. Leadership and Separation of Responsibilities:

c) The Dean should step back from involvement in day-to-day safeguarding activity to ensure the appropriate separation of leadership and governance from operational safeguarding activities.

d) Chapter should urgently appoint a suitably qualified and experienced individual as its Cathedral Safeguarding Lead (CSL).

2. Strengthening Safeguarding Expertise:

b) Chapter should urgently recruit and appoint a suitably qualified and experienced individual as its full-time Cathedral Safeguarding Advisor (CSA). This role should be based at the Cathedral for three days per week and be professionally line managed and supervised by the DSO.

- If it is anticipated that this recruitment will take time, they should immediately appoint a suitably qualified interim (using an accredited agency if necessary).
- To this end, Chapter should involve an NST representative (the RSL) and the DSO on the interview panel.

3. Enhancing Governance Oversight:

c) The Chair of the Safeguarding Management Group (SMG) should be invited to attend the Cathedral Chapter. This will ensure direct safeguarding representation at the highest governance level, facilitating informed decision-making and robust challenge.

d) A temporary 'Cathedral Safeguarding Improvement Board' should be created. This Board should involve appropriate Cathedral, Diocese, and NST (RSL) representatives to record, monitor, and report on progress and improvement to Chapter. The Board should be independently chaired by a professionally qualified individual with substantial safeguarding experience. This interim measure would terminate once the improvements had been made and the safeguarding arrangements at the Cathedral were considered sufficiently embedded.

4. Operational Safeguarding Framework:

d) The Cathedral should develop and implement a structured framework in line with national standards for risk assessment, management (safety planning), and mitigation, ensuring consistent and appropriate application across all Cathedral activities and with clear lines of responsibility.

e) The Cathedral should implement a robust and auditable record-keeping system for all safeguarding matters, ensuring records are easily locatable, complete, and securely stored. It should ensure that safeguarding training is provided to all relevant staff and volunteers on proper record-keeping procedures.

f) The Cathedral should conduct an immediate review of the safeguarding roles currently held by volunteers to assess the sustainability and appropriateness of these arrangements. It should develop a plan to transition these responsibilities to appropriately employed and professionally supported staff.

5. Comprehensive Action Plan Integration:

The detailed action plan developed by Chapter should incorporate all recommendations outlined within this report, alongside any other relevant internal or external safeguarding improvement recommendations identified in previous reports or reviews. This integrated approach will ensure a holistic and coordinated strategy for enhancing safeguarding across the Cathedral.

6. Monitoring and Accountability:

The Cathedral should implement a robust monitoring process to track progress against the detailed action plan and ensure accountability for remedial action.

Recommendation C3: **Strengthening the Safeguarding Management Group (SMG):**

h) The SMG's membership should be broadened to include representatives from diverse community organisations relevant to safeguarding, such as local charities supporting vulnerable adults, children, or those affected by domestic abuse or homelessness.

i) The SMG should conduct regular skills, diversity, and inclusion audits of its membership to identify gaps and ensure a balanced and effective committee.

j) Once appointed, the on-site Cathedral Safeguarding Advisor (CSA) should become a member of the SMG.

k) Once appointed, the Chapter Cathedral Safeguarding Lead (CSL) should become a member of the SMG.

l) The SMG should develop a comprehensive three-year strategic safeguarding plan for the Cathedral, outlining key priorities, objectives, and measurable outcomes. This plan should be regularly reviewed, updated, and agreed upon by Chapter.

m) Dedicated and robust challenge sessions should be introduced at SMG meetings. These sessions should specifically focus on in-depth reviews of safeguarding incidents, lessons learned reports, and the implementation of recommendations, encouraging critical analysis and constructive scrutiny.

n) The SMG should work with the CSA (once established) and the DSO to evaluate the benefits of creating a Safeguarding Operational Group (SOG) as a sub-committee to the SMG.

Recommendation C4: An effective MoU between the Cathedral and DBF should contain the following:

Key Principles

e) Operational independence of safeguarding

f) Professional collaboration

g) Consistent safeguarding standards

h) Mutual accountability

Structural Elements:

e) Clear definition of roles and responsibilities
f) Explicit lines of professional accountability
g) Mechanisms for consistent communication
h) Shared commitment to the CofE's National Safeguarding Standards

Operational Components:

f) Case Management
   v. Shared access to a case management system
   vi. Clear protocols for case allocation
   vii. Consistent record-keeping standards
   viii. Mechanisms for cross-organisational case review

g) Professional Supervision
   v. Clear supervision frameworks
   vi. Defined escalation processes
   vii. Mutual commitment to professional development
   viii. Transparency in decision-making

h) Resource Sharing
   v. Clarity on resource allocation
   vi. Defined capacity expectations
   vii. Mechanisms for collaborative resource deployment
   viii. Contingency planning

i) Quality Assurance
   v. Agreed quality assurance frameworks
   vi. Regular performance reviews
   vii. Shared metrics for evaluating performance and safeguarding effectiveness
   viii. Commitment to continuous improvement

j) Information Sharing
   v. Protocols for timely and comprehensive information exchange
   vi. Confidentiality guidelines

vii. Mechanisms for joint risk assessment

viii. Clear communication channels

Recommendation C5: A formal review should be undertaken by the Cathedral and DBF to assess the feasibility and benefits of shared support services, such as HR, finance, or IT, with the explicit aim of streamlining operations and generating cost efficiencies that can be reinvested into bolstering safeguarding resources across both organisations.

Recommendation C6: **Establish an Operationally Autonomous Safeguarding Directorate**

To significantly strengthen safeguarding across the Diocese, the DBF should establish an operationally independent Safeguarding Directorate, led by a Director of Safeguarding. This Directorate would consolidate all safeguarding resources and provide comprehensive and consistent support to the DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the authority and autonomy to:

a) Provide expert advice and robust oversight on all safeguarding matters.

b) Challenge senior clergy and church bodies when necessary, ensuring accountability.

c) Escalate concerns directly to higher authorities, including the NST, without undue influence.

To ensure the effectiveness and significance of this structure, the following is required:

a) The Director should attend or be a member of and report directly to key decision-making bodies, including the DBF, Bishop's Council, Chapter, and Vision and Strategy / Bishop's Appointments Team.

b) A comprehensive Memorandum of Understanding (MoU) between the DBF, Parish PCCs, and the Cathedral should clearly define the Director's authority and responsibility to provide safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the Diocese.

c) The Directorate should be equipped with sufficient resources and staffing, including the consolidation of all professional safeguarding staff (including those currently at the Cathedral), and the creation of at least two new positions: one to backfill the existing DSO role and at least one new Assistant DSO (ADSO) position.

Note: This recommendation should be read in conjunction with the section on a Safeguarding Directorate within the Independent Safeguarding Audits Annual Report (2024 / 2025).

Recommendation C7: The Cathedral should implement a low-level concerns log to ensure that handover observations, low-level concerns and patterns of behaviours are recorded by key staff.

Recommendation C8: The Cathedral should introduce a dedicated chorister phone, managed by key members of staff to allow for secure and structured communication through approved and preferred platforms such as email, text message and WhatsApp.

Recommendation C9: The Cathedral should undertake a review of its chorister staff to ensure that all are confident in making relevant safeguarding decisions appropriately, including who to report to and when. This could take the form of a staff survey or refresher safeguarding session.

Recommendation C10: Additional reference to safeguarding should be made in the 'Visiting Organists' package to ensure they are aware of arrangements and have read and signed the safeguarding policy before visiting.

Recommendation C11: The Cathedral should ensure that all relevant staff and volunteers have up to date DBS checks and are within the three-year cycle.

Recommendation C12: The Cathedral should review the functions of volunteers and other roles where a DBS check is currently not undertaken, including Education Volunteers, to ensure they follow contemporary Government guidance. For each role, the Cathedral should establish whether a check is necessary and at what level. To note, a basic check can be undertaken for any position or purpose.

Recommendation C13: The Cathedral should develop a communication plan which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of followers, adopting different techniques specific to the platform in use and utilisation of relevant awareness days, campaigns and events to amplify the message.

Recommendation C14: The Cathedral should provide visitors to the safeguarding webpage the ability to access relevant material on the Diocesan website. This could include, for example, an ability to subscribe to the DBF's Safeguarding Matters newsletter and hyperlinks to the Safeguarding Resource Hub.[8]

[8] https://www.blackburn.anglican.org/safeguarding-resource-hub

Recommendation C15: The Cathedral should review the mechanisms it has in place to capture the voices and experiences of children, vulnerable adults and victims and survivors. It should develop a defined 'engagement' plan that ensures stakeholders are identified, spoken to frequently, and that their views are routinely reported to Chapter and relevant committees. The plan should also include arrangements for how such voices influence contemporary practice and new initiatives.

Recommendation C16: The Cathedral should review and take steps to raise awareness and further embed the Lone Working Policy and associated protocols such as use of two-way radios throughout the Cathedral.

Recommendation C17: CCTV coverage should be expanded to include the area towards the back of the Cathedral

Recommendation C18: The Cathedral should take immediate action to ensure all of its staff and volunteers are alert to the process for escalating a safeguarding concern and to whom this should be made (the CSA).

Recommendation C19: The Cathedral should rapidly engage the DBF to expedite the signing of the data sharing agreement and adopting the NSCMS.

Recommendation C20: In collaboration with the DBF and DSO, the ADSO (who has prior statutory experience in this field) should review the existing Cathedral risk assessments and safety plans. The findings of this review should serve to strengthen identified vulnerabilities and oversee the improvement of these processes within the Cathedral.

Updates confirming the accuracy and effectiveness of the Cathedral's risk assessments and safety plans should be shared with the NST RSL and provided to the SMG for their scrutiny and assurance on a quarterly basis for the next 12 months.

Recommendation C21: The Cathedral should take steps to identify the root cause of files being incorrectly posted, enabling the implementation of preventative measures. These measures include strengthening backup and recovery procedures, refining user permissions, providing comprehensive user training, and consideration of implementing Data Loss Prevention policies.

If this incident resulted in the loss or mismanagement of personal data, Chapter should satisfy itself that it has followed any relevant reporting / compliance requirements.

Recommendation C22: The Cathedral should consider implementing a formal feedback mechanism to determine priorities for improvement planning to victims and survivors' provision. This could include surveys, feedback forms, or co-facilitated listening sessions.

Recommendation C23: To enhance safeguarding practices, the Cathedral should standardise contact information for safeguarding personnel across all resources, ensuring consistency between physical signage and the website.

Recommendation C24: The Cathedral should implement clear and accessible signposting resources for local support services (posters, noticeboards, online information) and establish formal partnerships with local charities like Nightsafe and Lancashire Mind (possibly by invitation to the SMG/DSAP) as this would help to build closer relationships and facilitate more timely access to vital support.

Recommendation C25: The Cathedral should implement a yearly training programme after consulting with staff to gain an understanding of their training needs.

Recommendation C26: The Cathedral should consolidate staff training records into a single centralised system, ensuring that training completion, renewal dates, and scheduling are easily tracked and managed.

Recommendation C27: The Cathedral should consider options to increase resourcing and capacity for support of Church Officers facing allegations or complaints.

Recommendation C28: Cathedral staff with a core safeguarding function should seek to engage with local multi-agency safeguarding forums or groups (independent to the DBF).

20 Appendix 3 – Glossary of Abbreviations

ADSA	Assistant Diocesan Safeguarding Adviser
ADSO	Assistant Diocesan Safeguarding Officer
AEC	Association of English Cathedrals
BACP	British Association for Counselling and Psychotherapy
CAFA	Cathedrals Administration and Finance Association
CCSL	Clergy Current Status Letter
CCTV	Closed-circuit TV
CDM	Clergy Discipline Measure
CJSM	Criminal Justice Secure Mail
CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
CPS	Crown Prosecution Service
CSA	Cathedral Safeguarding Advisor
CSL	Cathedral Safeguarding Lead
CSMG	Cathedral Safeguarding Management Group
DBE	Diocesan Board of Education
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
LSAB	Lancashire Safeguarding Adults Board
MDR	Ministerial Development Review
MOSOVO	Management of Sexual Offenders and Violent Offenders
MoU	Memorandum of Understanding
NAPAC	National Association for People Abused in Childhood
NPCC	National Police Chiefs' Council
NSCMS	National Safeguarding Case Management System
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
SEO	Search Engine Optimisation
SIR	Serious Incident Report
SLA	Service Level Agreement
SLT	Senior Leadership Team
SMG	Safeguarding Management Group
SOG	Safeguarding Operational Group

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