social care
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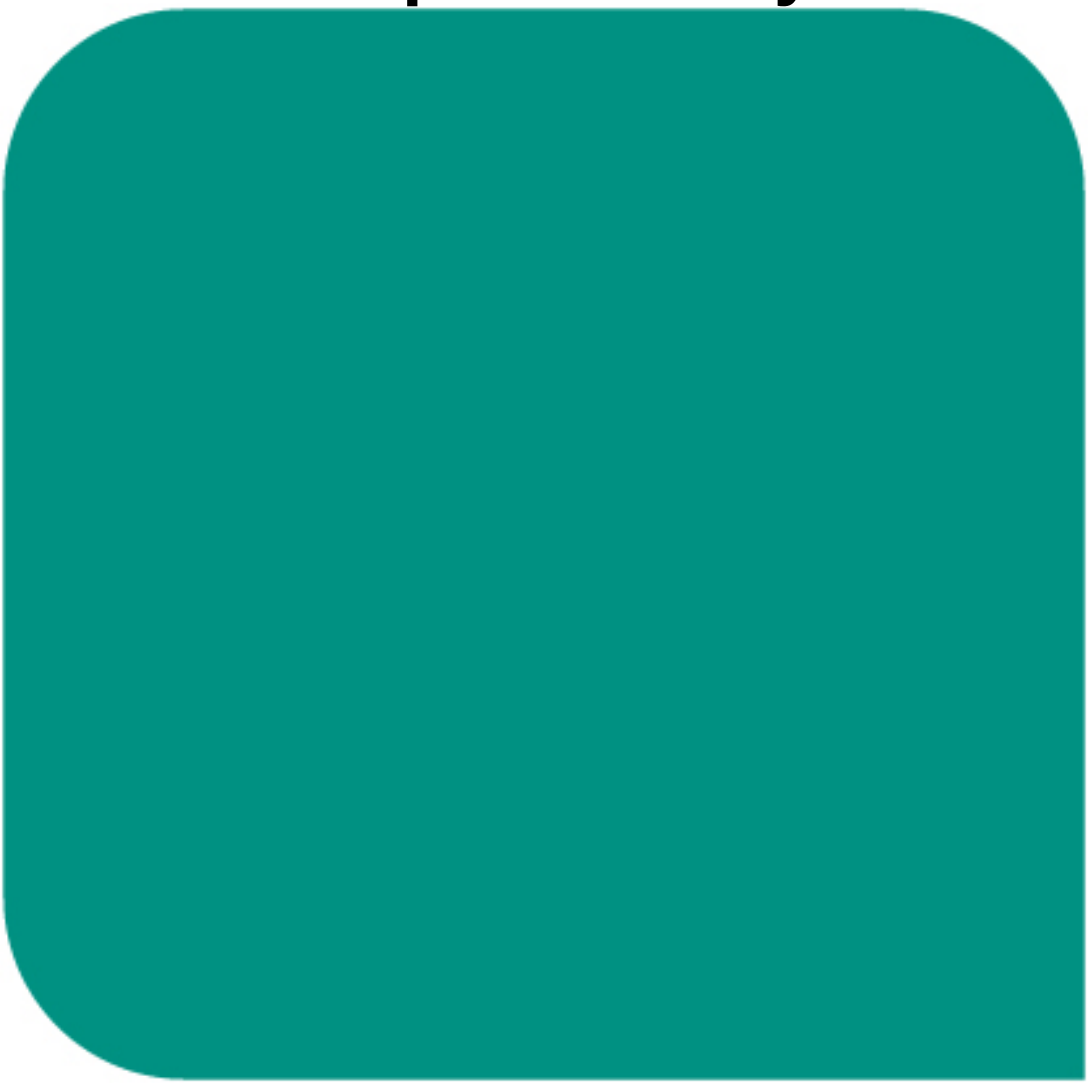
Independent auditing of safeguarding arrangements for the Church of England: Overview report to July 2016



THE CHURCH OF ENGLAND

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Contents

1 INTRODUCTION

1.1 THE AUDITS

The Social Care Institute for Excellence (SCIE) has been commissioned by the National Safeguarding Team of the Church of England to provide independent audits of diocesan safeguarding arrangements for the Church of England. The project covers all the dioceses in England. The numbers involved means that the time available within each diocese is limited to three days. Whilst this cannot provide an in-depth assessment of current safeguarding practice, it does provide an understanding of the main strengths and weaknesses of practice from the evidence provided by a small representative sample of case and recruitment files, from the perspectives of key people in the diocese, from a group meeting with parish representatives and written feedback provided by key links in statutory agencies.

The process began, in the second half of 2015, with pilot audits undertaken in the dioceses of Portsmouth, Salisbury, Blackburn and Durham. This tested the planning, conduct and output of the audit approach. The audit methodology and supporting documents were amended on the basis of the evaluation of the pilots. The national roll-out of the audits, using the amended methodology, commenced in February 2016, and will continue for the remainder of 2016 and 2017.

The focus of the audit is on the work of the diocese. The quality of safeguarding in individual parishes and in the Cathedral is not part of this audit, except where issues are raised through a case.

The perspectives of individuals who have been the victims of abuse or been affected by the abuse of others are not part of this audit. A parallel project commencing in 2017 will be specifically considering this aspect of learning.

1.2 PURPOSE OF THIS REPORT

The development of safeguarding arrangements differs between dioceses and consequently there are variations in how the service is organised and managed, albeit this should always be compliant with the national safeguarding policy and practice guidance framework.

The national audit provides the opportunity to independently assess the current strengths and areas of development in safeguarding arrangements within each diocese, and through this gives the opportunity to share good practice and strategies, so as to facilitate learning from each other.

This report provides an overview of the learning from the audits so far. This includes the pilots and the following dioceses audited between February and July 2016:

- Peterborough (February 2016)
- London (March 2016)
- Lichfield (March 2016)

- Birmingham (April 2016)
- St Edmundsbury & Ipswich (April 2016)
- Chester (May 2016)
- Southwell & Nottingham (June 2016)
- York (June 2016)
- Gloucester (July 2016)
- Liverpool (July 2016)
- Ely (July 2016)

This report highlights the strengths and areas for development in safeguarding practice. Issues which have national or systemic implications for safeguarding in the Church have been identified as needing specific consideration by the National Safeguarding Team (NST).

Some of the considerations for the NST will have previously been made in the pilot overview report and are being addressed in the National Improvement Plan. These recommendations have been repeated in this report, if still relevant, even though there have been plans made to address the issues concerned.

1.3 STRUCTURE AND CONTENT OF THE REPORT

1.3.1 Section 2: Findings and considerations

Findings

Section 2 presents an overview of the findings from the audits so far undertaken, discussion of what this indicates about national systemic strengths and weaknesses, along with the relevant national considerations that are indicated by the findings. Examples of good practice have been highlighted within some of these findings.

The dioceses are all at a point of active consideration of how to improve safeguarding practice and each had its own individual strengths and areas for development. The report avoids indentifying the practice of any particular diocese, as to do so for one practice issue alone could generate a biased view of the overall practice of that diocese.

Considerations

The considerations for the NST are provided at the end of each finding in section 2. These are not specific recommendations to be implemented. Instead, in keeping with SCIE's collaborative 'Learning Together' methodology, these are questions and points for the NST to consider and decide the best way to address the issue, and the priority to be attached to it. This approach ensures that those best placed consider these issues do so, and helps generate ownership of and accountability for the decisions that result.

1.3.2 Section 3: Conclusions

Section 3 provides an overview of what is working well and what needs to work better across the dioceses so far audited, along with the considerations for the NST about possible further actions. The details behind these conclusions are in section 2.

1.3.3 Glossary

A glossary of abbreviations and terms used is provided at the end of the report.

2 FINDINGS AND CONSIDERATIONS

This section provides an overview of the findings of the individual audits, as well as what this indicates about national strengths and weaknesses in practice and, where known, any underlying systemic obstacles in improving practice.

2.1 MANAGEMENT OF SAFEGUARDING

Bishops have embraced their leadership role in safeguarding generally and some have helpfully made positive public messages around its vital importance and integral place in Christian life.

Each diocese varied in the arrangements made for the organisation and management responsibility for safeguarding, but all have the following common arrangements and structures:

- The Bishop has identified themselves as having lead responsibility for safeguarding.
- At least one Diocesan Safeguarding Adviser (DSA) is in post (see 3.2).
- All have an independently chaired Diocesan Safeguarding Group (DSG) monitoring the effectiveness of safeguarding arrangements for children and adults in the diocese (the name of this group varies between dioceses – see 3.3).
- All have a senior management group/Bishop's leadership team providing a strategic overview of safeguarding in the diocese, some operational management responsibility and with a level of oversight of the DSG.
- Archdeacons responsibility for some quality assuring of safeguarding practice within parishes.

There were variations within these broad commonalities in the structure of safeguarding management.

2.1.1 Potential confusion around responsibilities and the meaning of delegated responsibility

Whilst all the Bishops accept that safeguarding is their responsibility, the arrangements for its delegation vary. The most common arrangement is for this to lie with an Archdeacon, but other models include the responsibility or some specific responsibilities being delegated to the Bishop’s Chaplain, Associate Archdeacon, Suffragan Bishop and in one case to the Diocesan Safeguarding Adviser (DSA). In one diocese, there was no delegation of any aspects of this leadership role.

What is less clear is the actual meaning of 'leadership' and 'responsibility for safeguarding'; in particular how this breaks down in terms of strategic, operational and theological leadership. The latter is the responsibility of the clergy, but responsibility for strategic and operational safeguarding leadership is sometimes less well defined and understood.

Auditors tended to report positively on close links between the Bishop and DSA in most instances, with consensual agreement reached about decisions needing to be made. However, there was evidence of disagreement in two dioceses, which highlights the possibility this could occur elsewhere. This potential lies in the lack of clarity around what can be delegated and who has the ultimate operational responsibility for case decisions e.g. if and when to make referrals to other agencies, initiating core groups and the responsibility for decisions as opposed to recommendations of core groups. This is not clear from current policy and practice guidance and is discussed further in 2.5.

Such disagreement is particularly problematic if there are conflicts between safeguarding professionals and senior members of the clergy, especially if this means that, for example, a qualified social work DSA feels unable to follow her/his professional responsibilities, such as the making of referrals to statutory duties when they judge the threshold for such action has been met. In one instance this led to the DSA referring herself to her professional body.

There needs to be a way to manage such disagreements, perhaps through the involvement of the National Safeguarding Team, and the recognition that such disagreements are a positive indicator of a culture where people feel able to openly disagree. It is of note that the two examples where such disagreements were aired both involve experienced confident DSAs, qualified safeguarding professionals with management experience. The reasons for the lack of such disagreement in the remaining dioceses may indicate consensus decision-making, but also may be the result of other contributory factors e.g. culture, individual personalities, knowledge and experience.

The potential for such profound disagreement does indicate the need for more clarity around operational management and decision-making, and in particular who is ultimately responsible for making safeguarding decisions around referrals. Should this decision be taken by those with professional background and experience in safeguarding or a member of the clergy, and if the latter, should this be the Bishop?

The Practice Guidance: Responding to Serious Safeguarding Situations Relating to Church Officers (June 2015) addresses the potential for conflict when Bishops are involved in the operational safeguarding decisions when it precludes them from being members of core groups, *'in order not to compromise potential decisions about disciplinary matters which rest with him or her'.* (7.20).

One Bishop spoke of the wider need to maintain a separation between pastoral duties and decision-making in safeguarding, in line with recommendation 6 of the 'Inquiry into the Church of England's response to child abuse allegations made against Robert Waddington' (known as 'The Cahill Report'), that decision-makers should not have a pastoral responsibility for the alleged perpetrator and *'that this means that whilst Bishops and Archbishops may be consulted, it should be someone qualified and independent of the Church who makes the final decision whether a matter should or should not, be reported to the statutory agencies or police*'.

This recommendation is not policy within the Church. It does though raise one of the underlying systemic difficulties there can be in decision-making relating to allegations of church officers, and consequently the need for a national position on the appropriate safeguards that need to be in place to minimise any potential for conflicts of interest involved in any decision-making about referrals to statutory authorities.

The receipt of referrals was another area of some confusion. In most dioceses, referrals were made to the DSA or a member of the safeguarding team in the diocese, but in one large diocese, the Bishop's Chaplain is the first point of contact for any possible safeguarding referrals. Whilst there was no evidence this has been problematic, it risks delay and the potential for decision-making that may not be in accordance with professional safeguarding practice. This would be helpful to have clarified in national guidance.

2.1.2 Senior management responsibility

The ways of managing the safeguarding service varied. All dioceses had some form of senior management team with regular meetings and which included in its remit safeguarding responsibilities. This group meets regularly and has different names in different places e.g. the Bishop's leadership / management team, diocesan safeguarding team. The DSA does not belong to this group, but in one diocese reports quarterly to it. Some had two such fora, one a management / operational team and one a leadership team. In one diocese the DSA was part of the management team.

The lack of professional safeguarding input into most of the senior management meetings could be a weakness, perhaps dependent largely on the grasp that others have of the safeguarding role. It would seem to be sensible for the DSA to be required to have, at the least, a reporting function to such meetings as a means of mitigating such risks

2.1.3 Management of safeguarding service

The most common structure for the management of the DSA and others with safeguarding responsibilities is for the responsibility to lie with the Diocesan Secretary or the Chief Executive Officer. This has the advantage of a clear management structure. Such an arrangement is not universal, with other arrangements involving split management between a number of senior managers and, in one case, an Archdeacon having management responsibility. This latter arrangement was perceived as providing a strong link to senior clergy, but this could be provided via alternative means. Such a link with a member of the clergy risks the DSA being perceived, as the 'Bishop's Safeguarding Adviser' and insufficiently embedded in the organisational structure, as opposed to an adviser to a particular member of the clergy. For this reason another diocese recently replaced a consultant Bishop's Safeguarding Adviser (BSA) with an employed DSA.

2.1.4 Parallel processes: Clergy Disciplinary Measures

Generally, the use of Clergy Disciplinary Measures (CDM)[1] was not presented as being problematic in safeguarding cases. However, a potential conflict could arise if the individual making safeguarding allegations is the person expected to make the complaint to initiate the CDM, as was suggested in one diocese.

2.1.5 Impact of size and complexity of structure of diocese

A factor that can affect how well safeguarding arrangements work is the size and complexity of the diocese, leading to potential challenges in the consistency of the safeguarding message and responses received to it in larger dioceses. This can risk the development of attitudes and/or practice that are highly localised and outside the safeguarding practice and culture that the diocese may be wanting to embed.

Further challenges arise with large mobile congregations and consequent increased difficulty identifying offenders.

2.1.6 Cathedral

The extent of 'working together' between diocese and Cathedral varies greatly. In some dioceses there was little evidence of any overlaps, whilst in others there have been recent moves towards increasing integration of systems and processes, including common training, Cathedral representation on diocesan safeguarding management groups, the DSA providing consultation to the Cathedral and the Cathedral making use of the expertise of the diocesan communications staff. In one diocese there was a service level agreement for the diocese to provide dedicated human resources (HR) and safeguarding advice and consultation.

2.1.7 Support to nontraditional organisations

One diocese was notable in its support to the growing number of non-traditional congregations, such as Fresh Expressions linking them into wider diocesan structures, including safeguarding.

2.1.8 Monitoring role of safeguarding in parishes

The monitoring role of safeguarding in parishes was well understood as being part of the Archdeacon's responsibilities (see 3.4).

[1] The Clergy Discipline Measure 2003 which came fully into force on 1 January 2006, provides a structure for dealing efficiently and fairly with formal complaints of misconduct against members of the clergy, other than in relation to matters involving doctrine, ritual or ceremonial.

CONSIDERATIONS FOR THE NATIONAL SAFEGUARDING TEAM

- *How to clarify the meaning of safeguarding leadership and its delegation, in particular around the operational receipt of concerns and the decision-making over referrals to statutory bodies: such responsibilities need to be with those who have no potential conflicts of interest and are the fundamentals of a professional safeguarding service.*
- *What form of escalation process is required to deal with disagreements about operational decision-making? Should this be through the National Safeguarding Team?*
- *Is there a need to clarify how the parallel process of Clergy Disciplinary Measures (CDM) sits with safeguarding processes, and in particular when it might or might not be appropriate for an alleged victim to make the complaint to initiate a CDM?*
- *Is there a need for DSAs to attend some senior management meetings in a diocese and, at a minimum, report on the safeguarding functions?*

2.2 DIOCESAN SAFEGUARDING SERVICE

2.2.1 The Diocesan Safeguarding Adviser (DSA)

All the dioceses audited have a paid Diocesan Safeguarding Adviser/s (DSA) in post. There was variation in the hours worked, employment arrangements, professional background and experience. In a few places the roles were split between different advisers, and in one diocese there was, in addition, a separate Bishop's Safeguarding Adviser (BSA), whilst another had recently changed from having a BSA to a DSA, with the changed management arrangements this implies. A third had four individuals in post, with different responsibilities and different job titles (one being the BSA).

2.2.2 Isolation v team support

The isolation of many DSAs from other safeguarding professionals is a feature of the working life of the majority of DSAs. In one diocese, this had been overcome through the breaking up of the role into four strands, with four different post-holders, with one (the qualified social worker) providing supervision to the others, as well as acting as the Bishop's Safeguarding Adviser. This team approach provided peers and supervision within a team and consequently enabled mutual support, but meant the core tasks of the DSA role were being undertaken by those without safeguarding professional qualifications or experience.

Another diocese contracts out the DSA role to a local charity, and the DSA is consequently part of a social work team receiving supervision and peer support. This appears to work well.

2.2.3 Support from the National Safeguarding Team

The extent of support from the National Safeguarding Team (NST) was not a focus of the pilots, but was included in the main stage of the audits. It is significant, because conversations with DSAs in the pilots highlighted their isolation and potential need for support and consultation, outside of the diocese. In exploring the use of available options, it appears that the national church has not historically offered this resource. The recent developments within the national team provide opportunities to explore this relationship and how it could be developed, to provide greater liaison and support to the individual DSAs.

Isolation was mentioned less in the subsequent audits, and participants spoke of having good links with the NST, in particular speaking of recent or anticipated visits by the National Safeguarding Adviser and group meetings with other DSAs. It is understood this is one of the many developments already implemented following the pilot audits.

2.2.4 Qualifications and experience

The professional qualifications and experience of DSAs varies, with more recent appointments coming from a professional background involving safeguarding. The extent to which this is the case varies both in terms of the profession of the post-holder and the level of safeguarding experience. Different dioceses have likings for specific professional backgrounds, for example one searched specifically for ex police officers. Others have nurses, teachers, social workers and lawyers. A few DSAs has undertaken a safeguarding post-graduate course, to be better qualified for the role. Some of those performing DSA functions have no professional safeguarding background, but have developed experience in the Church.

National guidance, whilst providing expectation of professional qualifications in safeguarding does not (perhaps intentionally) explain what this means, so leaves it open to local interpretation. The view of what training is actually required in safeguarding, and what experience is necessary is not defined. The SCIE audit team holds that social workers' training and experience provides the background that is most likely to equip DSAs with the breadth of knowledge and experience of both abusers (including offenders) and victims. The central core of social work involves working with other professionals and making referrals when required and also undertaking assessments of risk and provision of support where needed, not just for cases that meet thresholds for statutory intervention, but in the more complex area where thresholds are not met, but concerns remain. The size and scope of this audit does not enable a judgment to be made about the extent to which different professional backgrounds impact on safeguarding practice. The absence of any social work input in a few dioceses, in either the safeguarding service or the membership of the Diocesan Safeguarding Group, is of concern, given social work's central role and responsibility for safeguarding in the UK. In addition, it is of concern if a diocese, in thinking about how to provide the safest possible service, does not try to obtain such social work expertise when recruiting for DSAs.

A challenge for all the DSAs as well as the diocese is how to encompass knowledge and expertise in both vulnerable adult and child safeguarding. In a few dioceses, this has been overcome with separate posts and/or separate supervision arrangements.

A further consideration is the need or not for prior management experience, given the level of decision-making involved in the job, as well as the ability to liaise and negotiate at senior levels with clergy and with other agencies. Such experience is not universal and as it stands not required for the DSA function. It would be helpful to consider whether this should be an essential requirement, especially given the need for DSAs to be able to effectively challenge senior clergy and managers in statutory agencies.

2.2.5 Supervision

Supervision is universally left to the DSA to arrange, albeit paid for by the diocese. Some have difficulty in finding this provision. In the pilots, only one of the four dioceses had this in place. Of the 11 dioceses audited so far in 2016, three have no supervision arrangements in place for the DSA.

The regularity of supervision varies, from monthly to three monthly, usually though providing for additional ad hoc arrangements if required.

Because the DSA sources their own supervisor, there is a tendency for the person to be someone from the same professional background as themselves, which risks the loss of provision of other perspectives, especially when the DSA comes from a professional background which has a specialist focus, such as working with offenders. Moreover, if supervisors are selected by the supervisee, they are potentially less likely to be able to effectively provide professional challenge. In dioceses without social workers in the safeguarding service, the use of a social worker as supervisor could be helpful.

One of the dioceses in the pilot had particularly impressive supervision arrangements, with the commissioning of two supervisors, one with safeguarding social work expertise with children and the other with adults. DSAs will usually come with only a children's or adult services background, so this is a particularly helpful supervisory arrangement.

2.2.6 Is supervision integrated into the work of the safeguarding service?

Across dioceses, supervision is commonly perceived very much still as something that is for the DSA and for them to arrange, as opposed to part of the safeguarding service, answerable also to the Church and evident on case files as well as supervision records.

In one diocese, there were case records which demonstrated the supervision discussion, but this was not identified elsewhere. Another DSA described the existence of supervision notes signed by both supervisor and supervisee.

There are no links between supervisors and DSA line managers. It is not known how concerns regarding professional conduct are addressed by supervisors, given that they are essentially commissioned by the supervisee. The one exception to this was in one diocese, which commissioned out the DSA role to a social work charity, so the team manager, provided both supervision and management to the DSA. This worked well.

2.2.7 Conflict of interests for DSAs

A potential conflict of interests has become apparent with the appointment of DSAs who are also ordained ministers, lay preachers, parish priests etc. or who decide to become so after becoming DSAs. The potential for this leading to a conflict of interests had not been considered within the dioceses concerned, perhaps because the national policy is not explicit about what could construe such conflict.

2.2.8 Roles and responsibilities

There is a great variation in how the roles and responsibilities of the DSA are arranged, and in some dioceses, part of the functions are undertaken by other members of the team, such as responsibility for training, writing policies and for the DBS system. Other places contract out parts of the work, for example the DBS processes, or use volunteers to help deliver training.

Whilst most diocesan arrangements involve the DSA in the delivery of risk assessments and other case work, there is not an understanding that there is, arguably, an equal need for most of the training to be delivered by suitably experienced and qualified professionals, whether volunteers, consultants or paid staff.

2.2.9 Employment arrangements

All DSAs are paid for their work in line with national policy. In at least one diocese though, this is a relatively new position with the previous post-holders being volunteers.

Most of the DSAs are employees of the dioceses, but two commission a self-employed DSA. One diocese argues that it enables the DSA to be in a stronger position to provide challenge. The auditors were not convinced of this as self-employment can bring with it job insecurity and consequent disincentive for such challenge (although there was no evidence of any insecurity in these instances). A third diocese had two part-time DSAs, one employed and one self-employed and a fourth had recently replaced the consultant with an employee.

Another model in one diocese is to commission the DSA role to a local social work charity with long established links with both the Church of England and the Roman Catholic Church. This means that the DSA works alongside a colleague undertaking this role in the Roman Catholic Church and as part of a team, with social work management and supervision.

2.2.10 Resources

The wide variation in DSA time within a diocese ranged from one part-time DSA covering both vulnerable adults and children to an entire team consisting of four people with administrative support.

In order to provide flexibility of resources, some DSAs have additional hours they are able to claim to cover additional hours as and when required.

The DSAs have varying amounts of administrative support, some of which is dedicated to safeguarding and some not. There was a view that dedicated time worked better, as opposed to having to rely on the flexibility of individual administration staff.

The audits indicate that safeguarding resources have generally been increasing, either through increased DSA time, or through creative use of alternative sources of provision, such as the use of external agencies, to provide cover in the absence of the DSA or to undertake DBS checks; the use of other roles within the diocese to complete specific parts of the role, such as an events coordinator, communications assistant.

The use of volunteers features in the service in some dioceses, used for delivery of training, advising on domestic abuse or other specialist areas. The volunteers concerned are usually people who have professional experience in the field in which they are providing a service.

The auditors are becoming increasingly aware of the differences in resources between dioceses, especially between the older and generally wealthier ones and the newer ones. One diocese, which has experience of historical abuse, has committed additional resources to the service, but has had to achieve this through redundancies and restructuring elsewhere, as the diocese is running at a deficit.

There was a recognition that for many DSAs the practice and training requirements, introduced recently, have added to their workload, and in particular DSAs mentioned the struggle to maintain records that are both up to date and in accordance with required standard. The introduction of the new Learning & Development Practice Guidance has also involved additional delivery of training.

Some DSAs and their staff spoke about the limited capacity to be able to get around parishes to support their safeguarding work.

Considerations for the National Safeguarding Team

- *How to clarify the essential and desirable qualifications and experience for those in the safeguarding service, in particular for DSAs, those providing professional supervision, those writing any local policy and procedures and those delivering training.*
- *The need to define more clearly what could be conflicts of interest for any post-holder.*
- *How should supervision arrangements and advice be incorporated and demonstrated in the work of the DSAs and linked to the internal management arrangements?*
- *How to further develop stronger links and support services to the individual Diocesan Safeguarding Advisers.*

2.3 DIOCESAN SAFEGUARDING GROUP

2.3.1 Name and function

All the dioceses have established a forum to provide strategy, scrutiny, challenge and monitoring of safeguarding policy and practice, albeit the name varies and includes Diocesan Safeguarding Steering/Commissioning/Strategy Group or Panel. For this report the term Diocesan Safeguarding Group (DSG) is used. In some places the forum is also additionally specified to have a quality assurance function. Also in some places the term 'management' is used in the name of the forum. This is misleading as the group's function is not that of management, which usually rests with the Bishop's leadership group. It may be that this term reflects earlier perceptions of the role, which appears in the past to have involved consideration of casework.

What is less clear is how the strategic function of this forum inter-relates with the strategic functions of the Bishop and their management / leadership team/s and the extent to which it is able to hold the diocese to account.

The frequency of meetings varies, but was typically quarterly.

2.3.2 Chair

All the DSGs have Independent Chairs, albeit for some this is a recent introduction and in one case the arrangement had yet to commence at the point of the audit.

The role and time commitment of the Chair varied. In all but two dioceses this is a voluntary position, with expenses paid. In one diocese the position is paid and in another the Chair receives an 'honorarium'. There was no evidence that being a volunteer has had a detrimental impact on the Chair's input or performance. The auditors were mindful that the role, and hence the time commitment, varied. In one of the pilot dioceses it was particularly striking that the Chair was providing considerable time to supporting the safeguarding function, and the auditors were concerned that in the long run this may not be a sustainable position for a volunteer.

The background experience of the Chairs differs, although a legal background was a frequent feature.

2.3.3 Membership

Membership of the DSG varies, with most aiming to get involvement of external agencies. This is a challenge in some locations, especially the larger dioceses which have to liaise with several local authorities. One such diocese obtained professional input through paying for consultants. However, whilst giving professional expertise, this does not replace the need for the representation of statutory agencies in this group.

Also missing, in two dioceses, was any children's social work expertise at all in the group, but the newly appointed DSA in one would, in the future, attend the meetings and bring this expertise. The other diocese is of more concern, as it had neither social work expertise nor representation from statutory agencies nor professional consultants. The emphasis instead is on legal and ecclesiastical membership.

Some DSGs included DSAs as part of the membership of the groups and others distinguished between membership of the group and those officers attending to provide information and support functions. Usually the DSA's line manager is part of the group, but this is not so universally. The auditors considered that the line manager needs to be a member of this group.

A few bishops are part of the group, and this was perceived within the dioceses concerned as a positive reinforcement of the importance of safeguarding.

Cathedrals are represented in a few dioceses, but this is by no means standard practice. It was viewed as a positive development in working together on safeguarding.

A weakness for the Chairs in the pilots was the lack of active involvement in forums with other Independent Chairs. However, in the audits undertaken in 2016, one Chair spoke positively of having attended such a national meeting and another of the plan for a regional network. These are positive developments.

2.3.4 Good practice examples

There is a variation in how the groups function in different dioceses and each had developed their own individual characteristics. Examples of good practice include:

- members attending parish events on behalf of the group
- use of annual strategic plans, regularly updated and shared with the other strategic management groups within the diocese
- Cathedral representation on DSG
- safeguarding survey of parishes to inform planning.

Considerations for the National Safeguarding Team

- *How to develop national consistency around the role of the DSG, including its function, membership (including the need for children and adult social work expertise and representation from statutory agencies), role of officers in its work (including the DSA) and relationship to other safeguarding strategic management groups.*
- *How to develop stronger links between, and support services to, the Independent Chairs of the diocesan safeguarding groups.*

2.4 QUALITY ASSURANCE PROCESSES

All dioceses undertake a self-assessment audit for the NST and the Archdeacon's Articles of Enquiry (see below) provide a process which can also contribute to the monitoring of safeguarding in the parishes. Most DSGs have quality assurance as one of their main functions, accomplished largely via the DSA's reports to the meetings.

Over and above these universal systems of quality assurance several dioceses are developing their own individual processes to monitor the state of safeguarding within the diocese. Examples include:

- Independent audits of safeguarding arrangements, processes and casework
- Independent case reviews
- Case peer review between neighbouring DSAs
- Participation in section 11 audits as part of LSCB involvement

Despite the individual initiatives in a few dioceses, the auditors considered that the quality assurance function within most of the dioceses is at a relatively early stage of development.

2.4.1 Safeguarding in parishes

The large size of the Church and its constituent organisations provide a major challenge in knowing how well safeguarding is understood and applied, especially in relation to the number and diversity of the parishes. DSAs and Archdeacons mention that 'you only know what you are told' and consequently this is an area of unknown risk.

The lack of a 'command and control' management structure within the Church means that by and large changes are implemented through education and persuasion.

The Archdeacons were aware of their responsibility to monitor safeguarding in the parishes, usually to address safeguarding of both children and vulnerable adults through the Articles of Enquiry prior to a Visitation, albeit not universally applied in each of the Articles. In one diocese there is a preference for the use of Survey Monkey for specific questions, instead of what is viewed as the 'paper exercise' of Articles of Enquiry.

Whilst being able to collect factual information, it was identified that it is more challenging to understand the safeguarding culture in each parish and the quality of the work of the Parish Safeguarding Officers (when they exist). There was also recognition that the information collected about each parish is not analysed, in a systemic way, to assist planning.

Sometimes the lack of answers to factual questions provided evidence, but the subtler attitudes towards safeguarding tend to only be discerned via cases. DSAs are very aware that within available resources it is not possible to know where each parish is on its safeguarding journey and that such understanding is at an early stage.

Sometimes concerns are identified via issues raised in safeguarding training. Also some Archdeacons pointed out that often it emerges due to other issues, and that concerns around the parish falling short in general often include poor safeguarding performance.

Of particular concern are the parishes without a safeguarding officer, or this role being undertaken by the incumbent or their partner. Those incumbents with freehold (as opposed to common tenure) can prove a greater challenge, as it is more difficult to demand compliance.

There is wide recognition that the safeguarding of vulnerable adults is more complex and less well understood within parishes, and consequently provides the greater challenge.

2.4.2 Examples of good practice

- Use of both factual tick box questions and open questions as part of Articles of Enquiry and parish safeguarding list (e.g. existence of safeguarding policy and 'what else would be helpful in terms of safeguarding?')
- Parishes being asked to complete comprehensive safeguarding checklist
- Parishes asked to undertake a self-audit to provide detailed baseline information
- DSA maintaining databases of parish information to share with Archdeacons e.g. DBS checks, status of training
- Archdeacons using informal networks to understand better the state of safeguarding practice, such as church wardens, rural deaneries
- Archdeacons involvement in core groups relating to cases and in the process for individual safeguarding agreements in parishes
- Regular e-bulletins / newsletters / Facebook groups: tools for DSAs to keep parishes up to date and to develop links between each other
- Building up awareness in parishes of dementia as source of adult vulnerability
- Archdeacons conduct exit interviews on safeguarding issues with departing incumbents, to have better understanding of local challenges

Considerations for the National Safeguarding Team

- *Consider the development of national guidance around the components of a diocesan quality assurance framework, to encompass safeguarding practice in the diocese and the parishes.*

2.5 POLICY AND PRACTICE GUIDANCE

All the dioceses have already, or plan to, adopt the House of Bishops' Policy and Practice Guidance. However, the production of local policies, guidance and procedures has provided challenges for several reasons:

- Constructive delay whilst waiting for the production of up-to-date national safeguarding policies and procedures
- Debate about the need or not to produce local versions of national policies
- The recent pace of change with numerous new policy documents and consultations on further new policy making it difficult to maintain up-to-date local versions
- This area of work tends to be given less priority by the DSA than casework and training

2.5.1 Is there any need for local policies and practice guidance?

In the pilots, there was evidence of local effort being put into writing diocesan policies, without the knowledge of imminent new national guidance being produced. As a result there were examples of wasted time and effort locally. This was not an issue in 2016 indicating better communication centrally around forthcoming consultations and new policy development.

There are different views on the need or not for local policies and practice guidance. Some see this as a duplication of effort and provide no or limited added value. Local adaptations could also risk potential confusion if they are inconsistent with national documents and are not up to date. Some examples seen predated the Care Act 2014, Working Together 2015 and the introduction of the offence of controlling or coercive behaviour in the Serious Crime Act 2015.

Others appreciate local versions. Parish representatives in one diocese spoke positively of the fact that key documents had been broken down into an easier to understand format, as the national documents are often not in their view easy to comprehend.

The current volume of new national policy and guidance being produced is a challenge within the dioceses in terms of comprehension and dissemination.

2.5.2 Responding to Serious Situations relating to Church Officers (2015)

One diocese had not accepted this policy and wishes to retain its own Allegations Management Protocol, which it considered worked better. This is discussed in the individual diocesan report. Another had not yet introduced the use of core groups to manage the process in every 'serious safeguarding situation' in 2016.

SCIE understands that this guidance is currently being revised. The following discussion may be useful to address in any such revision and assist any confusion that may exist. The problems arise in part, as explained in section 2.1, to the lack of clarity in policy and guidance around defining who is responsible for case decision-making, and what to do when there are disagreements about the action required in the diocese.

Referrals to statutory agencies

In one diocese there were differences in understanding the threshold for referral to statutory agencies. The first procedural advice in the guidance about the threshold for making a referral is:

> *'If the threshold for reporting to statutory agencies has not been reached, for example if no criminal offence has been committed, or the alleged harm done to an adult victim or survivor does not warrant a referral to Adult Services, the Diocese should investigate the matter internally.' (3.5 Responding to Serious Safeguarding Situations Relating to Church Officers, 2015)*

The second example above – 'if alleged harm does not warrant a referral' – does not in itself help clarify what would count as warranting or not warranting this. The first example – 'if no criminal offence has been committed' – is a problematically narrow and categoric definition, not least because it excludes any *risk of harm* that has not yet been committed.

The above guidance is contradicted a few paragraphs later, where a much broader explanation of the threshold is provided:

> *'All concerns about the welfare of children must be referred to either the police or Local Authority Children's Services without delay'(3.6) and*

> *'All concerns about the welfare of an adult should be referred to Local Authority Adults Services by either the adult who is an alleged victim or the DSA. The police should also be informed if it is believed a crime has been committed.' (3.8)*

When there is a lack of clarity if the threshold is reached, the guidance suggests seeking consultation with the local authority in the case of children, but not in the case of adults. It is of note that the cases where there was disagreement in the audits were mainly around how to respond to concerns about adult safeguarding.

In the absence of such consultation, with the local authority, the guidance instructs further internal investigation prior to referral for those deemed not to meet the threshold. This can though risk compromising police investigations (if they are warranted), consequently where there are doubts about the threshold level for a referral, the SCIE audit team view is that a safer approach would be to seek consultation first in such circumstances.

Core groups

The variation of threshold for making a referral to statutory services may also impact on whether or not a core group is convened.

The Practice Guidance (7.20) provides the following instruction about the internal management of safeguarding cases, so that:

> *'In every serious safeguarding situation which relates to a church officer, the case should be managed by a defined core group, convened for the specific situation.'*

However, it does not define what is meant by a 'serious situation' other than:

> *'Most serious situations will involve referral to the police and/or Children or Adult Services. In the event of this threshold not being reached, on the advice of the Local Authority Designated Officer the Diocese/NCI should conduct its own investigation; the core group should establish a process for this, and if necessary commission an independent investigator to gather information and make an assessment on the facts.'*

In consequence, if there is a delay in consulting or making a referral to statutory agencies there may be a delay in setting up a core group, especially if the view is that further investigation is needed prior to deciding if the case does indeed meet this threshold. It may be that cases considered serious by some in a diocese, will never reach this threshold if the decision-maker decides no referral is required.

Further, as explained in 2.1, even when a core group has been convened, there is potential conflict around decision-making of the group. The Bishop, according to the guidance, must not be a member of the core group:

> *'in order not to compromise potential decisions about disciplinary matters which rest with him or her' (7.20).*

However, the Bishop retains the decision-making of all safeguarding decisions, unless they choose to delegate these to the core group, as indicated by the 7.19 of the practice guidance:

> *'The role of the Chair is to ensure that policy and practice guidance is followed, and to communicate to the Bishop/Archbishop any recommendations made by the core group, always in the knowledge of the DSA/NSA.'*

2.5.3 Safeguarding records: Joint practice guidance for the Church of England and the Methodists Church (2015)

This practice guidance had not been adopted yet in two dioceses – this has been addressed within their individual reports.

2.5.4 Risk Assessment for Individuals who may Pose Risk to Children or Adults (2015)

There was wide variation in the extent to which dioceses are compliant with all aspects of national practice guidance on risk assessment. Partly this reflected only recent implementation of systems since the guidance was published in 2015, but also for a few dioceses reflected questioning of the suggested templates and the clarity of parts of the guidance.

One diocese, whilst undertaking good risk assessments (or participating in these provided by other agencies), felt unable to provide these to the parishes responsible for implementing the subsequent risk management plan (or safeguarding agreement), because of concerns about data protection. This is discussed in the

individual report. The SCIE audit team view is that it is harder for a parish to implement the subsequent plan without a full understanding of the risks.

The quality of the risk assessments seen and the obstacles in full implementation in a few dioceses are addressed in 2.8, along with a consideration for the diocese.

2.5.5 Overlap between personal and professional roles

The overview of the pilot audits discussed the complexity around personal and professional boundaries arising from the involvement of the clergy and their families in Church life, including social and recreational activities. This leads to the potential for members of the clergy and their families having personal relationships with members of the congregation. When sexual relationships are between a member of the clergy and a member of the congregation, this can lead to questions about whether this is or is not appropriate. Clearly this would not be so if the relationship is with a child or a vulnerable adult. There are also particular issues raised for the Church around infidelity if either of the people are married. However, one of the Bishop's interviewed for this audit raised the wider point about 'duty of care' and abuse of trust involved if an unmarried member of the clergy has a relationship with an unmarried member of the clergy. The Bishop suggested that if the principles of the doctor / patient relationship were applied the position would be much easier to understand.

2.5.6 Examples of good local practice

- Links on diocesan website to the national policies and practice guidance (and would be improved with information on local organisations e.g. police, social care)
- Use of newsletters/ ebulletins to provide information of new policy and on major changes, including electronic links to the material
- Use of ‘toolkits’ on the website to break down national policy into navigable elements
- Good practice guidelines posters for parishes
- Development of social media policies
- Development of lone working policy in one diocese
- Safeguarding handbooks for staff
- Development of safeguarding procedures to address specific circumstances, such as choir festivals

Considerations for the National Safeguarding Team

- *Consider the need for the national team to provide DSAs with clarity about the need (or not) of any local guidance, policy or procedures to complement national editions, and whether or not it is possible to retain local procedures which are preferred to national ones.*
- *The need for open discussion within the Church about the implications of the inevitable blurring of personal / professional boundaries in Church life:*

implications of 'duty of care' of clergy, clarity over management responsibility of situations and conflicts of interest.

- *As part of the revision of Responding to Serious Situations relating to Church Officers, consideration be given to further clarification about the threshold for referral to statutory services, and the use of consultation processes with adult services, as well as children's social care to enable a fast resolve of disagreements.*
- *Further clarification about the threshold for referral to statutory agencies.*

2.6 COMPLAINTS AND WHISTLEBLOWING

There was limited case evidence of complaints and none of whistleblowing.

From available evidence in the records and in local policies, there is a lack of clarity around the distinction between a 'complaint', a 'grievance' and a safeguarding concern. There is also insufficient understanding of how these fit in with Clergy Disciplinary Measures. This lack of clarity also applies to the difference between whistleblowing and complaints, who is able to make these, what they might be about and the exact process for initiating either action.

Critically, some senior clergy did not appreciate the challenges involved here for some individuals, and were over-optimistic about people being able to take up their concerns if they are dissatisfied about the support they had received.

2.6.1 Complaints

Arrangements vary around the provision of a complaints procedure and what this covers. If it exists (and this is by no means universal), it is usually very brief and partial, for example only covering particular aspects of safeguarding work, such as the service from staff at the diocese office, or the DSA specifically or for parishes or for offenders refused employment. Others are general complaints policies, and do not make mention specifically of the safeguarding service.

The scope of the complaints procedures do not (with the exception of one diocese) allow for different approaches to include the use of an informal stage to resolve the majority of complaints, but then a formal independent investigation stage if this does not resolve the concerns, or for more serious circumstances, and a final appeal process. Most did not provide explicit expectations of the process, such as a timescale and expected responses.

Another weakness is the challenges in being able to locate the complaints procedure and their not coming up in the search engine on the website. The auditors often failed to locate the procedure without help from diocesan staff. Its accessibility is often then a further obstacle for would-be complainants. Lastly, there can be a reliance on formal written complaints and not allowing email or telephone contact in the first instance so making it more difficult rather than easier for someone to initiate a complaint.

Examples of good practice

- Three stage complaints process found in one diocese, with clear timescales and explanation of process involved
- Information on how to complain openly available within the safeguarding section of the website
- Clear instruction of how to make a complaint, including contact details
- Provision of options in first instance including letter, email and telephone call

2.6.2 Whistleblowing

The picture with regard to whistleblowing procedures is equally variable: many dioceses have none, others have ones for specific groups of staff (e.g. Board of Finance, Cathedral employees) or specifically for safeguarding concerns or complaints. Three dioceses do have comprehensive whistleblowing processes, either in a standalone format or as part of a staff handbook, and three more were about to launch a new procedure. However, in one of the latter instances this would apply only to staff employees, so would not cover the volunteers involved in Church life.

In one diocese, members of the parish focus group spoke about an environment that was not conducive to whistleblowing and referred to the existence of bullying.

2.6.3 Examples of good practice

- Comprehensive and accessible procedure published in staff handbook or as a standalone document
- Explanation in procedure of distinction between complaint and whistleblowing
- Clear contact details of how to whistleblow, with role of the responsible person and their contact details
- Reference to an independent source of advice (Public Concern at Work) – albeit when this was provided the contact details were incorrect or out of date

Considerations for the National Safeguarding Team

- *How to facilitate universal clear and explicit policies and procedures for both complaints and for whistleblowing as an integral part of safeguarding practice within each diocese: these need to be accessible to the staff and the public, explain the scope of what is covered, provide for a staged complaints procedure and a distinct whistleblowing procedure.*

2.7 RECORDING SYSTEMS AND IT SOLUTIONS

Many dioceses are in the midst of considering or implementing new IT solutions to meet the need to maintain a single, secure and up-to-date recording system. Some use electronic recording systems, some use paper files and others use a mixture of both.

A number of recently appointed DSAs referred to inheriting chaotic and idiosyncratic recording systems, in one instance consisting largely of post-it notes. Consequently, the development of recording processes has been a major part of their role and of the challenges faced coming into post.

There is evidence that more work is required to ensure that all safeguarding records are part of the diocesan document management and storage systems, in line with national practice guidance and data protection requirements. This may be a particular issue with those DSAs who are home-based and/or whose recording is stored on an individual laptop computer, as opposed to a diocesan recording system (this was the case for two of the dioceses). In several, the DSA records are not accessible to anyone other than the individual DSA, so in practice they are a personal recording system as opposed to one for the diocese.

Overall the audit demonstrated that there have been recent improvements in case recording practice, albeit the standards were variable. Particular weaknesses seen were a lack of front information sheets; illegible undated, unsigned hand-written records; records referring to individuals only by name and not by role; records not closed off in a timely manner and missing details of contacts made. It was felt that if files were structured by type of document they would also be more accessible e.g. safeguarding agreements. Evidence of historic information, prior to the arrival of some current DSAs is problematic in a number of dioceses, with scant information available.

The lack of written risk assessments was a particular weakness in a few dioceses and the use of different formats for the assessment in another diocese.

Capturing the training completed and the date DBSs are due within the parishes is a challenge, and has only been attempted in recent years. Such performance management functions are at an early stage of development, but most of the dioceses are making progress. The commissioning out of the DBS process has been viewed as being particularly helpful where this has occurred.

2.7.1 Examples of good practice:

- Storage of files in locked cabinets
- Use of case summaries and chronologies
- Stop the use of hard-to-read coloured paper in hard-copy records

Considerations for the National Safeguarding Team (NST)

- *How the NST can support dioceses in implementing safeguarding recording systems which are adequate, consistent with both national guidance and data protection requirements (particularly in relation to home working, risk assessments and historical record).*
- *How to share good practice between dioceses, so as to assist those areas still struggling to implement robust systems.*
- *Is there scope for any further development of common web-based recording resources, such as templates?*

2.8 CASEWORK

Generally the quality of casework was judged by auditors to be good, and clearly demonstrating progress over time, particularly with regard to improvements in information sharing with statutory agencies and an understanding of when referrals need to be made.

2.8.1 Response to allegations against church officers

In general, case audits demonstrated a change over time in responses to allegations, with increasing recognition of what is a safeguarding concern as opposed to a pastoral issue. Older records demonstrated more worrying practice, and the auditors picked up individual cases where there remained outstanding action still required, which was provided to the diocese concerned during the audit.

This improved safeguarding practice was judged to be both a reflection of:

- the increased quality of responses of DSAs (which may be associated with increased professionalism of the DSA role) and
- the increased understanding by clergy of the need for safeguarding priorities to work alongside canonical duties.

This change over time is evidenced in terms of improvements in timing, actions, collaborative working and outcomes. In many dioceses, core groups have been introduced recently and are being experienced as a helpful process in managing responses. Records demonstrate the complex nature of the DSA role and the need for the post-holder to be able to stand their ground when challenged, as well as make effective challenges to senior clergy.

Parish representatives largely described the helpful and supportive experience of working collaboratively with the DSAs, and particularly mentioned their speedy responses in evenings and week-ends.

When feedback to the audit was received from statutory partners, positive comments were made about the involvement of the DSAs in making appropriate and timely referrals, and their involvement in strategy meetings.

One of the themes repeatedly expressed in the audit is the vulnerability of the diocese, when concerns arise in circumstances outside its direct management e.g. school chaplains, clergy employment outside the Church. In these situations, the dioceses may have limited scope to swiftly respond and address the concerns.

Despite the general good quality of responses, there were areas that need improvement in one or more dioceses:

- Case recording not demonstrating either the timeliness, the entire log of contacts and communications and the account of what intervention actually took place (several dioceses)
- Lack of clarity around cases being closed and final outcomes
- Lack of response when the Cathedral was recipient of allegations (one case),

subsequently acted on when the referral was made to a senior manager in the diocese
- Understanding when to inform the NST, e.g. if a local case has links to a national case
- Indications that adult safeguarding concerns may not yet be identified sufficiently for referral to DSAs
- Under-reporting to DSAs of domestic abuse concerns, which subsequently emerge as being known about if allegations are subsequently made
- Lack of taking account of the full history and previously identified risks in deciding required interventions
- Need for more consultation with the Local Authority Designated Officer in situations which are less clear-cut and/or following outcomes of risk assessments
- Possibility of delays in the making of referrals to statutory agencies in one diocese
- Letters or records from senior clergy / DSA in two dioceses, to those who are the subject of concern, that may be construed by victims to be hurtful or to minimise the alleged / actual offences

2.8.2 Risk assessments and safeguarding contracts/agreements

Several dioceses did not have any written risk assessments and spoke of relying on statutory partners to have such an audit trail as the assessment was perceived to be their responsibility. The subsequent safeguarding agreement consequently existed without any audit trail to provide understanding of the risks it is designed to address. This could provide problems in the future as it would be too easy for a parish to lose sight of why there is a safeguarding agreement in place. It also means that there is no structure for undertaking risk assessments, in the absence of statutory partners undertaking such an assessment. Others have only recently implemented risk assessments, with a change in DSA and/or the publication in 2015 of national guidance.

Whilst the individual concerned is included in the assessment process, in one diocese the parish is not involved and therefore does not understand the risk factors that led to the subsequent safeguarding agreement.

There was evidence in three dioceses of Type B Assessments[2], by an independent assessor. In others this level of assessment had not yet been required, but the plan was to either use a DSA from a neighbouring diocese or, if this was not possible, to commission a consultant. There was though some concern whether they would be able to identify a suitable consultant if needed.

[2] A Type B Risk Assessment is commissioned by the diocese or responsible body and referred to an independent agency or professional person qualified and experienced in safeguarding risk assessments. A Type B Assessment will only be undertaken in relation to a church officer, whether ordained or lay, and on completion of a statutory investigation.

All the sites provided evidence of safeguarding agreements/contracts of known offenders, albeit with variations of quality. Some parishes have developed their own individual practice, as opposed to a centrally determined process, and in other places all assessments are undertaken centrally. Overall, there was evidence of increasingly robust agreements in the last couple of years, with clear expectations specified. However, older ones often remain in force.

Dioceses provided annual (or earlier if needed) reviews of these arrangements, but this was not universally applied and not consistently undertaken to the same high standard, with older well established agreements more likely to be undertaken by email. Whilst compliant with guidance, the auditors had concerns whether this was desirable. There were also examples of the lack of new risk assessments and reviews of safeguarding agreements, following a change in circumstances, such as re-offending.

In one diocese the assessments highlighted the difficulty that some senior clergy have in fully understanding the need for such detailed assessments and agreements, and the importance of balancing the pastoral needs of offenders with risk management and with the needs and views of survivors. It also showed that there is a risk the DSA is not always informed promptly of all relevant cases needing such assessment.

In another diocese, there was discussion within the focus group of the challenges they face and the lack of clarity around the current practice guidance (June 2015) with regard to:

- action to be taken when an employed lay officer is found to have an offence in the past
- whether a convicted offender should ever be given a position of responsibility as a volunteer
- available action when a member of the clergy declines to cooperate with a risk assessment on the grounds that there had been no prosecution due to lack of evidence.

2.8.3 Consultation with NST

There was little evidence on files of consultation with the NST around complex cases. It may be that this is not recorded, or that the past culture did not encourage consultation. The NST has informed SCIE that it is now dealing with a great number of queries.

2.8.4 Good practice examples

- Clear and concise risk assessments which evaluated both past and current risk
- Safeguarding agreements which are explicitly linked to the risk assessment
- Use of safeguarding agreements, even if the subject had not been convicted, but was assessed as a risk
- Groups within the parish to monitor safeguarding agreements (as in the national guidance)

- Use of early reviews (e.g. after three months) for new agreements and reviews brought forward due to changing risks
- Routine reviews twice a year, only moving to annual if the subject had demonstrated compliance over time
- Overt support by senior clergy in face of demand to 'soften' requirements
- Reliable database for scheduling reviews

Considerations for the National Safeguarding Team (NST)

- *The need for further debate and discussion with DSAs about the reasons behind the lack of diocesan compliance with parts of the national practice guidance relating to risk assessments.*
- *The NST to consider the need for a more consistent and agreed national approach to the risk assessment of known offenders including:*
    - format for risk assessments
    - risk assessments placed on record along with ensuing agreements
    - clarity in the role of the responsibility of parishes and DSAs in relation to the assessment, any consequent safeguarding agreement and its review
    - mechanisms to trigger new risk assessments if circumstances change
    - mechanisms and arrangements for reviews, including early first review and then regular meetings
    - arrangements for Type B Assessments, around suitable experience and sources of independent consultants
- *How to change recording culture so that DSAs evidence the role of the NST in complex cases.*

2.9 INFORMATION SHARING

The quality of information sharing by the diocese is related to the overall level of understanding about safeguarding. It was evident that this has improved in recent years, although there remained some obstacles.

2.9.1 Information sharing with statutory agencies

Generally there was good information sharing with police, probation and MAPPA, and usually with the Local Authority Designated Officer (LADO). However, in a few dioceses there was little evidence of the latter on the files.

Larger dioceses face bigger challenges in terms of building relationships that support information sharing, especially in relation to the many different points of contact to be identified.

There was a perception in one diocese that information is not consistently shared by the statutory authorities, with particular mention of the police, and in another that this had previously been a problem.

There was evidence of delays in communication to statutory agencies over allegations against clergy, due to the perception of the high level of evidence required to make such a referral (one diocese).

2.9.2 Information sharing within diocese

Information sharing within each diocese is generally good, but there were some exceptions:

- With DSA responsibility split between different posts responsible for children and vulnerable adults, there is a risk of insufficient communication between each other e.g. when a children's case involves a vulnerable adult offender.
- There were delays in communication to the DSA of allegations against clergy (one diocese) and historic delays in such communication (another diocese) associated with the use of Clergy Disciplinary Measures (CDM).
- There was occasional confusion around who needs to be informed of a case, with one example of the clergy lead for safeguarding not being informed of a potentially high-profile case.

Good practice examples

The following were innovative initiatives aimed to improve information sharing practice:

- The DSA is informed whenever an incumbent leaves a church where there is a contract in place, so enabling the DSA to formally inform the new priest of the existence of the contract
- Information sharing protocol between senior clergy and diocese

2.9.3 Information sharing between dioceses and with other denominations

The transmission of information about individuals of concern between dioceses usually works well if the whereabouts of the individual are known, along with where they choose to worship. When this information is unknown this is more problematic, with no system nationally to circulate details of such individuals amongst dioceses and denominations.

2.9.4 Information-sharing protocols

Some dioceses have agreed information-sharing protocols or local guidance with statutory agencies, but this is a challenge for those covering a wider geographical spread, due to having to negotiate with several different authorities, their Safeguarding Boards and a multitude of agencies.

There is little evidence that a lack of information-sharing protocol has any adverse effect on information sharing between the Church and statutory agencies. It may be though that in some places the information-sharing weaknesses are more likely to have arisen between members of the Church themselves, usually involving a delay in reporting concerns to DSAs.

One diocese, however, mentioned the lack of information sharing by the police – it is possible that a protocol might improve this. In a second diocese where this was also a problem, such a protocol has been developed with police and probation services, and in a third it is being developed.

There was some frustration in the dioceses about the need for national input into agreeing information-sharing protocols with national agencies, in particular the National Probation Service. The NST has advised SCIE that the Church of England is not able to do this.

Considerations for the National Safeguarding Team

- *Do dioceses need guidance around which information-sharing protocols are useful to develop, so that the focus is on where this is required, as opposed to an attempt to develop such agreements with all agencies?*
- *Is sufficient use made of information-sharing protocols within and between dioceses?*
- *Is there a need for a national arrangement, between dioceses and with other denominations, to share information about those subject to safeguarding contracts, but whose whereabouts are not known?*

2.10 TRAINING

The DSAs face a challenge in providing training to all who require it, especially in the face of backlogs from previous years, the need to establish refresher training input and the implementation of the national training and development framework from September 2016. The latter has been a driver in some dioceses for more training delivery resources.

The balance between e-learning and face-to-face training varies, with the latter recognised as being more effective in terms of positive feedback and links made with key people at parish level. However, providing this for all that need it is a challenge and the DSAs / dioceses have initiated varying strategies to be able to achieve this task, such as:

- Some dioceses provide e-learning for all Church staff, as an introduction, with the provision of face-to-face training dependent on role
- The use of experienced safeguarding professionals as volunteers delivering training
- Buying in additional training capacity or using the LADO
- Outsourcing some or all training to a charity experienced in Church safeguarding

The role of senior clergy is critical in facilitating the uptake of training. Escalation processes to the Bishop have been effectively used in one diocese to increase uptake by clergy. In several dioceses, no one applying for Permission to Officiate (PTO) is accepted until they have completed the safeguarding training provided by the DSA. Such training aims to meet the learning needs of new clergy in the diocese (including new curates), other applicants for PTO and lay readers. This strong lead from the Bishops concerned provides a clear message of the essential nature of safeguarding training as part of the ministry.

The position around responsibility to provide training for religious communities is less clear. One DSA mentioned this being provided on request for one of the three theological colleges in the diocese.

The introduction of the new national training framework is perceived as a positive opportunity to move from sometimes outdated training to a more contemporary approach and the inclusion of adult safeguarding. There is though some confusion around the level of flexibility that can be applied i.e. whether the framework is to assist trainers, or if it has to be delivered in its entirety as laid down by the NST. Also not clear is whether or not those who have been retrained in the last three years need retraining now, or when their refresher training is due.

The lead responsibility for training within dioceses is not always part of the professionally qualified DSA role, but lies with others in the safeguarding team. This raises the question of whether or not such a professional background is necessary for the delivery of the training. This is addressed in the first bullet point of the considerations for 2.2 (see p.12)

2.10.1 Grooming

In one diocese, the auditors were concerned whether senior clergy had sufficient understanding of how grooming operates and an awareness of their own individual vulnerabilities to such processes. This was a diocese which had not been the subject of any major historical abuse cases and so had had less opportunity to learn from experience. The auditors considered that additional training in this diocese may be helpful, but do not know if there may be a wider need for this in the dioceses still to be audited.

2.10.2 Good practice examples

The following provide particular initiatives to increase take-up and / or effectiveness of training:

- Inclusive training by diocese for Cathedral staff, property maintenance staff and other frontline workers who could be the first people to spot concerns
- Delivery of training within each parish: this is resource intensive, but increases uptake
- Joint training by the DSA and an Archdeacon for clergy and readers, with the Archdeacon using the theological element of the Chichester Report to stress the place of safeguarding within the whole context of the gospel message and living
- Development of written training and monitoring plans to achieve ‘buy in’ from senior management within the diocese
- Development of additional bespoke training covering for example mental health issues, child sexual exploitation or ‘grooming’ awareness for clergy
- Development of specialist training by an ‘expert’ for senior clergy and rural deans in speaking with victims
- Development of monitoring systems to have an accurate picture of who has and has not been trained / attended refresher training
- Annual refresher training for staff and volunteers at parish level, on the initiative of a parish safeguarding officer
- Safeguarding surgeries by the DSA within parishes: whilst not badged as training, have been accepted as being very effective in the transmission of safeguarding knowledge and good practice.

Considerations for the national safeguarding team

- *The need for a national position around the completion of safeguarding training prior to being accepted for Permission to Officiate.*
- *Clarification of the levels of flexibility in the content of the new training and whether retraining is required for those already trained, prior to the time their refresher training is due.*
- *Should there be consistent involvement of senior clergy in the delivery of safeguarding training to clergy? If so, how can this be achieved?*
- *Should the DSA have responsibility for training in cathedrals, religious communities and schools, to provide a consistent message within the area?*
- *Should additional training for clergy and other Church officials on the grooming process be provided to specified dioceses, or it this a more widespread training need?*

2.11 SAFE RECRUITMENT OF CLERGY, LAY OFFICERS AND VOLUNTEERS

Safe Recruitment has been subject to considerable change and development in recent years, with appointments now involving application forms, DBSs and references. This was not always the case some years ago. Its inclusion in modular training is a helpful way of disseminating awareness.

Overall, there has been a great change in the recruitment processes, but in one diocese, people are still being appointed prior to their DBS and/or references being received, despite the policy that prohibits this. More widely there were shortcomings in some clergy files, which did not consistently include references when these had been emailed through (as opposed to being sent as hard copy). Also observed frequently was a lack of a routine front sheet to access basic information and loose pieces of paper, risking the loss of important documents.

2.11.1 Disclosure and Barring Service (DBS) checks

The outsourcing of the DBS function is a common feature, which appears to work efficiently. There remains in some parishes resistance to the need for DBS checks for long-standing volunteers. This arises because of a perception that doing so is an insult to people who have been doing unpaid tasks for a long time, and because the process is viewed as bureaucratic.

2.11.2 Blue Files

The standard of the Blue Files (of clergy) seen by auditors was variable. They often pre-dated Safer Recruitment (2015) practice guidance, and offered little evidence historically of Safe Recruitment practices. More recent files are generally better organised and subdivided into sections, but in one diocese two recent Blue Files did not reference a safeguarding concern that had been dealt with previously.

The recruitment process was not consistently evidenced on the files, with missing applications forms and/or one or more of the three references. In two recent instances, there was no evidence of an application or interview process and no mention of references. The challenge of implementing Safe Recruitment practices for clergy was particularly striking in this latter diocese, as this is one where the Bishop is particularly aware of the need for this and safeguarding is a high priority in the diocese. In another diocese where there was a lack of application form for a recent appointment, there had instead been a letter from the Bishop proposing the individual as a suitable candidate.

A potential weakness within the system nationally is that a new diocese only receives the Blue File after clergy have been appointed, and sometimes after they have started work. The Current Clergy Status Letter (CCSL) is received from the previous Diocesan Bishop – this is effectively a reference, stating if the individual is suitable to minister. However, there was recognition that the contents of the Blue File may not always be represented adequately in the letter. One Bishop suggested that Blue Files should be electronic, so that they are accessible as part of the recruitment process.

There remain difficulties in always being able to identify previous safeguarding allegations within what are often poorly organised files. In some, this information was held within sealed envelopes and in others in a separate Red File. This is risky, unless the Blue File shows clearly the fact of there being a separate file / envelope with such information.

2.11.3 Appointment of chaplains

A particular weakness remains in relation to the appointment of chaplains in schools, prisons, etc. Recruitment is undertaken by the organisations concerned, and the diocese has no automatic right to have a say in the appointment, despite an assumption that the Bishop will license the successful applicant.

2.11.4 Good practice examples

- Use of a standard checklist at front of file, including date of DBS
- Routine questions about both children and vulnerable adult safeguarding in the interviews for clerical and other relevant posts
- Production of a helpful leaflet on what needs to be done in recruitment of volunteers and when a DBS is required
- Quarterly bulletins disseminating awareness of the need for Safer Recruitment
- Blue Files being sub-divided into sections, so that information is accessible and any allegations are easily located
- Use of Clergy Current Status Letter for every member of the clergy, not just those applying for posts from outside the diocese
- DBS clearance received prior to announcement of a new appointment (as opposed to before take-up of post)
- PTO given for limited period (three years) with a new DBS each time (as opposed to indefinitely)

Considerations for the National Safeguarding Team (NST)

- *What actions need to be taken to give the NST confidence that Safe Recruitment processes are being consistently applied with regard to clergy and that the Blue Files routinely demonstrate this.*
- *What actions can be taken to promote Safe Recruitment processes into the appointment of chaplain to schools, hospitals, prisons, universities, etc.*
- *The need for the Safer Recruitment Practice Guidance / Parochial appointments guidelines to address the level of information provided by the current Diocesan Bishop to a prospective Diocesan Bishop, prior to an appointment, and the possibility of moving to an electronic system to facilitate sharing of information prior to appointment.*
- *How to enable a standard front sheet on ALL files to provide date of most recent appointment, history of previous appointments since ordination, references, date of DBS check and any safeguarding allegations with outcome of enquiries.*

2.12 SUPPORT SERVICES FOR CHILDREN AND VULNERABLE ADULTS

2.12.1 Authorised Listeners

There were different views expressed about the role of Authorised Listeners, whether this was appropriate provision, and if so, who should do it.

Eight of the 15 dioceses had appointed Authorised Listeners, in one case using one of the individuals who is also both a member of the clergy and part of the safeguarding team. Most have made no use or limited use of them, despite in some cases consistently offering their services. One diocese has though used them three times in the first six months of 2016. In that diocese, the DSA is committed to developing the service further.

Five dioceses have commissioned this provision via external provider, who is also able to provide any necessary counselling services. Two more dioceses are in the process of making a decision to commission the service from a Christian counselling service. The advantage of outsourcing this service is identified as being able to use trained counsellors who are supervised. One of the dioceses currently using Authorised Listeners is considering switching to a charity, so that staff will receive regular training and supervision.

Other contributory factors leading to outsourcing the service arise from doubts about the appropriateness of it being in house, for the following reasons:

- The appropriateness of undertaking what can quickly develop into a counselling role
- Difficulty resourcing a service for which the demand fluctuates
- Whether victims / survivors might prefer support external to the Church

It was of note that Parish Focus Groups were not always aware of the role of Authorised Listeners and it may be that this contributes to their lack of use.

In addition to Authorised Listeners, some dioceses have developed counselling and other support services for children in particular, but in some cases also adults who were abused as children or vulnerable adults. Examples include:

- The provision of support to young people through youth workers and safeguarding representatives; the youth workers speak sometimes of fulfilling the role of advocates, but this is not specifically part of their job
- Provision of 10 unpaid counsellors through a diocesan Committee of Social Responsibility
- A diocesan group to support people with mental health issues (Open Minds)
- Promotion of local domestic abuse support services

The lack of take-up of the Authorised Listeners in some of the diocese may be due to this being a relatively new service and not well publicised. However, it may also be indicative of a reluctance to accept such help from the Church itself.

Outsource services have the advantage of being able to provide support perceived as more independent from the Church, with trained and supervised counsellors. If the victim or survivor needed more help, it would be possible to continue without a change of therapist.

2.12.2 Listening to the views of children and vulnerable adults

The extent to which children's and vulnerable adults' views are sought and listened to varies. Some places retain children's 'champions' (in one case having about 350 of them), but others no longer use them. In some places it is wholly dependent on the individual parish whether or not there is any provision for such a service.

Good examples of listening exercises

- Listening exercise with older people attending luncheon clubs and evening groups
- Listening exercises with children about how safe they felt in the Church undertaken via a specific exercise in parishes in several dioceses (albeit it is not clear the information is subsequently collated and analysed)
- A diocesan adviser for the children's ministry and a diocesan youth worker who take the lead in hearing the views of young people
- A third diocese employs a children's work adviser and a youth officer, both of whom sit on the DSMG and understand safeguarding responsibilities; the role of children's champions no longer exist

- Survey monkey to obtain views of young worshippers
- 'Growing Younger' facilitators working directly with parishes to reach out to children
- Parish children's advocates and 'Leads for Adults'

Considerations for the National Safeguarding Team

- *How to provide further clarification around expectations and best practice in relation to resources for the provision of Authorised Listeners, advocates and counselling support for children and vulnerable adults.*

3 CONCLUSIONS

3.1 WHAT'S WORKING WELL?

The overall evidence is that in recent years there have been significant changes made in practice with progression towards embedding a safer culture. This has been facilitated by leadership from the Bishops and senior clergy to facilitate the cultural changes necessary.

The Bishops have embraced their safeguarding leadership role and the auditors were impressed with the openness and desire to improve safeguarding practice common in all dioceses visited so far. The commitment to the safety of children and adults was evident in the openness with which people discussed their views about the changes already made and the challenges that remained.

The dioceses reported increased resources for safeguarding and an improvement in practice over recent years, especially in relationship to the growing understanding that safeguarding is everyone's responsibility, not just that of the Diocesan Safeguarding Adviser (DSA). This was confirmed generally by the auditors. However, the extent of progress made varies both between dioceses and between individual parishes.

Recent DSA appointments demonstrate an increasing professionalism of the adviser role: they are paid (as opposed to being volunteers), usually employed and coming from a background of professional training and safeguarding experience. Additionally, there is evidence that DSAs in post, without such a professional background, are now undertaking relevant training and qualifications.

All the dioceses have, or in one case about to have, Independent Chairs for the forum providing strategy, scrutiny, challenge and monitoring of safeguarding policy and practice, called the Diocesan Safeguarding Group (DSG) in this report (see 2.3).

The overview report of the pilot audits mentions the isolation of the DSA role, and that of Independent Chairs. Subsequent action taken by the National Safeguarding Team (NST) to address this was evident in terms of references made to having more contact with peers through group meetings.

In general, the Bishops and senior managers are supportive and accessible to the DSA, through both regular meetings and ad hoc discussions as required, albeit the extent of this varied between dioceses. The DSAs also had full access to personnel files for the clergy if needed.

Overall positive improvements were seen in the consistent use of the Disclosure and Barring Service (DBS), the improving quality of casework including risk assessments of offenders, the improvements in Safe Recruitment and selection practice, increased safeguarding training provision and attendance and good partnership working with other agencies.

3.2 WHAT NEEDS TO WORK BETTER?

There are different interpretations of the meaning of 'safeguarding leadership' and of where 'safeguarding responsibilities lie', especially in relation to operational (as opposed to strategic or spiritual responsibility). Whilst generally this has not caused problems and there is consensus around case decisions, there is however the potential for increasing disagreement, with the increased professionalism and experience of DSAs. This is particularly significant around the decision-making over referral to statutory agencies and the need for DSAs to be able to follow their professional codes of conduct and make referrals if they judge these as warranted. This is discussed further in 2.1.

The isolation of the DSA partly comes with the role, often being the only specialist safeguarding professional within the diocese. The Independent Chair can be a great support in these circumstances, but they in turn can be isolated from other Independent Chairs. Without the external support of supervision and the national team, it may be more difficult for the DSA to provide the effective challenge required in the role. The NST now provides greater support to the DSAs, but obtaining supervision remains a problem for some due to being unable to identify a suitable supervisor. Even when this exists, it is not clear how the arrangements fit into the diocesan safeguarding management structure (see 3.2).

There is a lack of understanding in some dioceses of the need to consider potential conflict of interests for those DSAs who are also licensed as priests or lay ministers, or who hold other senior management posts as well as the DSA role.

The management information systems generally need to be improved, to enable staff to access up-to-date information regarding people's training and DBS status, as well as to provide comprehensive and accessible case recording and management decision-making. There have been improvements in recent years through the individual efforts of the DSAs, but each diocese needs to ensure the systems in place are adequate and consistent with national expectations for all recording systems, including case records and clergy files.

Further work needs to be undertaken in some places to obtain parish understanding and compliance with safeguarding policy. Generally, there is awareness that the task of monitoring safeguarding in parishes is an immense challenge for DSAs and for the responsible senior clergy. This is largely due to the structure and size of the Church, but is compounded by the lack of management structures typically found in other large organisations.

There is scope for further efforts to change the culture to one where safeguarding is understood to be about adults as well as children; this is a particular challenge in some parishes.

Despite considerable improvement reported in Safe Recruitment practices, this was not consistently evidenced on clergy files and it was not always clear if all the requisite processes had been undertaken in line with national guidance.

There remains a variation in the quality of risk assessments and the extent to which practice guidance has been implemented. Whilst safeguarding agreements exists,

there remain a lack of written assessments in some dioceses, with a reliance on other agencies to do this. In consequence, it is not always possible to understand the rationale behind items in the safeguarding agreements.

Whilst there has been provision of advocacy and counselling support services for children and vulnerable adults in many dioceses, the Authorised Listening services seem to have only recently been developed and as of yet are not used fully, or in some cases not at all. Further work will need to be undertaken about whether this arises from the service being insufficiently known about and offered, or if there are intrinsic obstacles in this being provided by the Church itself and being separated from a counselling service.

GLOSSARY OF ABBREVIATIONS AND TERMS

BSA	Bishop's Safeguarding Adviser
CDM	Clergy Disciplinary Measure
DBS	Disclosure and Barring Service
DSA	Diocesan Safeguarding Adviser
DSG	Diocesan Safeguarding Group
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
NST	National Safeguarding Team
SAB	Safeguarding Adults Board