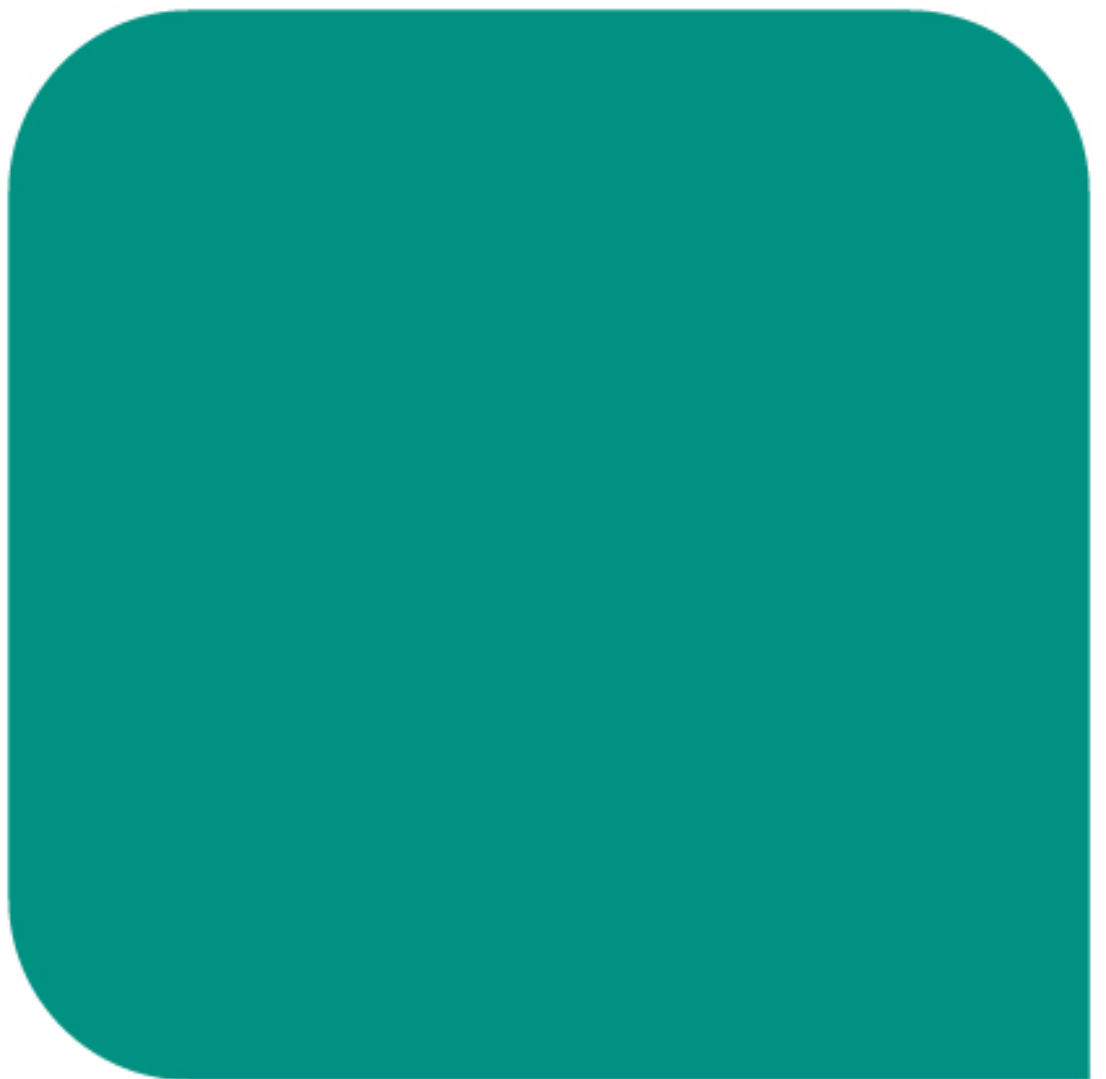




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# **Liverpool diocese independent safeguarding audit (July 2016)**



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**Independent auditing of diocesan  
safeguarding arrangements for  
the Church of England**

**Diocese of Liverpool**

Audit undertaken 5, 6 and 7 July 2016

**Lucy Erber, Meiling Kam and Edi Carmi**

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# Contents

<b>1</b>	<b>INTRODUCTION</b>	<b>1</b>
1.1	Context and background	1
1.2	The Diocese	1
1.3	Structure of the report	1
<b>2</b>	<b>OVERVIEW</b>	<b>2</b>
2.1	What is working well	2
2.2	What needs to work better?	2
2.3	Considerations for the Diocese	3
<b>3</b>	<b>FINDINGS</b>	<b>5</b>
3.1	Safeguarding management	5
3.2	Diocesan Safeguarding Advisers	5
3.3	Diocesan Safeguarding Monitoring Group	8
3.4	Policies, practice guidance and procedures	9
3.5	Resources of safeguarding service	9
3.6	Recording systems and IT solutions	10
3.7	Risk assessments and safeguarding contracts / agreements	10
3.8	Training	11
3.9	Safe recruitment of church officers	13
3.10	Response to allegations	13
3.11	Quality of case work	13
3.12	Complaints	15
3.13	Whistleblowing	16
3.14	Monitoring of safeguarding in parishes as part of Archdeacon's responsibilities	16
3.15	Resources for children and vulnerable adults	17
3.16	Information sharing	17
3.17	Quality assurance processes	18
3.18	Links with national safeguarding strategy and team	19
	<b>APPENDIX: REVIEW PROCESS</b>	<b>20</b>

# 1 INTRODUCTION

## 1.1 CONTEXT AND BACKGROUND

The Social Care Institute for Excellence (SCIE) has been commissioned to undertake an audit of the safeguarding arrangements of each diocese of the Church of England. The aim of these audits is to work together to understand the safeguarding journey of the diocese to date and to support the continuing improvements being made. Following pilot audits of four dioceses in 2015, an agreed audit model is being applied nationally during 2016 and 2017.

The audit of the Diocese of Liverpool was carried out by Meiling Kam and Lucy Erber on 5, 6, 7 July, 2016, using an agreed methodology incorporating both an examination of files and documents and individual 'conversations' with key individuals and a focus group of parish representatives.

This report was written by Meiling Kam and Lucy Erber, with quality assurance provided by Edi Carmi, the overall auditing lead.

## 1.2 THE DIOCESE

The Diocese of Liverpool comprises 202 parishes with 282 licensed clergy. The Diocese is predominantly urban, with some smaller, rural, areas, and covers eight local councils and four police constabularies. It covers 389 square miles and has a population of 1.53 million, including the seaside resort Southport and industrial towns of St Helens, Wigan and Warrington. It was created just over a hundred years ago coming out of the Diocese of Chester. The Diocese is led by the Bishop of Liverpool and the Suffragan Bishop of Warrington.

The long-standing diverse community in the city of Liverpool is due, in the main, to the large port area on the River Mersey with historical trading connections to the Baltic triangle, Ireland, China, and the Caribbean. This means that a wide range of different faiths are followed by the different communities represented in the diocese

In 2015, there were 14 new safeguarding referrals received by the Diocesan Safeguarding Advisor (DSA) in regard to children, and 28 by the Adult's Safeguarding Adviser (Adult's SA) in regard to vulnerable adults.

## 1.3 STRUCTURE OF THE REPORT

This report is divided into:

- Introduction
- An overview of what is working well, what needs to work better and a summary of considerations for the Diocese
- The findings of the auditors: these are linked to the safeguarding requirements for faith groups set out in section 11 of the Children Act
- Considerations for the Diocese are listed, where relevant, under each finding section
- An appendix sets out the audit process and any limitations of the audit

## **2 OVERVIEW**

This section provides the headline findings from the audit, in terms of what is working well and the areas for improvement. The detail behind these appraisals are in the Findings in section 3.

### **2.1 WHAT IS WORKING WELL**

- The Diocese has a Diocesan Safeguarding Advisor (DSA) and an Adult's SA both of whom are well known and respected throughout the Diocese and within the parishes, and by partners.
- The parishes appear to know who to contact and how to make a referral if they have safeguarding concerns about a child or adult.
- The blue personnel files for clergy that were reviewed are well kept and compliant with safer recruitment.
- The awareness of adults safeguarding is well developed.
- There are good links with the Cathedral, who are also represented in the Safeguarding Monitoring Group.
- A parish safeguarding audit has been developed which is undertaken in tandem with the Archdeacon's articles of enquiry.

### **2.2 WHAT NEEDS TO WORK BETTER?**

- The auditors felt, from their review of case files, that case recording could be much more specific and thorough.
- There is a lack of dedicated administration support for the DSA.
- Complaints and whistleblowing procedures, whilst in place, require updating and further development.
- A lack of professional challenge was observed in some of the casework.
- The authorised listener service is not well developed and its existence appears to be unknown in the parishes.
- There is room for significant improvement in the conduct of risk assessments, with a need to follow the correct format, to be written down and to directly inform safeguarding agreements.

## 2.3 CONSIDERATIONS FOR THE DIOCESE

The term 'considerations' instead of recommendations is used in the SCIE Learning Together methodology. The reason for this is that it is important that each diocese decides exactly how to implement the improvements indicated; this is likely to be different from place to place. Some considerations will be around taking specific types of action, whilst others will be alerting the diocese to develop their safeguarding planning in the future.

These considerations are to be found at the end of each of the sections in the Findings (see section 3). They are listed below for ease of reference, but the detail behind each of these is in the Findings section.

- Consider developing a better link between the professional supervision given to staff with their diocesan line management in order to strengthen the relationship between the improvement of practice and performance.
- Consider introducing a social work perspective into the supervision of the Diocesan Safeguarding Advisors (DSAs).
- Review the administration capacity specifically available to the safeguarding service.
- Review the capacity and organisation of the safeguarding service in order to address the possible time pressures arising from implementing practice and standards set out in recent National Safeguarding Team (NST) policies, procedures and guidance.
- The Assistant Diocesan Secretary to attend the Safeguarding Monitoring Group.
- Continue to try to involve key strategic partners in the DSMG.
- The Diocesan Safeguarding Monitoring Group via the chair to communicate with the NST if it has concerns about the quality of any aspects of national guidance being issued.
- Identify all areas of recent national Church of England safeguarding procedures that still require implementation by the safeguarding service and develop an action plan to monitor their introduction and embedding into everyday practice.
- Consider dedicated administration support for the safeguarding service.
- Adopt an information management system in order to keep track of renewal dates (i.e. DBS, safeguarding agreements etc.), and numbers of open/active cases.
- Develop a case file format in line with Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015).
- Risk assessments to be in written format and undertaken in line with the Church of England's practice guidance 'Risk Assessment for Individuals who may Pose Risk



to Children or Adults' (2015)

- Discuss with the NST what changes to the content of the training framework are possible and not possible.
- Review and update the monitoring systems to track who has had safeguarding training, when, and when it will need to be updated.
- To review the current diocesan practice against Responding to Serious Safeguarding Situations (2015) and Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015), so that local processes are consistent with national requirements.
- Consider an audit of all the case files, to decide which can be closed down (and moved into a different filing system) and which continue to require ongoing work.
- Start to record all contacts with safeguarding professionals in the case files.
- Consider and agree an appropriate approach to recording in line with Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015).
- Consider how to develop 'professional challenge' towards other safeguarding partners in relation to safeguarding work.
- Develop and promote a complaints procedure that refers specifically to safeguarding.
- Create a system to collate the information and learning to present to the Diocesan Safeguarding Monitoring Group (DSMG).
- Develop a whistleblowing procedure that refers to safeguarding and publicise it.
- Consider how information from the parish safeguarding audit can be integrated into the strategic planning of safeguarding within the Diocese.
- Formulate feedback into the DSMG of information gathered from the parish safeguarding audits.
- Consider how to raise awareness of the authorised listening service and how it can be accessed.
- Give consideration to how the views of children, young people and adults at risk might be heard and used to inform delivery of safeguarding services.
- All contact with local authority designated officers (LADOs) and Children's Services to be evidenced on case files.
- Consider developing a quality assurance framework for safeguarding.

## 3 FINDINGS

### 3.1 SAFEGUARDING MANAGEMENT

The Bishop of Liverpool has overall responsibility for safeguarding within the Diocese. His delegated clergy lead for safeguarding is the Archdeacon of Liverpool who has had this role for nine months.

The Bishop understands the need for both the DSAs to be as independent as possible from the clergy in relation to safeguarding and for himself to separate his pastoral role from decision-making.

Since March 2016, the Assistant Diocesan Secretary has taken over the line management of the DSA, and, in turn, the DSA line manages the Adult's SA.

The Bishop has introduced regular meetings (at least every three months) with the DSA and he has a management group (referred to in the Diocese as the 'core group') of senior staff he meets with every two weeks. A safeguarding report is compiled by the DSA and delivered by the Archdeacon with the lead for safeguarding at that management group meeting. In addition, the lead Archdeacon for safeguarding also sits on the Safeguarding Monitoring Group.

*(Reference: part 1 of S.11 audit: Provide a structure to manage safeguarding in the Diocese. Also to part 2: The Bishop appoints a member of his senior staff to be the lead person for safeguarding.)*

### 3.2 DIOCESAN SAFEGUARDING ADVISORS

There are 40 DSA hours dedicated to children's and adult's safeguarding. The time is divided in the following way:

- The DSA (covers both Diocese and the Cathedral) = 30 hours per week
- The Adult's SA = 10 hours per week

Both roles are paid and there is a job description for each.

The Adult's SA also has the role of Disability Awareness Officer, which she undertakes for the rest of her working week. She holds various relevant qualifications, including Preliminary residential social work 1974–1976 awarded by the Central Council for Social Work, Child care certificate – Southport Technical College 1974–1976 and The Open University – Mental Handicap: Patterns for Living 1988.

The DSA has been in post for 10 years. She started her paid post at seven hours a week, with it gradually being increased over the years. During this period, for five years she worked full-time as the DSA covering the dioceses of Chester, Liverpool and Manchester. She has a nursing qualification, a qualification in health visiting and an MA in child protection. During her career in nursing, she has held the role as lead nurse for safeguarding.

In the absence of the DSA during leave or significant sickness absence, the current

arrangement is that CCPAS (Church Child Protection Advisory Service) provides cover.

Both the DSA and the SA told the auditors that they have only recently worked together (March 2015) as they were line managed separately and from within different departments of the Diocese. Referrals used to go to each individual depending on the area (Children or Adults).

The current arrangement, in place since March 2016, is that the DSA is line managed by the Assistant Diocesan Secretary and the Adult's SA is line managed by the DSA. Both the DSA and Adult's SA receive professional supervision from outside the Diocese.

The DSA told the auditors that she received professional supervision from a manager with a nursing background and that supervision notes were made, shared with her and signed. She chooses which cases to bring to supervision. Her line manager in the Diocese was not linked into this process and does not receive copies of supervision notes, notified about complex cases etc. meaning that he is not kept in the loop in regard to the DSA's level of practice or performance.

The Adult's SA also has professional supervision from a gestalt therapist. The process is the same as with the DSA in that there are signed supervision notes, but these are not shared with her line manager, and she decides which cases are brought to supervision.

The auditors felt that both quality assurance and professional challenge would be better addressed if the professional supervision and line management of the two DSAs were more closely linked in order that they could both inform each other. They also felt that a social work perspective may assist the supervision of current staff, as such a professional could ensure the completion of written risk assessments, more comprehensive completion of case notes, etc.

In addition to these two roles, the Diocese has an adviser for domestic abuse and one for older people – these are both voluntary posts. Both these roles also work closely with the two DSAs, although are not located within the safeguarding service.

The two DSAs are able to request general support from the diocesan administration team. Whilst there is no dedicated and specifically identified administrative support to the safeguarding service, it is a recognised duty of the central team.

The DSAs have good and strong links to statutory safeguarding agencies. Although this could be better evidenced within case notes on files, the auditors were able to see this from minutes of meetings attended and feedback from a police officer, probation officer and member of a local voluntary organisation.

Both DSAs also deliver safeguarding training and this is done locally, in parishes, as far as possible in order to accommodate the fact that people would have to travel long distances if it were to be delivered centrally.

Both DSAs felt that they worked over and above their hours. Both roles are part-time

and they both can be rung outside their normal working hours. They felt under a certain amount of pressure, particularly in light of new policies, procedures and guidance that have recently been introduced by the National Safeguarding Team. They felt that they struggle to keep records and recording up to date and that files are not maintained to the standard they would both like and is identified within Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015). Whilst they are implementing Learning and Development Practice Guidance (2016) they both feel that this involves more work, in regard to training, than before.

Of note, one member of the Focus Group did say that whilst she found there was always a very prompt and efficient response to a referral/possible referral, sometimes other things did take longer to get organised. She specified the organisation and development of a safeguarding agreement.

The DSA has plans to retire within the next year, and this may present an opportunity to review the capacity and organisation of the safeguarding service. This could address the time pressures identified by the DSAs and also address standards set out in recent National Safeguarding Team policies, procedures and guidance.

*(References: part 1 of S11 audit: Appoint a suitably qualified DSA, and provide financial, organisational and management support. The adviser must have full access to clergy files and other confidential material.*

*Part 6: The DSA's role is clear in the job description and person specification. And*

*The DSA has sufficient time, funding, supervision and support to fulfil their safeguarding responsibilities, including local policy development, case work, advice, liaison with statutory authorities, training, personal and professional development and professional registration.*

*Part 8: The DSA should be given access to professional supervision to ensure their practice is reviewed and improves over time.)*

### **Considerations for the Diocese**

*Consider developing a better link between the professional supervision given to staff with their diocesan line management, in order to strengthen the relationship between the improvement of practice and performance.*

*Consider introducing a social work perspective into the supervision of the DSAs*

*Review the administration capacity specifically available to the safeguarding service.*

*Review the capacity and organisation of the safeguarding service in order to address the possible time pressures arising from implementing practice and standards set out in recent National Safeguarding Team policies, procedures and guidance.*

### 3.3 DIOCESAN SAFEGUARDING MONITORING GROUP

The Diocesan Safeguarding Monitoring Group (DSMG) is chaired by an independent person who currently teaches social work at one of the universities in Liverpool. She is a qualified social worker and was in frontline safeguarding practice and management for almost 20 years before taking over her current teaching post in 2003. She has undertaken the Chair's role for almost six years. This is a voluntary role and the Chair does not receive any payment.

The Chair is clear that the role of the monitoring group is to support the DSAs, to monitor safeguarding work in the Diocese, to follow up on actions and monitor training, for example. They do not get involved in individual cases or investigative issues. They can provide challenge and can make recommendations.

The Group meets quarterly. The Chair feels she would be able to ring and speak to the Bishop, if necessary, but has not had much cause to do so. She feels both DSAs are held in high regard throughout the Diocese and believes that they work beyond their allocated hours. The delivery of training is a case in point as this takes up a lot of time as it is delivered directly to the parishes, rather than centrally. The DSAs are doing well in getting training to people and are creative in getting people to engage in it, she feels. She holds the view that the new training package developed by the National Safeguarding Team is not as good as it could be and requires some further work on it. The Chair did acknowledge that the DSMG has not communicated this view to the National Safeguarding Team.

The Archdeacon, who is the Bishop's safeguarding lead, sits on this group. Other members include a police officer from a local Child Abuse Investigation Team, both DSAs, the Domestic Abuse Adviser, a representative from the Cathedral and a youth worker. However, the Assistant Diocesan Secretary who manages the DSA does not attend the DSMG and it is suggested that he does attend in order to provide a stronger connection between the Group and the line management of the safeguarding service.

There is no representation from any local authority or probation. The auditors were advised that this was not through want of trying, but both agencies simply did not have the time or staff to spare.

*(Reference: part 1 of S.11 audit: Provide a structure to manage safeguarding in the Diocese. Also to part 2: The Bishop appoints a member of his senior staff to be the lead person for safeguarding.)*

#### **Considerations for the Diocese**

*The Assistant Diocesan Secretary to attend the safeguarding monitoring group.*

*Continue to try to involve key strategic partners in the DSMG.*

*The Diocesan Safeguarding Monitoring Group via the chair to communicate with the NST if they have concerns about the quality of any aspects of national guidance being issued.*

### 3.4 POLICIES, PRACTICE GUIDANCE AND PROCEDURES

The auditors were told that the local synod had formally adopted Protecting All God's Children (safeguarding policy for children and young people, 4th edition, 2010) in 2015. It was clear from clergy blue files that were audited, that recruitment for members of the clergy, post 2013, was taking place in line with Safer Recruitment (2015). The DSAs are also delivering safeguarding training in line with Learning & Development Practice Guidance (2016) – although some of the issues arising from this will be discussed further under 3.8.

It is unclear as to how well embedded other national procedures are, such as Responding to Serious Safeguarding Concerns Related to Church Officers (2015) or Risk Assessment for Individuals who may Pose Risk to Children or Adults (2015), as recording in case files is quite variable and the DSA acknowledged that risk assessments were not written down, but kept in her 'head'.

Case files were not in line with the guidance laid out in Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015), for example they do not contain a running record of what has taken place or the Type A Risk Assessments that have been undertaken. Sec. 4 – What should be recorded? and Appendix 1 of the guidance were of particular concern to the auditors in regard to what was lacking from the records. However, case files were maintained in a neat and tidy fashion, with identifiable sections.

The auditors note that several months ago the Diocese saw the need to develop a policy around lone working within the parishes. This has been successfully implemented and was praised as being very helpful by some members of the Focus Group.

*(Reference: part 1 of the S. 11 audit: Ensure the Diocesan Synod adopts the House of Bishops' safeguarding policies, together with any additional diocesan procedures and good practice guidelines.)*

#### **Considerations for the Diocese**

*Identify all areas of recent Church of England national safeguarding procedures that still require implementation by the safeguarding service and develop an action plan to monitor their introduction and embedding into everyday practice.*

### 3.5 RESOURCES OF SAFEGUARDING SERVICE

As discussed in 3.2, the auditors were told by a wide range of people that they spoke to, that both DSAs appeared to be working under significant pressure during a period when there were changes in expectation about how safeguarding and safeguarding training is delivered by the Diocese. The DSAs are highly respected and well thought of by colleagues and concern was expressed about their capacity to deliver such significant changes.

The auditors were told during their conversations that whilst diocesan administration support staff are happy to help whenever asked, there is no dedicated support for safeguarding.

In the view of the auditors, this seemed too dependent on the flexibility of staff, and they suggest that consideration is given to some dedicated administration/business support to the safeguarding service.

The DSAs are both located in the diocesan offices, with their own separate room in a building that is mainly open plan. This is in order to facilitate confidentiality. They also have their own storage arrangements for files.

#### **Considerations for the Diocese**

*Review the capacity and organisation of the safeguarding service in order to address the possible time pressures arising from implementing practice and standards set out in recent National Safeguarding Team policies, procedures and guidance.*

*Consider dedicated administration support for the safeguarding service.*

### **3.6 RECORDING SYSTEMS AND IT SOLUTIONS**

The auditors were told that DBS checks are commissioned out to CCPAS and parishes are responsible for renewals although the Diocese also keeps a record. The auditors note there is no system to track DBS renewals (annual audit), which is of concern, and suggest that this might be something that could be incorporated into an information management system. Similarly, the tracking of training, the number of open cases, the renewal of safeguarding agreements etc. could be incorporated into such a system.

Currently the Diocese has a paper-based system of recording cases and these are kept in appropriately secured filing cabinets.

Individual cases are held within neat and well-kept paper files. The format of the files, however, does not comply with Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015), in that there are no front sheets, not all contacts/telephone calls etc. are recorded, risk assessments are not written down etc.

#### **Considerations for the Diocese**

*Adopt an information management system in order to keep track of renewal dates (i.e. DBS, Safeguarding Agreements etc.), and numbers of open/active cases.*

*Develop a case file format in line with Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015).*

### **3.7 RISK ASSESSMENTS AND SAFEGUARDING CONTRACTS / AGREEMENTS**

Risk assessments would appear to be undertaken when required, but it was difficult to assess their quality and the Children's DSA told the auditors that she did not write them down. It was also clear from conversations and viewing the case files that relevant professionals were involved in the formulation of risk assessments. The only written risk assessments viewed were Type B assessments that had required a level of specialist

and independent input. These were all of a good standard and undertaken by suitably qualified people.

Also, due to the lack of written risk assessments, it was difficult for the auditors to form a view as to how well the findings of risk assessments informed the formulation of safeguarding agreements.

Safeguarding agreements appeared to be in place whenever they were required. The relevant people were involved in monitoring them. All agreements had also been signed by the relevant parties. The auditors did see one case where the person supervising the contract was meeting the person subject of a Safeguarding Agreement in a café. They did not feel that this was appropriate, and alerted the Children's DSA, who was going to address this.

On the whole, safeguarding agreements were robust and clear. The auditors felt that it could be helpful to specify services for the individual subject of the agreement where it would be likely that there would be fewer children in attendance (i.e. early morning services).

Some cases were seen where it had taken some time to organise a meeting to agree a safeguarding agreement. This situation was also mentioned by someone from the Focus Group.

The DSA acknowledged that this could sometimes be the case due to the people required to coordinate in order to have such a meeting. This is often a challenge, but the auditors felt with dedicated administration support and a management information system in place this could be a way of addressing this.

*(Reference: part 1 of S. 11 audit: Provide access to a risk assessment service so the Bishop and others can evaluate and manage any risk posed by individuals or activities within the Church.)*

### **Considerations for the Diocese**

*Risk assessments to be in written format and undertaken in line with the Church of England's practice guidance 'Risk Assessment for Individuals who may Pose Risk to Children or Adults' (2015).*

## **3.8 TRAINING**

The Diocese was a pilot site for the Learning and Development Framework.

The DSAs and the Chair of the DSMG expressed some concerns at various aspects of the training and how it could be quantified by training participants. The Children's DSA said that she had fed this back to the National Safeguarding Team, but the Chair of the DSMG, who held the same view, said that she had not.

Both DSAs told the auditors that the training framework had to be delivered as specifically laid down by the NST. However, the auditors also note the following statement from the Learning & Development Practice Guidance 2015: 'This Guidance is for use by diocesan and national safeguarding advisers, archbishops, bishops and their



senior staff, provincial and diocesan registrars, **to inform and assist them** in resourcing and designing their delivery of safeguarding training, for ordained and lay people at different stages of their ministry'. This would suggest that there is a level of flexibility in adapting some of the slides, as long as their basic meaning is not changed.

There was some feedback too from the Focus Group. One member felt the basic training was good and liked the content relating to domestic abuse. Another member who had recently taken training with her group, said she and others felt disempowered over safeguarding by the end of the course and did not feel that they 'could be any good at it'. Written evaluations by participants following training were very positive.

A Diocesan Training Strategy 2016–17 is in place and was presented too, and agreed by, the DSMG.

All training is delivered in the parishes. Both DSAs felt that this can be very time-consuming but ensured a better attendance at training if participants could attend locally rather than travel in to a central place. To complement this, e-learning has recently been introduced by the Diocese.

The auditors were unclear about how training is tracked and who sends out reminders. The Archdeacons were clear that they had a role in keeping the profile of safeguarding training high within the parishes. The Bishop was clear that he would not agree Permission to Officiate without up-to-date safeguarding training, which is positive. However, the overall tracking and monitoring of who has been trained, and when, needs to be addressed, as training data from the 2015 Church of England Safeguarding Return shows that only six out of 125 members of the clergy with Permission to Officiate have undergone safeguarding training in the last three years. Likewise only 30 out of 286 lay readers had had safeguarding training, whilst all of the Bishop's staff and licensed clergy, had. There are plans in the forthcoming year that will ensure there is an increase in the number of those with PTO and lay readers being trained.

*(Reference: part 1 of S.11 audit: Select and train those who are to hold the Bishop's Licence in safeguarding matters. Provide training on safeguarding matters to parishes, the Cathedral, other clergy, diocesan organisations, including religious communities and those who hold the Bishop's Licence.*

*And to part 8: Those working closely with children, young people and adults experiencing, or at risk of, abuse or neglect ...have safeguarding in their induction and are trained and have their training refreshed every 3 years.)*

### **Considerations for the Diocese**

*Discuss with the NST what changes to the content of the training framework are possible and not possible.*

*Review and update the monitoring systems to track who has had safeguarding training, when, and when it will need to be updated.*

### 3.9 SAFE RECRUITMENT OF CHURCH OFFICERS

The auditors viewed eight clergy blue personnel files, mostly post 2013 and considered that they were all well organised and compliant with safer recruitment. For example, references were in place, a person specification and an application form seen, evidence of DBS checks (with a date) at the front of a file. Documents were securely attached and the auditors was able to understand the recruitment journey. A file where a Clergy Disciplinary Measure (CDM) had been followed through could be easily identified.

Unfortunately, the auditors did not have the time to audit any recruitment files of non-clergy posts within the Diocese.

*(Reference to part 7 of S.11 audit: The Diocesan Secretary has implemented arrangements in line with the House of Bishops' policy on Safer Recruitment 2015.*

*And to part 1: Keep a record of clergy and church officers that will enable a prompt response to bona fide enquiries...where there have been safeguarding concerns, these should be clearly indicated on file.)*

### 3.10 RESPONSE TO ALLEGATIONS

The case files reviewed suggest that some allegations are responded to within a timely way. However, because of the issue relating to the recording of information, the auditors are unable to comment on overall timing or outcomes. For example, in a case involving an older gentleman it seemed to take two months to refer to Adult Safeguarding.

It was clear from meetings attended by the Children's DSA that she was linked into local safeguarding arrangements, such as the Multi Agency Public Protection Arrangements (MAPPA). She also said that she had good relationships with Local Authority Designated Officers (LADOs), but this was not seen on case files, aside from attendance at some relevant meetings. The police officer from the Child Abuse Investigation Team, who is a member of the DSMG, told the auditors that she had a very good working relationship with the Children's DSA.

The auditors suggest that the document Responding to Serious Safeguarding Situations (2015) needs to be used as the basis for all practice in regard to the Diocese response to allegations and safeguarding situations, as well as Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015) in regards to the recording of information.

#### **Considerations for the Diocese**

*To review the current diocesan practice against Responding to Serious Safeguarding Situations (2015) and Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015), so that local processes are consistent with national requirements.*

### 3.11 QUALITY OF CASE WORK

From the files reviewed, it was hard to understand what had happened and what the outcome was. In one case, the question was posed of why there was not a referral to the LADO and the result was there was a referral but it was not recorded on the case file. This turned out to be a common feature, with the Children's DSA advising us that she had regular contact with LADOs, but it not being noted on the file.

For the cases involving children, these mostly consisted of safeguarding agreements and these were in order and signed although there was no risk assessment on file (this is discussed in section 3.7).

Due to the weaknesses identified in case file recording at times, it was difficult to identify if a case being audited was still ongoing or if it had been closed. The Children's DSA acknowledged that it was difficult (due to lack of time) to close down cases properly where no further action was required or if people had moved to another diocese.

The auditors had significant concerns about one case from 2014 when an individual who had PTO in the Diocese was found to have, in all likelihood, downloaded a file showing underage children performing sexual acts. The concerns identified by the auditors were:

- The DSA had not followed up, before this audit, with the police or LADO what action they were intending to take, or, indeed, check with them that the employer had passed on the same information to them that he had to her. It is understood that the police may not have ever examined this computer.
- An independent risk assessment on the individual was commissioned by the DSA. There were several recommendations arising out of this, which included that the person concerned should have counselling that addressed several areas specified by the assessor. Counselling was arranged for the person concerned, which concluded in six sessions, with the counsellor expressing the view that he had successfully 'moved on'. There is no record that shows the counsellor was briefed on the areas she needed to cover, as identified in the independent risk assessment, or, if she was, that she did cover them.
- It also materialised that the person had not told his wife the full nature of the allegations made against him. It is unclear if both the risk assessor and/or the counsellor were ever informed of this crucial information by the DSA.
- On examining the blue file for this person, the auditors noted that his first degree was in computing and software sciences. It is not clear if this information was ever shared with the police or the risk assessor.

The auditors highlighted their concerns to the DSA, her line manager, and the Archdeacon with lead responsibility for safeguarding in regard to this case. They also shared the audit form with identified follow-up actions that they felt should be done.

Overall, the auditors' judgment was that there had been a lack of 'professional challenge' in this case, as the DSA should have followed up with the police and LADO if their referral information was correct, and if it was, the action that they were going to take. The counsellor should also have been challenged about her refusal to provide any report or feedback into the areas she should have covered, as specified in the risk assessment.

By the end of the audit, the auditors were assured that the further action that they had suggested was already being followed up.

#### **Considerations for the Diocese**

*Consider an audit of all the case files, to decide which can be closed down (and moved into a different filing system) and which continue to require ongoing work.*

*Start to record all contacts with safeguarding professionals in the case files.*

*Consider and agree an appropriate approach to recording in line with Safeguarding Records: Joint Practice Guidance for the Church of England and the Methodist Church (2015).*

*Consider how to develop 'professional challenge' towards other safeguarding partners in relation to safeguarding work.*

### **3.12 COMPLAINTS**

The Diocese has a complaints procedure that was last reviewed in March 2015. It is separate and distinct from the whistleblowing procedure for the Diocese. There are three distinct stages for a complaint to be followed through by the complainant. However, no mention is made within the procedure about it including complaints about the safeguarding process, and there is not a separate complaints procedure for safeguarding.

A complaints procedure for safeguarding needs to be developed and promoted. A system for complaints will enable the Diocese to collate information from complaints and learn from any issues that arise. This information could also usefully be fed back to the Bishop's Safeguarding Support Group on an annual basis.

*Reference: part 1 of S. 11 audit: Provide a complaints procedure which can be used by those who wish to complain about the handling of safeguarding issues.*

*Also part 4: There is an easily accessible complaints procedure including reference to the Clergy Disciplinary Measures and whistleblowing procedures.*

#### **Considerations for the Diocese**

*Develop and promote a complaints procedure that refers specifically to safeguarding.*

*Create a system to collate the information and learning to present to the safeguarding monitoring group.*

### 3.13 WHISTLEBLOWING

The Diocese has a whistleblowing procedure that was last reviewed in March 2015.

There is no mention in the whistleblowing procedure about safeguarding, and how the policy could be used if an individual feels unable to disclose a concern through a referral to the DSA.

A separate whistleblowing procedure needs to be developed that would specifically address issues in regard to safeguarding and this should include making a distinction between whistleblowing and complaining, as well as allowing for a written (postal) submission.

When developed, the procedure would need to be publicised, including being placed on the diocesan website

*(Reference: part 4 of S. 11 audit: Whistleblowing arrangements are in place and addressed in training.)*

#### **Considerations for the Diocese**

*Develop a whistleblowing procedure that refers to safeguarding and publicise it.*

### 3.14 MONITORING OF SAFEGUARDING IN PARISHES AS PART OF ARCHDEACON'S RESPONSIBILITIES

The auditors were told that there is a two-year cycle of visitation by the Archdeacons and that this is preceded by the articles of enquiry. Whilst the articles of enquiry contain safeguarding questions it was felt that more specific questions were required and in November 2015, the parish safeguarding audit was introduced which is to be completed by parishes alongside the articles of enquiry.

The Archdeacon who has the lead for safeguarding told the auditors that he first introduced the parish safeguarding audit nine months ago. The thinking behind the introduction of the audit was that the completed form would be used as the basis for discussion during the Archdeacon's visitation. Should any concerns arise during this process, in regard to safeguarding, then they will be raised and fed back to the relevant DSA. The Diocese has moved from being divided into two archdeaconries to four, supported by strategic deans within parishes.

It is noted from the conversation with the Archdeacon that the Diocese is trying to build its awareness around dementia and widen its outlook regarding adults who might be vulnerable and welcoming them in the church.

The auditors felt that the introduction of the parish safeguarding audit was a very good initiative, and underlined the diocesan commitment to safeguarding in the parishes. The auditors also felt that information gathered from the audits could usefully be used to inform the strategic planning of safeguarding within the Diocese, and should be fed back into the DSMG.

*(Reference: part 1 of the S. 11 audit: Include the monitoring of safeguarding in parishes as part of the archdeacons' responsibilities.)*

#### **Considerations for the Diocese**

*Consider how information from with the parish safeguarding audit can be integrated into the strategic planning of safeguarding within the Diocese.*

*Formulate feedback into the DSMG of information gathered from the parish safeguarding audits.*

### **3.15 RESOURCES FOR CHILDREN AND VULNERABLE ADULTS**

The auditors were told that the authorised listening service has recently been outsourced to CCPAS. They were concerned, however, that not a single member of the focus group knew what an authorised listener was, what role they undertook or how the service could be accessed.

The Diocese has not yet established a way of incorporating the views of children, young people and adults at risk that could inform its delivery of safeguarding services.

*(Reference: part 3 of S.11 audit: There is a structure to hear the views of young people, there are children's and young people's advocates available, there are authorised listeners in place.)*

#### **Considerations for the Diocese**

*Consider how to raise awareness of the authorised listening service and how it can be accessed.*

*Give consideration to how the views of children, young people and adults at risk might be heard and used to inform delivery of safeguarding services.*

### **3.16 INFORMATION SHARING**

The DSA is an active member of the Churches Together Safeguarding Forum in Liverpool and the Halton Local Safeguarding Children Board (LSCB) Inter Faith Group. In the past she provided DSA support to the dioceses of Manchester and Chester, as well as Liverpool, for five years. She was also seconded to the National Safeguarding Team two years ago and attends national safeguarding meetings for DSAs. In this sense she appears to have strong links with other dioceses and DSAs.

The DSA told the auditors that she meets with the Bishop every three months. She has access to him at any point it is needed, and has a good working relationship with his Executive Assistant. She works closely with the Archdeacon with lead responsibility for safeguarding.

Although not evidenced in case recordings, the DSA says that she has good working relationships with local LADOs, and files do show that she attends LADO meetings when required.

According to the written documents provided by the Children's DSA, an information

sharing protocol is in place with the Merseyside National Offender Management Service and work is being done to develop a similar one with Merseyside Police.

*(Reference to part 1 of the S. 11 audit: Ensure that the DSA is informed of any serious safeguarding situation, including any allegation made against a member of the clergy or anyone else holding the Bishop's Licence, concerning misconduct.*

*Also: Share relevant information about individuals with other dioceses, other denominations and organisations or the national church as appropriate.*

*And to part 5: The Diocesan Secretary, who will have a lead on DPA matters, will ensure that there is clear information sharing protocols in place.)*

#### **Considerations for the Diocese**

*All contact with LADOs and Children's Services to be evidenced on case files.*

### **3.17 QUALITY ASSURANCE PROCESSES**

The Chair of the DSMG said that she felt one of the main roles of the Group was to have strategic oversight of the delivery of safeguarding services by the Diocese.

The Diocese makes an annual self-assessment (based on a Sec. 11 report) to the national safeguarding team. It has submitted one for 2015 and this was supplied to the auditors prior to their arrival for the on-site audit (see 1.2).

Case work is monitored via the professional supervisory process, although, as outlined in 3.2, this runs parallel to the line management process, so needs to be interlinked in some way. Also, the auditors felt that a social work perspective could assist in a more outcome-focused style of work.

The DSA meets quarterly with the Bishop and reports to his senior management meetings on a monthly basis.

Aside from the above there is no other formal quality assurance programme or framework.

Aside from the considerations outlined below, the auditors also felt that considerations outlined in 3.2 i.e. 'Consider developing a better link between the professional supervision given to staff with their diocesan line management in order to strengthen the relationship between the improvement of practice and performance' and 'Consider introducing a social work perspective into the supervision of the DSAs' was also of relevance here.

#### **Considerations for the Diocese**

*Consider developing a quality assurance framework for safeguarding.*

### **3.18 LINKS WITH NATIONAL SAFEGUARDING STRATEGY AND TEAM**

Both DSAs attend national DSA meetings. It is noted that the Diocese of Liverpool was a pilot site for the Learning and Development Framework and that the Children's DSA seconded to the national team two years ago with the remit of undertaking 'national cases'.



## **APPENDIX: REVIEW PROCESS**

### **Data collection**

Information provided to the auditors before or during the audit:

- minutes of the Safeguarding Monitoring Group (three sets prior to independent audit)
- diagram of management structure for safeguarding
- Church of England Safeguarding Audit 2015
- training strategy
- Diocese of Liverpool Safeguarding Children, Young People and Adults at Risk, Annual Report 2015
- training content C1, C2, C6, safer recruitment
- LD training strategy 2016/2017
- JD DSA
- JD Disabilities Awareness and Vulnerable Adults Adviser
- Terms of reference – Independent Chair
- whistleblowing
- complaints
- domestic abuse document 2015
- safeguarding children document 2015
- safeguarding vulnerable adults, 2015 doc

### **Participation of members of the Diocese**

The auditors had face-to-face conversations with:

- the Independent Chair
- the Bishop
- the Diocesan Secretary
- the Archdeacon with Safeguarding Lead
- the Assistant Diocesan Secretary, link person
- the Children's DSA

- the Adult's DSA
- a member of the Merseyside Police
- a youth leader
- the parish focus group comprised:
  - a parish safeguarding officer
  - an incumbent
  - Cathedral volunteer coordinator
  - parish administrator
  - domestic abuse lead
  - a Church Warden
  - Sefton Council for Voluntary Service

**The audit: what records / files were examined?**

- 11 case files
- eight personnel files (clergy blue files) in relation to safer recruitment

**Limitations of the audit process**

No recruitment files for non-clergy roles within the Diocese were audited, due to time factors.