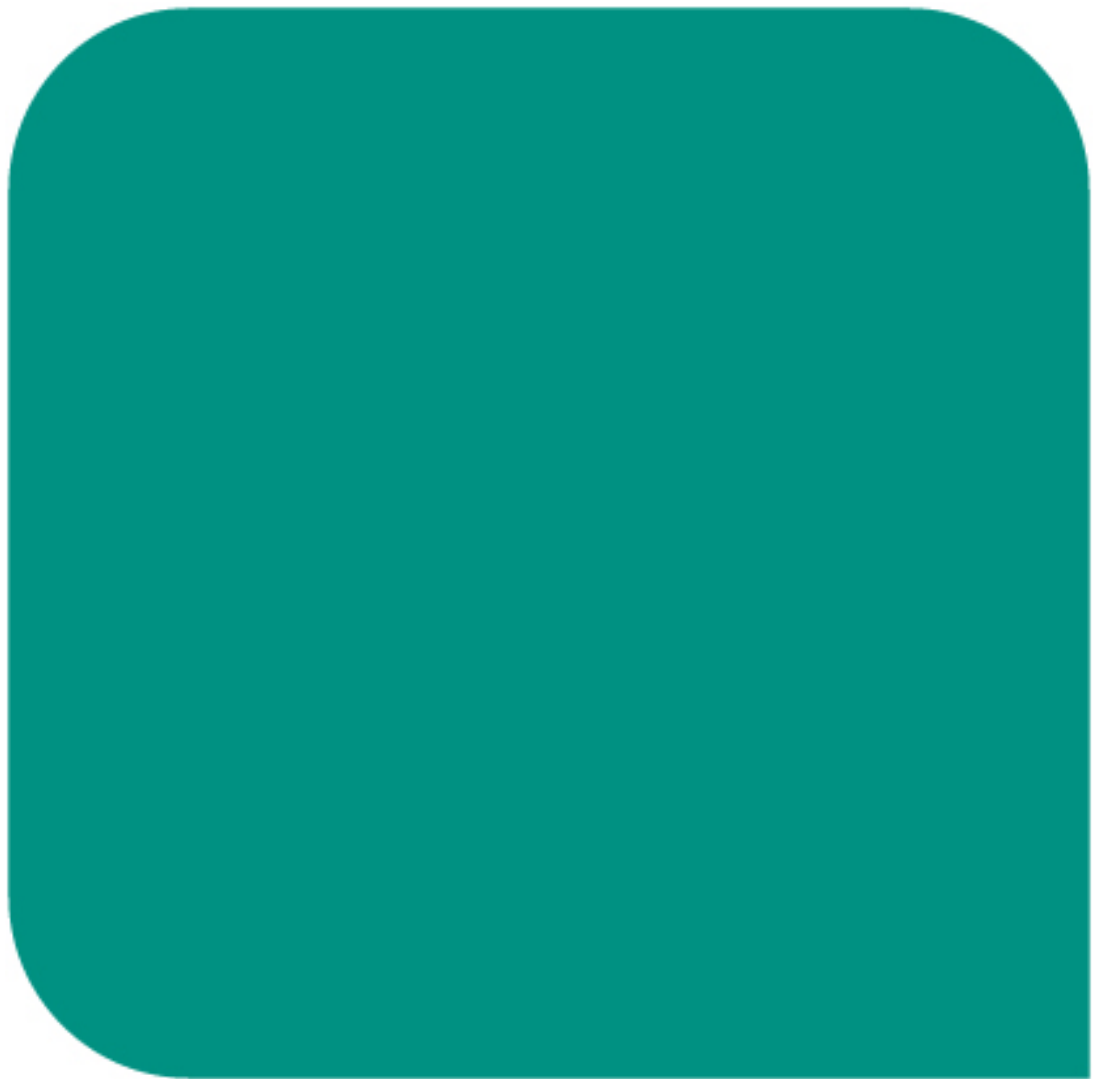




social care
institute for excellence

Salisbury diocese independent safeguarding audit



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Independent auditing of diocesan safeguarding arrangements for the Church of England

Programme of independent safeguarding audits of Church of England dioceses; commissioned by the House of Bishops through the National Safeguarding Team

Salisbury diocese audit

25, 26 and 27 August 2015

Edi Carmi, Susan Ellery and Hugh Constant

First published in Great Britain in January 2016
by the Social Care Institute for Excellence and the Church of England

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Written by Edi Carmi, Susan Ellery and Hugh Constant

Social Care Institute for Excellence

Kinnaird House
1 Pall Mall East
London SW1Y 5BP
tel 020 7766 7400
www.scie.org.uk

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1. Introduction

This is the second of the Social Care Institute for Excellence [SCIE] pilot audit of diocesan safeguarding arrangements for the Church of England. The aim of these audits is to work together to understand the safeguarding journey of each diocese to date and to support the continuing improvements being made.

The framework for the audit (and the consequent report) has been specified by the National Safeguarding Team of the Church of England and links to the Children Act section 11 / Working Together to Safeguard Children 2015 requirements as they apply to faith organisations and the House of Bishops' safeguarding policies and guidance documents. The National Safeguarding Team specified the national expectations and the auditors evaluated the progress the diocese was making in reaching these standards, applying them to the safeguarding of both children and adults.

The project is being started with the cooperation of four pilot sites to check the planning, conduct and output of the audit approach. The dioceses which have volunteered to be part of this pilot are Salisbury, Portsmouth, Blackburn and Durham.

The evaluation of the methodology (including using s.11 as the basis of the report structure) will be published in a separate pilot evaluation report. An overview report will also be published bringing together the learning from all four pilots and highlighting any systemic issues that are of wider significance.

Following evaluation of these pilots and any consequential adjustments to the methodology, the audits will be rolled out nationally during 2016 and 2017.

The fieldwork audit of Salisbury diocese was undertaken by Susan Ellery and Hugh Constant on 25, 26 and 27 August 2015. The audit process involved examination of case records, group and individual conversations along with consideration of local policies, protocols and guidance, within the context of leadership arrangements for safeguarding.

Structure of the report

Section 2 provides the overview of the auditors' findings about the culture and quality of safeguarding practice within the diocese.

Section 3 of the report provides the findings and is structured using the eleven headings set out in Working Together to Safeguard Children 2015, applied to the safeguarding arrangements for children and for vulnerable adults. Recommendations have been included (if relevant) at the end of each sub section within the Findings.

Section 4 provides the headline findings from the case file audit. The diocese has been provided with the detailed audit material on the individual cases: this is not included in this report due to the confidential personal information contained.

The **appendix** explains the methodology employed in the audit.

2. Overview

The auditors were impressed with the progress in safeguarding within the diocese, which was described as having been made in recent years. This has seen:

- funding to increase the Diocesan Safeguarding Advisor's (DSA's) hours
- the appointment of a new DSA to this post
- structures in place around safeguarding training
- the use of Disclosure and Barring Service checks on staff and volunteers
- the development of governance to set up the Diocesan Safeguarding Management Group (DSMG) under independent chairmanship.

The positive development of safeguarding within the diocese was recognised in the feedback from external agencies consulted as part of this audit.

The DSA is suitably qualified and experienced in her role and this is demonstrated in her casework. She receives professional supervision from two sources, one for adult and one for children's cases. This appears to be an excellent arrangement and is unique in the dioceses audited in this pilot.

The chair of the Diocesan Safeguarding Management Group has introduced positive changes to the way it functions, bringing in senior diocesan management and a professional reference group for risk assessment, annual meetings with the Local Safeguarding Children Boards (LSCB) and Safeguarding Adult Boards (SAB) chairs and an annual workshop.

The focus group was a small sample, but the vicar understood the importance of safeguarding for adults and children and talked openly about the challenges.

Senior management in the diocese are supportive of safeguarding and cooperate with and are generally supportive of the work of the DSA. However, there remains further work to fully embed a culture where safeguarding is recognised as everybody's business, as opposed to being primarily the responsibility of the DSA. Such cultural change will need overt leadership and for this to be cascaded through all levels of the church.

The nature of a large rural diocese has proved a challenge in the delivery of face to face training for all those eligible. e-Learning is being considered as an alternative, but there has been some resistance to this, partly due to mixed messages about the validity and applicability of the e-learning as well as (for some) a lack technological skills.

The need to incorporate the large number of new policy documents into training has provided additional delay, along with waiting for the new national training to be rolled out. There is now a need for a training plan. Whether this involves face-to-face training and/or e-learning, it must have senior management backing and must target everybody.

There is a need for an improved management information system so that the DSA is able to access information within the diocese regarding people's training and Disclosure & Barring System (DBS) status, and which ideally provides added functionality in terms of information about youth groups and other activities, so that

the DSA is able to target her efforts.

The auditors were concerned by the lack of willingness of parishes to answer the safeguarding policy questions in the archdeacons' Articles of Enquiry in 2013. Although the parishes are independent, further strategies can be employed to secure compliance about safeguarding. This would though have to be implemented by the archdeacons backed by the bishops.

In common with other dioceses, there is scope for further dissemination and cultural understanding that safeguarding is about vulnerable adults as well as children.

3. Findings

1. A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children and adults who are vulnerable.

The adoption of the House of Bishops' safeguarding policies

All House of Bishops' safeguarding policies have been adopted by the Diocesan Synod. Local policies and procedures are the DSA's responsibility, but this area is problematic, mainly due to the local focus on casework and training, and the time of one part-time DSA being inevitably limited.

The auditors noted that the diocesan policy on safeguarding uses the language of encouraging rather than expecting or even requiring. The auditors' view was that this is symptomatic of local culture and likely to be less effective in changing the culture of safeguarding, than clarity about what is mandatory.

Structure for management of safeguarding in the diocese

The structure for managing safeguarding within the diocese is that the responsibility is delegated by the Bishop to the Archdeacon of Wiltshire.

There is strong leadership of the Diocesan Safeguarding Management Group (DSMG), which has introduced a new structure to the group by bringing in the senior members of the diocese, to reinforce the message that safeguarding is everybody's responsibility. A professional reference group for risk assessments, annual meeting with board chairs (LSCB and SAB) and an annual safeguarding workshop have also been introduced.

Staffing of safeguarding service

The DSA has an appropriate background for her role; she is a qualified social worker, with experience of both children's and adults' services. Her experience as a manager and of policy development, whilst not essential for this role, is invaluable in being able to progress the role of safeguarding within the diocese.

Reporting of concerns and risk assessments

The DSA undertakes risk assessments of individuals known to pose any potential safeguarding risk. The assessments seen as part of the audit were of good quality, but two cases indicate that senior staff did not fully understand the need for such detailed assessments or agreements.

The DSA is not totally confident that she will be always be informed of safeguarding concerns. One of the cases audited demonstrated the fact the DSA was informed by a vicar of an offender moving into the locality, but had not been informed by the member of the senior clergy who knew of the man's presence. The DSA spoke of another case where she found out by chance of the need for her involvement.

Monitoring of safeguarding of parishes as part of archdeacons responsibilities

There is a reported widespread acceptance of an inability to force cooperation of the

parishes in the monitoring of safeguarding performance. This has contributed to monitoring being an undeveloped area as indicated by the poor response in the 2013 archdeacons' Articles of Enquiry, with only 109/452 parishes answering the question about having a safeguarding policy and only about 70 of the 109 confirming this to be the case.

Access to Disclosure & Barring Service (DBS)

The parishes, Cathedral, bishop's office and diocesan office have access to the DBS, but there is not yet a reliable system for renewal, nor a culture of compliance with this requirement for beneficed and licensed clergy, paid workers and volunteers who need to obtain disclosures.

Safeguarding training recording systems

The DSA initiated on her arrival in post (18 months ago) systems to record those who have undertaken safeguarding training. However, there was inadequate data prior to this time.

2. A senior board level lead to take responsibility for the organisation's safeguarding arrangements.

There is a lack of a clear and explicit diocesan safeguarding strategy, agreed by the bishop and his staff group. If this existed, it would enable the DSA and her line manager to set objectives which they know are supported at the highest levels within the diocese. Such a strategy needs to include what is to be accomplished, how and by whom, with the necessary resources identified. In practice without this strategy, the DSA's objectives are set between the DSA, the Deputy Diocesan Secretary and in collaboration with the chair of the DSMG.

Overall safeguarding is very much perceived to be the business of the DSA, and she is provided with support via professional supervision, an independent DSMG chair and funds for training. However, the auditors' perception was that safeguarding was not fully integrated into the culture and was not yet seen or experienced as everybody's business. Such cultural change will need the pro-active involvement of the senior leadership team within the diocese and cannot be left to the DSA on her own, or even to the DSA and chair of the DSMG.

The auditors were impressed with the commitment of the independent DSMG. He not only chairs the DSMG meetings but provides additional and valuable support to the DSA in her role, which does in part mitigate against her potential isolation as the only safeguarding professional. This involves further time for the unpaid chair. There is no evidence whether there is any impact on safeguarding if this function is undertaken in a voluntary or paid capacity, but the sustainability of such an unpaid role could become an issue in the future.

Whilst there has been progress made on safeguarding, there remain challenges in the management within the diocese, with reports of individuals who did not want to attend the national training day or who felt that there was too much safeguarding training.

There were suggestions in conversations with the auditors that the focus was

sometimes still more on the needs of the perpetrator rather than the victim. Whilst the perpetrator may be well known, loved and respected, and the victim may be unknown locally, one feature that illustrates the embedding of a safeguarding culture is the universally accepted primacy of the needs of the victim.

In particular, there was an example cited and evidenced in the case audit where senior clergy provided character references to the court about an offender in 2014. The victim/s may feel that this is a public demonstration of support to the offender. Although the DSA was consulted by both of the senior clergy concerned, her advice over the references was not followed. Moreover, earlier, despite previous historic convictions, the offender had been attending services in the Cathedral without an agreement in place, until the current DSA intervened to provide this.

Recommendation

1. *The senior management of the diocese in liaison with the DSA and chair of the Diocesan Safeguarding Management Group to develop a plan to integrate safeguarding into all aspects of the responsibilities of the diocese. This to include:*
 - a. *clear message from the leadership around role of safeguarding*
 - b. *clarity around who has lead responsibility for safeguarding in the diocese, and that this is communicated widely*
 - c. *regular meetings between the DSA and the identified safeguarding lead in the diocese in order to agree and track the strategic direction as well as monitor cases*
 - d. *policy documents to be written in the language of expectations as opposed to encouragement*
 - e. *consideration over how to change the culture so that the focus is firmly and consistently on the needs of the victim as opposed to the perpetrator, no matter how well known or respected the perpetrator may be*
 - f. *the practice of providing offenders with support or character references to be avoided, except in accordance with Practice Guidance: Responding to Serious Concerns, 2015*
 - g. *a communication strategy to be developed to provide clear and consistent messages about safeguarding throughout the diocese*
 - h. *development and implementation of plans for a reliable system for DBS renewals, which will involve development of a culture of compliance with this requirement for beneficed and licensed clergy, paid workers and volunteers who need to obtain disclosures*
 - i. *consideration of the sustainability of an unpaid DSMG role to not only chair the meetings, but devote additional time in consultation with the DSA*

Recommendation

2. *Safeguarding to be on the agenda of each Ministerial Development Review, archdeacons' Articles of Enquiry and archdeacons' Visitations.*

3. A culture of listening to children and adults who are vulnerable and taking account of their wishes and feelings, both in individual decisions and the development of services.

Authorised listeners are in place and have been used twice since March 2015. The contract is for use with adults only and there is no formal structure in place for the provision of advocates for children.

Recommendation

3. The senior management group to address the needs of children for advocacy so that the means by which this is to be provided is agreed, commissioned and communicated within the diocese.

4. Clear whistleblowing procedures, which reflect the principles in Sir Robert Francis's Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children [and adults] to be addressed¹

There is no local complaints or whistleblowing procedure in place other than that in national policy. The initial response to one complainant showed that there was a misunderstanding on how to respond when a concern is reported, without the use of the term 'complaint'. Subsequently, with the help of the DSA, this complaint was progressed, but because by then it was over 12 months later, there were obstacles in getting the complaint accepted.

It was explained that there is work being undertaken in Bristol on complaints and whistleblowing procedures, and the diocese is waiting for this.

Recommendation

4. The diocese to develop local procedures for both complaints and whistleblowing, which clearly distinguish these processes, but provide clarity around the distinction between a complaint and a safeguarding concern.

¹Sir Robert Francis's Freedom to Speak Up review report can be found at https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

5. Arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Adults² and Children Board³

There is a section within the local Framework for Safeguarding and Good Practice, which sets out the process for sharing information. Generally, there were functioning links with statutory agencies around casework.

6. A designated professional lead for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children and adults who are vulnerable, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their safeguarding responsibilities effectively.

The DSA's role is clear in the job description and person specification. The desirable requirement to have a 'Commitment to Mission and Ministry of the Church of England', may deter applicants; the use of 'in sympathy with...' may attract a wider range of candidates in the future. Also the description lists the role in relation to policies and procedures as Key Role A whilst Key Role B is advising the bishop, staff, parishes etc in safeguarding. If this order was changed it would reflect the importance of the DSA role in advising senior clergy.

The DSA is well qualified and experienced for the role and has funding for supervision. This is obtained from two sources, so as to provide advice from specialists in both children's and adults' safeguarding. This is commendable and unique within the pilots undertaken.

Case work audited demonstrated effective and prompt responses by the DSA and shows no indication of resource problems. This is supported by comments from those interviewed in other agencies; with comments made that responses are professional. However, it may be that time is an issue in relation to the development of local policy and procedure documents.

The DSA is employed for 25 hours per week and receives 17 hours administrative

² Safeguarding Adults Board is a multi-agency partnership which provides strategic leadership for the development of adults safeguarding policy and practice, consistent with national policy and best practice.

³ Local Safeguarding Children Boards (LSCBs) were established by the Children Act 2004 which gives a statutory responsibility to each locality to have this mechanism in place. LSCBs are now the key system in every locality of the country for organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.

support weekly, largely devoted to DBS checks, with additional time from within the diocesan administration team. However, the DSA herself reported that she is still directly responsible for some administrative work, such as booking training venues and photocopying material. The DSA perceives that her time is stretched between her responsibilities for casework, training, and policy writing and development, as well as administrative tasks.

The DBS checks are undertaken at a reception desk in open view of colleagues and visitors to the diocesan office. The administrator concerned is very aware of the confidential nature of this task and does try to hide the forms when visitors arrive; however, this arrangement does introduce vulnerability to the confidential nature of the task. Another pilot site (Blackburn) has commissioned out the DBS tasks, which has freed up administrative capacity internally.

Recommendation

5. Senior management to give consideration to the amount of administrative support provided to the DSA as well how this is provided, so that the appropriate level of confidentiality is provided. Consideration may wish to be given to looking at alternative ways to provide the DBS functions, so as to free administration support time for the DSA.

7. Safe recruitment practices for individuals whom the organisation will permit to work regularly with children and adults who are vulnerable, including policies on when to obtain a criminal record check.

Although not supported by the evidence from recruitment files, there was general agreement that there are some shortcomings still in terms of safer recruitment. There are potentially six different routes through which one might go to get a DBS, and a struggle to manage the sheer numbers involved at diocesan and parish level. But there has been an acceptance within the diocese of people being appointed prior to their DBS being received, or even without references, despite the policy which prohibits this.

Recommendations

6. Senior management to consider how to effectively communicate the policy prohibiting the appointment of individuals prior to receipt of references and DBS checks and what steps are required to check compliance with this in the future.

7. The DBS system within the diocese to be simplified so that there is one central route for it to be achieved. It would be worthwhile learning from elsewhere what works well e.g. Blackburn, who have contracted the service out.

8. Appropriate supervision and support for staff, including undertaking safeguarding training: employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and adults who are vulnerable and creating an environment where: staff feel able to raise concerns and feel supported in their safeguarding role; staff should be given a mandatory induction, which includes familiarisation with safeguarding responsibilities and procedures to be followed if anyone has anyone has concerns about a child's or adult's safety or welfare; and all professionals should have regular reviews of their own practice to ensure they improve over time

It is not clear historically whether staff were provided with appropriate safeguarding training, as there was no system in place to log training. This has been in operation now for the last 18 months, but until 2017 it will not be fully operational: this will be because training is required every three years, so in 2017 one would expect all staff will have received the training.

The training is considered to be good quality and this is recognised by the senior managers to be a particular strength of the DSA, who previously had such experience providing training for the Methodist Church.

The DSA has good supervision facilities as described above (Finding 6).

Recommendation

8. Senior management to agree a training strategy which scopes the extent of need over an agreed time (three years) and sets out plans to meet the need.

9. Clear policies in line with those from the Local Safeguarding Children and Adults Boards for dealing with allegations against people who work with children or adults who are vulnerable. An allegation may relate to a person who works with children or vulnerable adults who has behaved in a way that has harmed a child; or may have harmed a child or adults who is vulnerable; possibly committed a criminal offence against or related to a child; or behaved towards a child or children in a way that indicates they may pose a risk of harm to children or adults who are vulnerable.

Policies are in place in line with *Responding to Serious Safeguarding Situations Relating to Church Officers and Other Individuals Practice Guidance*.

There was a view that there had been a large number of policies from the centre all at one time, and that it has been hard to keep up to date. This was felt both in terms of the diocese, but even more strongly from the parish focus group.

10. Employers and voluntary organisations should ensure that they have clear policies in place setting out the process, including timescales, for investigation and what support and advice will be available to individuals against whom allegations have been made. Any allegation against people who work with children should be reported immediately to a senior manager within the organisation. The designated officer, or team of officers, should also be informed within one working day of all allegations that come to an employer's attention or that are made directly to the police. Any allegation should be reported immediately to a senior manager within the organisation.

A comprehensive policy is in place, and casework suggests that work is done sensitively in line with it.

11. If an organisation removes an individual (paid worker or unpaid volunteer) from work such as looking after children (or would have, had the person not left first) because the person poses a risk of harm to children or adults, the organisation must make a referral to the Disclosure & Barring Service. It is an offence to fail to make a referral without good reason

There are policies and processes in place to ensure such referrals are made; two DBS referrals have been made in the last four years.

4. Learning from case audits

The auditors examined 15 case files, five of which were cases suggested by the DSA. The balance was selected by the auditors to provide a spread over time and involving both clergy and lay people.

The confidential detailed audit material is being provided directly to the Deputy Diocesan Secretary. However, the following provides the headlines:

- Overall the cases demonstrate sound safeguarding practice by the DSA, with careful and sensitive negotiation with clergy in the diocese generally and within the Cathedral.
- Senior clergy providing character references to the court, without taking sufficient advice from the DSA.
- Senior clergy not having consistent understanding of the use of risk assessments and agreements with known offenders.
- The casework shows progress over time, with evidence in one case (2010) of delayed referral to social care.
- The DSA was not consistently informed by senior clergy of the arrival within the diocese of known offenders.
- There were examples when senior management wished to themselves handle the matter (in relation to risk assessment activity), either without being aware of the DSA's involvement or the need for such involvement. Whilst this was intended to be helpful, the DSA had to assert herself so as to ensure the communication of a clear, consistent safeguarding message.
- Examples of prompt and appropriate referral to the DSA by clergy.
- One case regarding a vulnerable adult, which would have warranted referral to police, but a referral, was not made. It was acknowledged that this would now be managed differently, but at that point took into account the wishes and feelings of the victim.
- Evidence from cases suggests that issues distinct to the Cathedral present particular safeguarding challenges.

Appendix: Review process

The framework for the audit links to the requirements of the Children Act section 11 / Working Together to Safeguard Children 2015 requirements as they apply to faith organisations and the House of Bishops' safeguarding policies. The National Safeguarding Office specified the national expectations, so that the auditors could evaluate the progress the diocese was making in reaching these standards.

Data collection

The audit involved both an examination of records as well as conversations with individuals and groups.

The audit approach includes seeing five types of cases:

- allegations of abuse against a Church officer
- people in the congregation who are known to potentially pose a risk of abuse
- other scenarios where there may be a risk of abuse e.g. domestic violence, adult safeguarding
- scenarios where a risk of harm has been identified in respect of a child
- complaints about the diocesan response to safeguarding concerns
- the DSA was asked to identify five cases ones that would help develop learning.

The DSA selected five cases of each type and then to ensure impartiality, the auditor then chose eight files from a case list. The latter included a spread of practice across the time period involving both clergy and lay members of the Church. A further two cases were subsequently added.

The people who contributed to the audit via individual face to face, telephone and group conversations were:

- Diocesan Safeguarding Advisor
- Diocesan Administrator
- Chair of DSMG
- Deputy Diocesan Secretary
- Diocesan Secretary
- Chair of Dorset SAB and Bournemouth & Poole SAB
- Archdeacon of Wilts (with lead responsibility for safeguarding)
- Bishop Nicholas (telephone conversation as the Bishop was away during the audit)
- LADO Poole
- Dorset LADO
- Focus Group including a vicar, curate, two church wardens and a parish administrator.

Prior to the audit the DSA provided the following documents for the auditors:

- Diocesan self audit for national church (2014) plus completed S. 11 audit
- Self audit feedback 2014, highlighting any areas of concern.
- Annual data / Safeguarding statistical returns for 2014 (2013 unavailable)
- Diocesan Safeguarding Policy 2014
- Lone Working Policy
- Safeguarding for Spiritual Directors
- Protocol for Immediate Response about Abuse (Past or Present)
- Safeguarding Flowchart (What to do, by whom and when)
- Safeguarding Media Policy
- Framework for Safeguarding and Good Practice
- Diagrams of local governance and structures
- Membership of Safeguarding Panel/group/Board and minutes of the last three meetings
- Authorised Listeners and their job description
- Job description of DSA and Safeguarding Panel Chair
- Information on safeguarding training provided
- Safeguarding Objectives for 2015 (Business Plan)
- Risk Assessment Template
- <http://www.salisbury.anglican.org/resources-library/parishes/safeguarding1>

At the end of the three days, the auditors provided the diocese with headline findings from the audit, broadly similar to the overview section of the report.