Independent Safeguarding Audits of **Church of England Dioceses *and* Cathedrals**

Annual Report 2025

Contents

Foreword

Within this year's report, you will see clear evidence of a positive trajectory in safeguarding improvements across the Church of England. Building on a solid foundation created by engaged leaders and blended diocesan safeguarding teams and supported by a reinforced national team, safeguarding arrangements continue to strengthen.

This report reflects the progress made since 2024, alongside the development and impact of the Church's response to the expectations set out in the CofE National Safeguarding Standards. What I hope comes through in every section is a maturing safeguarding environment: one where clergy leadership is reflective and sufficiently confident to step back from operational decisions, where the appetite to speak truth to power is growing, and where the voices of victims and survivors actively inform next steps.

The 2025 audits identified much good practice. Across most staff and worshipping communities, arrangements have improved and a safeguarding culture is becoming embedded. The words most frequently used to describe these working, volunteering, and worshipping environments were 'respectful', 'welcoming', 'supportive', and 'inclusive'. In several dioceses and cathedrals, safeguarding is increasingly understood as a gospel and theological imperative and a key feature of a healthy church, rather than a mere administrative requirement.

However, challenges remain, and to understate them would be a disservice to those the Church seeks to protect. In the first independent safeguarding report, covering 2024, we noted a failure in some quarters to recognise that the Church of today, whilst still on an improvement journey, is not the Church of yesterday. That evolution remains evident, and the findings within these pages will reinforce confidence in what is working and the tangible difference that strengthened safeguarding arrangements are making. Such progress requires sustained investment and an appetite for change, both of which must be driven by evidence, not by wishful thinking or opinion.

In last year's annual report, we expressed concern that some areas were delaying the adoption of recommendations, choosing instead to wait for the outcome of the Future of Church Safeguarding Report. We warned then that risk does not pause, meaning safeguarding cannot wait. A year later, only the excuse has changed: auditors now hear that some are waiting for the outcome of the Safeguarding Structures Programme. I wonder what we will hear next year, but our core message remains the same: ignoring evidence-based recommendations invites risk. While it makes sense to wait for decisions on wider structural issues beyond parish and diocesan operational delivery, stalling on the reconfiguration of frontline teams makes no sense. Furthermore, the audit identified no evidence that would justify delaying operationally independent Directors of Safeguarding covering dioceses and cathedrals.

Crucially, the primary inhibitors of progress do not stem from senior clergy, most of whom demonstrate a genuine desire for change. Instead, they are structural and, in certain cases, institutional. They arise from a small group of influential senior officers at the diocesan level and certain individuals within the national Church. This resistance manifests in unhelpful and frustrating ways, such as a readiness to hide behind exceptionalism, canon law, tradition, and procedural defensiveness. It is evident in the pushback against recommendations designed to secure the operational independence of safeguarding (including the Director of Safeguarding role), in challenges to the scope of the audits, and in unresolved conflicts of interest, specifically, where those advising the Church as an institution are simultaneously expected to provide 'safeguarding-first' advice. Though those responsible are few in number, their impact is disproportionately significant, and this must be addressed.

That said, none of this diminishes our confidence in the overall direction of travel. The inhibitors described in this report are real but not insurmountable; they are far outweighed by the commitment, professionalism, and candour we encountered across every audited body. Under the new Archbishop of Canterbury, the Church of England has the potential, capacity, and resolve to deliver the change needed to restore and sustain confidence in its safeguarding arrangements.

Provided the momentum evidenced in this report is maintained and resistance is met with the robust challenge it requires, there is every reason to believe the Church will continue to become a safer, more open, and more trusted environment for all who worship, work, and volunteer within it.

Jim Gamble QPM
Lead Auditor
INEQE Safeguarding Group

Introduction

This annual report provides an overview of the themes and good practice evidenced during the 2025 independent safeguarding audit programme. It also includes recommendations for improvement that have been designed to support and accelerate positive change. Whilst these are primarily focused on local safeguarding arrangements, some recommendations require a national response. Unless explicitly stated otherwise, these should be understood as applying to the National Safeguarding Team (NST), which serves as the central safeguarding function for the Church of England (CofE).

The Audit team strongly encourages everyone who volunteers, works, engages or worships across the Church of England to read and consider the findings and expectations set out in this document. In particular, anyone involved in safeguarding within a diocese, cathedral, Diocesan Board of Finance (DBF), or Chapter should review the themes, challenges, and good practice highlighted here. Crucially, you do not need to wait to be audited to strengthen your governance framework and safeguarding arrangements. The Audit urges you to reflect on these findings and apply any recommendations relevant to your specific circumstances.

About the Independent Safeguarding Audits

The independent safeguarding audit programme was commissioned by the Archbishops' Council and is overseen by the NST. Led by the INEQE Safeguarding Group and working to a consistent framework, the audits test the sufficiency of safeguarding arrangements within DBFs and cathedrals and are aligned to the CofE's National Safeguarding Standards.

Scope of the Audit

In 2025, ten audits were conducted across a selection of DBFs and cathedrals, each presenting unique histories, contexts, and challenges. The participating DBFs comprised Carlisle, Blackburn, York, Bath and Wells, Durham, Portsmouth, Peterborough, London, St Edmundsbury and Ipswich, and Chester. The respective cathedrals included Carlisle, Blackburn, and Wells; York Minster; and the cathedrals of Durham, Portsmouth, Peterborough, St Paul's, St Edmundsbury, and Chester. In addition, a further audit was conducted of the NST.

These audits involved a thorough review of documentation and survey responses, interviews with key personnel, and engagement with victims and survivors.

Total activity across all the audits involved:

10,348

The combined overall total of contributors across Year 2 of the Audit Programme.

Over 5,000 documents were collated and analysed prior to the Audit's fieldwork.

9,153 anonymous survey responses were received, gathering input from key communities connected to the CofE. These were victims and survivors, children and young people as well as those worshipping or working within DBFs, the cathedrals, parishes and nationally.

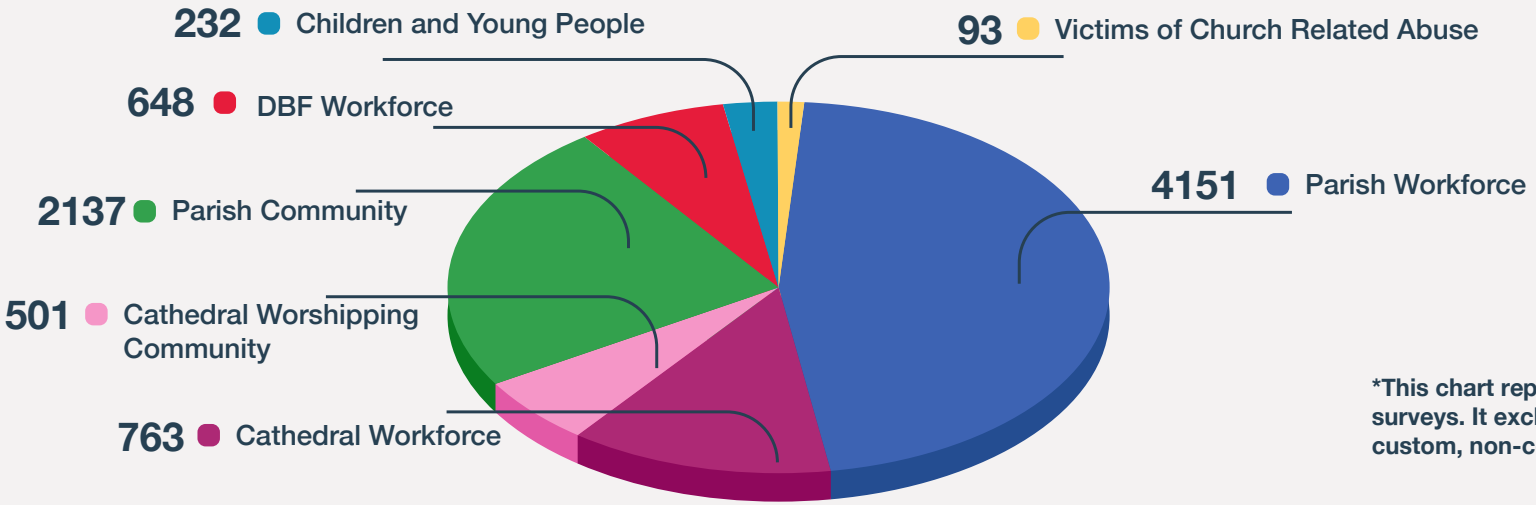
A confidential contact form being made available via a dedicated webpage received a total of **95 contacts**.

Over 500 separate engagement sessions and speaking with **over 1,100 individuals.**

68 focus groups were held.

A range of semi-structured discussions were held with Church officers (staff and volunteers), external partners, victims, survivors and other stakeholders.

Total Audit Survey Responses for Dioceses and Cathedrals in 2025



***This chart represents total figures from diocesan and cathedral surveys. It excludes NST stakeholder surveys as these used a custom, non-comparable methodology**

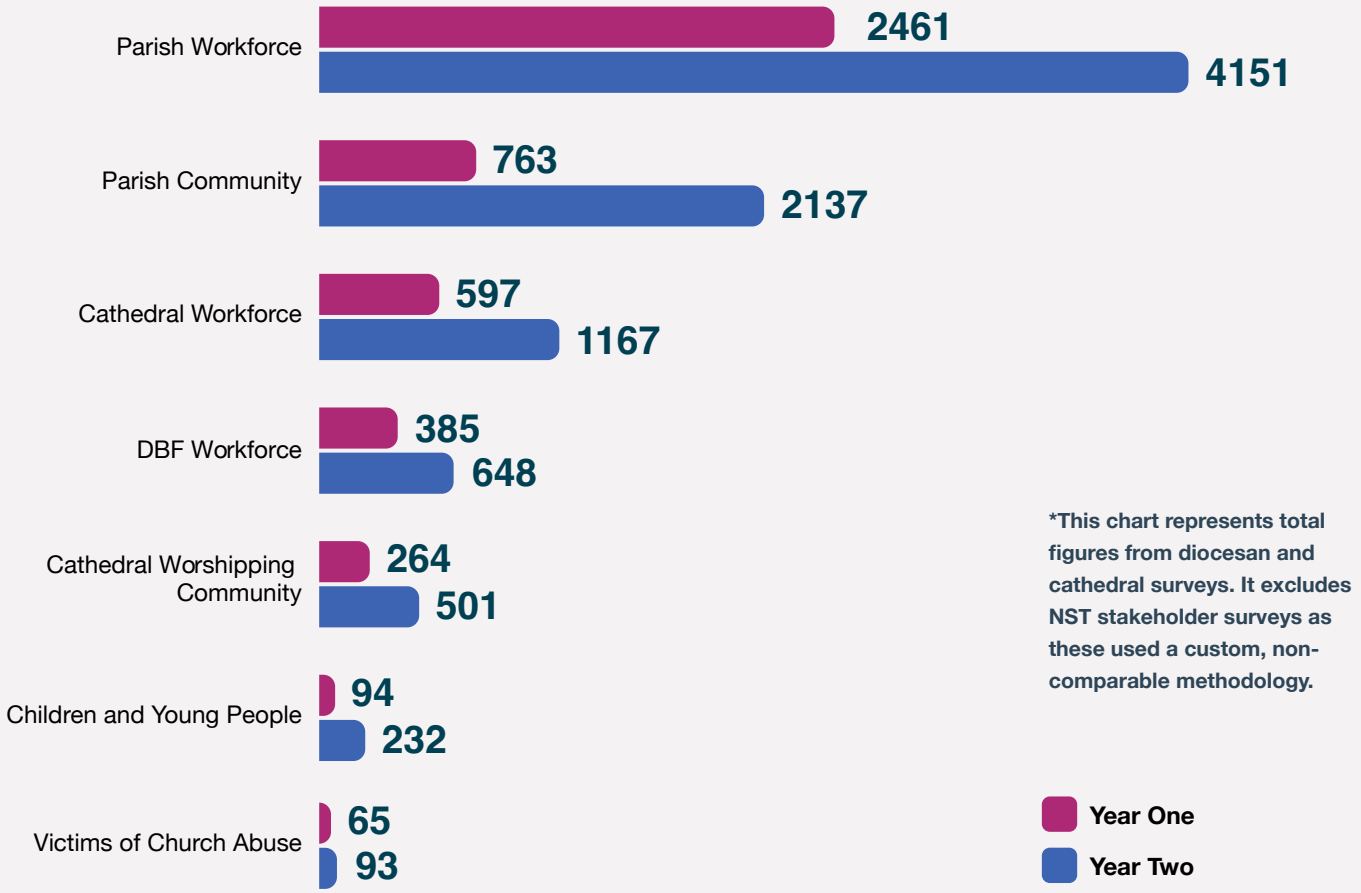
Targeted analysis of diocesan and cathedral surveys revealed significant growth from Year 1 to Year 2, reflecting the success of broad awareness raising strategies. The Parish Community saw the sharpest percentage rise at 180% (+1,374), followed by Children and Young People at 147% (+138). While the Parish Workforce recorded a lower percentage growth of 69%, it contributed the largest volume of new data with a numerical increase of 1,690 responses.

Feedback from victims and survivors was gathered through surveys, confidential contact forms, written correspondence, and discussions. The second year of data collection shows a rise in overall engagement and survey returns compared to Year 1. Specifically, engagement with victims and survivors grew by 38%, while responses to the audit surveys increased by 43%.

Beyond the diocesan audits, an audit of the NST captured the perspectives of 48 victims and survivors through three bespoke surveys focusing on the Interim Support Scheme, Casework Team Experience, and Participation and Volunteering.

This upward trend across all categories is highly encouraging, as it ensures audit findings are informed by a broad and representative range of voices.

Growth in Survey Responses
(Year One Vs. Year Two)



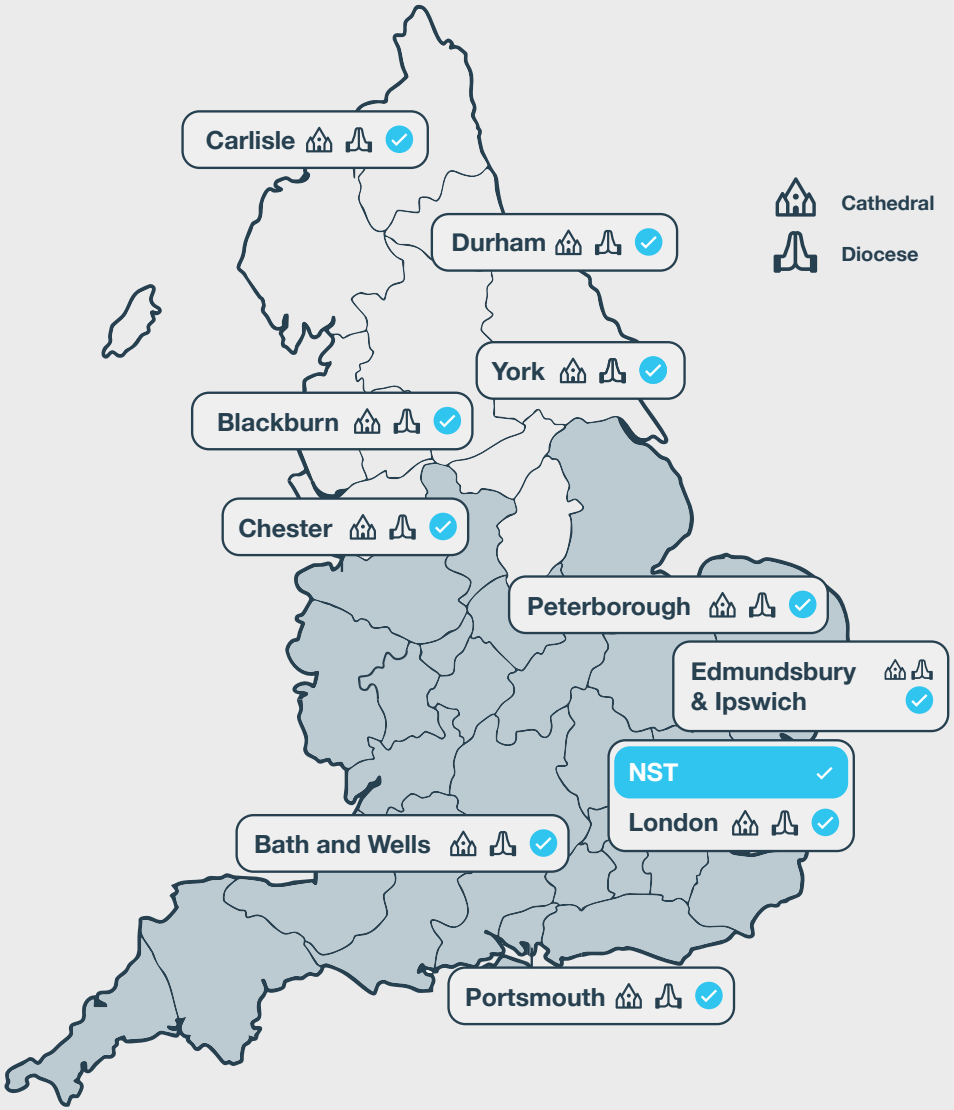
*This chart represents total figures from diocesan and cathedral surveys. It excludes NST stakeholder surveys as these used a custom, non-comparable methodology.

Context

The diocesan areas involved in this second year of auditing represent a wide range of socio-economic and geographical contexts. While some regions are affluent, others face significant challenges related to poverty, deprivation, and isolation. This diversity is most starkly illustrated by the Diocese of London, which stands out due to its unprecedented scale. Serving a population of over 4.2 million, the Diocese encompasses a worshipping community of 87,000, the largest in the Church of England. Consequently, its individual Episcopal Areas are as large as, if not larger than, many standalone dioceses.

In contrast, other audited areas manage vast, predominantly rural landscapes where “hidden” deprivation and limited infrastructure, such as unreliable broadband, pose unique operational hurdles. These diverse communities encompass varied cultural backgrounds; London reports that 69% of its population is from UKME/GMH backgrounds, while regions like Durham and Blackburn navigate the complexities of post-industrial regeneration and multicultural urban centres.

The ten iconic cathedrals audited, ranging from the medieval grandeur of York Minster to the highly urbanised naval hub of Portsmouth, serve as vital spiritual hubs and cultural landmarks. They offer daily services, world-class music, and extensive community outreach, often serving as the spiritual focal point of their respective regions. This diversity of context and scale makes it essential that safeguarding arrangements are sensitive to the distinct characteristics of each institution. With an understanding of each location's unique circumstances, appropriate measures can be put in place to better ensure the safety and wellbeing of all who visit, worship, and work within them.



Cumulative Audit Engagements **21,352**
(Years 1–2 with Year 3 Progress-to-Date)

Year One **5,713**

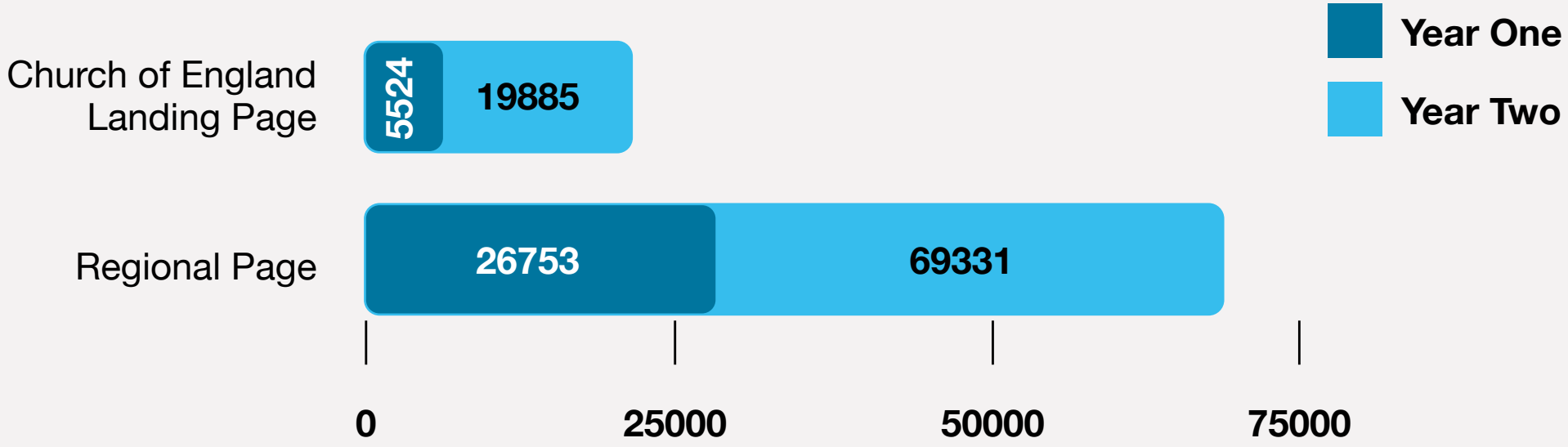
Year Two **10,302**

Year Three **5,337**
(Still in Progress)

Digital Traffic Growth

The Church of England landing page and its associated regional pages on ineqe.com serve as the main hubs for stakeholders, providing streamlined access to essential information, resources, and engagement surveys. Over the past year, these pages have seen a substantial increase in traffic, reflecting a clear growth in stakeholder interaction and overall engagement.

Page Views Year One Vs. Year Two



26,753
Page views on the Regional pages in Year One

69,311
Page views on the Regional pages in Year Two

159% Increase

5,524
Page views on the CoE Landing Pages in Year One

19,855
Page views on the CoE Landing Pages in Year Two

259% Increase

Methodology

360° Safeguarding Audit Tool

The 360° Safeguarding Audit Tool is a series of questions modelled against the CofE's 'National Safeguarding Standards and Quality Assurance' framework. Issued to both DBFs and cathedrals, the tool is used to capture baseline evidence about policies, practice and other information relevant to each audited body.

Online Surveys

A wide range of individual stakeholders from within the DBF, parish and cathedral communities were engaged through online surveys. These were designed as mechanisms through which the audit team could hear about the experiences and views of those involved with the Church. They were both anonymous (the Audit team was not seeking to identify individuals) and confidential (individuals who chose to provide their details were not identified in our report). The Audit Team also engaged with a range of individual stakeholders as part of the NST audit, including the national workforce, local diocesan and cathedral staff and victims and survivors of abuse who had engaged with the NST.

Audit Site Visits

Auditors were on the ground in each diocese area for between three and a half and a maximum of five days. Site visits typically involved the audit team conducting individual discussions, facilitating focus groups and examining written material, in both electronic and hard copy. Agreed schedules for the auditing activity were set on each occasion, with some of this work taking place prior to site visits when appropriate.

Each site visit concluded with a thorough verbal debrief of the audit's initial and emerging findings as they related to the DBF and cathedral being reviewed.

Dedicated Email Inbox and Confidential Contact Form

A dedicated safeguarding email address was set up along with a confidential contact form to enable individuals willing to engage with the audit to share information. The submission of contact forms was monitored by the audit team on a routine basis, with key lines of enquiry being identified and/or follow-up discussions facilitated as necessary.

Presentation of Audit Findings

One audit report was produced per diocese area covering both the DBF and the cathedral. Reports identified good practice, alongside areas that could be strengthened as well as related recommendations.
For a comprehensive explanation of the methodology used, please refer to the Church of England Audit webpage.

For a comprehensive explanation of the methodology used, please refer to the Church of England Audit webpage.

Independent Safeguarding Audit Methodology

www.ineqe.com/churchofengland/audit-methodology/

Progress

Local Audit Progress Themes

Each audit focuses on evaluating the response by DBFs and cathedrals to previous reviews they have undertaken. These included the Social Care Institute for Excellence (SCIE) audits, the Past Cases Review 2 (PCR2) process, Lessons Learned Reviews (LLR) and other formal or informal internal and external reviews.

Year 2 generally saw positive progress in response to previous audits and reviews, with clear evidence of an ongoing appetite to learn and improve. However, one factor that hindered the pace of progress was staff turnover and, in some instances, inadequate handover of action plans and institutional knowledge. Positively, the Audit Team also observed local safeguarding teams taking the initiative to revisit earlier recommendations, checking that actions had been completed and whether further improvements could be made. Where this did occur, this was recognised as good practice.

Similar to themes identified in Year 1, the oversight of progress is typically undertaken through defined safeguarding action plans, with Diocesan Safeguarding Advisory Panels (DSAPs), Chapters and Diocesan Safeguarding Officers (DSOs) responsible for overseeing, scrutinising and driving the delivery of these plans. Whilst many of these plans aim to consolidate all relevant safeguarding recommendations, their structure and implementation can vary. For example, some have dedicated action plans for each audit or review process, others combine all recommendations across a range of audits into one overarching plan and others integrate recommendations into broader diocesan strategies. Others are organised by theme, and more recently some have been aligned with the National Safeguarding Standards.

Reaffirming the recommendation from last year's Independent Safeguarding Audit Annual Report, the Audit Team continues to advocate for a consistent national model for tracking audit and review recommendations. Such a system would establish clear criteria for accepting recommendations, recording required actions and monitoring progress in real time, ensuring more consistent oversight. This standardised approach will support more effective resource allocation and enable the Church to identify patterns and build intelligence across common safeguarding themes.

Recommendation 1: National

A consistent national model for tracking audit and review recommendations should be created. Such a system should establish clear criteria for accepting recommendations, recording required

actions and monitoring progress, ensuring consistent oversight and measurable impact. This approach will enable the Church to identify patterns and build intelligence across common safeguarding themes, supporting more informed decisions and effective resource allocation.

Progress of 2024 Audit Recommendations

In preparation for the Annual Report, the Audit Team requested an update from church bodies audited in Year 1 and received status updates on recommendations and action plans from all audited church bodies. Where barriers to sharing action plans did arise, these did not come from safeguarding personnel or clergy but rather from a small number of Diocesan Secretaries. The following section addresses the 2024 recommendations and the responses received from audited bodies.

At the national level, the NST have not yet published a response to the recommendations put forward in INEQE's first annual report.

Encouragingly, the vast majority of local audit recommendations have been accepted, with clear progress being made to improve local practices. However, minor pockets of resistance persist. This is evidenced by instances where recommendations are only partially accepted or rejected entirely, a pattern consistent with the Audit Team's experience in seeking progress updates. In these cases, a small number of non-safeguarding professionals are making final judgements on the necessity of certain measures. These decisions are often based on personal interpretations of wider business needs rather than specialist safeguarding requirements, particularly those designed to reinforce the authority and operational independence of the professional safeguarding lead. This approach is both unhelpful and unsustainable if the Church is to continue making meaningful progress on its safeguarding improvement journey.

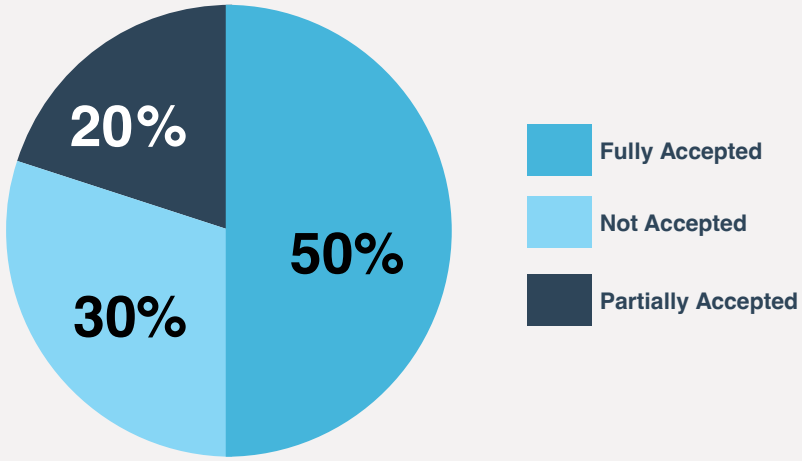
The rationale for rejecting or only partially accepting recommendations generally falls into three categories: the perceived efficiency of existing structures, strategic resource allocation, or proportionality considerations.

1. The creation of a Director of Safeguarding role / Safeguarding Directorate

The proposal to establish a new Director of Safeguarding (DoS) role was met with varying acceptance. 50% of DBFs audited in Year 1 appear to have fully accepted the recommendation, with most now working to embed this new strategic role within their organisational structure. In doing so, they must be true to the recommendation and the identified need. To clarify within the context of Canon Law, this is not merely a rebranding of the existing operational role, nor does it create a post that sits 'above' the Diocesan Safeguarding Officer (DSO) without legal basis. Rather, the preferred model is for the senior strategic DoS to formally incorporate the statutory authority of the DSO. The DoS would then delegate day-to-day operational case management and casework supervision to a Deputy Director or Deputy DSO.

30% did not accept the recommendation and a further 20% only partially accepted it. The rationales behind these decisions include continuing with existing arrangements, the belief that current

Year 1 Audit Report Update: Acceptance Rate of the Director of Safeguarding Role / Safeguarding Directorate Recommendation



leadership structures are sufficiently streamlined, and the view that recent restructuring has already given safeguarding functions a direct reporting line to senior operations management, rendering an additional high-level post redundant. The audit does not agree. Having examined 27 dioceses and cathedrals to date, the overwhelming evidence shows that the current structure positions the operational DSO role, at best, as a middle manager subject to the influence and direction of senior clergy and church officers. Resisting this recommendation is, in the opinion of the audit, symptomatic of a wider misunderstanding about what genuinely independent, strategic safeguarding requires.

2. Establishment / formalisation of dedicated Cathedral Safeguarding Officers / Advisors (CSO/A)

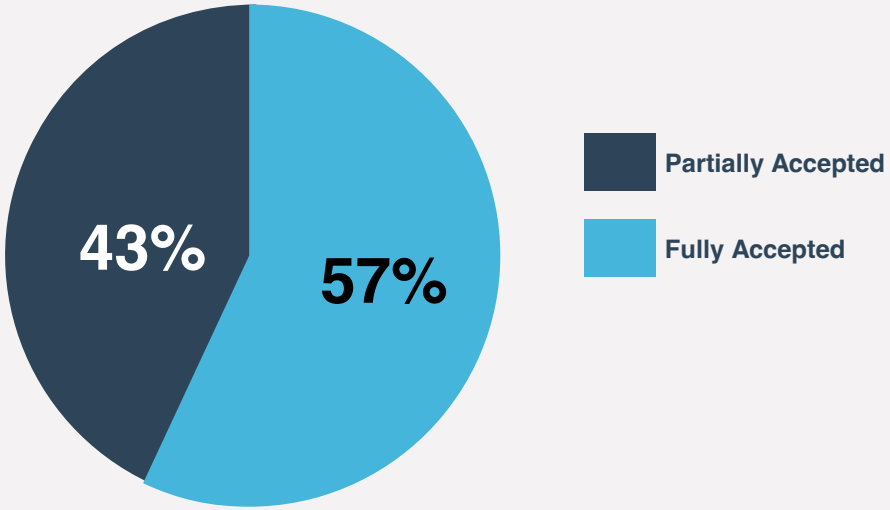
The central theme of the recommendations across the cathedrals is the establishment or formalisation of a dedicated Cathedral Safeguarding Adviser (CSA) or Officer (CSO) role, focused on local safeguarding activity and insight. A key element of this is the intention to integrate this new resource into the Diocesan Safeguarding Team (DST) for professional supervision, consolidated resources, and a uniform approach to policy and practice. Approximately 86% have been “fully accepted”. One cathedral did not accept, choosing instead to continue with its existing arrangement with the DST rather than creating a defined CSA resource. The Audit Team consistently recommends a safeguarding directorate, agnostic of place, a new integrated safeguarding team led by a Director of Safeguarding operating across the entire geography of the diocese, including the Cathedral. This is addressed further in the report.

Progress on the recommendations is ongoing, with approximately 29% marked as ‘complete’ and 57% currently in progress. Actions taken include advertising the new role and employing the CSO directly within the Cathedral while ensuring professional supervision is provided by the Director of Safeguarding/DSO.

3. Development of training on recognition of offender behaviour

Of the church bodies that received a recommendation relating to the development of training on recognising offender behaviours, 57% fully accepted and 43% partially accepted. A small number of DBFs have demonstrated ongoing progress towards this aim. However, most church bodies expressed a commitment to working within the existing national safeguarding training framework rather than

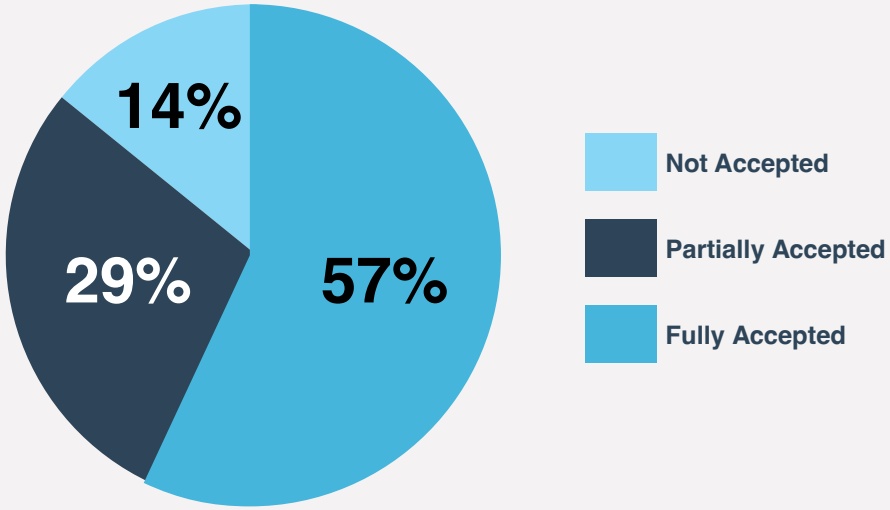
Year 1 Audit Report Update: Acceptance rate of the recommendation to develop training on recognition of offender behaviour



developing independent programmes. Additional factors contributing to partial acceptance included a focus on compliance with currently required training, the efficient allocation of resources, and, in some cases, questions regarding the cost-effectiveness of implementing new theme-specific modules. Some actions were considered partially accepted as implementation was pending further exploration and review with external stakeholders.

The Audit found that some training from credible third-party specialist providers was not fit for purpose, insofar as it was too academic for the intended audience. In the opinion of the Audit, it failed to provide practical insights for creating risk assessments and applying Safety Plans in the context of the CofE across what is a mixed-economy workforce.

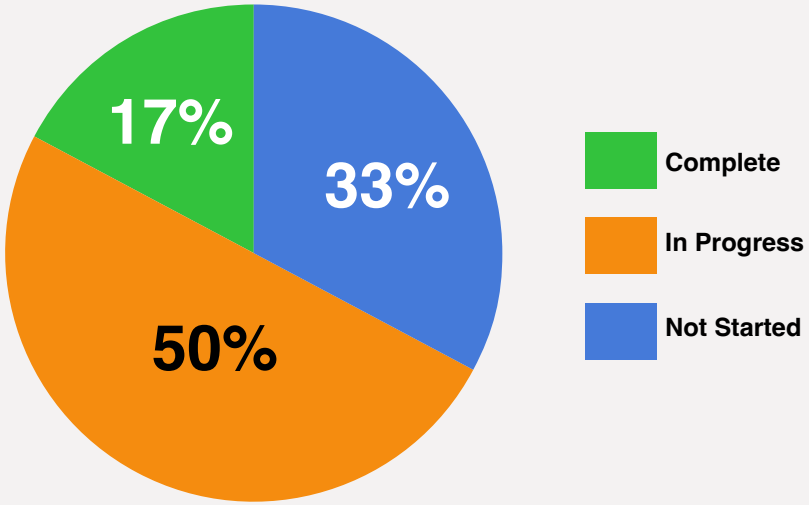
Year 1 Audit Report Update: Acceptance rate of mandatory counselling for DST members recommendation



4. Mandatory Wellbeing Check-ins through counselling for DSTs

This recommendation to mandate counselling for all members of the safeguarding team was made to seven DBFs and was met with varying acceptance. 57% ‘fully accepted’ the recommendation, 29% ‘partially accepted’, and 14% did ‘not accept’. The main rationale for non-acceptance was a collective view that a mandatory approach was disproportionate. Those ‘partially accepting’ did so on the basis that they would offer access to counselling whilst protecting individual autonomy. The issue for many professionals, however, is that when counselling must be requested, uptake is significantly lower. Given the risk of transfer trauma, an expectation that such support will be accessed is a more effective approach. Too often, people in such roles do not seek help until the impact of their work reaches a crisis point; early intervention and proactive engagement are key.

Year 1 Audit Report Update: Progress status update of conducting a training needs analysis.



5. DBF Training Needs Analysis

DBFs have fully accepted the recommendation to undertake a Training Needs Analysis, with many making good progress in establishing or continuing a Training Needs Analysis process. Key actions include routinely seeking feedback from stakeholders via workshops and case review sessions to inform training priorities, revising training strategies, and commissioning specialist training. Some have reported that current practice already aligns with the national safeguarding training framework while allowing for the development of bespoke support and identification of where it may be required.

6. Safety Plan Improvements

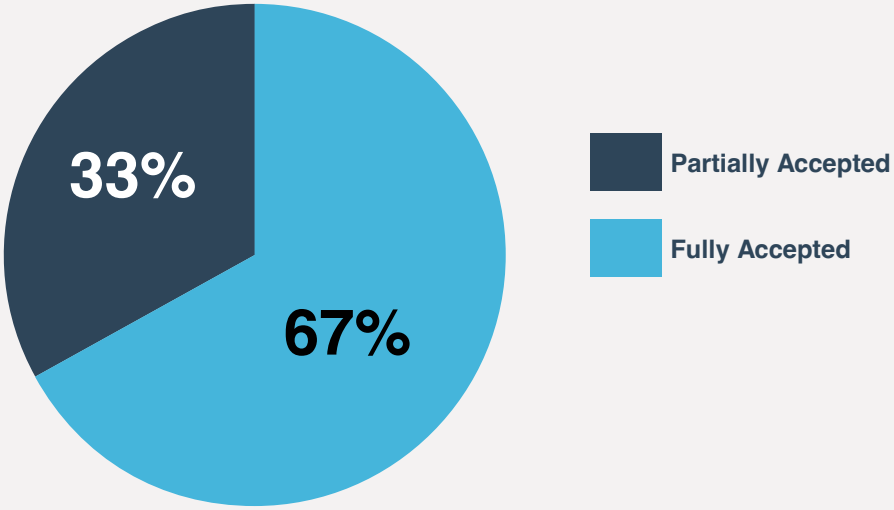
A range of recommendations centre on formalising and improving Risk Assessments and existing Church Safety Plans, focusing on their requirements, content, and review procedures. The core themes addressed include mandatory reporting for potential breaches, established protocols for respondent refusal to sign, and proper sign-off by all relevant parties, including the DSO/A, confirming the respondent's understanding of the plan. Furthermore, the recommendations emphasise the need to include specific clauses covering contact with Church attendees outside the formal setting and attendance at other churches or activities. To enhance accountability, the review process should also be formalised, ensuring reviews are conducted in person and in a formal setting, maintaining consistent policy application, and keeping case management records up to date. Notably, all recommendations made in this regard have been fully accepted. Implementation is well underway, with the overwhelming majority of recommendations complete and a small number in progress.

7. Skills, diversity and inclusion audits of governance meetings

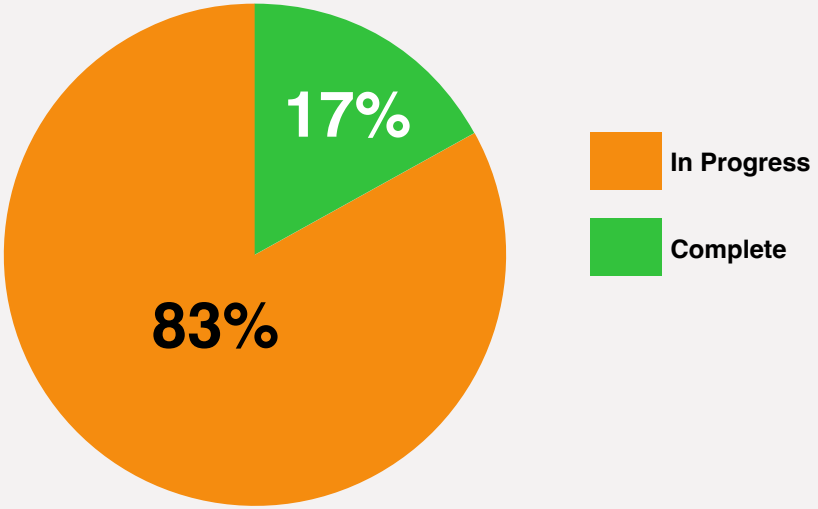
An emerging theme is the necessity of conducting Skills, Inclusion, and Diversity audits within key governance forums. This included meetings such as Bishops' Council, Cathedral Chapter, DSAPs and Cathedral Safeguarding Advisory Groups. The primary objective of these audits is to broaden and strengthen membership, ensuring sufficient safeguarding expertise and greater representation from the wider community or specific marginalised groups.

Of the recommendations concerning skills, inclusion, and diversity audits for governance bodies, 67% were fully accepted and 33% were partially accepted. Of these, 83% are currently in progress, with the remaining 17% marked as complete. Actions underway across governance bodies include carrying out the skills audits, recruiting new members to enhance diversity and expertise, and adopting a thematic approach to safeguarding oversight and reporting. This is a continuing area of focus that is addressed elsewhere in this report.

Year 1 Audit Report Update: Acceptance rate of recommendations around conducting governance meetings, skills, diversity and inclusion audits



Year 1 Audit Report Update: Progress state update of recommendations around conducting governance meetings skills, diversity and inclusion audits

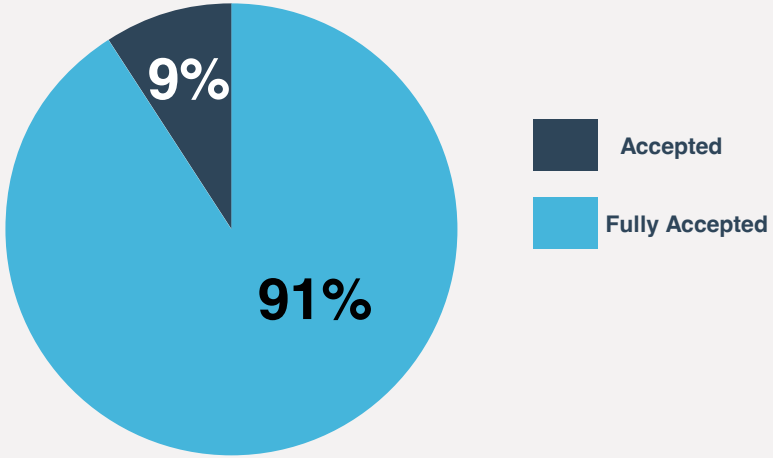


8. Embedding Safeguarding in Safer Recruitment

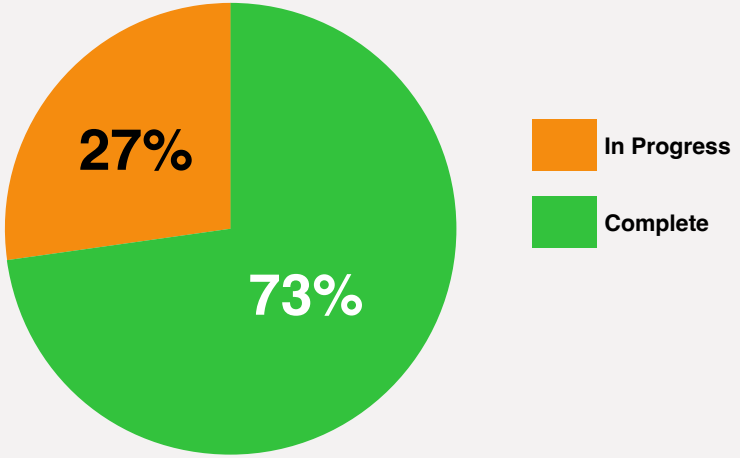
A consistent recommendation across the cathedral audits was for relevant staff to undertake Safer Recruitment training. All cathedrals accepted this recommendation, with most currently working towards implementation.

A range of recommendations across dioceses and cathedrals focused on ensuring a robust commitment to safeguarding is actively embedded in all job advertisements, application forms, and job descriptions. This includes specific requirements, including the need for self-disclosure or confidential declarations where relevant. For the overwhelming majority (91%), this recommendation was fully accepted, with only 9% partially accepting. Further, 73% of church bodies have completed this action, with 27% still working towards implementation. Those who partially accepted stated that integration would be on a case-by-case basis.

Year 1 Audit Report Update: Acceptance rate of recommendations around the inclusion of safeguarding commitment in job in advertisements, application forms and job descriptions



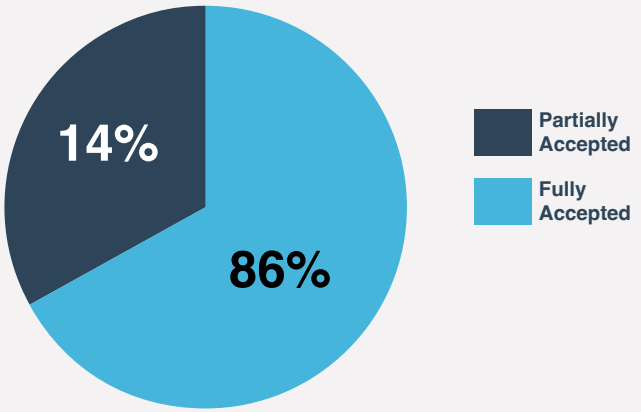
Year 1 Audit Report Update: Progress status rate of recommendations around the inclusion of safeguarding commitment in advertisements, application forms and job descriptions



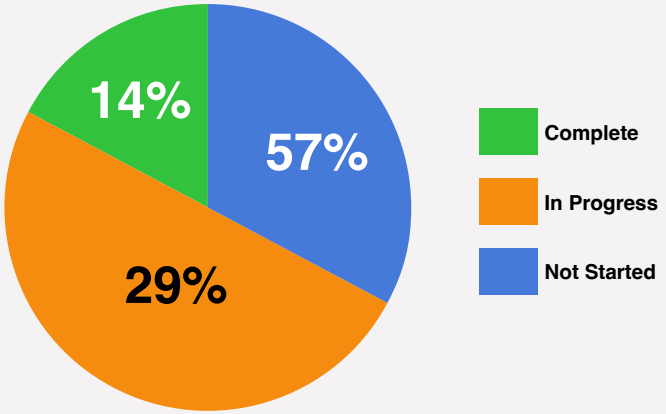
9. Victim and Survivor Engagement

As the audits progressed, a clear emerging theme was the lack of formal structures for outreach with victims and survivors, listening to their experiences and identifying how practice could be improved. 86% of church bodies who received a recommendation of this nature fully accepted and 14% partially accepted. Regarding progress, 57% reported having fully implemented this recommendation, 29% reported this work to be in progress and 14% had not yet commenced this work. Some have reported that further work is needed to formalise these structures, while certain cathedrals are relying on diocesan support in the interim. Conducting this work has faced some barriers, most notably where planned outreach events were unsuccessful due to a lack of participation, necessitating a new approach. This remains an area that requires a more sustained and proactive approach to engagement.

Year 1 Audit Report Update: Acceptance of recommendations around improvements to victim and survivor engagement



Year 1 Audit Report Update: Progress status update of improvements to victim and survivor engagement



10. Chorister Safeguarding

A range of recommendations were made in Year 1 relating to chorister safeguarding arrangements. Chorister safeguarding practice was found to vary across cathedral settings. These recommendations spanned multiple themes, including physical safety and environment, scheduling and wellbeing, and communication and information sharing. A number of recurring themes are highlighted below to illustrate the progress made in each area.

Child-friendly signage and posters in chorister spaces

Overall, the cathedrals reviewed are actively implementing or have completed the recommendations to improve chorister safeguarding signage, primarily by ensuring child-friendly safeguarding posters are clearly displayed in chorister areas such as the Song School and updating them with key staff details. A formal review of signage arrangements has also been initiated. Some actions remain in progress with a focus on introducing new signage that includes photos of key staff and clear reminders of procedures, demonstrating a shared commitment to improving child-friendly communication.

Recording and sharing of low-level concerns

Year 1 identified that many music departments within cathedrals had well-established low-level concerns logs. That said, this practice was inconsistent across cathedrals and as such recommendations were made to improve consistency of practice. Acceptance of such recommendations is generally positive. Some concerns were raised about sharing information with associated schools, particularly regarding the frequency of sharing and data privacy restrictions.

Scheduling and wellbeing

Recommendations for chorister wellbeing across cathedrals have been fully accepted and completed. These actions include implementing a formal, scheduled routine of voice specialist visits for choristers; mitigating heat-related issues by installing a thermometer and adjusting the thermostat; and coordinating with schools to protect choristers' free time and rest periods from encroachment by school catch-up obligations. This is a meaningful and welcome step forward for chorister wellbeing.

11. Cathedral CCTV Coverage

The six recommendations relating to CCTV across cathedrals have all been fully accepted, though progress towards implementation is varied, with two completed, three in progress, and one yet to be actioned. The completed actions comprise amending a CCTV policy to explicitly reference the safeguarding of children, young people and vulnerable adults/adults at risk, and installing CCTV in an organ loft. Those still in progress include expanding CCTV coverage to additional areas such as office spaces, entrance gates and choristers' practice rooms; completing the installation of CCTV in secluded areas with GDPR-compliant retention and signage; and exploring the installation of CCTV within a song school. The outstanding recommendation, on which no action has yet been taken, concerns establishing a clear CCTV policy setting out the scope of coverage, monitoring arrangements, access protocols, retention practices and warning signage.

Conclusion

Across the ten recommendation areas reviewed in this section, the overall picture of acceptance is strongly positive. The large majority of church bodies have fully or partially accepted the recommendations arising from their Year 1 audits, with active progress on implementation across all areas. Several recommendation areas, including Safety Plan improvements, Training Needs Analysis, and Safer Recruitment, achieved full acceptance, with implementation either complete or well advanced. Chorister wellbeing recommendations have been fully accepted and completed across all audited cathedrals.

Where partial acceptance or non-acceptance has occurred, this has most commonly centred on two areas: the establishment of a dedicated Director of Safeguarding role, where 30% of DBFs did not accept the recommendation; and the mandate for wellbeing counselling for safeguarding team members, where 14% did not accept. In both cases, the rationales offered, relating to the perceived adequacy of existing structures, resource allocation, and proportionality, are not accepted by the Audit Team, which considers them symptomatic of a wider misunderstanding about what genuinely independent operational safeguarding requires.

Implementation progress across all areas is encouraging. However, the overall picture is one of work in progress rather than completion: across most recommendation areas, the majority of actions remain underway rather than marked as complete. This reinforces the importance of continued scrutiny and oversight to ensure that acceptance translates into meaningful, sustained change.

To maintain this momentum, institutional focus should remain on strengthening handover protocols and preserving institutional knowledge. Crucially, any resistance to independent safeguarding recommendations should be met with robust challenge, ensuring that the protection of individuals remains the primary motivation behind all decisions. By prioritising safeguarding over financial or administrative considerations, church bodies can demonstrate an uncompromising commitment to an institutional culture of safeguarding.

Recommendation 2: National

The Audit Team should be commissioned to carry out targeted dip-sampling of reported actions across all recommendation areas, to assess whether the actions taken appropriately and fully address the recommendations made. This dip-sampling should be proportionate and risk-based, with particular focus on areas where recommendations have been only partially accepted or where implementation is self-reported as complete. Such independent verification would provide meaningful assurance that the Church is translating its stated commitment to safeguarding into genuine and effective practice. The outcome from these dip sampling evaluations would be published in future Annual Reports.

Culture, Leadership & Capacity

Introduction

This section of the Annual Report presents the consolidated findings on culture, leadership and capacity, the three domains that most directly determine whether safeguarding within the CofE is genuinely embedded or merely administered.

Safeguarding is increasingly lived rather than merely administered, driven by visible, accountable leadership, but these real gains are recent and still fragile. Confidence is uneven across the CofE. Workforces report consistently high levels of assurance, while worshipping communities, in particular occasional cathedral worshippers, are less certain, and local progress remains vulnerable to the effects of national events and non-recent cases. Most urgently, ambition consistently outruns capacity. The will and the leadership are present across the majority of audited bodies, but under-resourced and sometimes isolated safeguarding teams cannot sustain the standard of practice required of them. The establishment of a Safeguarding Directorate model, supported by investment in team capacity, is the central structural recommendation of these audits.

Across the audited bodies in 2025 the direction of travel is positive and consistent. Safeguarding is increasingly described as ‘everyone’s business’ and is moving from a procedural, compliance-driven activity towards a lived culture that many now regard as genuinely embedded. Workforces and worshipping communities most often describe their environments as ‘welcoming’, ‘supportive’, ‘respectful’ and ‘inclusive’, and the overwhelming majority report feeling safe and knowing how to raise a concern without fear of reprisal.

Three recurring tensions qualify this picture and run through the sections that follow: a confidence gap between workforces, where assurance is generally high, and worshipping communities, where it is consistently lower; a transparency gap between the fast and well-regarded initial response to concerns and the slower outcomes once a case is formally progressed; and a structural gap between the growing strategic importance of safeguarding and its under-resourced, sometimes isolated, operational base.

Culture

A majority of workforces and worshipping communities report that safeguarding arrangements have improved and that a safeguarding culture is now becoming embedded. The qualitative picture is strongly positive, with the most frequent descriptors being ‘respectful’, ‘welcoming’, ‘supportive’ and ‘inclusive’. In several dioceses and cathedrals there is an explicit shift in understanding: safeguarding is framed as a gospel and theological imperative and a feature of ‘healthy churches’, rather than an administrative requirement.

Confidence to raise concerns without fear of reprisal is a growing strength, particularly within workforces and, in many places, overwhelmingly so within parish worshipping communities. This sense of being able to ‘speak truth to power’ is closely linked to relational, approachable leadership and is one of the clearest signs of a maturing culture.

Alongside the positive trajectory, the audits identified several consistent caveats. Awareness of safeguarding arrangements and confidence in reporting concerns were often higher among staff and volunteers than among worshippers. This gap is most pronounced in cathedrals, a theme explored in detail below.

Several dioceses note the risk of a widening gap between the diocesan centre and the parishes, with Audit engagement and survey participation lower in the wider community than among staff, pointing to the need for stronger communication and outreach.

A small but consistent minority describe what they perceive as negative traits (‘cliquey’, ‘defensive’, ‘demanding’, ‘stressful’ and, in one DBF, ‘outdated’) and a perception in places that safeguarding can still feel procedural rather than lived.

Where leaders are seen to listen to concerns and opinions, culture is stronger; where they are not, confidence erodes. Tone from the most senior leaders materially shapes the lived experience of safeguarding.

Local progress is consistently described as vulnerable to national events and historical cases. High-profile failings, the handling of major investigations, and prominent reviews have diminished confidence, creating a 'national and local disconnect' where strong local practice is sometimes overshadowed by external controversies. This impact is felt acutely within dioceses and cathedrals navigating internal tensions and specific non-recent allegations. Nevertheless, sustaining local trust depends on addressing these wider issues transparently.

Cathedral cultures are more mixed. Many are positive and improving, with deans actively dismantling 'clerical exceptionalism', addressing the 'deference gap' (the tendency for senior clergy to receive uncritical deference) and welcoming challenge. Others are working through significant legacy issues, internal conflict and the after-effects of specific cases; in the most serious instance the audit judged arrangements "inadequate and requiring immediate action".

A recurring cathedral theme is the gap between a confident workforce and a less assured worshipping community, and the need to make the safeguarding lead more visible and decision-making more transparent.

Cutting across all of the above, the audit highlights a persistent institutional challenge: the tendency to define culture strictly within the formal boundaries of parishes, DBFs, and cathedrals, occasionally failing to realise its impact on wider communities and individuals who frequently feel unseen, unheard, or unvalued.

As the audit engaged with broader issues of inclusion and diversity, it occasionally encountered pushback from audited bodies, questioning whether such themes were genuinely matters of culture, or merely related to conduct, HR, or other operational factors. This resistance reveals a fundamental misunderstanding: a safeguarding culture cannot be mature if it excludes those it is meant to protect, a dynamic explored further under 'Critical Inhibitors' later in the report.

Leadership

The strongest and most consistent leadership finding is that bishops and deans unambiguously accept their ultimate accountability for safeguarding.

In a growing number of cases, leaders evidence a ‘safeguarding first’ philosophy, making difficult, authoritative decisions that put conduct linked to safeguarding before reputation or relationships, and reflecting honestly on their own practice. Good practice is consistently seen in areas where the diocesan bishop retains accountability and where day-to-day operational casework is directed and led by the Diocesan Safeguarding Team (DST), without the influence or direction of clergy or church officers.

Moving forward, however, the CofE must demonstrate that it can differentiate between accountability at a governance level and absolute operational independence. While much of the CofE has accepted the principle of operational independence when applied to individual casework, the Audit notes significantly less acceptance of this principle when applied to structure, funding, and broad influence.

Although the audit frequently hears claims of a clear separation of powers and respect for safeguarding professionals’ authority and expertise, this is not always the reality at either a national or diocesan level. While Diocesan Safeguarding Officers (DSOs) are granted autonomy over routine casework, they are often denied the same independence regarding strategic leadership. Furthermore, when challenging situations arise, a DSO’s ability to act independently can be seriously inhibited. Ultimately, the audit has found this to be a recurring theme, one that indicates that some within the CofE still struggle to fully relinquish operational control.

This approach stretches beyond the dioceses, for example, the Audit has seen evidence that the National Director of Safeguarding is neither acknowledged nor is their expert direction always sought or accepted by the national leadership, including the Archbishops’ Council. This position is replicated in many dioceses, where there is notional independence, but the influence of church officers and senior clergy remains problematic.

A specific and recurring source of this ambiguity is the title ‘Lead Safeguarding Bishop.’ Whilst this role serves a genuine and valuable function, providing episcopal support, advocacy, and pastoral engagement with safeguarding, the title implies a seniority

and authority over safeguarding that should properly reside with the National Director. In a number of instances, the Audit has encountered the Lead Safeguarding Bishop being positioned as the primary professional safeguarding voice. This is a structural and naming problem, not a reflection on any individual in post.

Recommendation 3: National

The role currently titled 'Lead Safeguarding Bishop' should be retitled 'Bishop's Lead Advocate for Safeguarding.' This change must be accompanied by a revised role description making explicit that the Bishop's function is to provide episcopal support, advocacy, and pastoral leadership for safeguarding and that the National Director of Safeguarding holds the highest professional safeguarding authority within the CofE. These are distinct and complementary roles, and the distinction must be unambiguous.

If the CofE is to avoid the imposition of a potentially detached safeguarding body, it must face up to and support the further recommendations and reconfigured structures that ensure unequivocal operational independence. These issues are addressed further in Capacity, Progress, and Inhibitors.

Archdeacons

Although it is best practice to separate clergy from operational safeguarding, Archdeacons provide a crucial bridge in this work. They are pivotal to local safeguarding through formal and informal visits, oversight of the Parish Dashboard, clergy development conversations, and their participation in, or chairing of, Safeguarding Case Management Groups (SCMGs). While their strengths are highly relational, audits repeatedly recommend a more structured framework for the role. Across dioceses, there is a strikingly consistent set of recommended requirements: quarterly meetings with the DSO; standardised pre-visit briefings and post-visit debriefs; a designated lead safeguarding archdeacon (rotating or tenured); specific training for SCMG chairs; and formal conflict-of-interest checks for those leading these groups. Furthermore, audit findings present persuasive evidence that workload pressure remains a significant constraint for those undertaking these critical duties.

Recommendation 4: Local

Each diocese should formalise the archdeacon's safeguarding function through a structured framework, comprising: quarterly meetings between each archdeacon and the DSO; standardised pre-visit briefing and post-visit debrief templates; designation of a Lead Safeguarding Archdeacon (rotating or tenured); targeted training for archdeacons chairing SCMGs; and formal conflict-of-interest checks for those in SCMG leadership roles. Dioceses should review archdeacon workload to ensure adequate capacity for these safeguarding responsibilities.

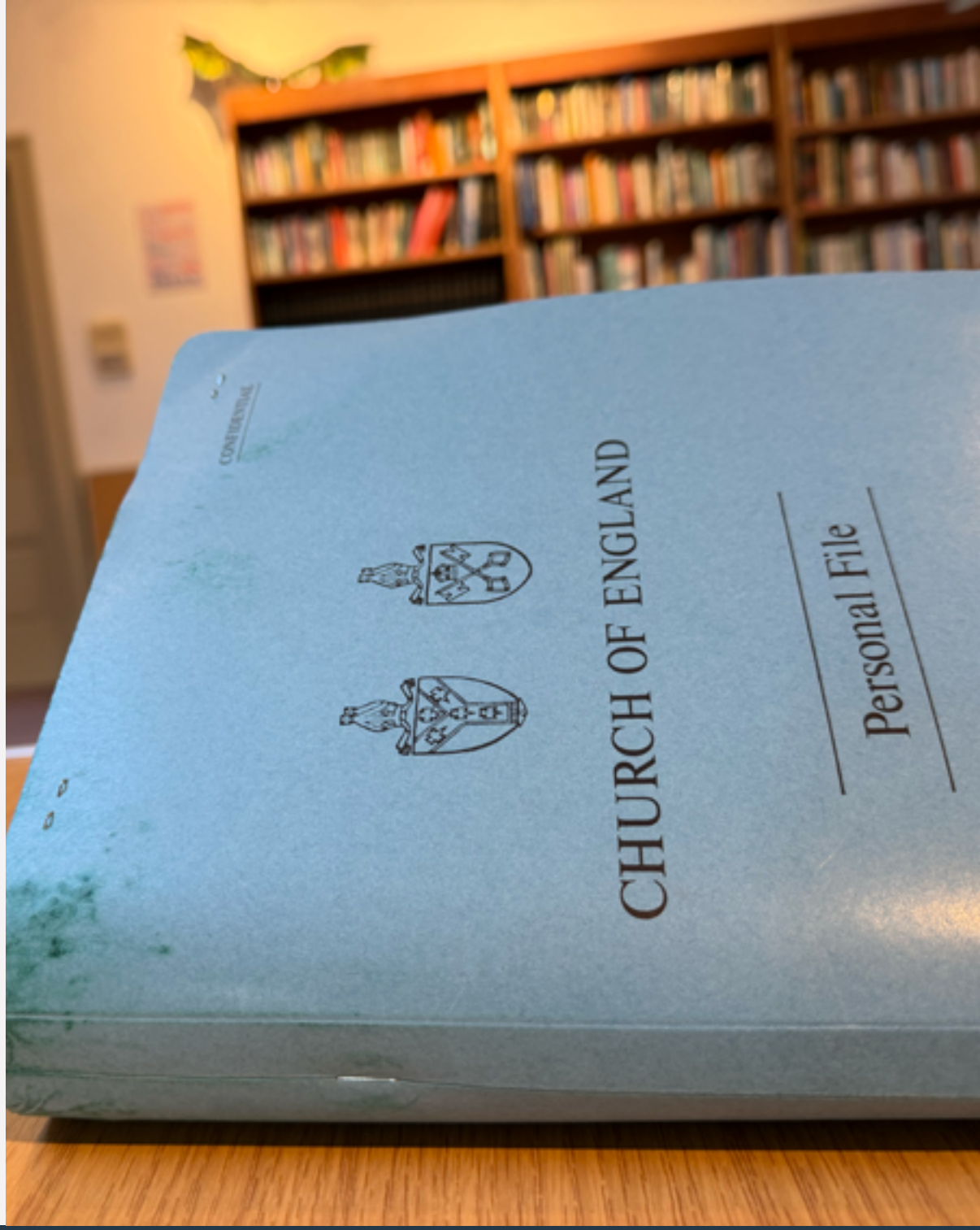
Ministerial Development Reviews and Clergy (Blue) Files

Ministerial Development Reviews (MDRs) are valued, but they are often perceived as performance reviews rather than developmental tools, and their link to safeguarding remains unclear. A consistent recommendation is to embed a structured safeguarding section, broaden review panels, and offer both internal and external training opportunities.

Recommendation 5: Local

Each diocese should revise its MDR process to include a mandatory structured safeguarding section in which ministers reflect on their safeguarding experience, their future role aspirations and the skills they need to develop. Review panels should be broadened to include safeguarding expertise. Bishops and cathedral deans should ensure MDRs function as genuine developmental tools rather than performance assessments, with both internal and external training pathways identified for each reviewee.

In practical terms, this involves clergy reflecting on their past safeguarding experience and how they apply it in their current role. It also requires establishing the roles they seek to fulfil in the future and facilitating access to environments that build relevant safeguarding skills.



For example, if a vicar in a rural church with an elderly congregation wishes to move to a more urban area to focus on youth engagement, the DSAP Chair or DSO could arrange short visits to appropriate youth justice schemes and/or to LA partners with strong youth representation within their safeguarding framework.

Clergy Files colloquially known as ‘Blue Files’, are generally well administered. Good practice is evident in content curation and the flagging of safeguarding concerns, alongside recent improvements in logging those who access this sensitive information and their reasons for doing so.

While earlier audits revealed discrepancies between some files and Clergy Current Status Letters (CCSL), there has since been a notable improvement in this area, with evidence of greater professional curiosity and stronger verification processes.

Despite this progress, recurring gaps remain. These include a lack of fireproof storage, the absence of formal DSO reviews upon receipt and prior to dissemination, inconsistent access logs and content sheets, and insufficient follow-up on delayed incoming files.

Recommendation 6: Local

Each diocese should address identified recurring gaps in Clergy File management by: installing fireproof storage for all Clergy Files; establishing a formal DSO review of files upon receipt and prior to dissemination; standardising access logs and content sheets across the diocese; and implementing a systematic process for following up on delayed incoming files.

Governance

Governance structures in most audited areas now broadly meet Church of England and Charity Commission expectations, with safeguarding increasingly serving as a standing agenda item. However, the consistent challenge remains the quality of scrutiny. Oversight tends to be observational, focused on receiving briefings, rather than actively testing practice, demanding data-driven assurance, and evidencing challenge. Audits repeatedly call for a shift from passive observation to active scrutiny. This shift must be supported by skills, inclusion, and diversity audits of governance bodies; a named lead trustee for safeguarding; comprehensive trustee induction and refresher training; and the integration of safeguarding into risk registers.

A closely related, near-universal issue is the positioning of the DSO within senior leadership. Safeguarding professionals are frequently excluded from formal membership of senior leadership teams, attending only by invitation. Furthermore, they are often line-managed by church officers who hold critical influence but lack safeguarding expertise.

Audits recommend that a dedicated safeguarding professional be present at all senior leadership and governance meetings. This ensures that safeguarding implications, whether relating to strategy, housing, growth, recruitment, or partnerships, are proactively identified, as these are often not immediately apparent to non-specialists.

Until a Director of Safeguarding (incorporating the authority of the DSO) is appointed, DSOs/DSAs must fulfil this role to challenge and inform decisions. While this may stretch their bandwidth, a significant strategic gap will persist until formal senior representation is established.

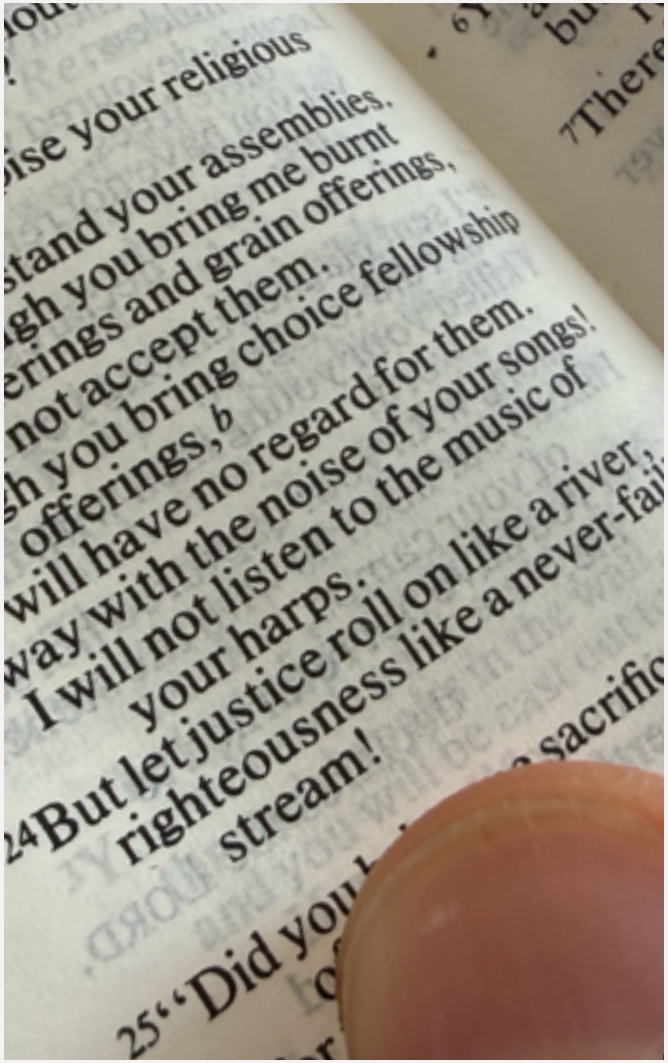
Recommendation 7: Local

Each diocese must ensure that the DSO (or, where established, the Director of Safeguarding) holds formal, standing membership of the senior leadership team, attending as of right rather than by invitation. Because the Director of Safeguarding role is inherently strategic and requires the legal authority to make independent decisions, they must be empowered to direct safeguarding action without operational interference. To protect this independence, the Director should not be directable by non-safeguarding senior church officers. Instead, the role should ideally report directly to the governing bodies (such as the DBF and Chapter), holding an equivalent structural position to the Diocesan Secretary. This structural change is essential to ensure that safeguarding implications are proactively identified across all strategic and operational decisions, while preserving the uncompromised legal authority required for effective safeguarding.

These concerns extend to the national level. The National Safeguarding Steering Group (NSSG) is currently chaired by the Lead Safeguarding Bishop. Whilst this arrangement reflects a longstanding convention, it embeds the same structural tension identified at diocesan level: an ecclesiastical officer holding governance authority over a body whose operational effectiveness depends on independence from that very hierarchy. The Audit's concern is not with the individual currently in post but with the structural design.

Recommendation 8: National

The NSSG should be reformed. The Lead Safeguarding Bishop should be replaced as chair by an independent professional with senior statutory safeguarding credentials, appointed through an open and transparent process. The Bishop's Lead Advocate for Safeguarding (as retitled in the Leadership section above) should sit as a member of the NSSG, contributing episcopal perspective without holding governance authority over it. The reformed NSSG should formally recognise the National Director of Safeguarding as the highest professional safeguarding authority within the CofE, with that recognition reflected in the NSSG's terms of reference and decision-making protocols.



Trustee Accountability

This lack of executive-level representation often mirrors deficits at the highest level of governance. Findings from audits conducted in 2025 indicated that effective oversight was not universally in place. For example, one DBF audit report noted:

"This environment has created a risk where accountability for safeguarding may be compromised, as safeguarding was not a consistent focus of the DBF or other governance meetings until very recently."

The report added that the DBF's oversight of operations had not reflected Church of England expectations or external Charity Commission requirements. These findings are reinforced across the wider CofE by official warnings issued by the regulator in January 2026 to two Diocesan Boards of Finance over failures to handle safeguarding allegations in line with trustee duties.

The Charity Commission's regulatory intent is explicit: it has assessed the Church's current safeguarding definitions as insufficiently robust and, while acknowledging positive steps, has identified an evidenced need for governance reform. The Trustees of the [Diocesan Board of Finance / Cathedral Chapter] operate at the intersection of ecclesiastical governance (Canon Law) and statutory regulation (Charity Law). Their fiduciary duties under the Charities Act 2011, the exercise of independent judgment, financial prudence, safeguarding and risk management, hold strict legal primacy. The charity exists to advance the spiritual mission of the Church; however, where Canon Law, internal ecclesiastical directives or expectations of canonical obedience conflict with the Charity Commission's expectations, the regulator has primacy. Trustees must act decisively in their capacity as statutory trustees to protect the assets, integrity and beneficiaries of the charity.

Successive audits have sought to remove clergy from operational safeguarding

oversight, recommending, for example, that Deans or other senior clergy do not chair Cathedral Safeguarding Management Groups (SMGs). This aligns with wider concerns about the concentration of power among faith leaders. The Audit has seen and heard evidence of how a structural conflict of interest can arise when governance authority and spiritual influence are held by the same individuals.

Clerical deference amplifies this structural risk: where lay staff and middle management defer to senior clergy rather than exercising independent challenge, safeguarding accountability is weakened at every level.

There are concerns about bishops and other senior clergy chairing trustee bodies, whether the DBF or Chapter. Good practice would dictate that the DBF should be chaired by an independent lay person rather than the Diocesan Bishop. The value of a suitably qualified independent lay chair should not be understated. Such individuals frequently bring senior statutory safeguarding experience from outside the Church, from policing, social care, health or the wider charitable sector, and with it an external benchmark against which practice can be tested. Crucially, an independent chair helps ensure that deference, intended or otherwise, does not influence decision-making or blunt scrutiny. Independent chairing of accountability bodies is established good practice in other fields, including health, policing oversight and sports governance.

The Chapter, whilst operating within the constraints of the Cathedral Measure, should reinforce the role of the Senior Non-Executive Member (SNEM) to minimise the structural conflict of interest inherent in the Dean chairing their own accountability body.

After reflection on the current varied approaches across the CofE, the Audit has come to the view that the Bishops' Councils and DBFs should maintain clearly distinct roles; dioceses should therefore formally separate their spiritual councils from their financial and charitable trustee functions.

This structural separation is a necessary condition of compliant governance, but it is only fully effective when matched by independent chairing: a DBF that remains chaired by the Diocesan Bishop cannot credibly demonstrate the separation of spiritual and trustee functions it is designed to achieve. Distinct roles and a suitably qualified independent lay chair are therefore mutually reinforcing elements of the same safeguard.

Recommendation 9: Local

Each diocese should formally separate the Bishops' Council from the Diocesan Board of Finance, establishing clearly distinct memberships, terms of reference, and governance agendas. The DBF, as the principal charitable trustee body, must operate in full accordance with Charity Commission requirements rather than ecclesiastical convention. Where a Bishop currently chairs the DBF, the diocese should transition to chairmanship by a suitably qualified independent lay person. Each cathedral should reinforce the role of the Senior Non-Executive Member (SNEM) of Chapter to minimise the structural conflict

of interest where a Dean chairs their own accountability body.

Safeguarding oversight at the trustee level must shift from merely receiving reassuring updates to strategically focused, professionally curious, and structured dip-sampling. To help mitigate the risk of clerical deference, an independent lay trustee with a specific safeguarding brief would significantly strengthen governance. Operating outside the ecclesiastical hierarchy and with no reliance on church institutions for their livelihood or spiritual standing, this individual should possess the structural freedom to scrutinise senior leadership objectively. Furthermore, candidates with a senior statutory background in areas such as social care, health, education, or probation would bring the expertise required to strengthen governance frameworks.

A designated safeguarding trustee creates an open communication pathway between the DSO/Director of Safeguarding and the board, eliminating structural bottlenecks where non-safeguarding officers act as gatekeepers. This aligns directly with the Charity Commission's lessons highlighted for all charities.

The Commission identified three specific needs:

"The need for safeguarding procedures and processes to be properly understood by all those who may receive reports of allegations, reinforced with regular training and an organisational commitment to continual learning and improvement."

"The need for appropriate reporting mechanisms to appraise the whole trustee body when safeguarding allegations are made (even if some details are kept confidential), to ensure trustees can fulfil their legal duties and assure themselves that the right steps are being taken to manage any safeguarding or other risks."

"The need for particular care and attention by trustees and charity leaders in handling allegations related to individuals in positions of power or influence, including spiritual influence. Trustees should be aware of the risks of individuals abusing positions of trust they hold within a charity, as reflected in the Commission's safeguarding guidance, including by virtue of holding a religious leadership position."

For this framework to succeed, Lay Trustees appointed as Safeguarding Leads require robust induction and training, specifically on serious incident reporting, alongside an organisational culture that actively values scrutiny and challenge.

When regulatory questions arise, particularly concerning serious incident reporting, trustees must prioritise charity law compliance and should seek advice from specialist charity law solicitors before consulting internal ecclesiastical advisers.

The following recommendations set out the changes required to strengthen board and trustee safeguarding responsibilities:

Recommendation 10: Local

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

Recommendation 11: Local

Implement a mandatory Trustee Induction and Refresher Training (every 2–3 years), focusing exclusively on the Board's strategic safeguarding governance. This training must distinguish between the Board's ultimate legal accountability and management's operational role. The Charity Commission has expressly identified 'the need for safeguarding procedures and processes to be properly understood by all those who may receive reports of allegations, reinforced with regular training and an organisational commitment to continual learning and improvement'.

Recommendation 12: Local

The Board should appoint an appropriately experienced independent lay Lead Trustee for safeguarding and establish a mechanism for regular, formal reporting to ensure continuous oversight.

Recommendation 13: Local

Trustees must be equipped to approve, resource, and critically review the Safeguarding Policy and associated frameworks. Crucially, they must ensure safeguarding risks are fully integrated into the overall Risk Register, focusing on high-level threats, and clarify the duty for prompt recognition and mandatory reporting of Serious Incidents to regulators. Serious incident reporting must be supported by rigorous documentation, recording who was involved, what occurred, where and when it took place, and why decisions taken were appropriate. Neither dioceses nor national bodies should assume the NST is acting on their behalf; individual parishes retain an independent duty to engage directly with serious incident reporting requirements.

Where regulatory questions arise, trustees should prioritise charity law compliance and take advice from specialist charity law solicitors before consulting internal ecclesiastical advisers.

Recommendation 14: Local

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

Recommendation 15: Local

Trustees should conduct an annual self-assessment of their compliance with the Charity Commission's code of governance. These self-assessments should be formally minuted and available to the regulator on request.

Diocesan and Cathedral Safeguarding Advisory Panels

A Diocesan Safeguarding Advisory Panel (DSAP) provides independent scrutiny and strategic safeguarding advice across the diocese, supporting the Bishop and the DBF in discharging their trustee responsibilities. Its remit covers system-wide governance and assurance: overseeing the implementation of National Safeguarding Standards, advising on complex casework at an oversight level, monitoring learning from serious cases, and scrutinising training, safer recruitment, and culture across parishes and diocesan structures.

While cathedrals and their Chapters often rely on Safeguarding Management Groups (SMGs) or Committees (SMCs), some utilise Cathedral Safeguarding Advisory Panels (CSAPs). Although all these models provide oversight and scrutiny, this review considers the CSAP the most effective approach. It allows for broader membership and operates with a specific cathedral focus. Crucially, its scrutiny function assures the Chapter that safeguarding is robust within its unique environment, encompassing high-risk areas such as choristers, the music department, bell ringers, volunteers, and visitor-facing activities. While the DSAP focuses on overarching governance, Charity Commission compliance, and diocesan-wide culture, the CSAP performs a parallel role tailored to the specific risks, practices, and culture of the cathedral.

DSAPs (and their cathedral equivalents) are a strength when well-chaired, featuring diverse statutory and wider membership and providing genuine challenge. However, recurring development needs remain remarkably consistent. Crucially, safeguarding panels must support rigorous scrutiny while remaining distinctly separate from clergy-led accountability functions. For this reason, it is strongly recommended that clergy do not chair DSAP or CSAP groups, as they are too close to operational practice and direction. The Independent Chair role is vital to maintaining objective oversight.

Key areas for improvement include establishing stronger, structured engagement with victims and survivors, alongside a three-year themed scrutiny cycle that explores the National Safeguarding Standards in depth. This cycle should align with the scrutiny focus of the DBF or the Cathedral, and its delivery would be significantly strengthened by the use of a centralised action tracker.

Furthermore, clearer escalation processes are required to address any non-compliance with training requirements. To improve meeting efficiency and preparation, members must provide written updates on their specific agency, function, or safeguarding activities. These

updates should be circulated alongside briefing papers well in advance of meetings.

Finally, membership should be actively diversified to encompass a broader range of perspectives. This expansion should incorporate community partners, local charities, victims' advocacy groups, food bank and shelter representatives, and volunteers. Where applicable, this must also include Parish Safeguarding Officers (PSOs) and chorister parents.

A recognised national limitation is that these panels currently rely on influence rather than formal authority. This issue was flagged in the previous Annual Report and remains unaddressed.

To promote a uniform and independent framework, this Annual Report recommends the wholesale transition of Cathedral Safeguarding Management Groups (SMGs) into Cathedral Safeguarding Advisory Panels (CSAPs). The continued use of the term "Management Group" poses a structural risk: intentionally or otherwise, it can erode the operational independence of the Cathedral Safeguarding Officer (CSO). It implies that safeguarding decisions, potentially including casework, are arrived at jointly by a group of church officers who are not safeguarding professionals. This confusion is compounded now that Core Groups are termed 'Safeguarding Case Management Groups'.

In a single safeguarding directorate model, the DSAP and CSAP should operate as distinct but closely aligned scrutiny bodies, each accountable to its own trustee body while drawing on a shared professional team providing casework, policy, training and data across both diocese and cathedral. The DSAP should retain oversight of diocesan-wide safeguarding governance, strategy and culture, including assurance that cathedral safeguarding is properly integrated into the overall framework; the CSAP should focus on cathedral-specific risk, culture and practice, formally linked into the directorate through the CSO and routine reporting. Information must flow both ways: the CSAP escalating significant issues and learning into the DSAP via the directorate, and the DSAP ensuring that diocesan policies, learning from complex cases and thematic scrutiny are applied and tested within the cathedral context.

The audit does not recommend simply expanding the DSAP to cover the cathedral. To do so would dilute focused scrutiny of high-risk cathedral activity, blur accountability between Chapter and diocesan trustees, and overload a body whose primary remit is system-wide governance. A dedicated CSAP, linked into Chapter and a single safeguarding directorate, offers clearer accountability, sharper contextual focus and stronger assurance for both Chapter and DBF.

Similarly, there is an urgent need to clarify individual safeguarding titles to prevent the blending of operational delivery and clergy oversight. The title 'Chapter Safeguarding Lead' is sometimes referred to as the Cathedral Safeguarding Lead. This has frequently created confusion,

suggesting that safeguarding is operationally led by senior clergy, with junior staff merely executing casework. Responsibilities need to be clearly understood and frequently reinforced. For example: The Cathedral Safeguarding Officer/Advisor (CSO/A) holds operational independence and is line-managed by the Diocesan Safeguarding Officer (DSO). The Chapter Safeguarding Lead function is strictly limited to good governance and accountability and the Dean is ultimately accountable.

Recommendation 16: Local

Local DSAPs should adopt a three-year themed scrutiny cycle aligned to the National Safeguarding Standards, supported by a single action tracker. Escalation processes for training non-compliance should be clearly defined and consistently applied. Members should submit written updates on their agency, function or relevant safeguarding activity, and these, together with any briefing papers, should be circulated ahead of each meeting to enable proper preparation. Membership should be actively diversified to include local statutory and voluntary sector partners, faith community representatives, and individuals with lived experience of safeguarding. Structured, independently facilitated victim and survivor engagement should be embedded within panel activity. Furthermore, all cathedrals should transition their SMGs into CSAPs led by an Independent Chair and ensure clarity regarding the role of the Chapter Safeguarding Lead (CSL), emphasising the operational function and independence of the CSO. DSAPs and CSAPs should operate as distinct but closely aligned scrutiny bodies, each accountable to its own trustee body and supported by the shared safeguarding directorate, with routine two-way reporting between them; the DSAP should not be expanded to absorb cathedral-level scrutiny.

Cathedral Leadership Structures

Good practice in cathedrals is a clear separation between governance/ oversight (a Chapter Safeguarding Lead, often a residentiary canon) and operational delivery (a professional Cathedral Safeguarding Adviser/Officer). Strong examples show independent-chaired safeguarding committees as sub-committees of Chapter, and the safeguarding lead present at Chapter. The weakest examples show the Dean acting as de facto safeguarding lead, heavy reliance on volunteers in significant roles, and a remote, part-time external adviser with little footprint, prompting urgent recommendations for a permanent professional adviser, an improvement board and a formal escalation route.

Recommendation 17: Local

Every cathedral should establish a clear structural separation between governance oversight (a Chapter Safeguarding Lead who is a non-executive lay person) and operational delivery (a professional Cathedral Safeguarding Adviser working a minimum of two to three days per week, professionally line-managed by the DSO and whilst embedded within the wider safeguarding team, situated within the precincts of the cathedral).

Where a Dean is currently acting as de facto safeguarding lead, this must be addressed as a matter of priority. Each cathedral should have a formally constituted safeguarding sub-committee of Chapter (preferably a CSAP) and an escalation route to the DST.

Capacity

Safeguarding Resourcing and the Case for a Safeguarding Directorate

This section of the annual report reviews the current framework for safeguarding resourcing across dioceses and cathedrals, drawing on evidence from 27 independent audits conducted over the past two and a half years.

While the drive to establish optimum safeguarding staffing levels is understandable, the audit evidence indicates that simply prioritising numbers over skills carries risk. A larger team of less experienced staff may present greater risk than a smaller, well-qualified and strategically deployed team; equally, competence alone cannot offset a team that is too small for the demand it faces. Capacity and competence must therefore be considered together.

There is a need to move from ad hoc resourcing arrangements to a formalised Safeguarding Directorate model that maximises capability, manages risk effectively and secures long-term financial and operational efficiencies.

Optimum resourcing is not a static number. It is a flexible framework determined by local circumstances rather than uniform quotas and is driven principally by three factors. The first is geographic coverage: the physical footprint of the diocese and the logistical realities of parish engagement. The second is the active caseload: the volume, complexity and severity of current live cases. The third is the weight of historic and legacy issues: the administrative and investigative burden of managing case backlogs and non-recent abuse claims.

The proposals in this section sit alongside work the DARE Unit is delivering on the resourcing model. The 2025 model is intended to move beyond basic benchmarking by introducing two complementary tools: a Benchmarking Model, built using data from all dioceses and cathedrals, and a Resource Model, derived from those dioceses and cathedrals assessed by Regional Safeguarding Leads (RSLs) as adequately resourced or better.

The intention is to move the conversation beyond simple comparison of dioceses with one another and towards an understanding of what realistic safeguarding capacity looks like in practice.

One of the more notable findings from the 2025 analysis is that, beyond genuine statistical outliers such as Sodor and Man, no single diocese would now be considered statistically significantly under-resourced relative to others. This should not be interpreted as meaning that dioceses are adequately resourced; rather, it suggests a degree of improved consistency across safeguarding teams.

That said, the Resource Model rests on RSL's assessments of adequacy, and the evidence underpinning the numbers reported by RSLs is not yet consistent or reliable enough to be treated as definitive. Its outputs should therefore be read as indicative until the underlying data matures, a limitation that reinforces the case for judging resourcing against local drivers and capability rather than comparative headcount alone.

In the experience of the audit team, the current resourcing model is often weaker than it appears on paper: some roles combine safeguarding with other duties ('double jobbing') or are delivered through limited part-time hours, and bandwidth is often further compromised by non-safeguarding tasks being allocated to staff nominally dedicated to safeguarding. DBS checks are a case in point: these are properly a human resources function, and safeguarding teams should be involved only where a check raises a concern (a 'blemished' disclosure).

The Proposed Model: A Safeguarding Directorate

The proposed model consolidates all professional, paid safeguarding resources into a single, cohesive and operationally independent Safeguarding Directorate.

Governance and authority

The structure is intended to provide clear lines of accountability, to professionalise the safeguarding function and to establish safeguarding as a core independent operational pillar.

Directorate Structure and Role Profiles

To secure both capacity and competence, the minimum viable Directorate would comprise the following roles.

Director of Safeguarding

- **Authority:** Holds the powers and authority traditionally vested in a Diocesan Safeguarding Officer (DSO).
- **Remit:** A strategic portfolio encompassing management, governance and oversight activity at senior leadership, Diocesan Board of Finance (DBF) and Chapter levels.
- **Operational posture:** Acts as the senior professional voice on safeguarding, with the authority to direct any clergy or church officer, as well as to advise.
- **Accountability:** Directly accountable to the DBF and Chapter.

Deputy Director of Safeguarding (Deputy DSO)

- **Remit:** Delegated operational oversight and case management.
- **Function:** Manages the day-to-day casework framework, providing guidance, clinical and operational supervision, and support to caseworkers.

Safeguarding Caseworkers (minimum of two FTE)

- **Remit:** Day-to-day management of active cases and direct engagement with parishes.
- **Deployment:** Rather than appointing two full-time generalists, these roles could be structured as job-shares to blend professional backgrounds within a multi-disciplinary model. The mix of expertise might include, for example, a former adult social care social worker, a police officer with public protection experience, a former probation officer with offender-management experience, or a former children's social care social worker. This builds a resilient, cross-functional team.

Dedicated Safeguarding Trainer

- **Remit:** Leads the safeguarding training portfolio.
- **Structure:** Ideally positioned as an additional caseworker (Assistant Diocesan Safeguarding Advisor) whose primary focus is the design and delivery of training, ensuring that training remains grounded in current operational practice.

Safeguarding, Parish and Training Support Officer

- **Remit:** Centralises and manages administrative and operational support functions.
- **Responsibilities:** Call filtering and triage (releasing caseworkers from routine intake), general administrative support, maintenance of and support for the Parish Dashboard, and assistance with training logistics and evaluation.

Cathedral Safeguarding Adviser/Officer (CSA/O)

- **Remit:** Leads safeguarding provision for the cathedral, reflecting its distinct governance under the Chapter and its particular operational profile.
- **Structure:** Depending on scale and local need, this could be a standalone CSA/O post or a caseworker holding a designated cathedral portfolio within the Directorate. Either route ensures that cathedral safeguarding is integrated into the Directorate's framework rather than managed in isolation. The CSA/O operates under the direct line management of the Director of Safeguarding/Deputy DSO. The Director of Safeguarding is ultimately accountable to Chapter.

Strategic Efficiencies and Financial Viability

Regional Safeguarding Lead (RSL)
The RSL network, nine leads covering eight regions, was established to bridge the gap between national policy and local implementation, following a pilot which concluded in March 2024 in response to Recommendation 1 of the Independent Inquiry into Child Sexual Abuse (IICSA).

The appointment of a suitably qualified Director of Safeguarding with formal authority might substantially reduce the need for the RSL role. That said, any decision to reconfigure their role, should be tested through consultation at regional and national level: the role remains relatively new, and the NST Audit report separately recommends near-term measures to strengthen it. The Directorate model set out here should be read as the longer-term structural evolution of those arrangements.

The evidence on the regional model, examined in detail in the NST's audit report of the RSL role, is nuanced. The model's primary strength lies in providing a credible, reflective supervision process that increases practitioner confidence, with a strong regional identity reducing professional isolation; these benefits are most evident among staff who previously lacked such support. At the same time, the quality of supervision remains inconsistent, the boundaries between reflective supervision and quality assurance remain blurred, and some DSOs report weakened connectivity with the NST, with RSLs at times perceived as separate from, rather than an extension of, the national team. The wider ambitions of the model, most notably a rigorous and consistent approach to quality assurance, are not yet being realised at pace.

The audit has further found that the RSL role sits in an ambiguous 'no man's land' between advisory support and formal authority: instances were identified where RSLs recognised risks or poor practice but lacked the formal authority to intervene directly. The Directorate model addresses the same structural weakness at its root, placing formal authority and accountability where the risk is held.

Under the Directorate model, the functions currently delivered regionally would be relocated rather than lost. Professional supervision would be secured locally, as set out below; quality assurance and professional oversight would sit with the Director of Safeguarding, who is directly accountable to the DBF and Chapter; and regional learning and collaboration could be sustained through peer networks between Directorates, supported by national coordination.

An association of Directors of Safeguarding, with a regionally elected representative body similar to that of the Directors of Children's and Adults' Social Care, would further strengthen policy development and leadership practice. It would provide a natural vehicle for consolidating strategic opportunities with the NST and the National Director of Safeguarding and, should the Directorate model be adopted, could carry forward the policy portfolio leadership the NST Audit

report proposed for RSLs, including its contribution to the recommended Virtual Church of England Safeguarding College.

The case for the Directorate over the current regional model is not that regional support has failed. It is that the most clearly evidenced benefit of that model, supervision, can be delivered more directly and accountably within a properly constituted local structure, while its wider functions are embedded in roles carrying formal authority rather than provided through an advisory tier.

Direct evidence for a model that has not yet been implemented is inherently difficult to collate; what the audit evidence does show, across 27 dioceses, is the cost of fragmented approaches. The argument therefore goes beyond numbers: it concerns the design, independence and accountability of the safeguarding function.

The benefits of a demonstrably independent Directorate, led by a senior and experienced Director, would be hard to ignore. The current model delivers blended teams, but these can be inhibited when led by practitioners who are perceived as middle managers and are therefore subject to wider senior church influence. A consolidated model would provide greater resilience, better uniformity of practice and the added value of consistent, locally delivered strategic supervision and senior support.

A recurring question in the evidence reviewed by the audit is whether the high cost of the RSL network is justified by substantive outcomes. As DSAPs mature and deliver a more consistent quality assurance framework, and with the potential for locally commissioned professional clinical supervision, it becomes difficult to justify a centralised system of quality assurance and reflective supervision.

Any potential central savings could offset the costs of Directors of Safeguarding and support investment in localised infrastructure, most notably appropriately qualified, locally commissioned clinical supervision for the Directorate team, an essential feature of a high-functioning safeguarding service.

The Safeguarding Directorate model responds directly to the findings of the recent independent audits and represents the evolution of the approach this audit programme has promoted since its first year. By shifting the emphasis from capacity alone to multi-disciplinary competence, it aims to reduce organisational risk, professionalise case management and enable an accountable safeguarding culture.

Subject to local circumstances and appropriate consultation, it offers greater uniformity, demonstrable independence and a credible, more financially sustainable basis for the future resourcing of safeguarding.

Recommendation 18: Local

Each diocese should establish an operationally independent Safeguarding Directorate (incorporating the entire geography of the diocese, including the Cathedral), led by a Director of Safeguarding who is a senior, strategically experienced safeguarding professional. The Director should be appointed by and remain accountable to the DBF and Chapter, with explicit operational independence from episcopal and diocesan management structures. A formal MoU or SLA should define the Director's authority across the diocese and cathedral. The Directorate should consolidate professional safeguarding resources across the DBF, parishes and Cathedral, with clear reporting lines to the DBF, Bishop's Council, Chapter and senior leadership, and minimum viable staffing comprising the Director of Safeguarding, a Deputy with delegated operational and case-management oversight, at least two caseworkers (potentially job-shared to blend professional backgrounds within a multi-disciplinary model), a dedicated safeguarding trainer, a support officer providing triage, administrative and Parish Dashboard support, and a CSA/O or a caseworker holding a designated cathedral portfolio.

Critically, whether located in the DST or a Cathedral CSA/O, the CofE must apply greater scrutiny during the recruitment process for safeguarding officers and advisers. Given that they operate in environments where they will sometimes be the sole perceived expert, individuals in these roles require a high level of proven competence.

On several occasions, the Audit has identified instances where a candidate's previous job title drove their recruitment, superseding a robust assessment of their actual safeguarding capabilities. Examples include former police officers with no safeguarding background, probation officers with limited operational expertise, and individuals holding social work degrees but lacking practical experience in frontline statutory services.

In future, the CofE must rigorously assess prospective candidates by seeking concrete evidence of their frontline experience, rather than assuming they possess the depth and breadth of knowledge required to fulfil these critical roles. To this end, the Audit makes the following recommendation:

Recommendation 19: National and Local

When recruiting for safeguarding officer roles, whether DSOs, DSAs, CSOs, CSAs, or caseworkers, the recruitment process must verify the operational and experiential claims made on a candidate's CV. To this end, the audit recommends establishing an experience threshold for DSOs, requiring them to demonstrate five years of post-qualification, frontline statutory, or similarly relevant experience. More junior roles should be benchmarked in the same manner, with the expectation that any candidate possesses appropriate expertise and a minimum of two years' post-qualification experience.

Cathedral Capacity

Cathedral safeguarding is frequently delivered through part-time and volunteer roles and a MoU/SLA with the diocese. The staffing baseline for a professional Cathedral Safeguarding Adviser is set out in the Cathedral Leadership Structures section above. Depending on scale and local need, this may be a standalone CSA/O post or a caseworker holding a designated cathedral portfolio within the Directorate; either route integrates cathedral safeguarding into the Directorate's framework rather than managing it in isolation.

Chorister safeguarding is generally strong; however, recurring operational gaps require structured attention. See the Audit's Chorister Companion Document 2025.

Funding of Safeguarding

Following the findings of the 2024 Independent Safeguarding Audit Programme's Annual Report, evidence from 2025 further highlights a critical disparity between rising demand and the current under-resourcing of DSTs. The audit team contends that the inability to build genuine safeguarding resilience remains one of the most significant risks facing the Church today. To mitigate this, the auditors propose a fundamental shift in the financial model: moving away from localised funding in favour of a centralised system. Under this proposal, funding would be provided by the Church Commissioners, while operational delivery would remain at a local level through DBFs / DSTs / Safeguarding Directorates. The following section outlines the formal case for centralising the funding of DSTs / Safeguarding Directorates via the Church Commissioners.

For the Church to flourish, safeguarding must be reclassified; it should no longer be viewed as an 'administrative overhead' but as a 'core mission enabler.' The Church Commissioners' 2026–2028 Spending Plans have allocated £1.6 billion to support the 'Vision and Strategy' for a growing Church, 'sharing the good news' and 'serving local communities' (Churchofengland.org, June 2025). However, growth is impossible in an environment where safeguarding is compromised or perceived to be under-resourced. By 'nationalising' safeguarding costs, mirroring recent successful initiatives to cover clergy pension deficits and training outlays, the Commissioners would release millions of pounds back into local parishes and strengthen the independence of Safeguarding Directorates, no longer reliant on funding from within the DBF or Cathedral budgets.

This shift would allow the Parish Share to be reinvested directly into frontline ministry and community outreach, fulfilling the Commissioners' primary objective: to support (safer) 'mission and ministry' of the CofE.

The NST's five-year Safeguarding Concern analysis highlights a significant shift in the complexity of cases, particularly regarding domestic abuse and spiritual abuse. These categories require specialised, high-level professional expertise. By establishing a centralised funding stream via the Church Commissioners, the Church can standardise professional roles across the board. This approach ensures that every diocese, irrespective of its local socio-economic circumstances, possesses the necessary resources to provide a consistent level of professional safeguarding support.

Evidence from the NST's Safeguarding Concern Data Review: 5-year analysis (2019–2023) demonstrates a sustained upward trend in the volume of safeguarding concerns and allegations reported across the Church of England. This evidence confirms that the workload of DSTs is not merely fluctuating but is experiencing a significant and sustained expansion. As the Church successfully develops a more robust 'culture of disclosure,' the resulting administrative and operational pressure on DBFs/DSTs grows in tandem.

There is a compelling 'prevention versus cure' argument for the Church Commissioners to intervene directly by adequately funding safeguarding. At present, the National Redress Scheme, which provides financial restitution to survivors with individual awards potentially reaching £660,000, is centrally funded by the Commissioners under the Redress Scheme Measure 2025. However, it is strategically inconsistent to fund the consequences of safeguarding failures at a national level while leaving the prevention of those very failures to be financed by insolvent or near-insolvent DBFs.

With the Commissioners already committing between £150 million and £200 million to the Redress Scheme, a clear precedent exists for using the endowment to cover the 'costs of failure.' Transitioning to a model that directly funds diocesan safeguarding services would represent a more logical and financially consistent use of these resources.

By prioritising prevention, the Commissioners would be fulfilling their fiduciary duty to protect the Church's financial and reputational assets from the catastrophic impact of future systemic failures.

Centralising these costs would also align with broader institutional goals. Moving the financial responsibility for safeguarding from DBFs to the National Church Institutions (NCIs) would directly fulfil the General Synod's 2025 mandate to reform national governance and provide much-needed support to struggling dioceses (GS 2314).

Funding safeguarding directly from the historic endowment supports the First Church Estates Commissioner's stated goal of 'intergenerational equity,' as failing to invest in robust safeguarding today creates vast, unquantifiable liabilities for the future Church (Church Commissioners Annual Report, 2024). The audit recognises that alternative approaches may exist; however, based on the evidence gathered, it considers this approach most likely to address the identified risks relating to capacity, consistency and operational independence.

Recommendation 20: National

The Archbishops' Council in consultation with Church Commissioners should commit to a fundamental shift in the funding of safeguarding by centralising financial responsibility for DSTs (Safeguarding Directorates), removing this burden from Diocesan Boards of Finance. Funding should be allocated directly by the Commissioners to each DBF or Safeguarding Directorate, with operational delivery remaining at diocesan level. The NST on behalf of the Archbishops' Council should work with the Church Commissioners to formally cost this transition, develop a phased implementation plan, and link funding levels to published resourcing benchmarks.

Financial pressure and Shared Services

Capacity cannot be separated from finance. Many bodies are 'asset rich, cash poor' and face real constraints on investment. The audits encourage DBFs and cathedrals to share support services (HR, finance, IT), where possible, to release efficiencies for reinvestment in safeguarding, to refresh MoUs/SLAs, and they note resource sharing such as the National Safeguarding Case Management System as good practice. Two further capacity concerns were raised consistently by respondents: the volume of training requirements placed on volunteers, and the risk of excluding elderly or digitally limited members from training and information.

Raising and Handling Concerns

Analysis of free-text responses to the Audit survey on raising and handling concerns reinforces a clear message: the system is robust and well-supported centrally, but experiences diverge once a case moves beyond the initial response. Consistent strengths are a fast, expert and reassuring first response (the 'golden hour'), the DST experienced as a "lifeline", clear next steps and reporting lines, and strong statutory partnerships with social services and the police.

The recurring frictions are equally consistent. Those who raise concerns are frequently left without feedback on outcomes; confidentiality, however necessary, can be experienced as a shield, eroding trust, and this is felt most painfully by victims and survivors. Despite the speed of the initial response, formal resolution through processes such as clergy discipline can take well over a year, causing real distress. Some clergy describe safeguarding fatigue and a sense that the definition of safeguarding has become overly broad. Community respondents are the most likely to report never hearing back, or to feel that concerns arising outside church premises have not been taken seriously.

Recommendation 21: Local

Each diocese should implement a formal feedback process ensuring that all those who raise a safeguarding concern receive timely and appropriate communication about its handling and outcome, subject to necessary confidentiality constraints. Minimum communication standards should be established, covering acknowledgement timelines, case closure summaries and signposting to relevant support. The DSO should monitor compliance with these standards, and the Board should receive a periodic report on communication performance. Concerns raised outside church premises must receive the same quality of response as those arising within them.

These strengths and frictions were experienced differently across the three respondent groups:

Staff (DBF)	**Clergy / faith**	**Community / congregation**
Primary strength: Efficiency and speed of response	**Primary strength:** Expert DSO support and navigation of statutory agencies	**Primary strength:** Immediate, pragmatic local action
Primary tension: Process over people; uncertainty about final resolution	**Primary tension**: Disciplinary delays and safeguarding fatigue	**Primary tension**: Lack of feedback and closure
Tone: Corporate / functional	**Tone:** Pastoral / complex	**Tone:** Observational / local

Progress Made and Critical Inhibitors

The trajectory of implementation of Audit recommendations across the audited bodies is encouraging but uneven. At the heart of every recommendation is the fundamental need to embed a 'Safeguarding first' culture across all aspects of the Church's life. Safeguarding culture, leadership, and capacity are all moving in the right direction, and there is evidence of progress.

The most significant structural recommendation, the establishment of a Director of Safeguarding role within each diocese, was accepted in full by around half of the DBFs audited in the first year, with those bodies now working to embed the position within their structures. A further one in five accepted it in part, while around a third rejected it, advancing reasons the audit does not consider sufficient, including the view that existing structures are already adequate or that recent internal restructuring has created a satisfactory direct reporting line for safeguarding.

The audit's position on this is clear: the objective is not to appoint a senior figure or rebrand the existing DSO role, but to create a dedicated additional post designed specifically to reinforce and strengthen the safeguarding directorate, ensuring that a 'Safeguarding first' voice is structurally embedded at the executive level. This resistance is examined further in the Critical Inhibitors section below.

Progress on the related recommendation to establish or formalise dedicated CSAs or CSOs has been more broadly embraced: most cathedrals accepted the recommendation in full, with one opting to maintain its existing arrangement with the DST.

Of those that accepted, around a third have already completed implementation and more than half have concrete actions in progress, including advertising for the role and securing appropriate professional supervision from the DSO.

Critical Inhibitors

The audit is clear that the vast majority of those within the CofE have a genuine appetite for the change needed to deliver an operationally independent safeguarding system. The evidence gathered across the audited bodies supports this assessment, and it is important to state it plainly. Most senior clergy, as a category, are not the obstacle. The Audit's concern is not with any particular professional group, but with governance behaviours, decision-making approaches and organisational dynamics which, in some settings, have the potential to inhibit safeguarding progress

The inhibitors to change are structural and, in certain cases, institutional. It is vital to stress that the critical inhibitions the audit has encountered are not a critique of the culture or necessity of church administration itself. Effective administration is the backbone of the diocese. Rather, the concern arises when administrative processes fail to be framed in and through the absolute need to make the Church as safe as possible. Administration, whether in the centre of the diocese or at the

national level, must embody a ‘Safeguarding first’ culture, and must be called out when it does not.

Currently, this resistance manifests in several ways. Some DSOs were able to respond immediately to the audit’s requests for updates on progress made in 2025 against the Audit recommendations from 2024. Others were required first to seek approval from their Diocesan Secretaries. In a small number of cases, those Diocesan Secretaries declined to provide the information requested, taking the position that these were matters for the church and its governing bodies.

The audit notes the difficulty in reconciling this position with two straightforward commitments: every individual audit report includes a section on progress, making a request to evidence improvement an entirely foreseeable one; and the Framework Agreement contained an explicit commitment to publish action plans for each audited body within six months of each report’s publication.

Resistance to the Director of Safeguarding recommendation has been similarly revealing. A few Diocesan Secretaries have asserted that current arrangements are adequate and that the existing DSO already holds the authority that would be conferred on a Director of Safeguarding. The audit does not share this analysis.

In examining those bodies most resistant to evidence-based change, it became apparent that certain church officers considered themselves sufficiently informed to determine, unilaterally, when safeguarding should be represented at senior leadership meetings. When one such senior church officer was asked to explain why safeguarding had not been present at meetings addressing housing provision, or at discussions about growing the church’s engagement with younger people, no satisfactory explanation was offered. The Church cannot grow if it is not a safe place. Every initiative must be viewed through a ‘Safeguarding first’ lens. This kind of institutional presumption, however confidently held, is itself

a warning sign and is inconsistent with the standard of independent operational safeguarding practice the CofE must now embrace.

A further and recurring form of resistance concerns the scope of the audit itself. On several occasions, the audit has been challenged as to whether particular findings or recommendations fall within or outside its terms of reference. These challenges tend to cluster around recommendations relating to organisational structure, areas that some stakeholders decline to recognise as safeguarding matters, and questions about the long-term financial sustainability of safeguarding provision across the CofE.

The audit provides every audited body with the opportunity to fact-check the content of its individual report before publication. During this process, feedback has on a number of occasions extended well beyond factual correction and into substantive challenges of the kind described above. A clear example arose during one audit in which it became apparent that many people with lived experience from the Black and Global Majority community felt unseen, unheard and, by consequence, not valued. The audit addressed this finding directly.

The response from some within the audited body was to assert that racial justice was not a safeguarding issue. The audit regards this as a significant and useful example of the institutional resistance it has encountered. When individuals or entire communities feel they are not valued, the barriers to speaking up and speaking out about

safeguarding concerns rise significantly. The relationship between belonging, trust, and the willingness to disclose is not peripheral to safeguarding; it is central to establishing a true 'Safeguarding first' culture.

Similar resistance has arisen in response to findings on current leadership and governance structures. The audit's mandate is not simply to assess compliance with existing policy or to describe current practice. It is to examine how safeguarding operates across the five National Safeguarding Standards in their entirety and to recommend where and how that might be strengthened.

A refusal to engage with structural findings on the grounds that they fall outside the audit's scope is, in the audit's view, itself a symptom of the institutional narrowing that inhibits progress. These themes emerged across multiple audits and stakeholder groups rather than from a single setting or isolated experience.

Another example relates to a key line of enquiry arising from victim and survivor feedback concerning an LLR. The concerns raised during the NST Audit by a victim / survivor in the case led to the audit seeking to access it. Difficulties arose because the body who held the LLR had already been audited and therefore took the position that they could not, or would not, provide auditors with access to the LLR in question. The Audit was therefore unable to test the veracity of the concerns raised. Carrying out an LLR serves little purpose if the learning is not shared, particularly with those commissioned to independently audit safeguarding in the Church of England. While there may be valid reasons to redact information and anonymise circumstances to avoid identifying and re-traumatising victims and survivors, methods exist to aggregate and share learning.

This issue is addressed in the NST Audit Report. Refusing to facilitate access by auditors reinforces the perception of a culture of secrecy in parts of the Church, and this practice must be challenged.

Other challenges exist with regards to the CofE's approach to seek compromise in the interests of unity. The provision of designated alternative episcopal oversight pathways for those whose convictions diverge from the Church's position on the ordination of women, and the approach taken to the Living in Love and Faith (LLF) process, both illustrate a broader tendency to accommodate theological divergence rather than apply a consistent standard. In several audits, findings relating to diversity and inclusion have attracted responses in the same vein, with some stakeholders characterising the audit's observations in this area as outside its remit.

The audit does not accept this position. Questions of who feels safe enough to participate fully in church life, and whether all communities feel genuinely valued, heard and treated fairly, are integral to any substantive assessment of safeguarding culture. It is precisely because such an assessment requires an evidence-led, safeguarding-first approach, and because robust evidence on

these lived experiences has historically been difficult to gather, that the Audit notes and welcomes the recent commissioning of two new groups taking forward questions of relationships, sexuality and gender as the LLF programme comes to an end. This welcome is tied strictly to the opportunity these groups present for bringing vital safeguarding realities to light, rather than as any commentary on the theological debates or their potential outcomes.

The audit's findings on the area model in the Diocese of London offer a further illustration. It was evident to the audit that the existing five-and-one structure created significant difficulties for resilience, credible governance oversight and consistency of approach across the diocese. Rather than engaging with the evidence underpinning these findings, the audit encountered substantial resistance as to whether it was appropriate for the audit to comment on such matters at all. This response, repeated across several different settings and bodies, reinforces the perception of an unwillingness to appropriately reflect on the wider structural issues that have the potential to undermine uniform delivery of safeguarding.

This resistance is not confined to individual dioceses and cathedrals. It extends to the central church bodies, where it again tends to arise not from senior clergy but from individuals in administrative and institutional roles. To reiterate, this is not a broader commentary making a targeted point against administration; it is a vital observation that administrative environments must also adopt a 'Safeguarding first' culture, framing their operational priorities through the necessity of safety.

The audit's report into the NST identified a clear need for significant restructuring to recognise and properly promote the role of the National Director of Safeguarding. That role should carry the highest independent safeguarding authority across the CofE. The qualifications and standing of the current postholder are not in question. What is in question is the practical recognition of that authority and its consistent

exercise. The audit has identified instances where serious safeguarding notifications have been discussed and decisions taken without the principal advice of the National Director of Safeguarding being sought. This cannot be right.

When the audit recommended strengthening the operational independence of the NST, including creating a dedicated safeguarding function within the National Church Institutions (NCI) and providing the NST with specialist support comprising a safeguarding-focused legal adviser, an HR professional and a communications officer, resistance was encountered. The argument advanced was that the Church's existing legal team, communications function and HR advisers could provide the necessary support. The audit fundamentally disagrees. There is an inherent conflict of interest where the same legal advisers who counsel the CofE as an institution are also expected to provide advice that must be "Safeguarding first" and independent of institutional interests. The same applies to communications: an officer whose primary duty is to manage the Church's reputation cannot simultaneously be the best-placed person to frame a difficult safeguarding message with the interests of victims and survivors at its centre.

The audit focuses primarily on the potential for real or perceived conflicts of interest within current arrangements, rather than suggesting these conflicts have arisen in every case. Until these conflicts of interest are acknowledged and resolved, the CofE will continue to experience difficulty moving at the pace the evidence demands and that the public, and those who have been harmed, have a right to expect. The audit is confident that the Church has the capacity and, across the majority of its leadership, the resolve to deliver the fundamental change needed to restore and sustain confidence in its safeguarding arrangements. The inhibitors described here are real but they are not insurmountable. What is needed is honest acknowledgement, structural remedy and, where necessary, the exercise of authority by those with the responsibility and mandate to act.

Recommendation 22: National

The National Church should take three specific steps to address the structural inhibitors documented above.

1. The Framework Agreement governing each audit should be strengthened so that DSOs/Directors of Safeguarding can respond to audit requests directly and without prior approval from Diocesan Secretaries; where access to information is withheld or disputed, the matter should be formally escalated to the National Church Institutions for resolution.

2. The National Director of Safeguarding must be formally recognised as the highest independent safeguarding authority across the CofE, with a clear and published protocol requiring that their principal advice is sought and recorded before any decision is taken on a serious safeguarding issue or where there is question about whether to submit a SIR to the Charity Commission.

3. The NST must be resourced with dedicated, ring-fenced specialist support, a safeguarding-focused legal adviser, an HR professional, and a communications officer, each with a primary accountability to safeguarding outcomes rather than to the institutional interests of the Church. The use of shared institutional advisers for matters that require “Safeguarding first” independence constitutes a structural conflict of interest that must be resolved.

Chorister Safeguarding

Year 2 findings indicate measurable progress in several areas. Safeguarding responsibilities within chorister contexts are more clearly articulated, chaperoning arrangements are better established, and there is greater confidence amongst staff in recognising safeguarding as integral to musical excellence rather than in tension with it. Communication between cathedrals and connected schools has continued to strengthen, particularly where regular formal and informal information sharing arrangements are in place.

Year 2 has also seen the emergence of more nuanced themes, including neurodiversity, behaviour management, and the pressures associated with high achievement environments. For further detail, please refer to the full Chorister Safeguarding Companion Report 2025.

Chorister Safeguarding Companion Report 2025

https://ineqe.com/churchofengland/#annual-report

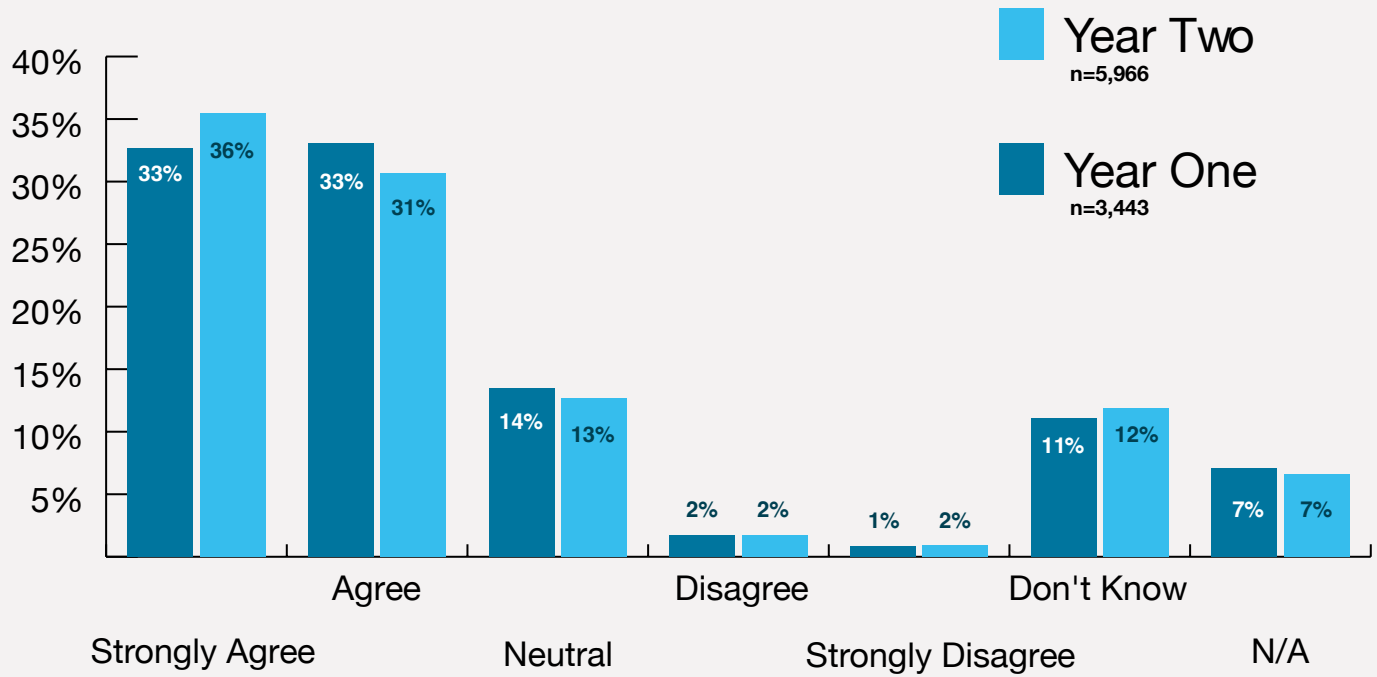
Prevention

Prevention is an essential aspect of safeguarding within the Church. If effective, it can mitigate risk, stop harm from occurring in the first place and ultimately lead to better outcomes for people. Safeguarding arrangements in this respect require not just clear policies, strong guidance, and accessible handbooks that articulate the focus on prevention, but also open communication and awareness-raising. Promoting a shared understanding of risks, signs of abuse, and reporting procedures empowers everyone to build safer environments.

The good practice seen by the audit team involving prevention activity is thanks to the dedication of the many volunteers who play a vital frontline role across parishes and cathedrals. Indeed, their diverse contributions are invaluable and reflect a shared commitment to fostering a safer environment for all.

Safer Recruitment

> “I have seen improvements with safer recruitment practices”



Across audited bodies, several key trends and findings regarding safer recruitment have emerged. There is a clear and consistent commitment to upholding the House of Bishops' Safer Recruitment and People Management guidance. This alignment is being strengthened by the strategic adoption of digital solutions, such as the Safeguarding Dashboard and Safeguarding Hubs. These platforms have become critical for monitoring parish-level compliance, allowing parishes to assess their safeguarding arrangements and effectively report on safeguarding matters to their PCCs.

Additionally, several audited bodies have undertaken administrative realignments, specifically transferring the processing of Disclosure and Barring Service (DBS) checks from safeguarding teams to Human Resource (HR) departments.

This change is designed to allow safeguarding professionals to focus on proactive engagement and casework, while HR manages the administrative volume, provided that robust protocols remain in place for handling 'blemished' disclosures. Finally, dioceses are increasingly prioritising the visibility of their safeguarding commitment by embedding explicit safeguarding statements within all job advertisements and role descriptions. This approach serves as a useful deterrent to unsuitable applicants while clearly establishing the Church's expectations from the very start of the recruitment process.

Good practice in the 2025 period is characterised by effective vetting procedures and enhanced transparency. One cathedral has demonstrated leadership in this area by implementing a policy for online candidate searches for roles involving direct work with children, aligning with Keeping Children Safe in Education (KCSIE) guidance.

The Cathedral policy is noted for its transparent approach, clearly outlining the purpose of the checks, ensuring candidate consent is sought, and specifying exactly what information is considered a concern. Other identified strengths in dioceses include the practice of 'early vetting', where candidates in the discernment journey complete DBS checks and training at the beginning of their process. Some bodies have also segmented their DBS systems into smaller, dedicated user accounts to improve data protection and resilience.

One diocese demonstrates a significant organisational strength through its use of a centralised Appointments Tracker for all clergy and incumbent vacancies. Given that the appointment process involves multiple departments and administrative offices, this SharePoint-based tool provides essential cross-departmental visibility and a collaborative platform for sharing information. Consequently, the tracker ensures that all pre-appointment formalities are thoroughly completed and verified by every relevant stakeholder before any appointment is finalised.

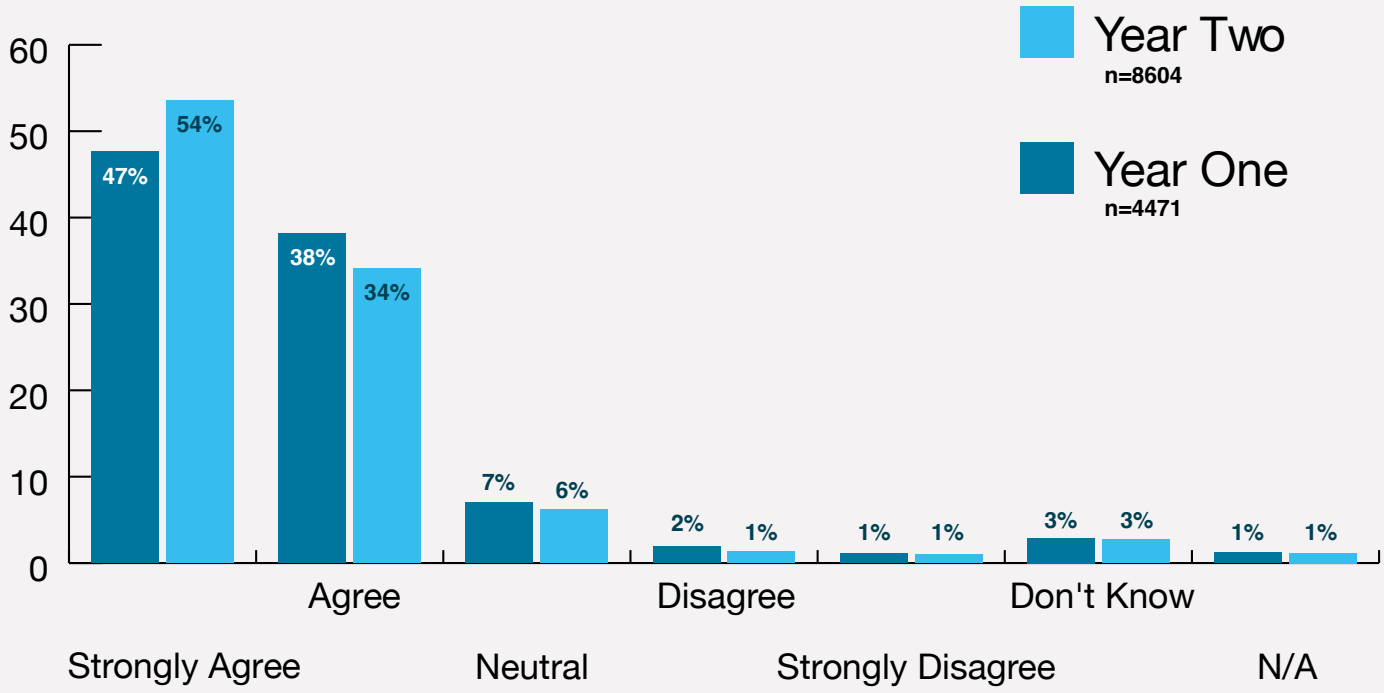
The audits underscored the importance of providing local parishes with tailored guidance and accessible resources regarding safer recruitment. To address this, role-specific matrices have been developed for groups like bellringers and visiting choirs, ensuring absolute clarity on the exact training and vetting requirements for each position.

To further streamline these administrative processes, comprehensive toolkits were introduced, incorporating model website copy, digital identity check guides, and induction packs for Parish Safeguarding Officers (PSOs). Recognising the need for inclusivity, many dioceses have also transitioned to mobile-responsive web designs and introduced video tutorials to better support individuals who may be less confident using digital platforms.

The findings further emphasised the critical importance of robust oversight and rigorous quality assurance. Effective practices identified throughout 2025 have maintained a focus on formalised risk-assessment processes for DBS returns, ensuring that previous convictions or ‘soft intelligence’ are subjected to appropriate consideration. Transparency is further maintained through regular reporting of DBS statuses to senior governance bodies, such as Chapter or Senior Management Groups. A final example of good practice lies in the approach taken by some dioceses towards ‘dip sampling’ data on the Parish Dashboard; by moving beyond self-assessment, they are able to actively test the veracity and quality of recruitment records across the Church.

Awareness Raising

> “I have seen improvements with raising the levels of awareness around safeguarding”



There continues to be a clear commitment to raising awareness of safeguarding through a multi-channel approach. Central to this strategy is the digital landscape, where diocesan websites now serve as primary hubs for policies and reporting tools. This is reinforced by the consistent use of e-bulletins and newsletters to deliver regular updates and 'safeguarding stories' to thousands of subscribers. While social media platforms like Instagram and Facebook are increasingly used to broaden reach, the audits highlight a growing need to ensure this digital content feels relevant to local parish contexts.

Beyond digital communication, the audits highlight the vital role that dedicated events and physical visibility play in maintaining a high safeguarding profile. A key example is 'Safeguarding Sunday', which has become an almost universal fixture, successfully integrating safeguarding themes into liturgy and sermons. In tandem with this, more specialised outreach is being developed for children and young people through interactive tools, such as 'Who's Who' posters and youth-led feedback forums. This combination of initiatives is further strengthened by the continued use of traditional, high-visibility signage.

The 2025 audits identified a lack of consistency and rigour across dioceses regarding the use of digital communication channels to raise safeguarding awareness. While individual audit reports have previously issued specific recommendations to address these local areas for improvement, the findings also highlighted a need for a broader strategic response. Given the NST's overarching remit, it was recognised that national initiatives could offer effective, universal solutions applicable to all dioceses. Consequently, a formal recommendation was included in the NST's audit report to ensure a coordinated national approach to digital safeguarding communications; this recommendation is replicated below.

Drawing on the 2025 safeguarding audits, clear trends of good practice have emerged in how awareness is raised through inclusive communication. One theme is the commitment to inclusivity in training and outreach. This is demonstrated through the provision of adaptive materials, such as enlarged fonts and coloured paper for those with dyslexia, alongside the use of hearing loops and automated text. Digital accessibility has also been significantly strengthened in some areas, with one diocese leading the way through a dedicated safeguarding playlist on YouTube while another area has focused on ensuring all video content is supported by subtitles and full transcripts.

The audits identified several innovative approaches to engagement that effectively lower barriers to support. In one diocese, for example, the proactive removal of 'tear-off' contact slips from safeguarding posters serves as a subtle yet powerful nudge; by suggesting that others have already sought help, it reduces the stigma associated with coming forward. There are also other methodologies that can be used to share contact information while disguising its source, so as to protect the safety of those who take it away. Given the sensitivity of these methods, the audit will not set them out here, but will make discreet recommendations to this effect through the appropriate channels. This commitment to accessibility is mirrored in provisions for children, where the use of Makaton on signage and the introduction of 'smiley face' feedback forms ensure that safeguarding remains approachable and easy to understand from a young age. To support these initiatives, the relevant DBF launched a broader campaign aimed at improving consistency across parish websites. By providing standardised 'model safeguarding wording' for local adoption, the DBF ensured that all parishes could implement clear, uniform messaging that aligns with diocesan expectations.

Across two dioceses in the Province of York, as well as in one Cathedral, auditors identified an innovative expansion of 'Safeguarding Sunday' into more comprehensive periods of observance. In one diocese, this evolved into a three-week 'Safeguarding Season', facilitating sustained engagement with complex themes; most recently, the programme focused on raising awareness and improving responses to domestic abuse.

Similarly, another diocese established a ‘Safeguarding Week’, offering an extensive range of events and resources. These sessions covered practical requirements, such as workshops on safer recruitment and Parish Safeguarding Dashboards, alongside specialised briefings on domestic abuse and the principles of trauma-aware practice.

At a national level, the audit observes that significant changes are underway to establish a more structured and systematic approach to the collection, analysis, and application of data. These improvements will facilitate more accurate progress tracking and enhance national oversight, while simultaneously providing deeper insights to inform safeguarding practices. Although the NST’s Data Analysis, Research and Evaluation (DARE) Unit is a relatively recent addition, the audit highlights the impactful work it has already delivered. A notable example is the **‘Five-Year Safeguarding Concern Review’**, which provides a comprehensive analysis of safeguarding concerns recorded across the Church of England between 2019 and 2023.

Recommendation 23: National

The NST should adjust its communication plan to include key safeguarding messages via its digital channels. This updated strategy should be explicitly role-specific, ensuring content is precisely targeted and relevant to the diverse stakeholders, be they staff, volunteers, or the general public.

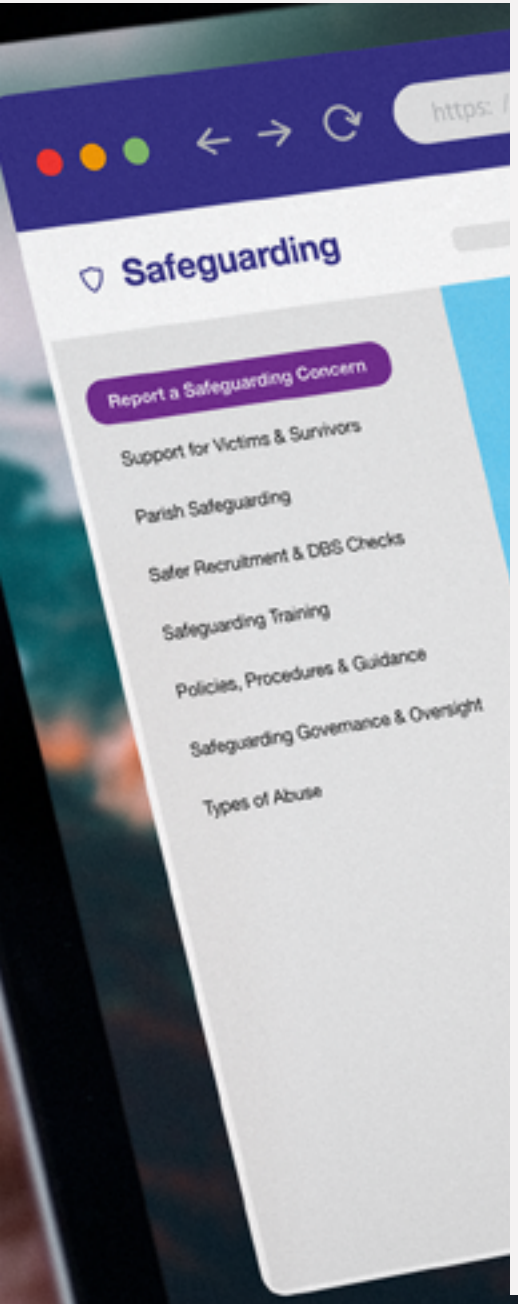
In order to enhance this engagement, it should:

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

b) Employ diverse communication strategies suited to each platform’s unique features and user expectations. For example, short-form portrait video, polls and support local events with targeted location-specific information.

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

d) The plan must also incorporate a robust process for capturing and analysing performance data to provide vital insight that will continuously inform and improve all future communications efforts.



Safeguarding Webpages

Building on a theme identified in 2024, safeguarding audits conducted throughout 2025 identified that organisations are prioritising the safeguarding information within their websites. Safeguarding is frequently featured as a primary menu item, positioned prominently on homepages and within main navigation bars to ensure high visibility and ease of access.

However, the audits also identified that there can be a tension between the quantity of information provided and its ease of use. As webpages evolve into centralised hubs, storing everything from DBS tools and training links to complex policy documents, the risk of 'information overload' has increased. A recurring finding across the audit reports is that essential tools, particularly those intended for parish-level use, can on occasion become buried within layered menu structures. To address this, organisations should implement clearer content hierarchies to ensure that critical reporting forms and safeguarding information remain intuitive for all users.

For practical guidance on achieving this, the **Independent Safeguarding Audit Annual Report 2024** provides a comprehensive overview of the standards required for high-quality safeguarding webpages. Furthermore, while current pages offer effective signposting for support services and disclosure pathways, there is a specific opportunity to strengthen victim/survivor engagement. Many sites would benefit from the creation of a dedicated, clearly marked page focused exclusively on victim/survivor support, ensuring these vital resources are both prominent and easy to navigate.

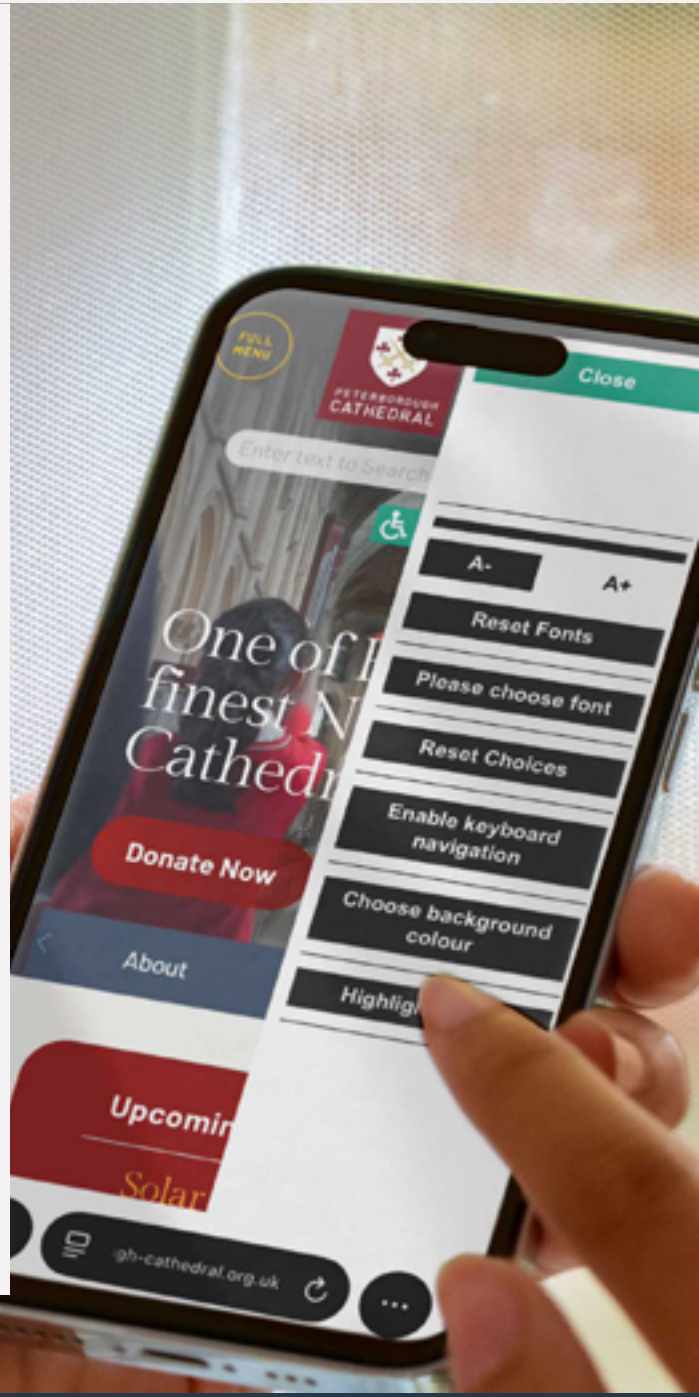
Findings from the 2025 audits consistently highlight the significant value that dioceses place on national resources and templates. This demand is clearly reflected in digital engagement trends, with the 'Templates and Resources' page becoming one of the most frequently visited sections of the national Church of England safeguarding webpages. Evidently, there remains a strong and ongoing requirement for practical tools and consistent resources to support the work of dioceses, parishes and cathedrals.

To improve inclusivity, organisations such as Peterborough Cathedral and the York DBF have been recognised for integrating various web-based accessibility tools. These features include on-site translation services and high-contrast colour schemes designed specifically for neurodivergent or visually impaired users. Furthermore, steps have been taken to ensure video content is supported by subtitles and full transcripts, making digital information more accessible to a wider audience.

The audit further highlighted the benefits of centralising support materials through dedicated, role-based platforms. A notable example was found on one diocesan website, which employed a tailored landing page specifically for PSOs. This page hosted curated welcome packs and instructional videos designed to guide officers seamlessly through core PSO responsibilities.

The 2025 audits have highlighted several examples of high-quality safeguarding communications, particularly where organisations have transitioned towards more strategically planned outreach. A notable strength is in the adoption of dedicated email marketing systems; by moving away from standard email clients, these organisations can track open and click-through rates, providing measurable insights into how effectively safeguarding content is being engaged with.

Furthermore, the implementation of structured content calendars has proven to be an effective way to ensure that messaging remains consistent, diverse, and proactive throughout the year. The audits also identified excellent practice in dioceses and cathedrals that actively monitor user behaviour via webpage analytics. By identifying which sections attract the most traffic, teams are able to make evidence-based decisions when redesigning digital platforms to better serve their communities.



Recommendation 24: National

While the existing Safeguarding Virtual Library provides a helpful foundation, the NST should develop a more ambitious Safeguarding Resource Library to actively drive the sharing of good practice across the Church. This enhanced library would build on current offerings by transforming a standard repository into a dynamic, comprehensive collection of resources and templates.

To achieve this, the NST could compile and host a wide array of online documents sourced not only from national materials but also from the best-practice examples already working well in different dioceses and cathedrals. An internal team would review all submissions to ensure clarity and consistency across the board.

Because many dioceses already have strong local templates, the NST should adopt a collaborative approach to sourcing this content. To streamline the collection and vetting of these materials, a clear process could be established where dioceses and cathedrals:

- Identify the specific type of resources they are offering.
- Align them with the corresponding national safeguarding standard.
- Agree to NST terms and conditions, ensuring that the resources meet agreed-upon quality assurance standards and that all material or image copyrights are secure.

Appropriate Boundaries

Building on the findings from 2024, the safeguarding audits in 2025 highlight several key trends regarding professional boundaries. The most notable development is the continued and comprehensive integration of national frameworks into local operations. Almost every audited body has adopted the Code of Safer Working Practice and the Safer Environment and Activities guidance as their essential benchmarks. These documents serve as the primary tools for defining acceptable conduct across the Church.

Audits conducted in 2025 demonstrate that safeguarding considerations are integrated into both the protocols and practical application of Deliverance Ministry in a deliberate and methodical manner.

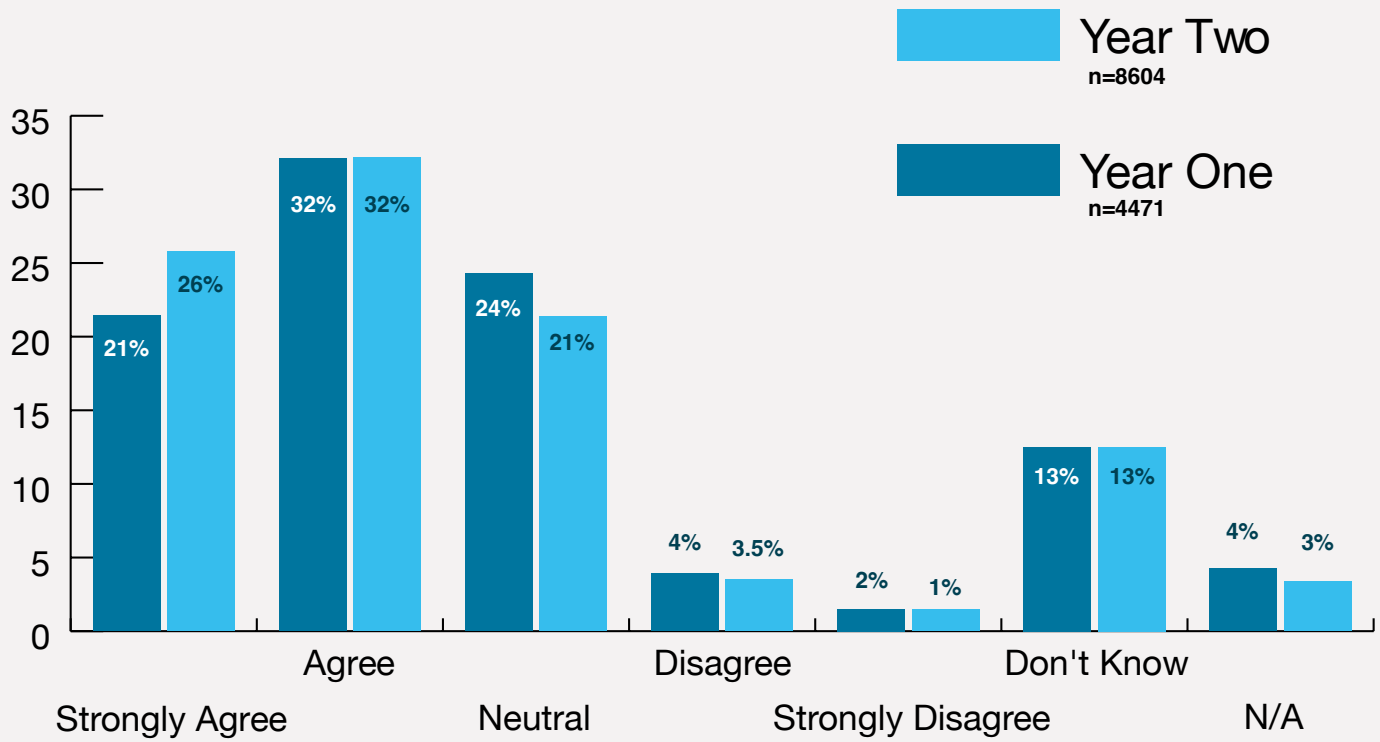
This approach aligns with the national House of Bishops' guidance, specifically within Section 4 of Safeguarding Children, Young People and Vulnerable Adults.

The 2025 safeguarding audits have identified several good practice markers that demonstrate a proactive approach to maintaining appropriate boundaries. A key focus is on proactive induction and training, where staff and volunteers are briefed on building layouts to identify potential blind spots. This is further supported by scenario-based learning, where small groups meet to discuss 'boundary scenarios' and share questions to embed a deeper understanding of safer practice.

'Codes of Behaviour' are now frequently displayed on noticeboards within bell towers and included in volunteer handbooks. This ensures that expectations regarding conduct are public, transparent, and easily accessible to all.

Children and Youth Ministry

> **I have seen improvements with the views of children and adults being heard.”**



The 2025 audits conducted across ten dioceses and cathedrals have highlighted several significant themes regarding the safeguarding of children and young people. A primary finding is that safeguarding is increasingly recognised as an integral component of youth ministry, rather than as an optional or additional requirement. However, the audits also identified a pressing need for greater consistency and uniformity in practice across the board. While there is an evident and enthusiastic appetite for expanding work with children and young people, this growth must be supported by a more robust framework, from initial funding and planning through to project delivery.

A key finding from the audit of the NST highlights that 'A Younger Church' remains a primary objective for the Archbishops' Council. In recognition of this commitment, the Council's Strategic Mission and Ministry Investment Board (SMMIB) has supported this objective by significant financial backing, with £97.3 million distributed through the Diocesan Investment Programme (DIP) and a further £3.8 million via People and Partnerships Funding (PPF). Significantly, almost 30% of these total allocations were earmarked specifically for youth engagement, discipleship, and leadership development. However, feedback suggests the grant application process requires very little detail from applicants regarding their safeguarding arrangements and current stipulations do not explicitly highlight opportunities for financial support directly aligned to such initiatives.

Furthermore, the requirements prevent allocated funds from being used to support "business as usual" services from already over-stretched DSTs. Consequently, the Audit finds it difficult to reconcile the distribution of such significant sums to youth-focused ministries without a proportional allocation for the safeguarding infrastructure required to protect them. To ensure the vision of 'A Younger Church' is both sustainable and 'safer by design', the financial commitment to growth must be matched by a commitment to protection. By aligning funding criteria with safeguarding requirements, the Church will address the current disconnect between ministerial expansion and the essential support services provided by safeguarding.

A standout theme is the meaningful inclusion of the "voice of the child." Several locations successfully established Youth Forums, empowering young people to influence practical safeguarding changes, such as adjusting the height of posters to ensure visibility for smaller children. This commitment to engagement extends to family activities, where targeted feedback forms are now used to explicitly gauge how safe children and parents feel during Church events.

Investment in people remains a cornerstone of good practice. There has been a notable move towards developing bespoke training for young leaders, often designed in partnership with professional children's and family workers. Furthermore, one diocese has enhanced its volunteer expertise by inviting external specialists including LADOs and Special Educational Needs Coordinators (SENCOs) to deliver briefing sessions.

A strong drive toward accessibility was highlighted in 2025. A significant strength identified across cathedral Education and Learning teams is the implementation of robust safeguarding measures for school visits and family engagement.

Several cathedrals have demonstrated a deep-seated commitment to enabling inclusive environments that go beyond standard curricular requirements, specifically tailoring their provision to support children and young people with additional needs.

This noteworthy practice is established at the outset through booking protocols, with some cathedrals mandating the collection of safeguarding information, including the details of the visiting school's Designated Safeguarding Lead, confirmation of adherence to required staff-to-student ratios, and the early identification of any additional needs.

This commitment to accessibility is further evidenced by the creative integration of practical resources designed to remove barriers to engagement. To support those with sensory processing sensitivities or communication difficulties, some cathedrals have introduced sensory backpacks, ear defenders, and social stories. Communication is also made more inclusive through child-friendly safeguarding posters featuring Makaton symbols.

Finally, some cathedrals have refined their feedback mechanisms to ensure the 'participant voice' is heard; by using evaluation forms equipped with visual aids, such as smiley-face scales, they ensure that children of all abilities can share their experiences.

Recommendations

Detailed findings and specific recommendations are set out in the full Audit Reports. Key national recommendations are included below to highlight immediate priorities.

Recommendation 25: National

In recognition of the unique risks and complex safeguarding considerations inherent in children and youth-focused ministries, it is recommended that Archbishops' Council, with the advice of the NST, and the Strategic Mission and Ministry Investment Board (SMMIB) undertake the following:

- Integrate Safeguarding into the Bidding Process: The SMMIB should mandate that all future funding applications for Children and Young People (CYP) ministries include a comprehensive outline of safeguarding measures and delivery arrangements. Evidence of robust oversight must be a prerequisite for the approval of any Diocesan Investment Programme (DIP) or People and Partnerships (PPF) award.
- Permit Proportional DIP Funding for Safeguarding Infrastructure: Current DIP funding stipulations should allow for a proportional allocation of grant monies to be directed towards safeguarding support services. This ensures that the expansion of youth ministry is accompanied by the necessary investment in DSTs and the professional infrastructure required to protect participants.

Recommendation 26: National

The Church of England's NST and the wider Archbishops' Council should establish a national safeguarding strategy for Children and Youth Ministries. This strategy should adopt a collaborative, coordinated, and holistic approach, with part of the implementation and local data collection being driven locally in Dioceses in support of the NST's national oversight role. This national strategy could include, but not be limited to the following objectives:

- Mapping of Programme Types: Scope the extent and the types of children and youth activities taking place across the Dioceses.
- Workforce Oversight and Data: To establish an ambition and work plan to support Dioceses in identifying and maintaining oversight of all paid and volunteer children and youth workers, feeding this critical data into a national database.
- Stakeholder Participation: to ensure appropriate consultation and engagement with children, youth, and their leaders through specific participation activities.
- A Tailored Learning Programme: To develop and implement safeguarding training that is specific to children and youth ministry, ensuring it is effectively tailored to both the individual's role (e.g., volunteer leader, paid worker, clergy) and the regional context in which they serve.

Recommendation 27: National

A collaborative and coordinated approach should be adopted for further development of national safeguarding guidance within the context of children and youth ministries. This must commence with a mapping exercise, conducted simultaneously with the identification of any existing gaps. This approach must include robust quality assurance mechanisms and specialist safeguarding advice and input. The objective would be to establish a centralised resource for the House of Bishops' Safeguarding Guidance (specifically its 'due regard' requirements) and integrate it fully into the Church of England's (CofE) Safeguarding e-manual. Implementing this centralised guidance would be expected to emulate the established benefits and efficiency demonstrated by the existing guidance and Codes of Practice within the manual.

Lone Working

Throughout 2025, a recurring theme has been the application of formal, standalone lone working policies and risk assessments designed to mitigate risks for both staff and volunteers. These local arrangements have been aligned with national Church of England frameworks, specifically integrating the Code of Safer Working Practice and the Safer Environment and Activities guidance.

Effective lone working occurs when formal policies are successfully integrated into daily operations. An example of this is the adoption of two-way radios within several cathedrals to ensure constant communication. Furthermore, various dioceses have enhanced provisions by providing parishes with standardised resources, such as comprehensive home-visiting checklists and personal risk assessment templates.

CCTV

Findings indicate that while CCTV is recognised as a fundamental component of physical security and safeguarding, its application and effectiveness vary considerably across cathedral estates. In several instances, CCTV is identified as playing a crucial role in enhancing overall security in cathedrals, yet these systems are not always monitored on a 24-hour basis, with some oversight being managed by verger teams or external companies. There is a widespread acknowledgment that existing coverage often contains vulnerable gaps that need to be addressed to ensure a safer environment for all visitors and worshippers.

To strengthen preventative measures, the audits have recommended a strategic expansion of CCTV coverage, particularly in sensitive locations where children and vulnerable individuals frequently congregate. This includes prioritising the installation of cameras in education rooms, chorister practice spaces, entry and exit points, and areas at the rear of buildings that may currently lack sufficient visibility.

Recognising, Assessing & Managing Risk

Risk Registers

Audits during 2025 have identified a recurring trend in which ‘safeguarding’ is treated as a subset of the DBF corporate or strategic risk registers. The audit frequently observed that this approach can limit the scope of oversight. As such, the audit recommends a decisive shift toward establishing standalone operational registers. By separating safeguarding from broader corporate risks, the organisation can ensure more focused scrutiny and facilitate the targeted analysis required to manage these sensitive issues effectively.

Another theme is the focus on governance and review cycles. While most registers are established, there is a noted inconsistency in the frequency and documentation of reviews. Auditors frequently recommended that registers should be updated on a minimum quarterly cycle. There is also an emphasis on ensuring clear risk ownership to strengthen accountability.

An audited cathedral was recently commended for its good practice in developing an environment-based risk register, which specifically logs the safeguarding risks inherent to its unique physical architecture and surroundings. This example highlights how risk registers can be significantly strengthened when they move beyond generic templates. By incorporating context-specific assessments, organisations ensure that their safeguarding measures are precisely tailored to the unique nature of their setting, rather than relying on a one-size-fits-all approach.

One of the audited bodies has aligned its risk register categories with the five national safeguarding standards. By mapping these risks directly to the national framework, the organisation has ensured that its internal reporting is both consistent and logically structured.

Good practice observed highlights that the risk register should not merely be ‘maintained’ in a passive sense. Instead, it should be subject to in-depth examination at the executive level, with its review serving as a standing agenda item for all relevant senior leadership and advisory groups.

Finally, as evidenced in one DBF, the most effective risk management is dynamic and proactive. Rather than being static documents, registers should be ‘living’ documents which respond to recent events and broader national trends. This ensures that the organisation remains sensitive to the evolving safeguarding landscape and can adapt its controls to meet emerging challenges.

Case Management

A consistent theme across Audit reports is the widespread adoption of a 'low-threshold' model for receiving contacts. By design, this approach develops a culture of open communication, ensuring that all contacts are captured, identified and addressed before they might escalate further. However, while this strategy has successfully increased the volume of engagement with DSTs, it has simultaneously created additional pressure on their workload and overall capacity.

The 2025 audits revealed that most DBFs have now adopted the National Safeguarding Case Management System (NSCMS) as their primary platform for case management. Among those yet to fully implement the system, the majority are currently in the process of transitioning to it.

Furthermore, one DBF has successfully completed the initial setup but has not yet finished migrating its existing records to the new platform.

A recurring theme identified across bodies audited in 2025 is the set of inherent challenges posed by the NSCMS. These difficulties stem primarily from the fact that the platform was originally designed for the education sector; consequently, it lacks the bespoke functionality necessary to navigate the Church's unique safeguarding environment. Despite these structural limitations, the audit identified several instances of good practice in how the NSCMS is being implemented, adapted and utilised within dioceses and cathedrals. To build on this, the NST audit report includes specific recommendations that address these recurring themes.

Key among these is the proposal to identify

'pockets of excellence' and establish a central online repository, ensuring that successful methods and resources can be effectively shared and accessed across the wider Church.

A recurring area for improvement identified during the 2024 to 2025 audits is the lack of consistency in how the NSCMS is utilised across different dioceses. Although the system employs a standardised configuration with uniform filters and categories, practical application varies significantly between dioceses. This divergence in data recording practices undermines the very uniformity the software was designed to achieve. Although this issue is addressed in more detail within the audit report for the NST, the recommendation is included below as it stems directly from findings identified during diocesan audits.

A small number of dioceses encountered challenges regarding legacy data, leading to specific recommendations for these DBFs. To ensure the ongoing accuracy of the NSCMS, it was recommended that these organisations 'cleanse' and curate any data migrated from older systems.

Another emerging trend is the transition toward geographical allocation models. Large dioceses like London and Portsmouth allocate advisers to specific episcopal or geographical areas to build stronger relationships with local parishes and provide more informed responses.

Several areas were commended for their robust and structured approaches to managing risk. One diocese has demonstrated significant procedural strength through the appointment of a dedicated casework manager. By centralising the assessment of all incoming matters and assigning initial risk thresholds, the diocese ensures an efficient and consistent triage process.

Furthermore, safeguarding teams have demonstrated significant ingenuity in managing administrative workflows by developing practical workarounds within the NSCMS. These solutions allow for a clearer distinction between cases requiring active allocation and those destined for closure, ensuring the system remains accurate, manageable, and efficient.

Recommendation 28: National

The NST should develop and issue comprehensive national guidance to refine the use of the NSCMS. This policy should move beyond basic functionality to establish clear, standardised principles for professional recording. The guidance should address, at a minimum:

- Clarity on the specific types and thresholds of safeguarding concerns that require formal entry into the system. This should include a clear protocol for recording “advice-only” interactions, such as when a diocesan team provides guidance to a parish, to ensure such interventions are captured consistently.
- Provide a framework for the decisions safeguarding teams make when allocating risk levels. This should include the specific criteria to be used when determining a risk rating, ensuring that risk is assessed and recorded uniformly across the Church.
- To improve the quality of casework oversight, the use of chronologies within the system should be reviewed. Recording should shift from a simple index of all administrative activity toward a practice-led approach that highlights “significant events,” providing a more meaningful narrative of the safeguarding journey.
- A requirement that a clear and comprehensive rationale is recorded for all decisions. Documentation should explicitly detail the justification for both the commencement of specific actions and crucially, the decision-making criteria applied when a standard intervention is deemed unnecessary or is intentionally omitted.
- Introduce and enforce formal naming conventions for all file types to ensure data remains organised, searchable, and consistent across different dioceses.

Safety Plans

Across the audited dioceses and cathedrals, Safety Plans are consistently a primary mechanism for managing risks posed by convicted offenders or who pose a potential risk within Church communities. These plans are typically initiated in response to concerns involving church officers or high-risk individuals seeking to participate in services. The volume of active plans varies significantly by region. While most cathedrals have established processes for such agreements, several did not have any active plans at the time of the audits.

A prominent trend is the adoption of a multi-agency approach, with many dioceses collaborating with statutory bodies, the police, and probation services to ensure plans are robust and well-informed. There is also a clear shift towards standardisation, with most areas now utilising the National CofE templates.

However, as raised previously by the audits, a need for specialised, context-specific training on this subject has been identified. There is a notable demand for bespoke training for incumbents, PSOs, and ‘reference groups’ who manage these individuals on the ground. This is particularly critical in faith-based environments where the dynamic nature of risk must be balanced with pastoral care. Furthermore, there is an emerging focus on the welfare of the respondent; several reports highlighted the importance of ensuring that while risks are mitigated, the individual’s own safety and support needs are considered, often within a trauma-informed framework.

The audits identified several areas of good practice that contribute significantly to the rigour of safety plan arrangements. A key factor in their effectiveness is the inclusion of detailed restrictions and transparency.

This is reinforced by structured review processes, where regular, face-to-face meetings involving the DST and local incumbents or those on the reference group ensure that plans remain dynamic and responsive to changing circumstances.

Furthermore, the audits commended the presence of strong professional relationships, noting evidence of professional curiosity and open communication between incumbents and their management of respondents. These arrangements are especially effective when respondents demonstrate a clear understanding of their own risk. In one noteworthy example, a DBF provided localised resources, such as video briefings regarding the risk of harm posed by some respondents and specific role descriptions for those in support roles.

Recommendations

Building on these findings, the NST's audit report sets out specific recommendations designed to address these themes. The key national recommendations are included below.

Recommendation 29: National

Archbishops' Council, working through the NST, should develop a national framework for addressing the issue of risk assessments and safety plans.

This framework must encompass, but not be limited to, developing a national risk assessment matrix for safeguarding individuals who pose a risk in church settings, context-specific training provisions, including the creation of comprehensive, structured national guidance materials. Crucially, this framework should be designed to directly assist the DSTs in their work establishing and supporting Reference Groups.

This national resource bundle should include several key elements: detailed Guidance Material for Reference Group Members, which clearly articulates the core purpose and implementation process of a Safety Plan; a defined Role Description providing a national template for the duties, responsibilities, and required personal qualities of Reference Group members; and a formal, mandatory Statement of Confidentiality for anyone with knowledge of a Safety Plan.

The bundle should also include robust Operational Training Materials, offering context-specific practical resources and techniques for applying the Safety Plan within specific parish scenarios and evaluating potential risks; for monitoring individuals, including techniques for conducting necessary conversations.

Recommendation 30: National

The NST, in collaboration with national ecumenical bodies, should seek to facilitate the development of a formalised National Information Sharing Model. This framework should be designed to mirror the efficacy of the INI (Interpreting National Intelligence) systems used by UK Police forces, ensuring that when a respondent moves between different denominational jurisdictions, the associated risk and oversight requirements move with them.

This framework should codify the “Bilateral Responsibility” for risk disclosure. The Respondent’s Obligation: To ensure full transparency, the framework should mandate that any individual currently subject to a Church Safety Plan (CSP) has a formal requirement to disclose their status to the leadership of any new church or denomination they join.

The DBF in the “exporting” diocese must have a formalised duty to notify their counterparts in the “importing” body. This must include the transfer of the most recent risk assessments, active CSPs, and Reference Group minutes.

Recommendation 31: National

The NST should develop and disseminate comprehensive guidance establishing clear thresholds and criteria for the cessation of Safeguarding Safety Plans. This framework is essential to ensure that the removal of individuals from active monitoring is a structured, objective risk-based decision rather than a subjective administrative decision.

Recommendation 32: National

The NST should review and consider options for how the NSCMS can be adapted to best meet the reporting and record-keeping needs associated with inactive or formally ended safety plans. This review should prioritise the introduction of a clear, auditable status field/flag (e.g., ‘Inactive’ or ‘Ended’) that allows users to retain the full plan record while accurately removing it from the count of active plans measured by the ‘Profile Flag’ mechanism.

Safeguarding Case Management Groups

A prominent theme across the audits is the formalisation and standardisation of Safeguarding Case Management Groups (SCMGs) to manage complex safeguarding cases involving church officers. Most dioceses have transitioned to using structured agendas to ensure that meetings are consistent and thorough. There is a clear trend towards multi-disciplinary collaboration, with attendance often including Archdeacons, Bishops' Chaplains, Registrars, and communications support to ensure legal, pastoral, and reputational risks are managed alongside safeguarding concerns. However, while activity is robust at the diocesan level, several cathedrals reported low volumes of SCMG activity

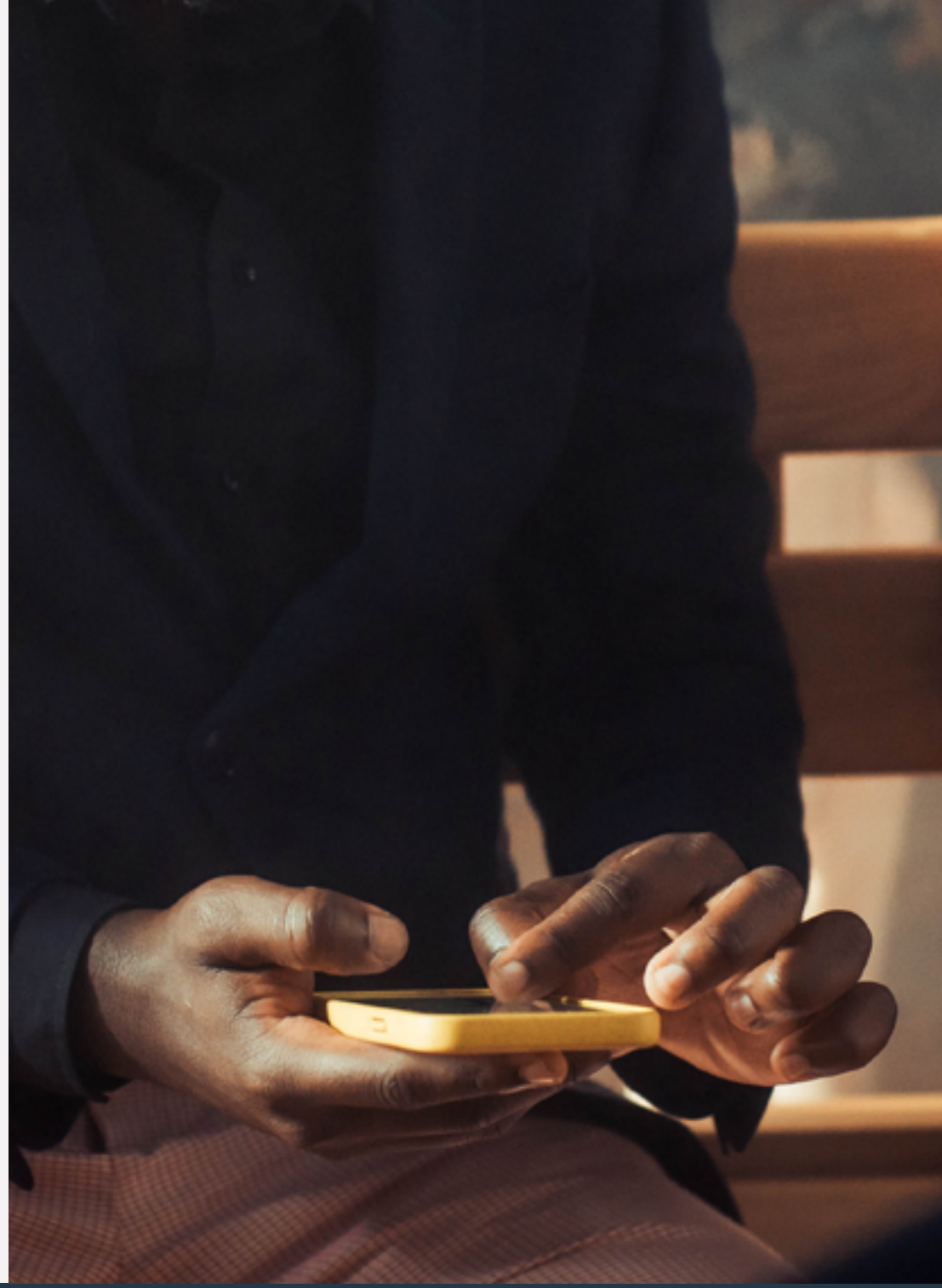
Good practice in effective SCMGs include efforts to streamline logistics and ensure a culture of scrutiny and authority. An example includes the implementation of prompt response mechanisms, such as pre-scheduled weekly slots. This proactive approach ensures that SCMGs can convene within 48 hours, facilitating swift decision-making when it is needed most.

Year 2 audits continued to highlight the value of SCMGs. These groups have proven essential for facilitating collaborative and transparent decision-making on complex cases, especially when chaired by senior figures such as an Archdeacon or a Bishop's Chaplain. Furthermore, incorporating a dedicated "lessons learned" segment into minutes demonstrates a commitment to systematic review and the continuous improvement of safeguarding practices.

Serious Incident Reports

A consistent theme across both DBF and cathedral settings is the recognition of the statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. This is an area that requires attention and will be an area of focus for the 2026 audits.

There is a disparity in the levels of information sharing concerning SIRs to the NST. While many entities ensure the NST is appropriately informed of all SIRs, others have not done so. The Audit is aware that the NST is working to address this.



Information Sharing Agreements

The following summary outlines the key themes, trends, and good practices regarding Information Sharing Agreements (ISAs) as identified across the 2025 safeguarding audit reports for DBF areas and cathedrals.

There is a clear trend towards formalising inter-organisational collaboration through MoUs and SLAs. These are frequently used to bridge the gap between DBFs and their respective cathedrals, defining how safeguarding data and case oversight are managed. However, the audits also identified a gap in some areas between the existence of these agreements and their actual implementation, with findings from several reports recommending regular reviews to ensure these documents remain effective and understood by all parties.

Several dioceses have demonstrated exemplary practice by establishing formal SLAs and ISAs with a diverse range of partners. These collaborations include translation services, survivor support charities, and ecumenical bodies such as the Catholic Church.

Beyond these broader trends, there has been measurable progress within individual dioceses between audit cycles. A primary example is a diocese in the South West, which, since its audit, has successfully implemented an ISA with the Probation Service. This framework ensures that the diocese is better equipped to collaborate and exchange information securely and systematically. By sharing vital information to mitigate risk, the Church strengthens its overall safeguarding provision, while simultaneously allowing the Probation Service and other statutory bodies to gain a more nuanced understanding of the specific requirements of a faith-based environment. Furthermore, the proactive adoption of the NSCMS, supported by dedicated data-sharing protocols, is enhancing data security and information governance.

GDPR / Data Sharing

The following analysis outlines the key themes, trends, and areas of good practice regarding GDPR, data sharing, and confidentiality identified across the 2025 safeguarding audits.

A recurring vulnerability identified in the audits is the use of personal email addresses and devices by volunteers and PSOs. This presents a substantial security risk, particularly regarding data succession; for instance, one audit highlighted the extreme difficulty in retrieving sensitive records from a deceased PSO's personal laptop. Consequently, there is a clear trend to-ward mandating dedicated Church email addresses and establishing formal data succession plans to ensure emergency access to records.

Furthermore, while staff typically receive regular GDPR training, there is an identified gap in extending this mandatory training to volunteers and clergy in some areas.

The audits identified several strong practices that support effective data management and confidentiality. A significant strength is the use of multi-layered encryption; the implementation of specialised tools such as Egress for communications with LADO, alongside Microsoft 365 encryption for internal sensitive data, represents a high standard of practice.

Furthermore, data sharing has been formalised through MoUs and ISAs. These agreements between DBFs, Cathedrals, and external bodies ensure a coherent framework for exchanging sensitive information.

Complementing these measures are strict access protocols. By using a dedicated safeguarding inbox restricted to authorised personnel and enforcing a total prohibition on the use of personal email addresses for sensitive matters, the organisation ensures data integrity is upheld.

Victims & Survivors

The audits conducted so far offer clear insights into how Church bodies engage with, listen to, and support victims and survivors. These lessons are collected in a dedicated companion document that outlines common themes, highlights areas of good practice, and proposes steps to ensure a consistent, trauma-informed, and survivor-centred approach across the Church of England.

The Audit Team is grateful to everyone who shared their experiences. Their voices have shaped this companion document and the Audit Team thanks them for their time, reflections and trust.

Please refer to the Victim and Survivor Engagement and Support Companion Report 2025

Victim and Survivor Engagement and Support Companion Report 2025

https://ineqe.com/churchofengland/#annual-report

Learning, Supervision & Support

Safeguarding Learning

Across Year 2 audits, compliance with the Church of England safeguarding learning framework remains strong. Most dioceses and cathedrals are able to demonstrate clear recording of training completion and oversight of mandatory requirements. There is clear commitment to ensuring clergy, staff, and volunteers undertake required safeguarding learning.

However, a consistent theme across diocesan and cathedral audits is the need to move beyond compliance towards impact. Whilst attendance and completion data are generally well monitored, fewer settings have structured mechanisms to evaluate whether learning is influencing confidence, decision making, or safeguarding culture. Impact evaluation remains underdeveloped in several contexts. Feedback on course material and delivery in general tends to focus on the Leadership module, with less importance given to basic and foundation safeguarding courses and other modules.

Capacity continues to shape quality. In settings where safeguarding learning is delivered by small teams or single post holders, sustainability and innovation can be constrained. Where there is broader training infrastructure, planning is more strategic and responsive to emerging themes. Contextualisation also remains a differentiator. Participants reported that training is most effective when it reflects the realities of their environment, whether that is cathedral life, rural ministry, complex urban contexts, or specialist roles. Generic delivery, whilst useful as an induction to Church safeguarding, is sometimes experienced as less directly transferable into practice.

The Audit of the NST in Year 2 examined learning strategy, evaluation processes, and feedback mechanisms at national level. Themes identified locally, particularly around evaluation of impact and contextual development of content, were tested directly through that audit. The recommendations made to the NST are therefore integral to strengthening consistency and responsiveness across the system and should be read alongside this section.

Strong practice was observed in dioceses and cathedrals where, despite limited capacity within central training teams, responsibility for maintaining training records was appropriately shared across relevant departments, such as Mission and Ministry and the Bishop's Chaplain. In these settings, individual teams managed their own records, with oversight and quality assurance provided by the safeguarding training lead or manager to promote local accountability while reducing the risk of gaps in recording or compliance.

Co-delivery models, trainer mentoring, and peer review processes were identified as strengthening quality assurance. Where training teams were adequately resourced, there was greater capacity to refresh materials, introduce thematic inputs aligned to emerging risks, and respond to participant feedback.

Particularly effective practice was evident where safeguarding learning was clearly contextualised. This included tailored sessions for cathedral teams, such as Music Departments, who engage regularly and routinely with significant numbers of children and young people. It also included the development/adaptation of courses to suit those with learning needs or under 18 volunteers.

Additionally, specialist briefings for roles carrying heightened safeguarding responsibility, alongside regular scenario-based sessions for wider staff groups were highlighted as good practice. These sessions drew on anonymised case studies and practical examples to explore how to respond in complex or less obvious situations. Participants consistently described this approach as practical, relevant, and reflective of the realities of their roles.

Finally, when constructing safeguarding courses, educators should prioritise trauma-informed design and avoid the mistaken assumption that audiences, even those comprising senior staff or experienced trainers, do not include survivors. While engaging survivors in co-production is vital, their lived experience is most safely and effectively embedded into training through composite scenarios rather than real cases, especially recent ones. Relying on actual events risks not only triggering trauma but also inadvertently exposing individuals through ‘jigsaw identification’, where a person can still be recognised even when names are removed.

Aligning with principles established by the Information Commissioner’s Office (ICO) and the General Medical Council (GMC), true anonymisation requires that individuals cannot reasonably be identified by combining available details. If robust anonymisation is impossible, educators must either obtain explicit consent or use composite cases. In practice, composites are widely regarded as good practice across medicine, social work and policing; they shift the burden onto the educator to justify the necessity of an identifiable case, prevent learners from becoming distracted by public personalities or media narratives, and allow multiple complex safeguarding themes to be integrated into a single realistic scenario focused on transferable professional judgement and decision-making.

Recommendations

The recommendations arising from the audit of the NST relating to learning strategy, evaluation of impact, and feedback mechanisms are directly relevant to this section and should be read as forming part of the system wide response. In addition:

Recommendation 33: Local

Dioceses and cathedrals should develop or refresh a documented safeguarding learning strategy aligned to the national framework, incorporating mechanisms to evaluate impact beyond attendance and completion rates.

Recommendation 34: Local

Dioceses and cathedrals should ensure that safeguarding learning is appropriately contextualised to reflect the environments in which clergy, staff, and volunteers operate, including cathedral and specialist ministry settings.

Supervision and Support of Safeguarding Roles

Structured professional supervision for DSOs is widely established and consistently valued. Access to supervision through Regional Safeguarding Leads provides reflective space, professional challenge, and case discussion. Participants frequently described supervision as essential to maintaining professional resilience in the complex safeguarding work they undertake.

However, the translation of learning arising from supervision into wider organisational improvement is less consistently evidenced. Whilst individual supervision conversations are generally reflective and robust, mechanisms to collate recurring themes and feed them into training development, policy review, or governance reporting are variable.

Workforce resilience remains a theme across year 2 audits. The Audit's surveys reveal commentary that highlights safeguarding teams being stretched and overworked. Where teams are small, workload pressures can affect capacity for strategic development, thematic analysis, and proactive engagement.

The audit of the NST examined supervision frameworks at national level, including structures supporting Regional Safeguarding Leads. Strengthening clarity, consistency, and feedback loops within national supervision structures will further reinforce local arrangements.

Good practice was observed where supervision was underpinned by clear agreements, structured recording, and protected time. In these settings, supervision considered practitioner wellbeing alongside oversight of cases to reinforce sustainability and reflective practice.

Particularly strong examples included periodic thematic review of supervision discussions to identify recurring trends, training needs, or emerging risks. Where these themes were reported to senior leadership or governance bodies, there was clearer evidence of organisational learning.

Collaborative relationships between DSOs, senior leaders, and governance bodies also strengthened safeguarding oversight, particularly where supervision insights informed strategic planning.

Recommendation 35: Local

Dioceses and cathedrals should ensure that supervision arrangements for safeguarding roles include periodic thematic review to identify recurring issues, workforce pressures, and training needs.

Recommendation 36: Local

Governance bodies should receive regular reporting on supervision themes and workforce capacity to support strategic oversight and resilience planning.

Clergy Support

Clergy safeguarding learning and support arrangements continue to develop across dioceses. Survey data indicates high confidence in knowing how to report concerns and strong belief that safeguarding is everyone's responsibility.

Integration of safeguarding within MDR processes is increasingly evident and reflects recognition that safeguarding is core to ministry rather than an adjunct responsibility.

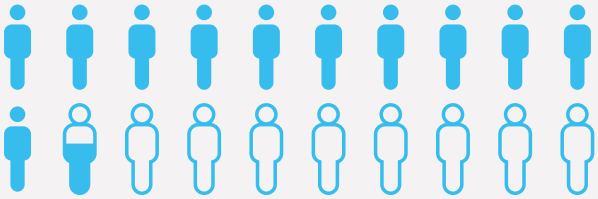
However, consistency in the depth and documentation of safeguarding reflection within MDRs varies. In some settings, safeguarding is meaningfully discussed and linked to development planning. In others, engagement is more limited or compliance focused.

Clergy wellbeing remains closely connected to safeguarding culture. Where clergy feel supported, appropriately challenged, and able to seek advice without stigma, safeguarding confidence is strengthened. Conversely, where support mechanisms are unclear or inconsistently applied, risk of isolation increases. Most workforce respondents expressed confidence they would be supported if a complaint were made against them. A notable proportion were either unsure, neutral, or did not feel confident that appropriate support would be available.

Where clergy or church officers lack clarity about how they would be supported during a safeguarding process, this can contribute to anxiety, defensiveness, or cultural hesitancy. Strengthening transparency around processes, expectations, and available support mechanisms would reinforce confidence and help ensure that safeguarding procedures are experienced as both rigorous and just.

Clergy Responses to Audit Surveys on Perceived support if a complaint is Made

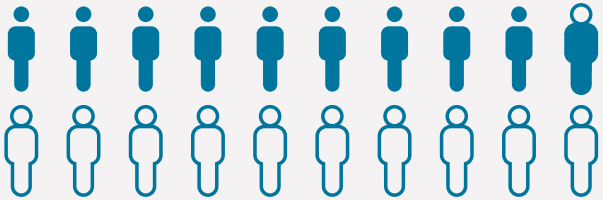
Clergy who completed DBF Workforce Survey *(n=107)*



57%

61/107 feel they would be supported if a complaint was made against them.

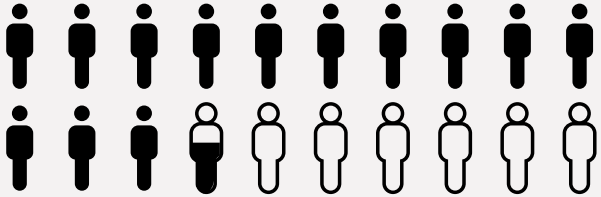
Clergy who completed the Parish Workforce Survey *(n=919)*



49%

446/919 feel they would be supported if a complaint was made against them.

Clergy who completed the Cathedral Workforce Survey *(n=80)*



68%

54/80 feel they would be supported if a complaint was made against them.

Source: 2025 DBF, Parish and Cathedral Workforce Surveys issued by the Audit.

Themes identified through diocesan audits regarding clergy learning and support were also considered through the audit of the NST, particularly in relation to guidance, national coordination, and clarity of expectations.

Strong practice was observed where safeguarding formed a substantive part of MDR conversations and where clergy were encouraged to reflect on safeguarding leadership within their minis-try context.

In several settings, bishops and senior leaders demonstrated visible commitment to safeguarding learning, reinforcing expectations through communication or personal engagement with staff and volunteers.

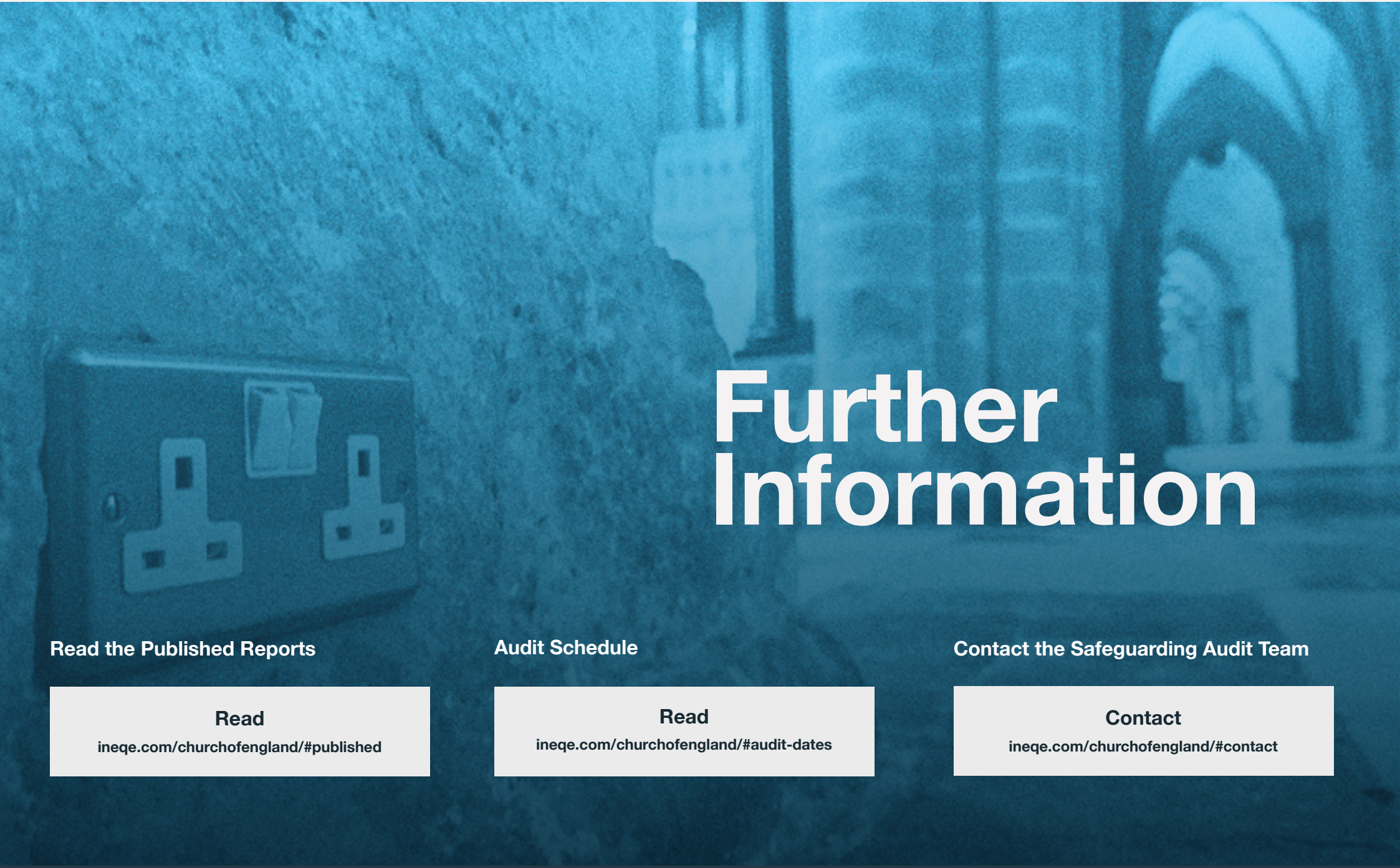
Accessible advice lines, informal consultation opportunities with DSOs, and early engagement in emerging concerns were also highlighted as strengthening clergy confidence and reducing escalation risk.

Recommendation 37: Local

Senior leaders should continue to promote visible engagement with safeguarding learning and reinforce expectations that safeguarding is integral to ministry leadership

At the time of writing, the Audit has noted that paragraphs 3.5 and 3.6 of the Clergy Discipline Commission's Annual Report for 2024–2025 (GS Misc 1457) raise concerns about the adverse publicity experienced by clergy named in connection with the Makin Review. While the report rightly highlights the impact on their wellbeing and affirms the confidentiality provisions of the CDM Code of Practice, the Audit is concerned that, as currently constructed, the commentary could be interpreted as criticising the institution for confirming the existence of CDM proceedings.

However, on balance, given the individuals in question had already been publicly identified in the published Makin Review, the Audit views the approach as proportionate and consistent with the Code. Most importantly, the actions aligned with good practice regarding victims and survivors, promoting transparency, survivor confidence and public accountability.



Further Information

Read the Published Reports

Read
ineqe.com/churchofengland/#published

Audit Schedule

Read
ineqe.com/churchofengland/#audit-dates

Contact the Safeguarding Audit Team

Contact
ineqe.com/churchofengland/#contact

Diocesan Safeguarding Contacts

To locate the contact details of the safeguarding team from the diocese you need to contact please visit:

Diocesan safeguarding contacts | **The Church of England**

www.churchofengland.org/safeguarding/diocesan-safeguarding-contacts

Under 19 and Need to Talk?

Call Childline for free on 0800 1111 or get in touch online. You can talk to Childline about anything. No problem is too big or too small. It's confidential.

Contact Childline

www.childline.org.uk

Safe Spaces

Safe Spaces is a free and independent support service, providing confidential, support to survivors of church related abuse. Call for free on 0300 303 1056.

Email Safe Spaces

safespaces@firstlight.org.uk

Visit Their Website

www.safespacesenglandandwales.org.uk

Samaritans

Samaritans adult helpline is available for whatever you're going through. Call for free, anytime on 116 123.

Email Samaritans

jo@samaritans.org

Visit Their Website

www.samaritans.org/how-we-can-help

NSPCC

Contact the NSPCC Helpline for adults concerned about a child's safety or wellbeing. Call for free on 0808 800 5000.

Email NSPCC

help@nspcc.org.uk

Visit Their Website

www.nspcc.org.uk/keeping-children-safe/reporting-abuse/nspcc-helpline

Glossary of Terms

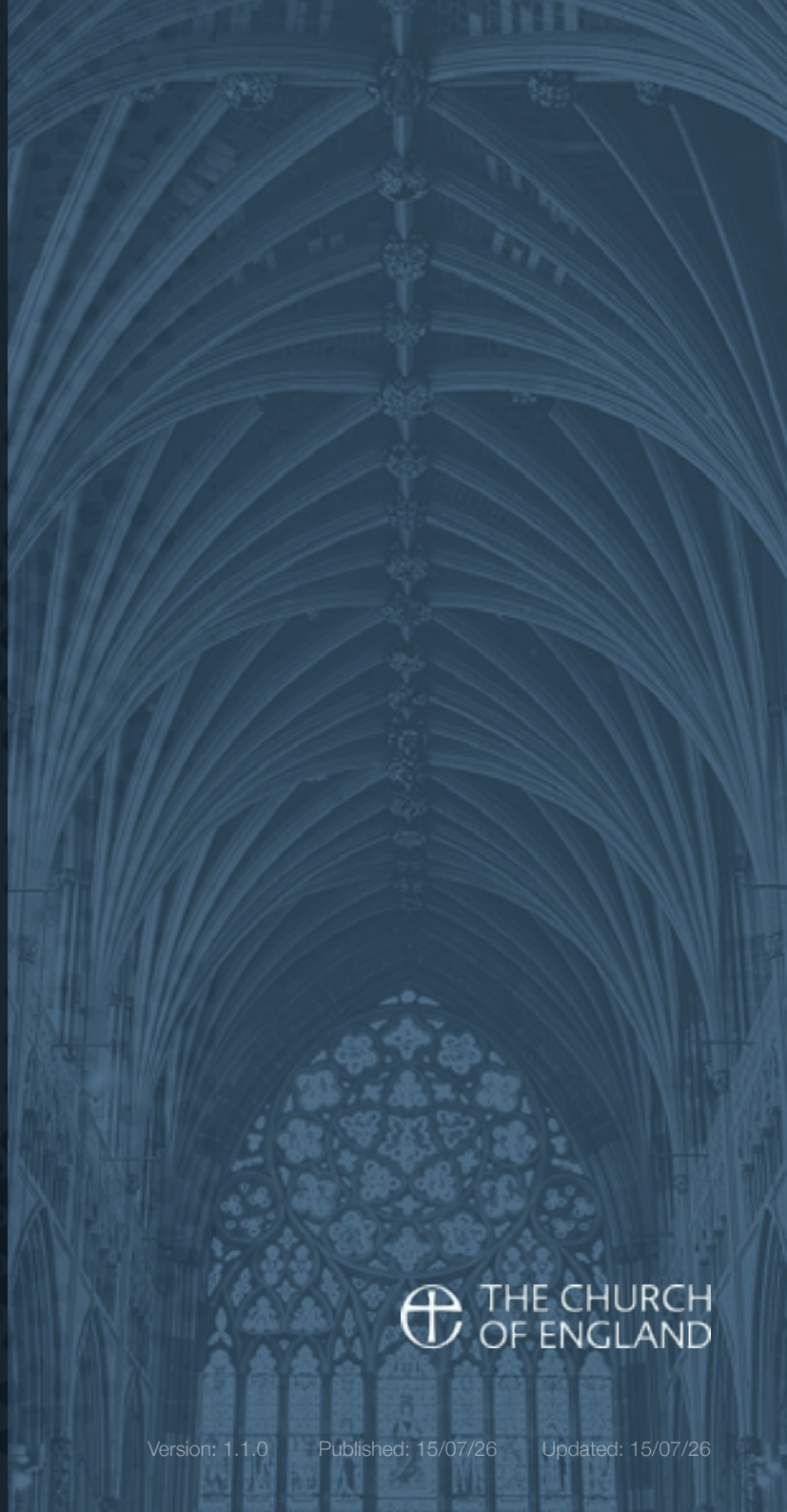
Acronym	Full Definition
CCSL	Clergy Current Status Letters
CDM	Clergy Discipline Measure
CofE	Church of England
CSA	Cathedral Safeguarding Adviser
CSAP	Cathedral Safeguarding Advisory Panel
CSO	Cathedral Safeguarding Officer
CYP	Children and Young People
DARE Unit	Data Analysis, Research and Evaluation Unit
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DIP	Diocesan Investment Programme
DSAP	Diocesan Safeguarding Advisory Panel
DSL	Designated Safeguarding Lead
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
GDPR	General Data Protection Regulation
GMH	Global Majority Heritage
HR	Human Resources
ISA	Information Sharing Agreement
KCSIE	Keeping Children Safe in Education
LADO	Local Authority Designated Officer
LLF	Living in Love and Faith
LLR	Lessons Learned Review
MDR	Ministerial Development Review
MoU	Memorandum of Understanding
NCI	National Church Institution
NSCMS	National Safeguarding Case Management System
NSSG	National Safeguarding Steering Group
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PPF	People and Partnerships Funding
PSO	Parish Safeguarding Officer
SCIE	Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SENCO	Special Educational Needs Coordinator
SIR	Serious Incident Report
SLA	Service Level Agreement
SMG	Safeguarding Management Group
SMMI	Strategic Mission and Ministry Investment Board
SNEM	Senior Non-Executive Member
UKME	United Kingdom Minority Ethnic

Contact Us

+44 (0) 2890 232 060

ineqe.com/churchofengland/#contact

ineqe.com/churchofengland



THE CHURCH OF ENGLAND

Version: 1.1.0 Published: 15/07/26 Updated: 15/07/26