Independent Safeguarding Audit of the Southwell and Nottingham Diocesan Board of Finance and Southwell Minster

2026

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Introduction

1 Introduction

1.1 The independent safeguarding audit programme for the Church of England (CofE) was commissioned by the Archbishops' Council and is overseen by the CofE's National Safeguarding Team (NST). Led by the INEQE Safeguarding Group and working to a consistent framework, the audits test the sufficiency of safeguarding arrangements within Diocesan Boards of Finance (DBFs) and Cathedrals. They have a particular focus on the CofE's new National Safeguarding Standards that provide the structure for this report.[1]

1.2 Audit findings have taken account of the Social Care Institute for Excellence (SCIE) audits, Past Cases Review 2 (PCR2) outcomes, other relevant material as well as evidence from surveys, focus groups, direct correspondence and interviews. For Southwell and Nottingham Diocesan Board of Finance (DBF) and the Cathedral, Southwell Minster, this involved the following:

- Over 830 documents being collated and analysed prior to the Audit's fieldwork.
- A range of interviews being held with church officers (staff and volunteers), external partners, victims, survivors and other stakeholders.
- 1015 anonymous survey responses being received, which gathered input from key communities connected to the Church. These were submitted by victims and survivors, children and young people as well as those worshipping or working within the DBF, the Cathedral and parishes.
- Eight focus groups.
- A confidential contact form being made available via a dedicated webpage.
- In total, the Audit undertook 50 separate engagement sessions reaching 103 people.

[1] https://www.churchofengland.org/sites/default/files/2023-10/national-safeguarding-standards-and-quality-assurance-framework_sep23.pdf

1.3 The Audit report is separated into Part One, Southwell and Nottingham DBF and Part Two, Southwell Minster. This has been done to ensure that each audited body is able to focus on their own strengths and areas for identified improvement.

1.4 The report has been reviewed for factual accuracy by both the DBF and the Cathedral.

Part One - The Southwell and Nottingham Diocesan Board of Finance

2 Context

2.1 The Diocese of Southwell and Nottingham encompasses a geographic territory that covers the entirety of Nottinghamshire and parts of South Yorkshire. The administrative footprint of the Diocese spans multiple local authorities, with the vast majority of its parishes served by Nottinghamshire County Council, the largest population area falling under Nottingham City Council, and two parishes in South Yorkshire served by Doncaster Borough Council. Additionally, a local cross-border arrangement assigns the provision of community services for one southern Nottinghamshire parish to Leicestershire County Council and Leicestershire Police. This includes the area where a small religious community resides.

2.2 For administrative oversight and operational management, the Diocese is structured into two archdeaconries, Newark and Nottingham, each led by its respective archdeacon. This framework supports a network of 229 parishes, 151 benefices, and 296 churches. Based on statistical data from 2021, the Diocese holds a total population of approximately 1,152,000 residents. According to the 2024 Statistics for Mission data the Diocese recorded a Usual Sunday Attendance of 9,306 adults and 1,372 children. Additionally, the Average Weekly Attendance, calculated from October data, accounted for 9,904 adults and 1,696 children.

2.3 Educational provision is supported across the territory by 73 Church of England schools. Theological training links are maintained with St Mellitus East Midlands Theological Training College to equip future ministers. While the college is headquartered in London, its East Midlands campus operates locally out of Trinity Church, Nottingham.

2.4 The region features a highly diverse geographical and economic landscape, blending open countryside such as Sherwood Forest and the Peak District with sharply contrasting

economic drivers. Urban centres, most notably Nottingham City, benefit from targeted growth and modern infrastructure in education, healthcare, and technology. Regional identity is divided by former industrial and coalmining areas, which face systemic socioeconomic challenges including high unemployment, low incomes, and limited prospects for young people. While affluence and social stability are concentrated in specific suburban and rural localities, the urban and post-industrial sectors suffer from profound health inequalities affecting life expectancy and mental wellbeing. Meanwhile, in deep rural areas where public transport and physical access to statutory services are limited, local churches serve as lifelines for community life and social cohesion.

2.5 While traditional configurations remain prominent in rural sectors, Nottingham City exhibits an expanding secular population among younger demographics alongside highly active multicultural and multi-faith communities, including Muslim, Sikh, Hindu, Jewish, and Black Pentecostal congregations.

2.6 Developed in collaboration with parishes, the Diocese operates under a long-term strategy. Its core objective, *"Growing Disciples of Christ with Compassion, Confidence and Courage"*, includes a strong commitment to mission, diversity and accessibility.

3 Progress

3.1 Overall, the Social Care Institute for Excellence (SCIE) Safeguarding Audit and Past Cases Review 2 (PCR2) made 43 ‘considerations’ / recommendations for Southwell and Nottingham DBF. These covered a range of issues which included more strategic working with the Minster, improving governance arrangements, capacity, training, updating of policies and record keeping.

3.2 The SCIE audit was published in August 2016, and resulted in 21 ‘considerations’, all of which were accepted. The DBF initially responded to the SCIE report and developed a dedicated action plan. However, administrative gaps exist, as accurate Diocesan Safeguarding Advisory Panel (DSAP) meeting minutes are only available from 2020 onwards, coinciding with the current Diocesan Safeguarding Officer’s (DSO) appointment. This followed a period where safeguarding services were managed by an external provider. Consequently, there is no documented evidence that the original action plan received formal approval from the DSAP.

3.3 The Diocesan PCR2 report was published in September 2021 and resulted in 22 recommendations (two of which were solely for national consideration). A detailed action plan was developed in response to PCR2, which was discussed and subsequently signed off as complete by DSAP. An oversight plan was also created, which was shared with Diocesan Synod.

3.4 The DST conducted a subsequent ‘gap analysis’ to assess progress made since initial SCIE ‘considerations’ and PCR2 recommendations. From this, it was identified that the vast majority of areas were completed, or were referred to the NST or remain ongoing areas of work. Areas marked as ongoing were migrated to an overarching action plan

which, at the time of the Audit, was still in draft form. That said, the Audit was told of progress made in some core areas, e.g. the initial development of a risk register and evaluation forms for Parish Safeguarding Officer (PSO) induction training.

3.5 The DBF has completed one external Lessons Learned Review (LLR) to date. Following this review, an action plan was created and subsequently received formal sign-off from the NST upon its conclusion. The four specific recommendations designated for local implementation have all been successfully completed.

3.6 The DBF has conducted two internal LLRs, each overseen by an independent chair. While the Audit Team was initially informed that action plans for both reviews had been developed and formally approved, these claims could not be readily substantiated. The implementation of the first LLR shows visible progress, though its recommendations are not yet fully embedded into daily operations. At the time of the Audit, the lack of available evidence meant that progress against the second LLR could not be verified.

3.7 The Audit was informed that upon the conclusion of casework, the Diocesan Safeguarding Team (DST) now conducts a Reflective Practice Exercise. Resulting recommendations are collated, anonymised, and presented to the DSAP. Currently, two significant Reflective Practice Exercises remain outstanding. One is being chaired by the Regional Safeguarding Lead (RSL), due to its complexity, while the other has been postponed. Consequently, the Audit Team cannot comment on these specific cases at this time.

3.8 Overall, the DBF has demonstrated good progress through the comprehensive gap analysis and formal sign-off of the vast majority of PCR2 recommendations. The priority now is ensuring that the ongoing implementation of these practices produces documented, visible evidence, so that safeguarding improvements and institutional learning remain transparent, verifiable and measurable over time.

4 Culture, Leadership and Capacity

Culture

4.1 The Audit revealed a positive and robust trajectory in the safeguarding culture across the diocese, demonstrating substantial progress towards openness, shared ownership, and a survivor-centred approach.

4.2 Surveys conducted by the Audit confirmed that recognition of the importance of safeguarding has risen significantly. This achievement was acknowledged by the vast majority of the DBF, the parish workforces, and the wider worshipping community.

4.3 This heightened awareness underpins a strong sense of personal safety, with most individuals feeling that a safeguarding culture is becoming deeply embedded. Consistently described as supportive, welcoming, and inclusive, this environment reflects a clear move away from historical defensiveness towards greater candour and collective responsibility. Key staff reported feeling well supported, noting that safeguarding has been prioritised and has received increased investment.

4.4 While there is overwhelmingly positive feedback and clear evidence of good practice, notably from senior leaders and the safeguarding team, who actively encourage an environment of respectful challenge, some nuanced concerns were raised. A minority of contributors suggested that theological views on sexuality have led to worries that LGBTQ+ individuals might experience isolation or a lack of support within the wider church environment.

4.5 This perspective must be balanced against the broader Audit findings. These show that the Diocesan Bishop and his leadership team have made sustained, largely successful

efforts to ensure everyone feels welcome across the diocese. Indeed, the Audit saw evidence of their consultation with those holding differing views to sense-check communications from the Bishop. However, even if the survey indicates that these concerns are held by only a few, the underlying dynamic requires careful attention. If left unaddressed, it risks undermining the significant progress already achieved. To support the work already being done by the diocese, the Audit makes the following recommendation:

Recommendation D1: The DBF should continue to host carefully guided, empathetic conversations that balance traditional theology with pastoral care to develop a genuinely inclusive community.

Leadership

4.6 The Diocesan Bishop provides highly active, visible and survivor-informed safeguarding leadership. Drawing on his lived experience as a long-term foster carer, he provides structured oversight with clear governance accountability and unambiguously accepts ultimate responsibility.

4.7 This level of attention provides robust scrutiny, which has been entirely appropriate in specific circumstances. However, such close engagement risks blurring the DSO's operational independence. Although this dynamic can prompt professional challenges, the Audit found no evidence that it has compromised the DSO's ability to execute their duties independently.

4.8 Strategically, the Diocesan Bishop has driven positive structural changes, including the groundwork for an integrated safeguarding directorate with the Cathedral and implementing independent governance reviews. His leadership is further characterised by an attentive and focused professional curiosity and a willingness to challenge established

experts; indeed, this vigilance enabled him to identify flaws in a previous historic safeguarding provision.

4.9 The office he holds and his decisive leadership style may occasionally, and inadvertently, promote a perceived culture of deference. The Audit noted evidence that the Diocesan Bishop is keenly aware of this and actively works to counterbalance it by welcoming robust findings as learning opportunities. Nevertheless, ongoing effort by him and his senior team is required to ensure all stakeholders feel fully empowered to speak up.

4.10 To support the Diocesan Bishop and his Senior Team to address these issues the Audit makes the following recommendations.

Recommendation D2: To reinforce the Diocese's commitment to building on the positive safeguarding culture developed thus far, the Diocese should adopt a range of engagement and listening initiatives. These should include:

a) Implement structured dialogue sessions that encourage staff to respectfully challenge and share alternative views with senior leadership.
b) Introduce anonymous feedback tools and appoint independent workplace advocates.
c) To avoid any ambiguity, the Diocesan Bishop should continue to reinforce the operational independence of the DSO and clearly communicate how their advice shapes executive decisions.

The Diocesan Chief Executive

4.11 The Diocesan Chief Executive plays a central role in supporting the commitment of the Bishop by explicitly prioritising safeguarding provision. He line manages and engages directly and effectively with the Interim DSO, who spoke highly of his commitment, delivering support and financial investment when required. The Audit heard and saw evidence of this approach, including instances where he enabled collaborative problem-

solving and encouraged staff to escalate concerns. The Audit also noted a clear willingness to consider the need for additional resources, provided that robust, data-driven business cases were prepared to secure funding.

The Archdeacons

4.12 The Archdeacons champion safeguarding through robust and compassionate leadership. They actively collaborate to promote a culture of humility and continuous improvement, utilising reflective practice to manage the personal impact of their demanding roles. Discussions highlighted a strong appetite to further develop their approach and the frameworks used to drive awareness and safeguarding activities. However, given their broad range of responsibilities, additional resourcing and support would enable greater frontline engagement.

Recommendation D3: To strengthen existing practice, ensure consistency, and build capacity across the diocese, the following recommendations are made:

a) Adopt yearly strategic safeguarding planning meetings to formalise forward-looking oversight and governance.

b) Develop standard parochial pre-visit and post-visit briefings for formal visitations and informal visits to ensure consistent information sharing and robust preparation across the diocese.

c) Progress the recruitment of associate archdeacons to build leadership capacity and operational resilience.

d) Implement national recommendations regarding core group structures, including mechanisms to provide independent occupational health support.

The Bishop's Chaplain

4.13 The Diocesan Bishop is supported by an effective Bishop's Chaplain and a personally reflective Suffragan Bishop who is highly engaged with safeguarding matters. The Bishop's

Chaplain plays a vital administrative and analytical role in curating personnel records and undertaking detailed reviews of clergy files. This role is central to identifying patterns of concern, whether related to safeguarding, finance, or general conduct, thereby ensuring comprehensive oversight and triangulation of data before information reaches the Bishop.

The Diocesan Safeguarding Officer (Head of Safeguarding)

4.14 The Interim DSO is a highly competent safeguarding professional who brings extensive statutory experience to her role within the Church. As a qualified social worker since 2011, her broad background spans charity and local authority settings, encompassing mental health, homelessness, learning disabilities, and family support.

4.15 Stepping into the interim DSO position in November 2025, she has placed the service on a markedly stronger footing by introducing logical structure and prioritising core business, particularly casework and record management. She has effectively stabilised a previously fragile team, navigating complex personnel situations with fairness and building a supportive culture that encourages respectful challenge without defensiveness.

4.16 Her positive leadership is evidenced by her timely escalation of issues, openness to external scrutiny, and supervision practice, which provides detailed narratives that strengthen oversight, accountability, and staff welfare.

4.17 Alongside these vital internal improvements, she has supported the expansion of training provision and developed a more robust service level agreement with the Cathedral. Her ability to consolidate practice and implement decisive changes makes her a significant asset to the wider diocese.

Administration of Blue Files and Ministerial Development Reviews

4.18 The current administration of Clergy Blue Files demonstrates a highly controlled and

effective process for the reception, verification, and dissemination of sensitive safeguarding records. The established procedure ensures clear record keeping and restricted access, beginning with an immediate request for incoming files and subsequent formal logging by an administrator upon receipt.

4.19 Crucially, the DSO (or an appropriately delegated member of the DST) rigorously examines each incoming file to complete a mandatory safeguarding cover sheet. The Bishop's Chaplain then conducts a detailed curation to identify any underlying patterns of concern. This multi-layered approach, which includes consultation with the safeguarding team and Archdeacons, ensures that all information is thoroughly verified for accuracy.

4.20 Despite these strong procedural controls, a significant vulnerability exists regarding appropriate storage, as physical files are not currently kept in fire-resistant cabinets owing to financial and infrastructural limitations.

Recommendation D4: To safeguard these critical Clergy Files, it is recommended that the Bishop's office investigates alternative, cost-effective fire-resistant storage options or prioritises an interim transition to a secure, encrypted digital filing system to mitigate the risk of physical loss.

Senior Management Team (SMT)

4.21 A review of meeting documentation and individual feedback indicates that the Senior Management Team has transitioned from basic safeguarding oversight towards a more proactive and systemic level of engagement. Leadership currently prioritises safeguarding as a standing agenda item, which represents a positive development, although earlier records lacked sufficient detail in their minuting. Oversight and risk management continue to evolve through targeted improvements in digital compliance, policy dissemination, and the standardisation of risk assessments.

4.22 The Audit noted that overall safeguarding capacity was recently identified and acknowledged by management as fragile. However, senior leaders have demonstrated a clear commitment to addressing this vulnerability, most notably through active consideration and increased financial investment in the safeguarding team. Audit survey results, focus group feedback, and individual discussions confirm a clear strategic intent by the Senior Management Team to embed safeguarding effectively within the wider operational culture.

Recommendation D5: To consolidate recent progress, enhance executive oversight, and ensure safeguarding remains central to the organisation's strategic framework, the following recommendations are proposed:

a) Standardise the minuting process for all management meetings to ensure that safeguarding discussions, decisions, and action points are recorded comprehensively.

b) Review and monitor the impact of recent investments in the safeguarding team on a regular basis to ensure the previously identified capacity vulnerabilities are effectively resolved.

c) Maintain the current strategic momentum by formally defining how safeguarding metrics will be continuously tracked and evaluated to ensure they remain fully embedded within the wider operational culture and aligned to the DSAP regarding identification and mitigation of risks.

Governance

4.23 The DBF operates governance and oversight structures in line with the expectations of the CofE and other regulatory bodies such as the Charity Commission. Within Southwell and Nottingham, the Bishop's Council and the DBF operate as a single, consolidated trustee body. The Chief Executive acts as both company secretary and secretary to the Board. This integrated structure results in a more manageable board. However, given the position of the Charity Commission and the expectations linked to the operation of the DBF, as the

body accountable to the regulator, there needs to be a distinction between functions, and a separation of chair.

4.24 The trustees are correctly recognised as individually and collectively accountable to the Charity Commission. At present, there is no specific safeguarding-lead trustee on the Board.

4.25 Historically, safeguarding oversight at the DBF level has been largely observational and compliant rather than scrutiny-based. The Board's engagement has relied on episodic and periodic inputs from safeguarding staff and the DSAP Chair, rather than operating on a fully embedded, continuous model. Consequently, information is often received passively rather than being actively interrogated.

4.26 Following an independent governance review and a residential away-day, the Board is actively seeking to transition towards a rigorous, scrutiny-based approach. The aim is to ensure that safeguarding is routinely scrutinised at every level of governance, to move away from infrequent, surface-level observation.

4.27 Overall, the DBF's current governance framework meets basic Charity Commission regulatory expectations, and the Bishop's Core Team demonstrates a high level of competence in operational risk management, with improvements actively being made.

Recommendation D6: To consolidate recent governance reforms and strengthen the Board's ability to meet Charity Commission expectations, the following priorities must be addressed:

a) The diocese should ensure a clear separation between the Bishop's Council and the regulatory role and responsibilities of the DBF. This should include appointing an independent lay chair to the DBF.

b) The DBF must explicitly adopt a scrutiny-based approach. This requires adding a standing safeguarding assurance item to every DBF agenda. Trustees must receive regular written and verbal reports on casework activity, risk, supervision, quality assurance, and resourcing, thereby enabling them to actively question, challenge, and track progress.

c) It should become standard practice for the Diocesan Safeguarding Officer (and ultimately the future Director of Safeguarding (if accepted)) to routinely attend all DBF trustee meetings. They should present reports and explain key risks, enabling trustees to make informed, evidence-based decisions regarding safeguarding and its resourcing across all agendas (including housing, finance, and HR). They should also be free to question any activity or strategic priority they consider to have a safeguarding element.

d) The DBF should formally designate a Safeguarding Lead Trustee with a clear, documented brief to champion the subject, liaise with safeguarding professionals (DSO/Director and DSAP Chair), and support the Board's scrutiny. Additionally, the DBF should undertake a light-touch safeguarding skills and confidence audit of all trustees, followed by targeted training to ensure ongoing safeguarding literacy.

e) The Diocese must document how the Diocesan Synod's responsibility for resourcing safeguarding aligns with the DBF's regulatory accountability. This includes mirroring the annual safeguarding report to Synod with a summary focused on DBF assurance and decision-making, and explicitly mapping how information flows between the Synod, DBF, and the safeguarding service to prevent gaps, duplication, or ambiguity.

DSAP

4.28 The Diocesan Safeguarding Advisory Panel (DSAP) is a key strength of Southwell and Nottingham DBF's safeguarding arrangements. Led by an experienced chair with strong local authority credentials, the panel provides independent scrutiny, informed challenge and system leadership. Although the chair has been in post for a relatively short time, there is already clear evidence of their positive impact.

4.29 DSAP demonstrates a clear strength in its outward-facing engagement with statutory safeguarding partnerships. By maintaining strong links with local safeguarding children and adults' boards and integrating with local authority training arrangements, the panel ensures it aligns diocesan expectations with wider multi-agency standards. Consequently, the DBF does not operate in isolation but actively draws on and contributes to the broader safeguarding system.

4.30 The panel engages some high-calibre local authority representatives, including a safeguarding manager and the Local Authority Designated Officer (LADO), who chairs the performance subgroup. Their involvement embeds essential statutory practice, challenge, and assurance within diocesan governance. However, due to the heavy demands of their primary roles, the attendance of some statutory partners is inconsistent. To mitigate this and broaden the scope of independent scrutiny, the panel could expand its membership to include other external figures, such as local charity, business, and civic leaders.

4.31 DSAP greatly benefits from the direct involvement of a survivor representative, whose insights make a valued contribution to the panel's work. The diocese intends to build on this strong foundation by broadening participation and developing a more structured engagement framework over time. Ensuring that such provision includes regular support to avoid re-traumatisation is key.

4.32 There is evidence that the panel has begun to move beyond passive receipt of reports into active oversight of DST capacity, testing the reliability and veracity of dashboard compliance data through deep dives (e.g. lay minister training) and developing a DSAP-owned safeguarding risk register intended to inform corporate risk and DBF/Bishop's Council oversight.

4.33 The DSAP is also building a more structured relationship with the Cathedral Safeguarding Management Group, particularly around chorister safeguarding, and is consciously reviewing its own structure and meeting model. However, a formal three-year DSAP strategic plan is still in development; the risk register is not yet fully embedded, the performance subgroup's Performance/Challenge/Impact function remains emergent, and arrangements for children's voice and survivor engagement, while positive, have not yet coalesced into consistently evidenced, diocese-wide strategic frameworks.

Recommendation D7: To build on the clear strengths of the DSAP and address the areas where practice is still developing, the following recommendations are proposed to consolidate its strategic role, sharpen its use of risk and performance information, and strengthen the voice and influence of children, survivors and key partners.

a) Develop and deliver a three-year DSAP strategic plan with clear priorities, milestones and evidence of impact (including performance, survivor engagement and children's voice).

b) Finalise, adopt and embed a DSAP safeguarding risk register, ensuring it routinely informs the corporate risk register and DBF/Bishop's Council scrutiny.

c) Establish the performance subgroup firmly on a Performance/Challenge/Impact footing, with a clear remit to interrogate data, track systemic risk and report on impact rather than activity.

d) Implement diocese-wide frameworks for children's participation and survivor engagement, including the use of listening events and extending beyond existing

pockets of good practice and evidencing how their feedback changes policy and practice.

e) Formalise joint working between DSAP and the Cathedral Safeguarding Management Group, and complete DSAP's own structural and meeting-model review (including hybrid options) to secure broader representation and clearer governance impact.

f) Conduct a skills, diversity and inclusion review to strengthen Panel membership, proactively recruiting independent leaders from local charities, businesses and civic organisations.

Capacity

4.34 The DBF's transition from outsourced safeguarding provision, which ultimately proved inadequate, due to the financial collapse and subsequent closure, to an in-house team has established a solid foundation of resilience and professionalism. At the time of writing, the DST is a well-structured, supported, and effectively led unit. It comprises high-calibre professionals with a blended, complementary skills mix drawn from social work, education, and the voluntary sector.

4.35 There is strong evidence of excellent practice across the team's core business, particularly in case management, risk assessment, safety planning, and training provision. Innovations such as robust work-tracking systems, parish integration via sessional trainers, and the highly valued Parish Safeguarding Support role are significant assets. The team also demonstrates remarkable adaptability, maintaining a culture of shared learning and mutual support while managing escalating demand and complex casework.

4.36 Despite its high performance, the team is currently working significantly beyond its capacity. Practitioners are sustaining operations largely through goodwill and discretionary effort, regularly working above their contracted hours to maintain safeguarding oversight.

This over-reliance on discretionary effort is neither appropriate nor sustainable and presents a critical risk of staff burnout.

4.37 Capacity shortages have hindered both routine casework and the proactive, developmental work required for systems improvement. Periods of staff absence frequently result in backlogs, the need for internal cover, and delays in embedding new processes. This strain has been further exacerbated by the reduction of training manager hours and the redundancy or reassignment of key administrative tasks, such as DBS checks, which has shifted administrative burdens directly onto frontline practitioners.

4.38 While the team actively seeks external agency support, this is often constrained by recruitment challenges, the unique complexities of Church of England safeguarding, and the intensive induction required for temporary staff. Quality assurance processes, such as trauma support and supervision, have improved but require further embedding, particularly for non-case-holding administrative and support staff.

4.39 To ensure safeguarding need is appropriately prioritised, the diocese must focus on formalising and strengthening its operational core. Building on the effective working practices already established between the Cathedral and the DBF will be crucial. Formalising these arrangements into a dedicated Safeguarding Directorate, led by a Director of Safeguarding, will ensure that operational safeguarding is demonstrably autonomous across the diocese, without diminishing accountability under existing governance structures. Going forward, integrating smarter working practices, such as the use of artificial intelligence (AI) and digital management tools, will be essential to optimising capacity.

Recommendation D8: Appoint a Director of Safeguarding: This role will lead the new directorate and provide single, professional line management for all specialist safeguarding resources. The Director should not be line managed by a single church officer but as the most

senior authoritative operational voice regarding safeguarding be accountable to the DBF and Chapter.

Recommendation D9: Formalise current collaborative practices between the Cathedral and the Diocesan Board of Finance by creating a distinct Safeguarding Directorate, led by a Director of Safeguarding, to ensure operational autonomy and robust accountability.

Recommendation D10: Conduct an immediate review to ensure all safeguarding roles are remunerated at market rates, aiding in the recruitment and retention of key staff.

Recommendation D11: Immediately upgrade the current caseworker role to full-time. Recruit an additional caseworker, potentially utilising a job-share model, to provide vital contingency cover and reduce reliance on overtime.

Recommendation D12: Secure a Safeguarding Support Officer with a comprehensive role profile to relieve practitioners of administrative burdens. Concurrently, upgrade the training manager role to a full-time position.

Recommendation D13: Ring-fence capacity for staff to focus on proactive projects, systemic learning, and essential supervision.

Recommendation D14: Establish dedicated survivor advocacy roles to systematically embed the survivor voice in decision-making processes and consider exploring and piloting a shared regional survivor support and advocacy service utilising a collaborative funding model.

Recommendation D15: Provide ongoing professional development for all leadership on survivor-focused, trauma-informed practice and institutional learning.

Recommendation D16: Invest in smarter working technologies, including AI-enabled record management and dashboard reporting, to optimise staff time and enhance risk oversight.

Recommendation D17: Deliver targeted, ongoing training and comprehensive inductions for all safeguarding team members, encompassing new starters, agency staff, and volunteers.

5 Prevention

5.1 Safer recruitment is a priority for the DBF. The House of Bishops' guidance (Safer Recruitment and People Management) is followed, procedures are aligned to legislation and practice is robust. There are established role descriptions, reference gathering, role-specific vetting and a defined process to manage 'positive' returns on DBS checks. The DBF has a single central record of DBS applications provided through the third-party DBS provider and generates a monthly report to monitor the data.

5.2 The DBS function has recently transitioned to the HR department in the DBF, and steps have been taken to establish formal connections with regional DBS leads. The Audit views these arrangements as positive and supports continuing the initiatives.

5.3 The Audit highlighted significant concerns regarding the accuracy and currency of data within the Contact Management System (CMS), particularly concerning critical roles such as Parish Safeguarding Officers (PSOs). The current system is undermined by limited staff capacity, fragmented ownership and a reliance on data updates from parishes, which vary in quality and timing. While the DBF has acknowledged that this area requires urgent action to ensure the CMS records are fit for purpose, the Audit makes the following recommendation to support such initiatives and ensure focus and oversight.

Recommendation D18: The DBF should establish a clear protocol to ensure the CMS retains accurate and up-to-date contact information for key safeguarding personnel, such as PSOs and churchwardens. This protocol must identify who is responsible for these records and for verifying parish information on a scheduled basis. Those assigned these tasks should be given the dedicated capacity to maintain the system.

5.4 Alongside its own arrangements, the DST provides a good range of support to parishes

on safer recruitment. The DST also oversees and tests the sufficiency of safer recruitment in parishes via the Safeguarding Dashboard. It is encouraging that the diocese has high engagement with the Safeguarding Dashboard and maintains robust processes for monitoring, reporting and dip sampling data on parish data trends. This is good practice.

5.5 The DBF maintains a comprehensive range of policies and protocols to guide safeguarding practice. These include a Diocesan Safeguarding Policy, alongside policies for the recruitment of ex-offenders and whistleblowing. Specific procedural requirements are further detailed in other documentation including the Local Safeguarding Recording Protocol, the Terms of Reference for bi-monthly meetings between Archdeacons, the Cathedral Lead, and Safeguarding, a Lone Working Protocol and the Diocese of Southwell and Nottingham Survivor Engagement Protocol Statement. Good practice is further embedded through supporting materials such as the Caseworker Initial Visit Checklist and the Initial Caseworker Report for Safeguarding Case Management Group (SCMG) meetings. Information leaflets are also provided to manage safeguarding concerns and allegations against church officers, to assist parishes when such allegations arise, and to guide responses to those presenting a potential risk to children, young people, or vulnerable adults. These resources are supported by the Safeguarding Process Flowchart 2025. Positively, these local resources expand upon the national policies and practice guidance found in the E-manual.

5.6 The sharing of good practice is supported through regional Church of England groups and attendance at the Diocesan Annual Safeguarding Conference; the most recent conference was attended by over 80 people from across the diocese. At a parish level, the DST communicates information and good practice through several direct channels. These include the DST newsletter, briefings for PSOs, and individual engagement visits. The DST further distributes information using a cascade model. This involves regular updates at

Archdeacon and Associate Archdeacon meetings, as well as presentations to the Deanery Chapter. Team members attend Area Dean meetings and can join Parochial Church Council (PCC) meetings upon request to provide specific guidance.

5.7 Additional collaboration occurs through various informal and structured networks. The DST facilitates national standards workshops and maintains contact via WhatsApp groups and Dashboard Champions.

5.8 The DBF uses several methods to raise awareness of safeguarding across its parishes. Information regarding policy updates and general news is distributed through a dedicated newsletter and termly briefings. These channels ensure that parish leaders remain informed about current requirements and developments. The DBF also hosts a safeguarding conference for individuals from across the diocese to attend. This is good practice. Members of the DST also visit churches to speak directly with congregations, which includes participating in annual Safeguarding Sunday services.

5.9 The DBF covers a diverse range of safeguarding topics and social issues tailored to the specific needs of the community. Areas of focus have included online fraud prevention, domestic abuse, and methods for responding to the needs of neurodivergent children. Jubilee House is also a recognised J9 Safe Space. This initiative raises awareness of domestic abuse and provides the skills needed to recognise abuse. It aims to give staff the confidence to respond to disclosures, which helps people access safety and support. The J9 training has been rolled out to several parishes that have also achieved accredited J9 status.

5.10 The DBF has addressed specific communication requirements on a case-by-case basis to help more people engage with safeguarding material. For example, additional work has

been undertaken at a parish level, with support from the DST, to translate the Basic Safeguarding training module into Spanish.

5.11 The Diocese's website has a strong, clean theme and is mobile responsive. It is positive that the 'safeguarding' section has prominence. Within the Diocesan safeguarding webpage, there is signposting to internal help and external support, the ability to report a concern, and access to DBS guides, tools and policies. The safeguarding webpage contains links to resources located on various internal pages. Currently, there is no sub-menu on the safeguarding page itself, despite the existence of a logical group of pages that could be organised this way. Implementing a sub-menu would significantly improve access to essential information for the parish. The Audit notes that the safeguarding pages are scheduled for an upgrade to improve navigation, particularly as they receive the highest volume of traffic on the site. The following recommendation is intended to support this planned development.

Recommendation D19: The DBF should conduct a review of the analytics for the safeguarding webpage to ensure the layout meets user requirements. This review should inform the creation of a new sub-menu to improve navigation. For example, if the data shows that Safer Recruitment and DBS tools are among the most frequently accessed resources, these should be made more prominent through placing them within a safeguarding sub-menu.

5.12 The DBF has developed a Safeguarding Communication Strategy that seeks to highlight positive initiatives, such as the 'Living Hope' video series. To build on this, the Audit found that similar balanced messages should be regularly integrated across the diocese's website and social media platforms. The following recommendation is therefore made:

Recommendation D20: The DBF should adjust its communication plan to include key safeguarding messages via its digital channels. To enhance this engagement, it should:

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

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

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

5.13 As with all good communication, this needs to be a two-way process and actively engaging children, young people and vulnerable adults is an important part of successful prevention planning and implementation. Evidence from the Audit survey demonstrates why this engagement matters, reflecting the deep value children place on their church community:

"When I attend church I feel respected, excited, happy, encouraged, supported, safe and welcomed. My church is a place where we enjoy worshipping God." (13-year-old female).

"I think that churches are a comfortable place for me to be myself and explore my faith and push my comfort zone." (16-year-old male).

5.14 While the Audit survey highlights the value of these perspectives, the DBF recognises that its own engagement with children and young people has previously been limited. The Audit supports the DBF's stated intention to do more in this respect.

Recommendation D21: Further to reviewing existing practice, the DBF should consider implementing new and/or extended models for youth participation in consultation with parishes and its existing networks.

5.15 The Audit observed evidence of appropriate risk assessments for Church activities where potential safeguarding risks were identified.

5.16 In terms of the arrangements to ensure that DBF staff are sufficiently safeguarded and potential risks mitigated, there is a Lone Working Policy in place. Beyond the DBF, these issues are addressed in general terms in the Basic, Foundation and Leadership Training Modules and supported by national guidance.

5.17 Guidance covering the structural environment and risk assessments across the Diocese is covered by the CofE's Safer Environments and Activities guidance which is aimed at developing a secure and protective environment for all involved parties. In addition, specific instructions regarding the physical layout of buildings are provided locally to church officers during their local induction.

5.18 Safeguarding within youth and children's work is generally strong and well embedded in day-to-day practice. There has been significant investment in this area, and safeguarding is understood as part of the work rather than an added extra. Youth workers spoke positively about access to advice and support from the DBF's Children, Youth and Families team and the DST, and about the way safeguarding is woven into training and supervision. This includes attention to culture, boundaries, online engagement, transitions, and contextual safeguarding, reflecting the realities of current practice. Feedback to the Audit indicated a desire for further support and training around topics of mental health and working with children with additional needs. This is addressed in Part One, Learning, Supervision and Support section of this report.

5.19 The Audit has highlighted growing pressure, particularly in churches working in areas of deprivation, where safeguarding concerns are more frequent and complex. Good practice is leading to more disclosures and referrals. This is positive, but it places additional strain on churches, youth workers, and diocesan teams. There are also ongoing challenges around online communication, mentoring, and one-to-one work, which are currently being managed well through a relational approach but rely heavily on capacity.

6 Recognising, Assessing and Managing Risk

6.1 The DBF maintains an overarching Risk Register, while each department keeps its own specific version. This system was introduced in 2024, and the safeguarding elements of the main register were reviewed in November 2025. The departmental register was also updated in 2025 and will undergo a full revision in the summer of 2026. Relevant material is already shared with the DSAP. However, the Audit recommends creating a dedicated Risk Register for safeguarding, which would be developed and overseen by the DSAP. This arrangement would include appropriate escalation to the DBF's Risk Register as required. Establishing a standalone register ensures a comprehensive and focused assessment of both strategic and operational safeguarding risks.

Recommendation D22: The DSAP should develop a standalone operational safeguarding Risk Register to allow for more focused scrutiny on the full range of safeguarding concerns, some of which might graduate to the strategic Risk Register held by the DBF. This should be reviewed and updated at a minimum cycle of quarterly.

6.2 The DST operates a structured intake and triage system to manage incoming safeguarding concerns. Most initial contacts arrive via a centralised email address or through other methods, such as telephone calls or an online form. A nominated duty worker monitors the inbox from Monday to Friday to collect initial details, gather context, and upload the information onto the National Safeguarding Case Management System (NSCMS). Urgent matters involving an immediate risk of harm bypass this process entirely and go straight to statutory emergency services. A weekly case allocation meeting is held to review all new submissions and categorise them using a traffic-light system based on the nature of the issue.

6.3 The DSO retains ultimate responsibility for determining whether information meets the threshold for a safeguarding concern. Matters that do not meet the threshold for full active

casework but involve safeguarding queries are logged on the NSCMS as advice-only files. This has the benefit of ensuring a clear audit trail exists if patterns reoccur. Matters unrelated to safeguarding are excluded from the system.

6.4 The weekly allocation meeting serves as the mechanism for assigning cases, factoring in current individual capacity, working patterns, and previous experience with specific subject matters. The Audit commends the introduction of mandatory recording of management rationales for these decisions. Post-allocation, staff undergo formal supervision on a four-week cycle. Cases are only closed during allocation meetings after both the allocated worker and the DSO have recorded comprehensive closure rationales on the NSCMS. A defined process is also in place to provide supervision to the DSO and support the quality assurance of safeguarding cases. This involves supervision meetings with the DSO chaired by the NST RSL. The Audit also noted recent case records demonstrating that the RSL is actively delivering quality assurance reviews.

6.5 In June 2023, the diocese became an early adopter of the NSCMS, which is built on the MyConcern platform. The DBF had previously used MyConcern as a standalone system since April 2021. While other dioceses had to migrate data from entirely different software, this diocese merged its existing system into the national structure. However, because the two versions were built to different specifications, the merger created data anomalies. For example, bespoke profile roles created before June 2023 cannot be extracted from the new reporting structures, making it difficult to generate accurate benchmarking data against national or regional figures.

Recommendation D23: The DBF should map relevant legacy data points (such as “categories of concern” and “profile flags”) from the DBF’s original configuration to the NSCMS framework. This is to resolve existing data anomalies between the two configurations, ensuring accurate data extraction and establishing a reliable baseline for national and regional benchmarking.

6.6 Over the last three years, a total of 934 concerns were recorded on the NSCMS. Of these, 521 were recorded as advice cases. In the 12 months between 1 November 2024 and 1 November 2025, the DBF made 32 referrals to Adult Social Care, Children's Social Care, the LADO, the police, probation services, or mental health services. There are 99 open cases within the DST, 36 of which are currently inactive. Previously, with the exception of referrals to the LADOs, the DST advised the local PSO or a member of the clergy to contact statutory agencies directly. The DST has only recently begun to record data on all statutory agency referrals, whether they were made by the DST or the PSO.

6.7 A project is underway to transfer non-recent paper files to the NSCMS platform. The DBF has engaged an external contractor to conduct this work. The Audit supports this activity and emphasises the need to progress at pace, noting that the capacity recommendations in Part One (Culture, Leadership and Capacity) apply here.

6.8 Feedback to the Audit indicates that response times from the DST are inconsistent, and stakeholders have reported communication delays. Additionally, the phrasing of 'out-of-office' notifications during seasonal periods can cause a potential barrier to contact, which risks undermining confidence in how routine queries are managed. The Audit attributes this inconsistency to capacity issues and notes that the capacity recommendations in Part One (Culture, Leadership and Capacity) apply here. The following recommendation addresses the specific use of language in communication.

Recommendation D24: The DST should review and update its out-of-office notifications to ensure the language is welcoming and active, rather than creating a barrier to routine communication.

6.9 The DBF currently manages 35 Church Safety Plans (CSPs). These plans are shared with the subject, the PSO, the Incumbent, and the designated supervisors. When a subject is

under the supervision of statutory monitoring agencies, such as the police or probation services, the relevant officers assist in drafting the plan and receive a copy of the final document. CSPs are first reviewed after three months and then every six months, with the annual review being undertaken by the DSO.

6.10 To standardise its processes, the DST has developed specific protocols supported by a diocesan information leaflet for individuals subject to a CSP. This leaflet sets out the framework for risk assessments, timescales, and the sharing of confidential information with parish supervisors and statutory agencies. It also details available support and the process for reviewing plans or appealing decisions. As part of this initiative, a new workshop addresses the lack of local awareness regarding CSPs. Aimed at parishes without current plans, this training explains Church of England safeguarding processes and how to manage church attendance for individuals who pose a risk or have caused harm. This is good practice.

6.11 The Audit found that CSP details for respondents are categorised and flagged inconsistently on the NSCMS. While individual names and profiles exist on the system, discrepancies in the profile flags and categories create an incomplete and inaccurate overview when filtering data.

Recommendation D25: The DBF should standardise the categorisation and flagging of respondents subjected to safety plans on the NSCMS to ensure data consistency. This involves reviewing allocation of 'profile flags' and 'concern categories', establishing clear internal data entry procedures, and incorporating these protocols into briefings and induction materials for the safeguarding team.

6.12 The Audit observed good practice in the content and parameters of CSPs. The significant majority of safety plans examined by the Audit set clear prohibitions regarding expected

behaviours and were well defined, proportionate and authorised appropriately. This thoroughness was positively demonstrated in one reviewed case where, although the respondent maintained they posed a low risk in line with statutory agency assessments, the DST provided their own rigorous opinion on how the safety plan should continue. This decision was based on the level of risk assessed by the DST rather than offender registration or court orders. During the review meetings, minutes outlined that the DSO suggested that once statutory monitoring ended, there was a higher risk of the individual reverting back into previous behaviours, and that a period of support through the CSP would be beneficial.

6.13 Safeguarding Case Management Groups (SCMGs) are established for all safeguarding concerns pertaining to church officers, except for those assessments required for a CSP. SCMGs are usually chaired by an Archdeacon or an Associate Archdeacon. A review of the SCMG minutes reveals a highly structured, operational framework built around consistent themes of statutory liaison, proactive risk management, and holistic pastoral care. A primary focus of the SCMG is the continuous monitoring of external statutory investigations led by the police and LADOs. The group systematically defers internal investigations until these external processes conclude, focusing immediate efforts on deploying and transitioning CSPs and stepping respondents back from ministerial or volunteer duties to manage community risk. This is complemented by robust forward-planning and communications scheduling, wherein the SCMG collaborates with media advisers to map “what-if” legal scenarios and draft proactive statements, ensuring the diocese is not reactive when sensitive cases are publicised. The minutes also demonstrate a rigorous commitment to establishing distinct, dual-track pastoral structures that provide separate, specialised support or ‘Link Persons’ for respondents while concurrently safeguarding the counselling and welfare needs of complainants, affected families, and parish leadership.

6.14 The DST has implemented robust processes to support the effective and focused use of resources. Caseworkers complete an 'Initial caseworker report' which is shared in advance of a SCMG. This detailed pro forma covers areas such as the respondent's role, a summary of the allegation, the LADO's decision, the caseworker's analysis, and recommendations. A 'Checklist for Triaging Safeguarding Concerns' is also built into everyday practice.

6.15 Capacity is heavily impacted by the high volume of SCMGs managed by the DBF and administrative backlogs mean that SCMG minutes face delays of up to two weeks.

Recommendation D26: The DBF should consider adopting Artificial Intelligence (AI) and Large Language Models to enhance administrative efficiency within the DST. This programme of work should begin by identifying the routine, time-consuming tasks that impact staff capacity, such as calendar management, email sorting, and meeting transcription. Following this assessment, the DBF can introduce approved, secure, and professionally licensed AI tools to streamline general administration and minute-taking. To ensure safety and quality, the rollout must include clear guidelines and staff training, alongside a strict policy requiring a team member to review all AI-generated outputs for accuracy.

6.16 The DBF submits Serious Incident Reports to the Charity Commission, and adheres to the corresponding House of Bishops' guidance. All submitted reports are also shared with the NST. In 2020, parishes delegated authority to the DBF to submit these reports on their behalf. However, a recent NST update to safeguarding officers prompted a review of this arrangement. Due to regular turnover among PCC members, the DBF now plans to renew this delegated authority annually.

6.17 The DBF operates a structured, four-stage process designed to resolve complaints within the Diocese (including those that relate to safeguarding), moving from informal resolution

and internal managerial reviews to external expert investigation, culminating in an executive-approved action plan which is shared with DSAP.

6.18 DBF staff are provided training on data protection and GDPR requirements. However, the Audit found that several members of the DST had not completed this training.

Recommendation D27: All members of the DBF who have not yet done so should complete the data protection and GDPR training within the next six months.

6.19 The DBF maintains several information-sharing agreements to assist with data exchange between key organisations. A Service Level Agreement (SLA) is currently in place with the Cathedral, and a separate SLA with APCS, the online DBS checking company, includes a clear section on data handling that details how the DBF must share data so APCS can meet its contractual obligations. Additionally, the DBF maintains an agreed single point of contact and information-sharing arrangement with Nottinghamshire Police.

7 Victims and Survivors

7.1 The experience of abuse can have a deeply traumatic impact on individuals. Disclosing these experiences can be an incredibly vulnerable process, often accompanied by concerns about navigating systems, the possibility of re-traumatisation, or uncertainty about potential outcomes. To address this, it is crucial that Church bodies establish and maintain a safe and supportive environment. This will help to ensure that victims and survivors feel truly heard, supported, and protected, while also creating opportunities for the Church to learn and grow from their experiences.

7.2 The Audit evaluated the DBF's safeguarding response by gathering anonymous survey feedback from victims and survivors, facilitating one-to-one discussions with victims and survivors and discussions with key stakeholders, and through content analysis of arrangements in place.

7.3 The Diocese's current survivor engagement protocol evolved from the strategy developed for PCR2. While the title excludes the term 'victim', the document itself addresses victims, survivors, thrivers, and those who prefer no label. This inclusivity reflects a commitment to trauma-informed practice by recognising that different self-perceptions are vital to a person's healing journey. The protocol also ensures that individuals who experienced trauma outside the church are signposted to appropriate services. This framework was informed by House of Bishops guidance and key findings from PCR2, IICSA, and recent lessons learned reviews. Its scope includes Southwell Minster. This is good practice.

7.4 The survivor engagement protocol, approved in 2022, is tabled for revision in June 2026. To better capture continuous learning and procedural improvements, the Audit recommends increasing the review frequency to once per year.

Recommendation D28: The DBF should transition the Survivor Engagement Protocol to an annual review cycle to ensure it immediately incorporates learning from engagement and evolving safeguarding practices.

7.5 The DBF currently promotes the House of Bishops' *'Responding Well to Victims and Survivors of Abuse'* guidance through various channels, including the Safeguarding Resources webpage, parish briefings, newsletters, inductions, training and leaflets. That said, survey results indicate that awareness remains low among victims and survivors, with less than half of survey respondents knowing of these procedures prior to reporting abuse. The DBF should continue to promote its existence and consider how to ensure reach is as effective as possible.

Recommendation D29: The DBF should continue to promote House of Bishops' guidance 'Responding Well to Victims and Survivors of Abuse', and its Survivor Engagement Protocol and review how to improve awareness to maximise reach.

7.6 A range of support resources and signposts exist, including contact information and signposts to further support on the Diocesan website. However, survivor support resources on the website are limited. At the time of the Audit, it was said that new resources were being developed. The Audit also heard directly from individuals who really valued the therapy and counselling sessions funded by the DBF, which alleviated financial stress, and helped them on their healing journey.

7.7 The 'Survivor Support and Engagement' webpage currently presents a fragmented and outdated user experience that hinders accessibility and trust. The site contains outdated information, including references to defunct services like the Authorised Listening Service and invitations to contribute to expired projects such as 'The Truth Project'. While the webpage does offer some signposting to external support services, this repository could

be reviewed and expanded. Collectively, these issues create potential barriers for users seeking active support and modern resources.

Recommendation D30: The DBF should conduct a comprehensive update of the 'Survivor Support and Engagement' webpage to remove defunct references and expired projects. This refresh should prioritise a cohesive, trauma-informed user experience by expanding the repository of active external support services. Implementing a regular maintenance schedule will ensure information remains accurate, restoring accessibility and user trust.

7.8 The DST is actively working toward a clear separation of roles between staff who support victims and those who support respondents. This boundary is being pursued to mitigate unconscious bias and promote greater trust in the integrity of the process. The Survivor Engagement Protocol also outlines that, as resources allow, the DST strives to accommodate preferences for a male or female caseworker to serve as a single point of contact. The Audit regards this as good practice.

7.9 Data from INEQE's Audit survey and one-to-one discussions with victims and survivors suggest that recent support improvements have increased the likelihood of individuals reporting harm in the future. Most survey respondents felt they were taken seriously and that the DST successfully facilitated a safe environment. Specific praise was noted for the prompt and regular communication provided to some, with the personal and relational support from DST members being highly valued.

7.10 The Audit observed evidence of bishops engaging meaningfully with victims / survivors, offering sincere apologies supported by thorough prior preparation. In these instances, the positive impact on the individual was evident. That said, the Audit also engaged with individuals who did not receive an apology that recognised the harm they had experienced.

7.11 Further, the Audit has identified some cases where support has not met the required standard, some of which relate to the speed of initial responses and the consistency of follow-up care, support and advice. Feedback to the Audit Team indicated that some victims / survivors had to initiate contact themselves, while others experienced distress due to the timing of relaying safeguarding decisions, receiving inaccurate or unclear information. The Audit was also informed of instances where advice shifted after consultations with others, raising concerns regarding its independence and integrity.

7.12 That said, the Audit acknowledges the DST's commitment to refining its practice by listening to victims and survivors, not least when experiences have fallen short of the required standard. To ensure that policy commitments are consistently reflected in practice, the Audit recommends that the DBF integrate these findings into a revised Survivor Engagement Protocol.

Recommendation D31: The revision of the Survivor Engagement Protocol must include:

a) The implementation of mandatory standards for prompt, DST-initiated communication to ensure survivors are consistently informed without needing to prompt for updates. Follow-up communications should take a diarised approach.
b) Embedding trauma-informed practices into the delivery of safeguarding outcomes, specifically by providing advance notice and transparent rationales while avoiding poorly timed disclosures.
c) The DST should agree and develop with victims and survivors a support-end plan so support does not abruptly end.

Recommendation D32: In practice, the DST must take care to avoid providing conflicting advice and ensure all information provided is technically accurate and provided in simple, jargon-free language.

7.13 The Audit identified that caseworker transitions during staff leave can cause significant apprehension for survivors, particularly regarding the perceived need to repeat their accounts. To mitigate this risk of re-traumatisation, the DBF should implement formal contingency and handover strategies, ensuring continuity of care and removing the burden of retelling their experience to new personnel.

Recommendation D33: The DBF should strengthen formal handover protocols and contingency plans to manage staff leave effectively. These strategies must ensure continuity of care and remove the burden on survivors to retell their stories to new personnel. For unplanned absences, the DBF should provide prompt caseworker introductions alongside clear, compassionate explanations within confidentiality limits.

7.14 Beyond direct casework, the Audit was made aware that the DBF is working on creating safe, accessible environments for disclosure, for example proactive training for church officers and the rollout of the J9 initiative, which designates the diocesan office and various parishes as safe spaces for victims of domestic abuse.

7.15 Feedback to the Audit Team identified a small number of instances where initial disclosures relating to domestic abuse were not fully recognised or escalated appropriately by local management. In one instance, when a case progressed, the intervention process was felt to be constrained by a focus on regulatory compliance rather than an individualised, supportive approach. A lack of timely, comprehensive risk assessment in this instance meant that formal safeguarding mechanisms were not fully utilised, potentially leaving individuals in vulnerable situations.

Recommendation D34: The DBF must mandate that domestic abuse disclosures are never minimised, ensuring all responders prioritise victim safety and belief. Formal escalation pathways should be risk-assessed to ensure that procedural actions, such as initial contact or information sharing, never inadvertently increase the risk of harm to the survivor.

7.16 The Audit has seen evidence of members of the DST offering practical advocacy and assisting with applications to the Redress and Interim Support Schemes, and insurance claims.

7.17 Of particular note is the creation of a survivor-led blog, pioneered by the ADSO (Acting DSO). Victims / survivors play a central role in creating the blog's content and resources, which are available for wider use. These contributions include poetry, art and reflections. The blog serves as a low-pressure, anonymous connection point for victims / survivors. Notably, a book written by a survivor has been integrated as recommended reading for the new Trauma-Informed Practice training, with copies distributed to all delegates of the pilot prior to a wider rollout in 2026.

7.18 The 'Hope Bench' at the Cathedral was a concept innovated by the ADSO (Acting DSO), which provides a physical, quiet space for those who have experienced trauma. This bench is also shared with a neighbouring diocese to signpost victims to share this space. This is good practice.

7.19 To ensure strategic challenge, the Diocesan Safeguarding Advisory Panel (DSAP) maintains two survivor representative roles. This structure seeks to provide peer support and helps maintain consistent participation. Notably, one of these representatives also works for a voluntary organisation that supports individuals with lived experience of trauma. Since 2024, the panel has worked to fill gaps left by a previous survivor support representative; however, they have struggled to recruit for this role. The goal remains to broaden the panel's scope to cover diverse experiences of abuse. Given the clear dedication to victim and survivor voices, the Audit recommends exploring the creation of a survivor reference group to further strengthen this work.

Recommendation D35: The DBF should consider transitioning from individual representations to a dedicated survivor reference group model. This should include victims and survivors, family members / those who care for them and representatives from survivor support services. This collective approach will ensure strategic governance is informed by a diverse range of lived experiences while providing a peer-supported framework that reduces pressure on individual representatives.

7.20 While the DBF demonstrates a clear commitment to expanding survivor advocacy and engagement, current capacity constraints and communication inconsistencies hinder the pace of practical implementation. These hurdles occasionally undermine victim and survivor confidence and overshadow the significant range of good practice evidence present in the DBF's activities. The Diocese must move from positive intent to consistent execution by stabilising resources and refining communication protocols. Closing this gap between policy and practice will ensure a reliable, trauma-informed environment that effectively supports and protects victims and survivors.

8 Learning, Supervision and Support

Safeguarding Learning

8.1 The Diocese has invested in safeguarding learning and development and has established a training model that reflects both the Church of England Learning and Development Framework and the Diocese's wider commitment to creating safer Church communities.

8.2 The Audit found a strong emphasis on safeguarding as a shared responsibility, with learning viewed not simply as compliance activity but as a mechanism for developing culture, confidence and professional curiosity. Evidence gathered through documentation review, surveys and discussions demonstrated a clear commitment to continuous professional development, reflective practice and learning from experience.

8.3 The safeguarding training team is a strength. Team members bring a wide range of professional backgrounds, including social care, health, law, and parish safeguarding, which has added depth and credibility to the learning offer.

8.4 Training provision is aligned with national Church of England pathways and supplemented by diocesan initiatives that respond to local safeguarding needs. The Audit heard positive examples of parish-based delivery models, particularly in relation to domestic abuse training, which have increased accessibility and encouraged collective parish reflection on how learning should be implemented locally. Trainers reported that parish delivery has generated stronger engagement than centrally delivered sessions and has supported practical action planning within local Church communities.

8.5 The Diocese has also begun strengthening its evaluation of learning through feedback mechanisms and review processes. The Audit heard that evaluation forms have been

developed for PSO induction training and that learning outcomes are increasingly considered within wider safeguarding planning processes. This is good practice.

8.6 Feedback from discussions across a range of roles indicates that national training content does not always feel fully contextual to the roles undertaking it. Whilst this is being addressed at a national level, the Audit recognises the steps already taken within the team to make training feel more relevant. That said, there remains an opportunity to further strengthen this area. Whilst training quality was consistently praised, some clergy highlighted that mixed-role training environments can limit discussion of issues unique to ordained ministry and Church leadership. Several participants suggested that additional opportunities for clergy-specific safeguarding reflection could support deeper exploration of accountability, decision-making and leadership responsibilities.

Recommendation D36: The Diocese should consider introducing periodic clergy-specific safeguarding learning opportunities to complement national training pathways and enable deeper exploration of safeguarding leadership, professional boundaries, risk management and accountability within ordained ministry.

8.7 The Audit also identified opportunities to continue strengthening safeguarding learning in relation to neurodiversity, additional needs, trauma-informed practice and inclusive safeguarding. Whilst examples of this learning were evident, increasing complexity across parish settings means ongoing development in these areas would further enhance confidence and practice.

Recommendation D37: The Diocese should continue expanding learning opportunities relating to neurodiversity, additional needs, trauma-informed approaches and inclusive safeguarding to ensure church officers remain equipped to respond effectively to increasingly diverse safeguarding needs.

8.8 Parish support is another area of real strength. This includes direct advice to PSOs and clergy, support with safer recruitment processes, help interpreting national guidance, and assistance with resolving lower-level safeguarding issues before they escalate into formal referrals, among other positive features. Given that parish support is now well embedded, and that the combined Training Manager and Parish Support Officer role has clearly added value in raising the profile of safeguarding training and strengthening links with the DST, the Audit believes there to be scope to place greater emphasis on developing the training offer and strengthening training records at a diocesan level. Any such shift would build on what is already working well, rather than replace it.

8.9 Training records for the Bishop's Office and the Discipleship and Ministry Team are currently held and managed within those respective teams. The Audit supports this arrangement in terms of day-to-day oversight, and it is clear that the Training Manager liaises appropriately with these teams. However, there is scope to strengthen diocesan level oversight of safeguarding learning through the development of a centrally held system that brings together training records for diocesan and parish roles. This would not remove individual or parish responsibility for ensuring training is up to date but would provide an additional layer of scrutiny as well as supporting a clearer, more strategic view of safeguarding learning across the diocese.

Recommendation D38: The Diocese should implement a centrally coordinated safeguarding learning record system that provides oversight of training across diocesan teams and parish roles. This should complement existing local records and provide senior leaders with greater assurance regarding compliance, support workforce planning and enable a more strategic approach to safeguarding learning and development.

Clergy Support

8.10 Clergy described a safeguarding system that is accessible and responsive. There is confidence in the safeguarding team and clarity about how to seek advice. Survey findings further support this position, with a majority of respondents reporting confidence in safeguarding arrangements and understanding their responsibilities.

8.11 Clergy also spoke honestly about the pressures they face, particularly around administrative burdens, complex safeguarding cases, and the emotional impact of the work. While formal supervision structures are in place within the safeguarding team, there is more variability in how supported clergy feel at parish level. This was particularly evident in larger benefices and multi-parish settings where safeguarding administration, governance requirements and risk management expectations continue to grow.

Recommendation D39: The DBF should continue reviewing how safeguarding learning and guidance can be delivered in ways that remain accessible and proportionate for clergy serving increasingly complex benefice structures, whilst maintaining compliance with national requirements.

8.12 Induction arrangements were viewed positively. Survey findings indicate that most respondents received safeguarding information and expectations as part of their induction process. The Diocese has also developed dedicated induction arrangements for PSOs and continues to review these processes through evaluation and feedback mechanisms. This is good practice.

Supervision and Support of Safeguarding Roles

8.13 The DBF demonstrates a strong commitment to reflective safeguarding practice. The Audit found evidence of formal and informal supervision structures across safeguarding roles, supported by a culture that encourages reflection, challenge and professional curiosity.

Reflective Practice Exercises are undertaken following casework, with learning identified, anonymised and shared through governance structures including DSAP.

8.14 The DST described supervision arrangements that support decision-making, accountability and practitioner wellbeing. The Audit heard evidence of professional challenge within the team and an environment where differing perspectives can be explored constructively. This provides an important safeguard against isolated decision-making and supports consistent safeguarding practice. Survey responses reflected strong confidence in the Diocese's handling of safeguarding concerns and the support provided by safeguarding staff.

8.15 The DBF has also developed a range of peer support mechanisms, including PSO networks, training events and parish engagement activity. These arrangements help reduce isolation, particularly within rural communities, and create opportunities for shared learning and mutual support.

8.16 The Audit also heard evidence of strong collaboration within the training team. Trainers described benefiting from informal peer support and opportunities to draw on one another's professional expertise. These arrangements contribute positively to trainer confidence, consistency and wellbeing.

8.17 Whilst these arrangements were viewed positively, the Audit found limited evidence of a structured continuing professional development programme for trainers. Given the breadth of experience within the team, there is an opportunity to further strengthen professional development through more formal opportunities for learning, reflection and the sharing of practice.

Recommendation D40: The Diocese should develop a structured continuing professional development programme for safeguarding trainers, incorporating opportunities for peer mentoring, observation, feedback and reflection. This would support ongoing professional development, consistency of delivery and the sharing of specialist expertise across the training team.

9 Conclusion

9.1 This Audit finds Southwell and Nottingham Diocese at a meaningful and encouraging point in its safeguarding journey. The considerable progress made since the SCIE audit of 2016 and PCR2 of 2021 demonstrates that the DBF has approached its obligations seriously, and the overarching picture is one of an organisation moving purposefully in the right direction.

9.2 The safeguarding culture is a genuine strength: recognition of its importance has risen markedly across the DBF, parishes and the wider worshipping community, and the environment is consistently described as supportive, inclusive and increasingly candid. The Diocesan Bishop's active and personally informed leadership has set a clear tone from the top, the Diocesan Secretary has provided essential financial and operational backing, the Archdeacons champion safeguarding with rigour and compassion, and the DSAP offers independent scrutiny and statutory-quality challenge that ensures the diocese does not operate in isolation.

9.3 The DST is a well-structured, professionally led unit, and the Head of Safeguarding has placed the service on a markedly stronger footing by stabilising a previously fragile team and introducing the structure that effective casework demands. Innovations such as robust work-tracking systems, the Parish Safeguarding Support role and parish-based training delivery have strengthened the connection between diocesan and local safeguarding. Prevention work is broad and well-conceived: safer recruitment processes are robust, training provision reflects both national pathways and local need, and initiatives such as the J9 Safe Space, the survivor-led blog and the Hope Bench at the Cathedral demonstrate that the DBF's commitment to safeguarding is genuinely felt rather than merely procedural.

9.4 The Audit also identifies areas requiring the DBF's focused attention. The most pressing is capacity. The safeguarding team is performing at a high level but is doing so through goodwill and discretionary effort, and the risk of burnout among skilled, experienced staff is real. The creation of a Safeguarding Directorate, the expansion of caseworker roles and investment in administrative and training support are not aspirational enhancements but necessary steps to protect the foundations already in place. Governance arrangements meet regulatory expectations and are actively improving, but the transition from an observational model to one based on genuine scrutiny is still under way; the designation of a Safeguarding Lead Trustee and the routine engagement of the Head of Safeguarding at DBF meetings will consolidate the improvements already in motion.

9.5 The DBF's commitment to victims and survivors is evident, and the personal support provided by DST members has been genuinely valued. However, the Audit has identified inconsistencies in response times, instances where advice lacked the consistency expected, and cases where the approach to domestic abuse was insufficiently survivor-centred. The revision of the Survivor Engagement Protocol and the embedding of formal handover and communication standards will help to ensure that commitment is reflected consistently in practice.

9.6 In learning and development, central oversight of training records, clergy-specific learning opportunities and continued development of trauma-informed and inclusive safeguarding practice will equip church officers more fully for an increasingly complex landscape. Reliable data quality across both case management systems also requires attention, as it is the foundation on which sound risk management and accountability depend.

9.7 The recommendations in this report are constructed to build on the DBF's considerable strengths, not to catalogue its shortcomings. They identify where strong foundations can be reinforced, where emerging practice can be brought to maturity and where the gap

between policy intent and lived experience can be closed. Southwell and Nottingham Diocese has the leadership, the values and the professional capability to be an exemplar of safeguarding practice within the Church of England. The trajectory is positive, the commitment is real, and the willingness to engage openly with external scrutiny and to learn from experience is itself a mark of an organisation that takes its responsibilities seriously. With focused effort on the priorities set out in this report, the DBF is well placed to build on its considerable strengths and achieve its full potential.

Part Two - Southwell Minster

10 Context

10.1 Southwell Minster originated as a religious community in the Anglo-Saxon period, built on the site of a significant Roman villa. The present Romanesque building dates from 1109 and evolved from a Collegiate Church into a designated Cathedral in 1884. As the Mother Church of the Diocese of Southwell and Nottingham, it serves as the seat of the Bishop and a central hub for diocesan services, including ordinations and confirmations. The institution maintains a dual function, acting as a spiritual resource for 307 parishes while simultaneously serving as the primary parish church for the local community.

10.2 Southwell is a prosperous market town governed by a Town Council under Nottinghamshire County Council. Although it is the seat of a Bishop, the town is not officially recognised as a city. The population of approximately 7,500 is growing through new housing developments and the infilling of brownfield sites. The area is highly connected, situated 15 miles from Nottingham and 8 miles from Newark, which provides fast rail links to London. In 2024, the Minster welcomed over 64,000 visitors and was awarded Visitor Attraction of the Year in the Nottinghamshire Tourism Awards 2025.

10.3 Southwell is recognised as one of the most prosperous towns in England, though the wider Diocese includes a diverse mix of rural, urban, and post-industrial settings. Outside the town, the county contains 31 areas ranking in the 10% most deprived nationally, particularly in districts such as Ashfield and Mansfield. The Cathedral faces substantial financial challenges, including a significant operating deficit and under-utilised property assets. While the current congregation has a large representation in the 60+ age range, strategic efforts are focused on engaging younger leadership and growing the community spiritually and numerically.

10.4 The Cathedral offers traditional worship styles, including daily Morning Prayer, Holy Communion, and Choral Evensong. Beyond its spiritual role, it serves as a vital community venue for art exhibitions, theatre productions, and concerts. The education programme engages thousands of children annually through festivals and 'Time Travelling' Religious Education (RE) days. Its mission combines welcoming and hospitality with the presentation of its heritage, including the 'Leaves of Southwell', which was voted the nation's number one cathedral treasure in 2023.

10.5 Prior to 2018, safeguarding was managed by an external body before transitioning to an in-house diocesan model. Following a 2021 audit, the Cathedral established a dedicated Cathedral Safeguarding Officer (CSO) role and a Cathedral Safeguarding Management Group (CSMG) to oversee operational developments. A period of leadership transition followed, including the appointment of an interim Dean and several key senior staff to address financial deficits and establish a clear strategic vision.

11 Progress

11.1 The Social Care Institute for Excellence (SCIE) audit of Southwell Minster, published in November 2021, resulted in 42 ‘considerations’. The Minster was also included in the Diocesan Past Cases Review (PCR2) process in 2021, although no specific recommendations pertained to the Cathedral itself.

11.2 All 42 ‘considerations’ put forward in the Minster’s SCIE audit in 2021 were accepted. A dedicated action plan was created in response by the Chief Operating Officer (COO), Dean and Chapter which the previous CSO and COO then began to work through and implement. Progress was discussed at Cathedral Safeguarding Management Group (CSMG) meetings before being presented to Chapter. Themes arising from the ‘considerations’ include record keeping, accessibility of policies and procedures and their implementation, formalisation of policy, training oversight and strategy and safer recruitment practices.

11.3 Regarding PCR2, the Cathedral’s only involvement in the subsequent work was completing requested risk assessments, which occurred approximately two years after the review. The new CSO seeks to embed diocesan processes to achieve greater consistency across safeguarding, rather than maintaining separate systems.

11.4 Since the SCIE audit, there has been a significant change in personnel and leadership at the Minster, with a healthier approach to communication and information sharing. Whilst most recommendations were complete or ongoing at the time, recommendations have since been re-assessed in terms of current practice and future considerations, with future improvements being planned.

11.5 There have been no formal or significant LLRs at the Minster. That said, the Audit heard of some informal reflective practice reviews completed by the former CSO which were taken to the CSMG for review and discussion. It was agreed these would be added to the wider SCIE action plan, to be discussed at CSMG; however, the Audit was unable to verify that this took place.

11.6 The Minster has also completed the National Standards Cathedral workbook and reported having found it extremely helpful in enabling them to identify gaps in practice.

11.7 In conclusion, while Southwell Minster has made demonstrable progress in restructuring its personnel and addressing the 2021 SCIE audit considerations, these changes must not give rise to complacency. The Cathedral's primary focus must now be the robust standardisation of institutional learning drawn from active casework, ensuring that insights from past shortcomings are consistently embedded in daily safeguarding practice.

12 Culture, Leadership and Capacity

12.1 Southwell Minster presents a markedly different picture from that recorded by the 2021 SCIE audit. Five years ago, personal safeguarding leadership at the Cathedral was considered strong in individuals but weak as a collective function: the organisation was not experienced as safe by all its members, strategic oversight was underdeveloped, and concerns went unreported as a result. The current Audit found that this has changed materially. A culture that was reportedly by the SCIE audit in 2021 to be (at times) defined by control and, a sense of victimisation, has given way to one in which responsibility for safeguarding is genuinely shared, difficult conversations are held, and the organisation is experienced by most of those within it as a safe place to raise concerns.

12.2 This shift is validated by Audit survey data, with a large majority of both the workforce and the worshipping community reporting that they now feel safe. Staff describe feeling confident to raise concerns without fear of reprisal, and respondents frequently characterise the prevailing atmosphere as supportive and inclusive. There is a strong sense that safeguarding is embedded throughout the organisation and that arrangements have significantly improved in recent years.

12.3 The Audit observed substantial activity designed to sustain and reinforce this culture. Services of commitment to respect and care, tailored sensory-aware provision for vulnerable individuals and their carers, survivor-sensitive prayer cards and child-friendly safeguarding posters co-designed with the choristers are all in place. The HOPE Bench, with its prayer and support post box and Need to Talk signage, provides a visible point of pastoral contact. A redesigned Green Guide (designed for the congregation and visitors) has been placed on every nave seat, a dedicated Yellow Guide is available for staff and volunteers, and the annual Safeguarding Sunday includes the public recommissioning of

the safeguarding team. The Audit regards this body of work as good practice and as evidence that the Cathedral's cultural commitment is genuine and actively expressed, rather than confined to policy statements.

12.4 While leadership has been the primary driver of this positive change, a divergence of views remains about whether leaders genuinely listen to those they serve. Feedback to the Audit surveys indicates that a notable minority of the workforce and the congregation either disagreed or remained neutral when asked whether leadership listens carefully to their opinions and concerns. This scepticism appears rooted in legacy failures raised repeatedly during focus groups and individual discussions. Sustaining the improvements achieved will depend on securing the active confidence of all staff and volunteers, including those who retain reservations. The Audit considers that more visible and accessible listening mechanisms are necessary if the cultural gains made thus far are to be consolidated and extended to those who currently feel less heard.

Recommendation C1: To strengthen communication between leadership, the workforce and the worshipping community, the Cathedral should:

a) Establish regular open forum sessions, in both formal and informal settings, at which staff, volunteers and members of the worshipping community can engage directly with leadership.

b) Introduce a secure and anonymous feedback mechanism to provide a safe route for those who remain hesitant to raise concerns openly.

c) Ensure that leaders respond visibly to feedback received, acknowledging the issues raised and communicating clearly how the views of staff and the community have informed decisions. This discipline of transparent follow-through is essential to rebuilding the trust of those who remain sceptical.

d) Acknowledge openly the legacy of past failures and the impact these have had on individuals within the Cathedral community. A genuine and clearly communicated

recognition of historic shortcomings would help address the residual scepticism identified in this Audit and reinforce that the cultural change now under way is both understood and sustained.

Leadership

12.5 Those engaged by the Audit were consistent in describing a previous administration marked by what many described as toxicity, a culture of control and significant senior leadership turnover. Staff reported feeling unable to challenge poor practice or raise concerns, and that decision-making was heavily centralised in ways that constrained the development of effective safeguarding, and a widespread view that previous communication was poor. Against that backdrop, the Audit is satisfied that the present leadership team has, in a short period and under considerable financial and structural pressure, created the conditions for genuine and sustainable recovery.

The Interim Dean

12.6 The interim Dean is widely regarded as a central figure in driving positive cultural change. He has demonstrated genuine commitment to doing the right thing, modelling openness by acknowledging past failings and making organisational transformation grounded in safeguarding a clear priority. This has meant maintaining an open-door approach, promoting kindness and respect, and addressing prior cultural failings decisively. His support for the safeguarding team and his openness to external scrutiny were given clear public expression during his first sermon on Safeguarding Sunday in November 2024, when he recommissioned the Independent Chair and the Cathedral safeguarding team. He has also referenced safeguarding directly in pastoral correspondence to staff, volunteers and worshippers on four separate occasions over the past year.

12.7 The Audit considers his leadership style, and the team he has assembled around him, to

have been instrumental in the Cathedral's recovery. Continuity will be important as this work continues, and the Audit welcomes the active interest shown by the incoming substantive Dean.

The Chief Operating Officer

12.8 The COO has made a positive impact on the working environment and the morale of those who work, volunteer and worship at the Cathedral. He brings relevant expertise in project delivery and has made leadership accessible, engaging directly in congregational forums and conducting detailed reviews that connect with safeguarding integrity. He provides tangible support to safeguarding professionals and takes responsibility for maintaining accountability.

The Chapter Safeguarding Lead

12.9 The Chapter Safeguarding Lead, who also serves as the Acting Canon Missioner, brings strong personal commitment, sound expertise and a genuine willingness to reflect critically on her own practice. She is widely regarded as an asset to the Cathedral community and has made a meaningful contribution to safeguarding governance across Chapter and other oversight meetings. She approaches safeguarding as a leadership responsibility rather than a compliance obligation and seeks critical feedback on her own performance. She has communicated consistently about safeguarding, addressing staff and volunteers directly on multiple occasions and reaching the wider community through Pew and Minster News, sermons, and a local newspaper article promoting engagement with the Audit surveys. Her work has helped establish an environment in which leadership forums engage openly with safeguarding matters.

The Canon Precentor

12.10 The Canon Precentor is engaged and reflective and has played an active part in the Cathedral's safeguarding journey, helping to model a move away from defensiveness,

openly acknowledging past failings and the need for continued development. This kind of transparency is important in guarding against any drift back towards a culture of silence, and it reinforces that safeguarding is now consistently on the agenda.

The Cathedral Safeguarding Officer

12.11 The CSO adds considerable value to the organisation. The close working relationship between the CSO and the DST is a major operational strength, and the Audit found clear evidence that the CSO provides professional guidance on complex safeguarding matters and supports both leadership and governance functions. The Audit also heard consistent feedback that the capacity of this role to drive systemic improvement is critical to the Cathedral's ongoing development.

Recommendation C2: The Cathedral should increase the operating hours of the Cathedral Safeguarding Officer to three days per week (see Capacity section). Reducing the current resource at this stage of the Cathedral's safeguarding development would represent a significant and avoidable risk to the progress already made.

12.12 A further illustration of the current approach concerns the handling of a complex legacy matter regarding a financial contribution. Previously, a significant donation was accepted without undergoing the necessary safeguarding scrutiny, despite the donor's background presenting serious risks. This decision bypassed the appropriate internal oversight, and standard documentation was not retained. On becoming aware of the matter, the current leadership team acted immediately. They secured legal counsel, engaged transparently with key governance and stakeholder groups, made formal referrals to national oversight bodies, and engaged proactively with regulatory reporting. The handling of this case reflects both the difficult historical gaps the current team has inherited and the robust, transparent approach to decision-making now in practice.

Recommendation C3: The Cathedral should introduce a formal donor due diligence policy that requires safeguarding checks to be carried out before any significant gift is accepted, regardless of the financial context at the time. The policy should define who is responsible for the check, set a threshold above which it is mandatory, require sign-off at Chapter level, and specify how records of the decision-making process are to be retained.

Governance

Chapter

12.13 Southwell Minster Cathedral complies with the governance expectations of the Church of England and the Charity Commission, and Chapter demonstrates a working awareness of its legal obligations and its ultimate responsibility for safeguarding.

12.14 Auditors observed a constructive working relationship between the Dean and the Senior Non-Executive Member (SNEM). The Dean provides executive and pastoral leadership, while the Senior Non-Executive Member offers independent scrutiny and assumes the chair when conflicts of interest arise. As this arrangement currently operates informally, the process could be strengthened by adopting the practice as a formal local policy.

Recommendation C4: Chapter should embed in local Cathedral policy a formal arrangement whereby the Senior Non-Executive Member assumes the chair whenever the Dean's executive role creates an actual or perceived conflict of interest.

12.15 A recent skills audit confirmed that all but one non-executive member joined Chapter during 2025, resolving a period of instability through an open national recruitment process. The membership is motivated and credibly appointed, supporting public confidence in Chapter independence. Corporate memory is consequently limited and requires active management through structured induction and mentoring.

12.16 Chapter is at an early stage of governance maturity, with trustee safeguarding knowledge identified as a priority development area. While overall attitudes are positive, a minority of members did not consistently identify certain scenarios as safeguarding concerns. This indicates a gap in baseline knowledge that requires immediate attention across the trustee body. Face-to-face trustee safeguarding training for all trustees has not yet been delivered.

Recommendation C5: All Chapter members should receive face-to-face, operationally focused safeguarding training covering core safeguarding concepts, contextual application within a cathedral setting, risk assessment, and trustees' collective responsibilities under charity law.

12.17 The safeguarding trustee role is currently held by a member of the clergy. This structural decision creates a risk of a perceived conflict of interest that must be resolved to ensure optimal independent oversight.

Recommendation C6: At the next available recruitment opportunity, Chapter should appoint a non-clergy, non-executive trustee with a credible statutory background in both frontline and senior strategic safeguarding to hold specific safeguarding oversight responsibility. This will not impact on the status and trustee accountability function of the current post-holder.

12.18 Chapter is engaged and well intentioned, yet its safeguarding oversight remains primarily observational rather than active. Governance can be materially strengthened by ensuring operational safeguarding data is consistently presented to trustees and by adopting a structured framework for inquiry. The overarching safeguarding strategy was paused pending the new Dean's arrival and requires urgent completion.

Recommendation C7: The CSO (to be replaced at such meetings by a Director of Safeguarding if agreed), should be formally established as a regular attendee at Chapter

meetings, ensuring that operational safeguarding expertise is always available and safeguarding considerations are directly and consistently represented at the governance level.

Recommendation C8: Chapter and the CSMG (addressed below) should adopt a structured, rolling three-year programme of themed safeguarding scrutiny aligned to the National Safeguarding Standards, moving oversight from observational tracking to active, focused inquiry.

Recommendation C9: The development of an overarching Cathedral safeguarding strategy must be urgently resumed and completed.

The Cathedral Safeguarding Management Group (CSMG)

12.19 The Cathedral Safeguarding Management Group acts as the primary subcommittee supporting Chapter, providing focused operational and strategic scrutiny. The formal appointment of an experienced Independent Chair in December 2025 is a material governance improvement. Given the recency of this appointment, evaluation will be necessary to assess its effectiveness.

Recommendation C10: A formal review of the Cathedral Safeguarding Management Group under the Independent Chair should be scheduled for December 2026 to assess the impact of this transition and embed ongoing accountability.

12.20 The CSMG faces membership gaps that limit its effectiveness. The survivor representative position has been vacant since mid-2025, representing a serious deficit in lived experience scrutiny. Attendance by NHS and Local Authority statutory partners has also been inconsistent, depriving the group of essential multi-agency perspectives. The Independent Chair should prioritise re-engaging these partners, using virtual sessions where necessary to maintain statutory input.

Recommendation C11: The appointment of a survivor representative must be treated as an immediate priority to address the current gap in lived experience scrutiny.

Recommendation C12: The Independent Chair should reach out and engage directly with Local Authority partners, including adults and children's safeguarding partnerships. This could facilitate short focused virtual one-to-one meetings from which the Chair can cascade relevant information into the CSMG.

Several governance documents are overdue for review and must be updated to align with Chapter's proposed three-year themed cycle, ensuring both bodies provide complementary oversight.

Recommendation C13: The CSMG Terms of Reference, the Diocesan Service Level Agreement, and the broader policy framework must be completed and ratified without further delay.

12.21 The Audit identified a need for enhanced oversight of minor behavioural concerns at the Song School to prevent escalation.

Recommendation C14: An online system should be implemented to track low-level, non-safeguarding behavioural concerns at the Song School, enabling patterns to be identified before they escalate.

Capacity

12.22 Capacity is the area of greatest concern identified by this Audit, and the findings are unambiguous. Safeguarding at the Minster is delivered by a single CSO engaged through a Service Level Agreement with the DBF, supported by a volunteer Safeguarding Coordinator (now refocused as the Cathedral Volunteer Coordinator) and, when the CSO is absent, by the DST. The CSO post carries a recognised single-point-of-failure risk,

brought into sharp relief by the fact that the Cathedral had three CSOs across four months between May and September 2025.

12.23 The level of provision sits below the national benchmark. The CSO resource was originally set at 0.6 Full-Time Equivalent (FTE) in 2022 to enable the implementation of best practice and policy and was reduced from May 2024 to two days per week (0.4 FTE). The NST resourcing model for cathedrals predicts an expected professional safeguarding resource for Southwell of 0.5 FTE (17.5 hours per week), with a minimum threshold of 0.4 FTE. The Cathedral's current provision therefore sits at, or marginally below, the national floor and beneath the expected level.

12.24 The same model indicates that around seven hours on culture and leadership and five hours on prevention are needed each week for systemic improvement work, which is precisely the work set out in the Cathedral's own Safer Cathedral Development Plan. A casework-focused SLA at the current level therefore leaves the Cathedral materially under-resourced for the improvement activity it has itself identified.

12.25 The risk of reducing provision further was expressly flagged. When the previous CSO resigned in February 2025, and against a backdrop in which the COO had questioned the SLA cost as potentially high relative to other cathedrals, the DSO warned in writing that reducing provision below two days per week, or cutting remuneration, would pose a significant risk to the Cathedral and would likely attract criticism in this Audit.

12.26 The DSO recommended recruiting a replacement at no less than two days per week and a minimum full-time-equivalent salary of £37,000 to £38,000. The Audit endorses that professional judgement.

12.27 The sector picture is highly variable: the 2024 Cathedrals Survey found that 59% of

cathedrals pay nothing for diocesan safeguarding provision while others pay up to £40,000, with no clear link between payment and quality. Variability across the sector does not, however, reduce the assessed need at Southwell, where the improvement agenda is substantial.

12.28 Several elements of the Cathedral's own capacity review were, by its own account, not completed: prevention and awareness training was not reviewed, and victim and survivor engagement has not been reviewed. The reviews that were undertaken, covering the CSO's and Coordinator's tasks and hours, functioned as internal assessments of workload but stopped short of a leadership conclusion that staffing is sufficient to meet all responsibilities.

12.29 The Audit's assessment is that the deficiency at the Cathedral is structural rather than a matter of professional skill or leadership will. The financial pressures are real and are acknowledged; but the safeguarding provision is operating below the expected national level at precisely the moment the Cathedral has committed to an ambitious programme of systemic improvement, and it remains exposed by its reliance on a single post-holder. This is neither appropriate nor sustainable.

12.30 The Audit considers that the most effective means of consolidating resource and providing greater operational resilience is the creation of a diocese-wide Safeguarding Directorate led by a Director of Safeguarding. Under this model, the CSO would remain embedded in and responsible for the Cathedral whilst forming part of the wider DST. This structure would deliver greater resilience, consistency of practice and effective supervision, and would reinforce the operational independence of the safeguarding function. The Director should not be line-managed by the Diocesan Secretary or the COO but should be accountable directly to the DBF and Chapter.

Recommendation C15: A Director of Safeguarding should be appointed to lead the new Directorate and provide professional line management for all specialist safeguarding staff. As the most senior operational safeguarding voice, the Director should be accountable to the DBF and Chapter rather than to any single church officer. (This recommendation should be read in conjunction with the Capacity section of Part One of this Report).

Recommendation C16: The Cathedral should ensure:

a) Ring-fence dedicated capacity to ensure safeguarding staff can focus on systemic learning, improvement projects and essential supervision.
b) Sustained professional development for leadership in survivor-focused, trauma-informed practice and institutional learning.
c) Investment in appropriate technology, including AI-assisted record management and dashboard reporting, to make efficient use of staff time and strengthen risk oversight.

Chorister Safeguarding

12.31 Southwell Minster maintains a long-established choral tradition. While most choristers attend the Minster School, a newer outreach initiative welcomes a small number of children from other schools. Safeguarding arrangements for the choristers are robust, built upon clear structures, well-defined responsibilities, and effective collaboration between the Cathedral, the music department, and Southwell Minster School.

12.32 The Audit also noted evidence of positive cultural development within the choir in recent years. Management openly acknowledged previous challenges regarding group dynamics and peer pressure among the choristers. This was accompanied by clear evidence of proactive efforts to enhance the choir's overall culture, ensure parity between boys and girls, and strengthen pastoral oversight.

Scheduling and Wellbeing

12.33 The Audit found that there are clear structures surrounding the choristers' weekly schedule. The Audit heard evidence that staff know the children well and maintain regular informal pastoral contact.

12.34 Music department staff demonstrated awareness of the pressures involved in balancing choir commitments alongside school, family life and wellbeing. Whilst the Audit identified good practice in this area, with evidence that the Cathedral is mindful of these demands, some feedback suggested that particularly busy periods, including weekends with significant choir commitments, may place additional pressure on choristers and reduce opportunities for rest and downtime.

12.35 Whilst this did not emerge as a significant concern, the feedback indicates that there may be value in periodically reviewing arrangements during busier periods and considering whether additional opportunities for recovery time are appropriate, such as reduced commitments at the start of the week where weekend commitments are higher.

Recommendation C17: The Cathedral should periodically review chorister schedules during busy periods to ensure existing arrangements continue to provide an appropriate balance between choir commitments, education, family life and rest, including consideration of compensatory time or reduced commitments following particularly demanding periods of choir activity.

Parent and Chorister Views

12.36 Whilst parental engagement with the Audit was limited, those who did engage spoke highly of the safeguarding and pastoral arrangements and expressed confidence in the care provided by staff.

12.37 Particular praise was given to the Canon Precentor, who was described as approachable, visible and genuinely concerned with children's wellbeing beyond musical performance. This reflected wider evidence heard throughout the Audit regarding improved culture, openness and pastoral leadership within the Cathedral.

Chaperoning and Staffing

12.38 The Cathedral currently employs one chorister supervisor who maintains oversight of children throughout the day, including registration processes, movement between school and cathedral spaces, supervision during breaks, and handover to parents at the end of rehearsals and services.

12.39 The Audit heard positive feedback regarding the chorister supervisor, with staff describing her as experienced, respected by the children and a strong source of support within the department.

12.40 Risk assessments and briefing documents for chaperones were provided to the Audit, including arrangements relating to transfers between school and Cathedral spaces and external visits.

12.41 However, staffing capacity within the music department was identified as an ongoing pressure. Music staff consistently described concerns regarding limited supervisory capacity, particularly when balancing musical leadership responsibilities alongside safeguarding and supervision for the choir. Whilst measures are in place for children to be kept safe, existing arrangements place considerable strain on staff resources.

12.42 It is therefore positive that the Cathedral is seeking to recruit additional volunteer chaperones to strengthen supervisory arrangements, particularly during larger events and periods where multiple groups are rehearsing simultaneously. The Audit supports this decision.

Recommendation C18: The Cathedral should consider the appointment of an additional permanent chaperone with responsibility for administrative and coordination functions, to support safeguarding oversight, record keeping and the sustainable delivery of chorister provision as the choir develops.

12.43 The Audit also heard acknowledgement from leaders that previous choir culture had included unhealthy peer dynamics and behaviours which had become normalised over time. Staff demonstrated insight into this history and highlighted sustained efforts to improve relationships, inclusion and parity across the choir, such as children involved in choosing safeguarding posters and messaging in the Song School and the introduction of 'post boxes' where children can share their worries or feedback more privately. New measures are also being introduced to provide an individualised plan for each chorister, with regular review and more structured one-to-one conversations about feeling safe. This evidences the Cathedral's willingness to listen to the voice of the child and is considered good practice.

Physical Environment

12.44 The Audit heard that the Cathedral recognises the complexity of the physical environment in which chorister activity takes place. Music staff described aspects of the environment as challenging from a safeguarding and supervision perspective, particularly where rehearsals occur across multiple spaces.

12.45 The Audit noted that future plans to grow the choir may place further demands on existing safeguarding arrangements. The location of toilet facilities away from the Song School requires staff to leave the immediate area to supervise children when these facilities are used. Whilst this is being appropriately managed at present, growth in choir numbers may increase the practical challenges associated with supervision, coordination and record

keeping. The Cathedral should therefore consider whether additional resources may be required to support the long-term sustainability of safeguarding arrangements. The addition of a secondary permanent chaperone / volunteer chaperones will likely ease this difficulty.

12.46 Leaders acknowledged current CCTV limitations (with coverage largely confined to public corridors) and indicated they are already considering enhanced provision; given the complex layout and presence of secluded areas such as the organ loft, it is recommended that the Cathedral progresses plans for robust CCTV coverage in key chorister spaces (including the Song School and organ loft), ensuring this is implemented in line with data protection and privacy requirements.

Recommendation C19: The Cathedral should implement its proposed enhancements to surveillance arrangements within key chorister areas, including the Song School and organ loft, ensuring appropriate oversight of secluded spaces whilst maintaining compliance with data protection and privacy requirements.

Information Sharing

12.47 At the time of the Audit, safeguarding concerns within the music department were primarily recorded using paper-based systems, with plans underway to transition to a more centralised electronic recording process. Staff demonstrated awareness of the limitations of maintaining standalone records and recognised the benefits of improved information sharing and oversight, and plans to digitise these arrangements are welcomed by the Audit.

12.48 The school and Cathedral currently operate with a joint safeguarding agreement and a memorandum of understanding that defines roles and responsibilities in relation to choristers. Safeguarding communication is embedded through regular structured meetings, with the key school and Cathedral staff meeting fortnightly to discuss any

safeguarding or pastoral concerns regarding choristers.

12.49 In addition, there are half-termly governors' meetings, along with termly meetings with the CSO to review safeguarding and the operational agreements between school and cathedral.

Training

12.50 Staff consistently demonstrated thoughtful and child-centred approaches to safeguarding responsibilities, such as an awareness of behaviour management strategies, pastoral support and safeguarding escalation procedures. Additionally, the Audit heard positive examples of reflective learning being undertaken in response to previous chorister-related incidents.

12.51 There is evidence of increasing awareness regarding additional needs and neurodiversity within the chorister cohort. Staff appear to adapt approaches where required and work closely with children and families. That said, training around neurodiversity and behaviour management was identified by staff themselves as an area for development. Early planning work has already begun and is welcomed by both Cathedral staff and the Audit. This presents a good opportunity to build confidence and shared understanding, and to support staff to respond consistently to a range of needs within the chorister cohort.

Policies

12.52 A number of documents were submitted to the Audit relating to chorister activity, including risk assessments, safeguarding agreements with the Minster School, and briefing guidance for chaperones.

12.53 Whilst it is positive that a Safeguarding Policy for Children, Young People and Adults At Risk covers activity relating to choristers, parts of the policy (particularly the social networking section) contain ambiguous and cautious language that weakens its effectiveness as a safeguarding directive.

12.54 The policies currently rely heavily on advisory terms, telling staff and volunteers they are 'asked to be careful', 'advised to send messages to groups', and that it 'might be harder to maintain a professional distance'. This phrasing dilutes accountability. Safeguarding procedures must be definitive to ensure boundaries are maintained. Staff and volunteers must know exactly what is expected of them to protect children, young people, and themselves from harm.

Recommendation C20: The Cathedral should review and rewrite its safeguarding policies to replace all ambiguous, advisory phrasing with clear, mandatory instructions. Advisory terms such as 'asked to be careful' and 'advised to send' must be replaced with explicit requirements, such as 'must use group messaging platforms' or 'must not accept friend requests from individuals under 18'. The policies should clearly state the consequences for non-compliance, ensuring staff and volunteers understand that adherence to social media boundaries is a compulsory requirement of their role.

12.55 The Audit highlighted an opportunity to further simplify and bring together the Cathedral's chorister-specific safeguarding arrangements into a single, comprehensive handbook or policy document. Currently, useful guidance and operational procedures are spread across multiple documents and daily practices. While the chorister section within the main Safeguarding Policy provides a helpful foundation, there is scope to broaden this framework.

Recommendation C21: The Cathedral should consider developing a consolidated chorister safeguarding framework or handbook bringing together operational safeguarding expectations, supervision arrangements, escalation pathways, behavioural expectations, photography guidance, trips and visits arrangements, and safer working practice expectations for all staff and volunteers working with choristers.

13 Prevention

13.1 Safer recruitment policies and practices are a vital part of creating safer environments, discouraging unsuitable individuals from joining an organisation and preventing the abuse of children, young people and vulnerable adults.

13.2 The Minster has a system in place to support safer recruitment and various policies and procedures that define practice expectations. The Minster follows the House of Bishops' "Safer Recruitment and People Management" guidance as its minimum standard requirement. A range of checks are undertaken to ensure the suitability of applicants such as references, DBS checks and confidential declaration forms for eligible roles. Relevant messaging on job descriptions and voluntary roles also reference the Minster's commitment to safeguarding, and training is provided for those involved in the recruitment process. These measures help to create an environment that deters those who might be unsuitable or pose a risk to the young and vulnerable from working in the Minster.

13.3 A review of materials showed that all Minster staff held appropriate DBS checks. Among the Minster's volunteers, a small number of DBS records carried a 'TBC' status, reflecting that these individuals had not responded to recent requests and it had not yet been confirmed whether they were still volunteering.

Recommendation C22: The Minster should ensure that all relevant volunteers have up-to-date DBS checks, including by following up with those whose status is currently unconfirmed.

13.4 The Minster updated and published its safeguarding policy in October 2025. This document incorporates the House of Bishops' safeguarding policy, 'Promoting a Safer Church'. These policies are easily accessible via the Minster website. Providing direct digital access to these documents represents a positive step toward transparency and

professional standards. The Minster also adheres to national and diocesan guidance regarding other safeguarding requirements.

13.5 Safeguarding practice at Southwell Minster is integrated through a collaborative relationship with the wider Diocese and the national Cathedral network. Beyond formal training, safeguarding is embedded into the fabric of worship and shared learning. A key example of this is the collaborative work on “Sharing the Peace,” where the Minster and DBF have developed specific inclusive guidance. This involves placing clear instructions within the Order of Service rubrics and providing verbal introductions during worship to ensure the practice is safe and comfortable for all. This is good practice.

13.6 On a broader scale, the CSO maintains high standards by engaging with national and regional expertise. The CSO regularly attends learning events hosted by the NST and has prioritised peer-to-peer learning by visiting other Cathedrals to observe and exchange ideas. To further improve, the CSO is currently liaising with the NST RSL to explore how resources and learning can be better pooled across neighbouring Cathedrals.

13.7 Safeguarding is a central theme during services at the Minster, highlighted by an annual Safeguarding Sunday service held each November. A children’s church activity in 2025 further reinforced this priority, allowing facilitators to discuss safety with the children and identify trusted individuals for them to approach with concerns. The Audit heard that feedback from this session outlined that participants found it constructive.

13.8 Safeguarding awareness is further supported by digital and physical signage throughout the buildings. Child-friendly posters have been installed on display boards in prominent locations, having been designed in collaboration with children and young people. These posters feature photographs of the individuals that children can talk to if they have a worry. The Audit highlights this as an effective way to humanise the process and make it easier

for a child to seek support. The provision of printed material extends to wider safeguarding themes, including domestic abuse, county lines, and modern slavery. These displays serve to raise awareness and offer guidance on how to access help. There is also information displayed providing signposting for victims and survivors who require specialist support.

13.9 The Minster has undertaken a significant range of work to improve public-facing safeguarding communications. The safeguarding webpage has been comprehensively updated. This work involved restructuring the information hierarchy, adding more detailed content, and introducing photographs of the team. Clear guidance on how to make a complaint was also added, alongside a redesigned layout that uses colour and buttons to improve navigation. This is good practice.

13.10 To raise awareness, the Cathedral uses a range of tools to disseminate information to its key stakeholders. Notices on safeguarding are included in various printed materials, and information is also included within standard email footers across communications. Whilst not directly related to safeguarding, the Audit observed positive reach and engagement through its social media and believes there are opportunities to enhance these channels as a mechanism to connect, inform and share important safeguarding information.

Recommendation C23: The Cathedral should develop a communication plan aligned with its safeguarding communication strategy, which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of followers, adopting different techniques specific to the platform, and the use of relevant awareness days, campaigns and events to amplify the message.

13.11 To maintain a safer environment, the Minster conducts specific risk assessments for its various activities. A dedicated Lone Working Policy is also in place that sets out risk assessments and safe working procedures. These measures align with good practice.

13.12 The Audit found that the Minster has engaged in active discussion on how to shape appropriate boundaries, including when “Sharing the Peace” . The guidance developed is now integrated into all Eucharistic services, with a monitoring process in place to track its implementation. The Audit supports the work on developing a broader policy regarding appropriate boundaries.

13.13 Safeguarding arrangements regarding bellringers are proportionate and appropriate to the activity. Bellringing is predominantly adult-led. Where children are involved, there is awareness of safeguarding expectations and a clear understanding that safeguarding sits within wider parish and cathedral arrangements.

13.14 Given the specific circumstances unique to Southwell Minster, the Audit believes that the Minster’s CCTV provisions require attention. Several factors contribute to an increased risk profile, notably the Minster’s reliance on the nearest police station in Newark, which may affect response times. The Archbishop’s Palace is also a detached building, and because there is no direct line of sight into the State Chamber inside it, a significant security blind spot is created. These logistical challenges present a particular risk for staff in lone-working roles, such as Vergers, who are often required to lock up the premises late at night without immediate oversight or support.

Recommendation C24: The Minster is encouraged to expand CCTV coverage across the site. This should include, but not be limited to, key areas within the Minster itself, various entry and exit points, and specific sensitive locations, e.g. the Archbishop’s Palace. To improve physical safety on the grounds, the Minster should install sensor-based security lighting along dark exterior pathways, throughout the gardens, and along the exit routes used by staff during late-night departures.

14 Recognising, Assessing and Managing Risk

14.1 The Audit observed a considered approach to safeguarding at the Cathedral aimed at identifying, managing and mitigating risk. This framework includes having the relevant policies, procedures and guidance in place, as well as promoting a culture where everyone is aware of and responsible for safeguarding.

14.2 The Chapter of Southwell Minster has delegated its authority for reporting serious incidents to the Cathedral Safeguarding Triage Group. Documentation reviewed by the Audit confirms there is a comprehensive draft policy outlining how the Chapter, acting as charity trustees, delegates its responsibility for reporting serious incidents to the Charity Commission. This draft policy establishes the operational frameworks required to triage, manage, and report both safeguarding and non-safeguarding incidents to protect the Cathedral's beneficiaries, staff, and reputation.

Recommendation C25: The Chapter of Southwell Minster should formally review and approve the draft 'Delegation by the Chapter of Reporting Serious Safeguarding Incidents to the Charity Commission' policy at its next scheduled meeting.

14.3 The Cathedral's risk register, last updated in May 2025, covers various strategic issues, including safeguarding. While risks and mitigating factors are documented, the Audit found that safeguarding entries are high-level and lack specific detail. To address this, the Audit recommends establishing a separate, dedicated safeguarding risk register. This would involve a more focused approach; for example, explicit reference to the potential risks associated with non-compliance with the DBS re-check process. It is further recommended that these specific risks are clearly mapped to the appropriate governance bodies for regular oversight, namely the Chapter, the CSMG, or any operational safeguarding sub-groups.

Recommendation C26: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral.

14.4 All cases are allocated to the single CSO. Referrals are made directly to the diocesan safeguarding team via the contact details on the Cathedral safeguarding information. Because of this, the triaging process aligns with the diocesan system. If urgent action is required, diocesan safeguarding workers handle the immediate response in the absence of the CSO, before allocating the case to the CSO for ongoing work. Non-urgent cases are allocated straight to the CSO. This streamlined process was implemented at the end of September 2025 when the current CSO took up the post. The Cathedral uses a separate, secure Microsoft SharePoint site to record low-level referrals and requests for advice, particularly regarding choristers.

14.5 At the time of the Audit, four safeguarding cases were active. Two were expected to close shortly following the provision of advice and support. The third case involves a church safety plan, which was scheduled for further review in 2026. The final case relates to past behaviour by an individual who no longer holds a post.

14.6 The Audit also found inconsistencies in case management and record keeping and the Minster was unable to quantify the number of safeguarding concerns. Although systems are in place, these are largely insufficient, with case records for safeguarding concerns containing ‘inaccuracies’. Overall, the Audit noted a lack of a systematic and consistent approach to the recording and storage of safeguarding information resulting in a lack of confidence that all matters are properly recorded and stored.

Recommendation C27: The Minster should prioritise cleansing the data on the NSCMS. Dedicated time should be allocated to review records and ensure all details are appropriately logged. Additionally, any external notes from the past 12 months that were omitted from the NSCMS must be reviewed and backdated into the system.

14.7 The CSO holds primary responsibility for case management at the Cathedral, with quality assurance and supervision provided by the DSO.

14.8 During the Audit, there was one Safety Plan in place for the Cathedral which had been recently reviewed by the DST. The findings regarding Safety Plans are addressed in Part One of this report and apply equally to the Cathedral.

14.9 There have been no Safeguarding Case Management Groups (SCMGs) or disciplinary processes related to safeguarding at the Minster over the past 12 months. The findings in relation to SCMG procedures are outlined in Part One of this report.

14.10 The Cathedral is registered as a charity and has a legal requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. Whilst it has yet to make any SIRs, the Cathedral follows the House of Bishops' guidance set out in 'Safeguarding Serious Incident Reporting to the Charity Commission'.

14.11 The CSO is based within the DBF Safeguarding team and works with the Cathedral under a SLA between the DBF and the Cathedral Chapter. Under the terms of this agreement, any complaints concerning the speed or quality of safeguarding advice or commissioned projects should be referred to the Diocesan Chief Executive. The Chief Executive will work with both parties to resolve the matter. The Audit noted that the SLA currently outlines complaints regarding the service provided by the DBF, but it could be strengthened to clarify the specific protocols for handling disputes or escalations related to safeguarding practice.

Recommendation C28: The Minster and DBF should update the Safeguarding Support SLA to make a clearer distinction between standard service complaints and the formal escalation protocols required for disputes over safeguarding practice.

14.12 The Minster operates under several information sharing agreements (ISAs), including the National Data Sharing Agreement with the police. In tandem, the Southwell Cathedral Chapter and The Minster School are joint signatories to a safeguarding agreement designed to ensure seamless care and continuity for all children and young people in the Southwell Minster Choir. This is good practice.

14.13 The Cathedral advised the Audit that all personal information is stored and shared in ways which are compliant with data protection legislation and the General Data Protection Regulations (GDPR). Testing in this context was limited, although for safeguarding concerns arising in the Cathedral, there is a layer of reassurance with the use of the newly implemented NSCMS.

14.14 Survey findings showed most Cathedral staff were aware of the Cathedral's privacy notice in respect of data protection.

15 Victims and Survivors

15.1 Southwell Minster is committed to following the House of Bishops' guidance as set out in 'Responding Well to Victims and Survivors of Abuse'. Through a Memorandum of Understanding (MoU) with the DBF, the Cathedral benefits from a dedicated CSO who is under the supervision and support of the DSO. This arrangement should ensure a consistent approach to responding to victims and survivors of abuse and the provision of advice on how to respond appropriately.

15.2 Reporting pathways and signposts for further support are available on the Minster's website, and posters are located within key spaces, e.g. in toilet facilities and on notice boards. The Minster website's Safeguarding webpage includes contact details for the CSO and DST and a Report a Concern button which navigates to the Diocesan website. Advice on what to do in the case of an emergency is available, along with contact information on who to contact in out-of-hours cases.

15.3 The Safeguarding webpage includes a dedicated sub-section on Support for victims and survivors of abuse. A clear statement of commitment to supporting victims and survivors is evident, along with encouragement to seek advice from external services, such as Safe Spaces, NSPCC, Childline, Samaritans and Hourglass.

15.4 An additional webpage outlines a promise of respect and transparency regarding legal and confidentiality protocols. It functions as an additional resource directory, linking to specialised external agencies for domestic abuse, modern slavery, and church-based trauma. Ultimately, the page reinforces Southwell Minster's commitment to victim-centred care. House of Bishops' Guidance 'Responding Well to Victims and Survivors of Abuse' is also signposted here. While this is positive, and a range of useful information is present,

the Cathedral could strengthen this by centralising information on one consolidated webpage for victim and survivor engagement and support, instead of information split across two locations.

Recommendation C29: The Minster should consolidate all victim and survivor support resources and information into a single, unified and searchable webpage. This will provide a more accessible, seamless experience for those seeking help.

15.5 The Audit has seen evidence of support provided for individuals who have experienced harm within the Church. This included funding for accessing counselling services, referrals to external resources, an official letter of apology, and the opportunity to meet with the Dean. That said, the Audit has also engaged with individuals who received neither an apology nor appropriate support. To develop a healthy culture, it is imperative to learn from past experiences and prevent these shortcomings from reoccurring. Additionally, the Church must recognise that vulnerability can develop and change over time, an insight that extends beyond the Minster itself and will be addressed in our broader work.

Recommendation C30: The Minster must standardise its safeguarding response to ensure all individuals who have experienced harm receive appropriate care and formal apologies where desired. Support frameworks must also transition to an adaptive model that accounts for how vulnerability and trauma evolve over time.

15.6 A Survivor Engagement Protocol Statement is in place, addressing core principles and expectations. This is a well-rounded statement, informed by key policy, guidance and learning from reviews. Southwell Chapter's 'Survivor Engagement Protocol' establishes a foundational framework for supporting those with lived experience of trauma, including victims, survivors, and thrivers of abuse within the Church of England. The document outlines essential principles such as taking all allegations seriously without judgment and empowering survivors to participate in the reporting process. The Audit notes that some

fields remain incomplete in the version control matrix. On a positive note, the protocol commits to support options and regular reviews of support packages. To maximise effectiveness, the Audit recommends clarifying the specific mechanics of these reviews, including their frequency and execution methods.

Recommendation C31: The Minster should ensure that all missing fields within the version control matrix of the Survivor Engagement Protocol are complete, to ensure full administrative traceability and document compliance.

Recommendation C32: The Minster should ensure the Survivor Engagement Protocol clearly defines the formal process, timelines, and specific frequency for reviewing survivor support packages to provide clear guidance on how they will be maintained.

15.7 The Minster's 'Hope Bench', as part of the work spearheaded by the ADSO, is located in an outdoor space in the quiet of the Palace Gardens. The Hope Bench seating area is for anyone affected by trauma and loss. All are welcome to use this space to reflect, find solace and leave requests for prayer or support. The Audit has heard of services and blessings occurring at the bench, which is an innovative, inclusive and trauma-informed way of engaging with victims and survivors who may not feel ready to enter a Church building. This bench is also shared with the neighbouring diocese to signpost victims to share this space. This is good practice.

15.8 At present, the Minster's overall approach to engagement with victims and survivors appears more preventative and reactive than proactive. The Minster is aware that engagement with victims and survivors needs to be more meaningful and move beyond signposting to support. In order to engage with and learn from a wide range of voices, the Minster needs to broaden its approach to listening to and learning from the experiences of those with lived experience, and from those close to them. In this regard, the Audit makes the following recommendation.

Recommendation C33: The Minster should partner with the DBF to host Diocese-wide listening events, providing an additional platform to hear from a diverse range of voices to inform local safeguarding practice.

16 Learning, Supervision and Support

Safeguarding Learning

16.1 At the time of the Audit, learning, supervision and support arrangements within the Cathedral were developing within a context of organisational change. The previous CSO appears to have provided a strong foundation for early parish-based safeguarding training, giving the DBF something practical and credible to build on as its wider training offer has developed. The appointment of a new CSO represents a significant and positive step forward. The Audit found evidence of early impact in terms of visibility, confidence and engagement across the Cathedral community. Staff and volunteers consistently spoke of safeguarding becoming more visible, accessible and embedded within day-to-day Cathedral life.

16.2 Safeguarding learning is taken seriously across the Cathedral and is underpinned by the Church of England Learning and Development Framework. The Cathedral has begun developing its own training and development programme to complement national learning pathways and respond to local safeguarding needs. At the time of the Audit, a draft training and development programme had been prepared and was due to be considered by the Cathedral Safeguarding Management Group.

16.3 Training is delivered through a combination of national Church of England provision, diocesan safeguarding training and Cathedral-based delivery. The Volunteer Coordinator has completed 'Train the Trainer' training and delivers Basic and Foundation safeguarding training face-to-face, helping to increase accessibility and support volunteer engagement. The Audit heard positive examples of collaboration between the Cathedral and Diocese in delivering safeguarding learning and sharing good practice.

16.4 The Audit found evidence that safeguarding learning is increasingly influencing culture and practice. Survey responses demonstrated strong confidence in safeguarding arrangements, with the majority of workforce respondents agreeing that safeguarding arrangements within the Cathedral have improved.

16.5 Discussions with staff and volunteers suggested that safeguarding is increasingly understood as a shared responsibility rather than a standalone function. The CSO described a clear focus on helping individuals understand how safeguarding relates to their own role and responsibilities, moving away from perceptions that safeguarding is something undertaken solely by designated individuals. This is positive.

16.6 The Audit also found evidence of efforts to strengthen safeguarding compliance among the Cathedral's large volunteer workforce. Leadership took decisive action to improve training completion rates and introduced systems to improve oversight of training, DBS checks and safeguarding records.

16.7 Whilst safeguarding learning is clearly valued, arrangements remain in development. The Audit noted that safeguarding training is evaluated through participant feedback; however, the Cathedral acknowledged that it does not currently have a formal process for assessing the longer-term impact of learning on practice, behaviour and decision-making.

Recommendation C34: The Cathedral should develop a formal process for evaluating the impact of safeguarding learning beyond attendance and participant feedback. This should include consideration of how learning influences behaviour, decision-making, culture and safeguarding practice across the Cathedral.

16.8 The Audit also found that arrangements for recording and monitoring safeguarding learning are continuing to develop. Areas of strength include the development of the

Cathedral's own training strategy and improved record keeping, with plans to centralise records through ChurchSuite.

Clergy Support

16.9 Supervision and wellbeing arrangements for clergy were still being developed at the time of the Audit, however, it was clear that clergy understand the importance of safeguarding learning and generally remain compliant with Church of England training requirements. Safeguarding forms part of MDRs, and diocesan processes provide oversight of clergy learning requirements.

16.10 The Cathedral benefits from wider diocesan support arrangements for clergy wellbeing and development. This includes access to the Principal for Clergy Wellbeing and Development and funded counselling support where required. Some clergy have also attended trauma-informed church training to better understand the impact of trauma both on those they support and on themselves as practitioners.

16.11 Safeguarding is increasingly being recognised as a leadership responsibility within ordained ministry, and recent changes in Cathedral leadership have supported a more open and reflective approach to safeguarding.

16.12 Positively, induction arrangements for staff and volunteers include safeguarding components, links to training requirements and opportunities to meet with the CSO. The Cathedral has recognised opportunities to strengthen these arrangements further and is already reviewing induction processes to ensure safeguarding expectations are explicit from the outset.

Supervision and Support of Safeguarding Roles

16.13 The Audit found that supervision and support arrangements for the CSO are a particular strength. The Cathedral benefits from a SLA with the Diocese, with the CSO reporting to

the DSO and receiving support through wider diocesan safeguarding structures. This provides access to professional advice, challenge, supervision and specialist safeguarding expertise.

16.14 The Audit heard that these arrangements are particularly valuable given the potential isolation associated with safeguarding roles within cathedral settings. The CSO is appropriately connected to wider safeguarding networks and has engaged with learning opportunities involving other cathedrals and the NST. This includes attendance at national learning events and peer engagement with safeguarding colleagues in other cathedrals.

16.15 However, support arrangements are less developed for others who hold safeguarding responsibilities within the Cathedral. Discussions and documentation submitted identified that support mechanisms to help staff and volunteers manage the emotional impact of safeguarding work are currently limited and remain under review.

Recommendation C35: The Cathedral should formalise support arrangements for those undertaking safeguarding responsibilities, including clergy, staff and volunteers. This should include opportunities for reflective discussion, wellbeing support and access to guidance following complex or emotionally demanding safeguarding matters.

17 Conclusion

17.1 Five years on from the SCIE audit of 2021, the Cathedral is a measurably safer place. The transformation from an organisation in which fear was reported as a feature of daily working life to one in which the large majority of staff, volunteers and worshippers feel safe, valued and confident to raise concerns represents a considerable achievement. It has been led by individuals who have been able to be honest about the past and disciplined enough to drive change.

17.2 The cultural change is one of the report's most significant findings. The interim Dean's personal commitment has set the tone for a leadership team that, taken collectively, has demonstrated the kind of sustained and visible engagement that delivers change and is capable of transforming safeguarding culture.

17.3 The Chief Operating Officer has made governance accessible and accountable. The Chapter Safeguarding Lead has made safeguarding a leadership priority rather than a compliance exercise. The Canon Precentor has modelled the transparency that guards against a return to silence. The CSO has provided expert professional guidance and built a close and effective working relationship with the DST. Together, these individuals have created the conditions in which progress is possible and sustainable.

17.4 Beyond leadership, the Audit identified genuine strengths across the breadth of the Cathedral's safeguarding arrangements. Safer recruitment processes are in place and aligned with House of Bishops' guidance. Prevention work is embedded in worship and in the fabric of the building, with child-friendly materials co-designed with choristers, the HOPE Bench, inclusive guidance on the sharing of peace, and a comprehensive and accessible safeguarding webpage. Chorister safeguarding arrangements are robust, built on clear structures, strong joint working with Southwell Minster School, and a

demonstrably child-centred culture that has been actively and honestly improved.

17.5 The working relationship between the Cathedral and the DST is a material operational strength, and the CSO's engagement with national networks and peer cathedrals reflects an outward-looking approach to professional development that the Audit commends.

17.6 The areas requiring action should be understood in that context. They do not indicate a safeguarding culture in retreat; they indicate an organisation that has come far and must now consolidate what it has built. Safeguarding capacity remains the most pressing concern. A single post-holder operating at or below the national minimum threshold, at precisely the moment the Cathedral has committed to an ambitious programme of systemic improvement, represents a structural risk that neither goodwill nor professionalism can fully compensate for.

17.7 The recommendations regarding a Director of Safeguarding and a dedicated Safeguarding Directorate are not aspirational additions; they are the practical infrastructure on which the Cathedral's improvement work depends. The DBF and Chapter have a shared responsibility to ensure that resource decisions do not become the limiting factor in work that matters this much.

17.8 Chapter is engaged and well intentioned, but its safeguarding oversight has been more observational than active, trustee training has not yet been delivered face-to-face, and the overarching safeguarding strategy remains incomplete. These are not irreversible weaknesses; they are defined and manageable gaps that the recommendations in this report are designed to close.

17.9 The appointment of an Independent Chair to the Cathedral Safeguarding Management Group is an important step. The recommendation to appoint a survivor representative to

the CSMG as an immediate priority reflects a principle that should run through everything the Cathedral does: that those with lived experience of harm must have a meaningful voice in shaping the safeguarding response.

17.10 Record keeping and information management require sustained effort. The inconsistencies identified in case recording, the gaps in DBS compliance, the need to cleanse data on the NSCMS, and the reliance on paper-based systems in the music department all point to the same underlying requirement: that the systems and disciplines which sustain good practice in busy organisations must be treated as core functions rather than administrative burden.

17.11 The Audit recognises that these tasks fall disproportionately on a small team already stretched by competing demands, which reinforces rather than diminishes the case for adequate resourcing.

17.12 The recommendations in this report are constructed to enable the Cathedral to build on its considerable strengths, address the areas identified with purpose and resolve, and achieve its full potential as a genuinely safe and welcoming institution. Southwell Minster has shown that it is willing to face difficult truths and do the work that follows from them. The Audit has every confidence that, given appropriate resource and continued leadership of the quality observed, the Cathedral will continue to build on the safer foundations it has set.

Appendices

18 Appendix 1 – DBF Recommendations

Recommendation D1: The DBF should continue to host carefully guided, empathetic conversations that balance traditional theology with pastoral care to develop a genuinely inclusive community.

Recommendation D2: To reinforce the Diocese's commitment to building on the positive safeguarding culture developed thus far, the Diocese should adopt a range of engagement and listening initiatives. These should include:

d) Implement structured dialogue sessions that encourage staff to respectfully challenge and share alternative views with senior leadership.

e) Introduce anonymous feedback tools and appoint independent workplace advocates.

f) To avoid any ambiguity, the Diocesan Bishop should continue to reinforce the operational independence of the DSO and clearly communicate how their advice shapes executive decisions.

Recommendation D3: To strengthen existing practice, ensure consistency, and build capacity across the diocese, the following recommendations are made:

e) Adopt yearly strategic safeguarding planning meetings to formalise forward-looking oversight and governance.

f) Develop standard parochial pre-visit and post-visit briefings for formal visitations and informal visits to ensure consistent information sharing and robust preparation across the diocese.

g) Progress the recruitment of associate archdeacons to build leadership capacity and operational resilience.

h) Implement national recommendations regarding core group structures, including mechanisms to provide independent occupational health support.

Recommendation D4: To safeguard these critical Clergy Files, it is recommended that the Bishop's office investigates alternative, cost-effective fire-resistant storage options or prioritises an interim transition to a secure, encrypted digital filing system to mitigate the risk of physical loss.

Recommendation D5: To consolidate recent progress, enhance executive oversight, and ensure safeguarding remains central to the organisation's strategic framework, the following recommendations are proposed:

d) Standardise the minuting process for all management meetings to ensure that safeguarding discussions, decisions, and action points are recorded comprehensively.

e) Review and monitor the impact of recent investments in the safeguarding team on a regular basis to ensure the previously identified capacity vulnerabilities are effectively resolved.

f) Maintain the current strategic momentum by formally defining how safeguarding metrics will be continuously tracked and evaluated to ensure they remain fully embedded within the wider operational culture and aligned to the DSAP regarding identification and mitigation of risks.

Recommendation D6: To consolidate recent governance reforms and strengthen the Board's ability to meet Charity Commission expectations, the following priorities must be addressed:

a) The diocese should ensure a clear separation between the Bishop's Council and the regulatory role and responsibilities of the DBF. This should include appointing an independent lay chair to the DBF.

b) The DBF must explicitly adopt a scrutiny-based approach. This requires adding a standing safeguarding assurance item to every DBF agenda. Trustees must receive regular written and verbal reports on casework activity, risk, supervision, quality assurance, and resourcing, thereby enabling them to actively question, challenge, and track progress.

c) It should become standard practice for the Diocesan Safeguarding Officer (and ultimately the future Director of Safeguarding (if accepted)) to routinely attend all DBF trustee meetings. They should present reports and explain key risks, enabling trustees to make informed, evidence-based decisions regarding safeguarding and its resourcing across all agendas (including housing, finance, and HR). They should also be free to question any activity or strategic priority they consider to have a safeguarding element.

d) The DBF should formally designate a Safeguarding Lead Trustee with a clear, documented brief to champion the subject, liaise with safeguarding professionals (DSO/Director and DSAP Chair), and support the Board's scrutiny. Additionally, the DBF should undertake a light-touch safeguarding skills and confidence audit of all trustees, followed by targeted training to ensure ongoing safeguarding literacy.

e) The Diocese must document how the Diocesan Synod's responsibility for resourcing safeguarding aligns with the DBF's regulatory accountability. This includes mirroring the annual safeguarding report to Synod with a summary focused on DBF assurance and decision-making, and explicitly mapping how information flows between the Synod, DBF, and the safeguarding service to prevent gaps, duplication, or ambiguity.

Recommendation D7: To build on the clear strengths of the DSAP and address the areas where practice is still developing, the following recommendations are proposed to consolidate its strategic role, sharpen its use of risk and performance information, and strengthen the voice and influence of children, survivors and key partners.

g) Develop and deliver a three-year DSAP strategic plan with clear priorities, milestones and evidence of impact (including performance, survivor engagement and children's voice).

h) Finalise, adopt and embed a DSAP safeguarding risk register, ensuring it routinely informs the corporate risk register and DBF/Bishop's Council scrutiny.

i) Establish the performance subgroup firmly on a Performance/Challenge/Impact footing, with a clear remit to interrogate data, track systemic risk and report on impact rather than activity.

j) Implement diocese-wide frameworks for children's participation and survivor engagement, including the use of listening events and extending beyond existing pockets of good practice and evidencing how their feedback changes policy and practice.

k) Formalise joint working between DSAP and the Cathedral Safeguarding Management Group, and complete DSAP's own structural and meeting-model review (including hybrid options) to secure broader representation and clearer governance impact.

l) Conduct a skills, diversity and inclusion review to strengthen Panel membership, proactively recruiting independent leaders from local charities, businesses and civic organisations.

Recommendation D8: Appoint a Director of Safeguarding: This role will lead the new directorate and provide single, professional line management for all specialist safeguarding resources. The Director should not be line managed by a single church officer but as the most senior authoritative operational voice regarding safeguarding be accountable to the DBF and Chapter.

Recommendation D9: Formalise current collaborative practices between the Cathedral and the Diocesan Board of Finance by creating a distinct Safeguarding Directorate, led by a Director of Safeguarding, to ensure operational autonomy and robust accountability.

Recommendation D10: Conduct an immediate review to ensure all safeguarding roles are remunerated at market rates, aiding in the recruitment and retention of key staff.

Recommendation D11: Immediately upgrade the current caseworker role to full-time. Recruit an additional caseworker, potentially utilising a job-share model, to provide vital contingency cover and reduce reliance on overtime.

Recommendation D12: Secure a Safeguarding Support Officer with a comprehensive role profile to relieve practitioners of administrative burdens. Concurrently, upgrade the training manager role to a full-time position.

Recommendation D13: Ring-fence capacity for staff to focus on proactive projects, systemic learning, and essential supervision.

Recommendation D14: Establish dedicated survivor advocacy roles to systematically embed the survivor voice in decision-making processes and consider exploring and piloting a shared regional survivor support and advocacy service utilising a collaborative funding model.

Recommendation D15: Provide ongoing professional development for all leadership on survivor-focused, trauma-informed practice and institutional learning.

Recommendation D16: Invest in smarter working technologies, including AI-enabled record management and dashboard reporting, to optimise staff time and enhance risk oversight.

Recommendation D17: Deliver targeted, ongoing training and comprehensive inductions for all safeguarding team members, encompassing new starters, agency staff, and volunteers.

Recommendation D18: The DBF should establish a clear protocol to ensure the CMS retains accurate and up-to-date contact information for key safeguarding personnel, such as PSOs and churchwardens. This protocol must identify who is responsible for these records and for verifying parish information on a scheduled basis. Those assigned these tasks should be given the dedicated capacity to maintain the system.

Recommendation D19: The DBF should conduct a review of the analytics for the safeguarding webpage to ensure the layout meets user requirements. This review should inform the creation of a new sub-menu to improve navigation. For example, if the data shows that Safer Recruitment and DBS tools are among the most frequently accessed resources, these should be made more prominent through placing them within a safeguarding sub-menu.

Recommendation D20: The DBF should adjust its communication plan to include key safeguarding messages via its digital channels. To enhance this engagement, it should:

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

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

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

Recommendation D21: Further to reviewing existing practice, the DBF should consider implementing new and/or extended models for youth participation in consultation with parishes and its existing networks.

Recommendation D22: The DSAP should develop a standalone operational safeguarding Risk Register to allow for more focused scrutiny on the full range of safeguarding concerns, some of which might graduate to the strategic Risk Register held by the DBF. This should be reviewed and updated at a minimum cycle of quarterly.

Recommendation D23: The DBF should map relevant legacy data points (such as “categories of concern” and “profile flags”) from the DBF’s original configuration to the NSCMS framework. This is to resolve existing data anomalies between the two configurations, ensuring accurate data extraction and establishing a reliable baseline for national and regional benchmarking.

Recommendation D24: The DST should review and update its out-of-office notifications to ensure the language is welcoming and active, rather than creating a barrier to routine communication.

Recommendation D25: The DBF should standardise the categorisation and flagging of respondents subjected to safety plans on the NSCMS to ensure data consistency. This involves reviewing allocation of ‘profile flags’ and ‘concern categories’, establishing clear internal data entry procedures, and incorporating these protocols into briefings and induction materials for the safeguarding team.

Recommendation D26: The DBF should consider adopting Artificial Intelligence (AI) and Large Language Models to enhance administrative efficiency within the DST. This programme of work should begin by identifying the routine, time-consuming tasks that impact staff capacity, such as calendar management, email sorting, and meeting transcription. Following this assessment, the DBF can introduce approved, secure, and professionally licensed AI tools to streamline general administration and minute-taking. To ensure safety and quality, the rollout must include clear guidelines and staff training, alongside a strict policy requiring a team member to review

all AI-generated outputs for accuracy.

Recommendation D27: All members of the DBF who have not yet done so should complete the data protection and GDPR training within the next six months.

Recommendation D28: The DBF should transition the Survivor Engagement Protocol to an annual review cycle to ensure it immediately incorporates learning from engagement and evolving safeguarding practices.

Recommendation D29: The DBF should continue to promote House of Bishops' guidance 'Responding Well to Victims and Survivors of Abuse', and its Survivor Engagement Protocol and review how to improve awareness to maximise reach.

Recommendation D30: The DBF should conduct a comprehensive update of the 'Survivor Support and Engagement' webpage to remove defunct references and expired projects. This refresh should prioritise a cohesive, trauma-informed user experience by expanding the repository of active external support services. Implementing a regular maintenance schedule will ensure information remains accurate, restoring accessibility and user trust.

Recommendation D31: The revision of the Survivor Engagement Protocol must include:

d) The implementation of mandatory standards for prompt, DST-initiated communication to ensure survivors are consistently informed without needing to prompt for updates. Follow-up communications should take a diarised approach.

e) Embedding trauma-informed practices into the delivery of safeguarding outcomes, specifically by providing advance notice and transparent rationales while avoiding poorly timed disclosures.

f) The DST should agree and develop with victims and survivors, a support-end plan so support does not abruptly end.

Recommendation D32: In practice, the DST must take care to avoid providing conflicting advice and ensure all information provided is technically accurate and provided in simple, jargon-free language.

Recommendation D33: The DBF should strengthen formal handover protocols and contingency plans to manage staff leave effectively. These strategies must ensure continuity of care and remove the burden on survivors to retell their stories to new personnel. For unplanned absences, the DBF should provide prompt caseworker introductions alongside clear, compassionate explanations within confidentiality limits.

Recommendation D34: The DBF must mandate that domestic abuse disclosures are never minimised, ensuring all responders prioritise victim safety and belief. Formal escalation pathways should be risk-assessed to ensure that procedural actions, such as initial contact or information sharing, never inadvertently increase the risk of harm to the survivor.

Recommendation D35: The DBF should consider transitioning from individual representations to a dedicated survivor reference group model. This should include victims and survivors, family members / those who care for them and representatives from survivor support services. This collective approach will ensure strategic governance is informed by a diverse range of lived experiences while providing a peer-supported framework that reduces pressure on individual representatives.

Recommendation D36: The Diocese should consider introducing periodic clergy-specific safeguarding learning opportunities to complement national training pathways and enable

deeper exploration of safeguarding leadership, professional boundaries, risk management and accountability within ordained ministry.

Recommendation D37: The Diocese should continue expanding learning opportunities relating to neurodiversity, additional needs, trauma-informed approaches and inclusive safeguarding to ensure Church officers remain equipped to respond effectively to increasingly diverse safeguarding needs.

Recommendation D38: The Diocese should implement a centrally coordinated safeguarding learning record system that provides oversight of training across diocesan teams and parish roles. This should complement existing local records and provide senior leaders with greater assurance regarding compliance, support workforce planning and enable a more strategic approach to safeguarding learning and development.

Recommendation D39: The DBF should continue reviewing how safeguarding learning and guidance can be delivered in ways that remain accessible and proportionate for clergy serving increasingly complex benefice structures, whilst maintaining compliance with national requirements.

Recommendation D40: The Diocese should develop a structured continuing professional development programme for safeguarding trainers, incorporating opportunities for peer mentoring, observation, feedback and reflection. This would support ongoing professional development, consistency of delivery and the sharing of specialist expertise across the training team.

19 Appendix 2 – Cathedral Recommendations

Recommendation C1: To strengthen communication between leadership, the workforce and the worshipping community, the Cathedral should:

e) Establish regular open forum sessions, in both formal and informal settings, at which staff, volunteers and members of the worshipping community can engage directly with leadership.

f) Introduce a secure and anonymous feedback mechanism to provide a safe route for those who remain hesitant to raise concerns openly.

g) Ensure that leaders respond visibly to feedback received, acknowledging the issues raised and communicating clearly how the views of staff and the community have informed decisions. This discipline of transparent follow-through is essential to rebuilding the trust of those who remain sceptical.

h) Acknowledge openly the legacy of past failures and the impact these have had on individuals within the Cathedral community. A genuine and clearly communicated recognition of historic shortcomings would help address the residual scepticism identified in this Audit and reinforce that the cultural change now under way is both understood and sustained.

Recommendation C2: The Cathedral should increase the operating hours of the Cathedral Safeguarding Officer to three days per week (see Capacity section). Reducing the current resource at this stage of the Cathedral's safeguarding development would represent a significant and avoidable risk to the progress already made.

Recommendation C3: The Cathedral should introduce a formal donor due diligence policy that requires safeguarding checks to be carried out before any significant gift is accepted, regardless of the financial context at the time. The policy should define who is responsible for

the check, set a threshold above which it is mandatory, require sign-off at Chapter level, and specify how records of the decision-making process are to be retained.

Recommendation C4: Chapter should embed in local Cathedral policy a formal arrangement whereby the Senior Non-Executive Member assumes the chair whenever the Dean's executive role creates an actual or perceived conflict of interest.

Recommendation C5: All Chapter members should receive face-to-face, operationally focused safeguarding training covering core safeguarding concepts, contextual application within a cathedral setting, risk assessment, and trustees' collective responsibilities under charity law.

Recommendation C6: At the next available recruitment opportunity, Chapter should appoint a non-clergy, non-executive trustee with a credible statutory background in both frontline and senior strategic safeguarding to hold specific safeguarding oversight responsibility. This will not impact on the status and trustee accountability function of the current post-holder.

Recommendation C7: The CSO (to be replaced at such meetings by a Director of Safeguarding if agreed), should be formally established as a regular attendee at Chapter meetings, ensuring that operational safeguarding expertise is always available and safeguarding considerations are directly and consistently represented at the governance level.

Recommendation C8: Chapter and the CSMG (addressed below) should adopt a structured, rolling three-year programme of themed safeguarding scrutiny aligned to the National Safeguarding Standards, moving oversight from observational tracking to active, focused inquiry.

Recommendation C9: The development of an overarching Cathedral safeguarding strategy must be urgently resumed and completed.

Recommendation C10: A formal review of the Cathedral Safeguarding Management Group under the Independent Chair should be scheduled for December 2026 to assess the impact of this transition and embed ongoing accountability.

Recommendation C11: The appointment of a survivor representative must be treated as an immediate priority to address the current gap in lived experience scrutiny.

Recommendation C12: The Independent Chair should reach out and engage directly with Local Authority partners, including adults and children's safeguarding partnerships. This could facilitate short focused virtual one-to-one meetings from which the Chair can cascade relevant information into the CSMG.

Several governance documents are overdue for review and must be updated to align with Chapter's proposed three-year themed cycle, ensuring both bodies provide complementary oversight.

Recommendation C13: The CSMG Terms of Reference, the Diocesan Service Level Agreement, and the broader policy framework must be completed and ratified without further delay.

Recommendation C14: An online system should be implemented to track low level, non-safeguarding behavioural concerns at the Song School, enabling patterns to be identified before they escalate.

Recommendation C15: A Director of Safeguarding should be appointed to lead the new Directorate and provide professional line management for all specialist safeguarding staff. As the most senior operational safeguarding voice, the Director should be accountable to the DBF and Chapter rather than to any single church officer. (This recommendation should be read in conjunction with the Capacity section of Part One of this Report).

Recommendation C16: The Cathedral should ensure:

d) Ring-fence dedicated capacity to ensure safeguarding staff can focus on systemic learning, improvement projects and essential supervision.

e) Sustained professional development for leadership in survivor-focused, trauma-informed practice and institutional learning.

f) Investment in appropriate technology, including AI-assisted record management and dashboard reporting, to make efficient use of staff time and strengthen risk oversight.

Recommendation C17: The Cathedral should periodically review chorister schedules during busy periods to ensure existing arrangements continue to provide an appropriate balance between choir commitments, education, family life and rest, including consideration of compensatory time or reduced commitments following particularly demanding periods of choir activity.

Recommendation C18: The Cathedral should consider the appointment of an additional permanent chaperone with responsibility for administrative and coordination functions, to support safeguarding oversight, record keeping and the sustainable delivery of chorister provision as the choir develops.

Recommendation C19: The Cathedral should implement its proposed enhancements to surveillance arrangements within key chorister areas, including the Song School and organ loft,

ensuring appropriate oversight of secluded spaces whilst maintaining compliance with data protection and privacy requirements.

Recommendation C20: The Cathedral should review and rewrite its safeguarding policies to replace all ambiguous, advisory phrasing with clear, mandatory instructions. Advisory terms such as 'asked to be careful' and 'advised to send' must be replaced with explicit requirements, such as 'must use group messaging platforms' or 'must not accept friend requests from individuals under 18'. The policies should clearly state the consequences for non-compliance, ensuring staff and volunteers understand that adherence to social media boundaries is a compulsory requirement of their role.

Recommendation C21: The Cathedral should consider developing a consolidated chorister safeguarding framework or handbook bringing together operational safeguarding expectations, supervision arrangements, escalation pathways, behavioural expectations, photography guidance, trips and visits arrangements, and safer working practice expectations for all staff and volunteers working with choristers.

Recommendation C22: The Minster should ensure that all relevant volunteers have up-to-date DBS checks, including by following up with those whose status is currently unconfirmed.

Recommendation C23: The Cathedral should develop a communication plan aligned with its safeguarding communication strategy, which aims to embed key safeguarding messages throughout its online and digital channels. Consideration should be given to understanding the needs of followers, adopting different techniques specific to the platform, and the use of relevant awareness days, campaigns and events to amplify the message.

Recommendation C24: The Minster is encouraged to expand CCTV coverage across the site. This should include, but not be limited to, key areas within the Minster itself, various entry

and exit points, and specific sensitive locations, e.g. the Archbishop's Palace. To improve physical safety on the grounds, the Minster should install sensor-based security lighting along dark exterior pathways, throughout the gardens, and along the exit routes used by staff during late-night departures.

Recommendation C25: The Chapter of Southwell Minster should formally review and approve the draft 'Delegation by the Chapter of Reporting Serious Safeguarding Incidents to the Charity Commission' policy at its next scheduled meeting.

Recommendation C26: Safeguarding risks as they pertain to the Cathedral should form part of a dedicated safeguarding risk register for the Cathedral.

Recommendation C27: The Minster should prioritise cleansing the data on the NSCMS. Dedicated time should be allocated to review records and ensure all details are appropriately logged. Additionally, any external notes from the past 12 months that were omitted from the NSCMS must be reviewed and backdated into the system.

Recommendation C28: The Minster and DBF should update the Safeguarding Support SLA to make a clearer distinction between standard service complaints and the formal escalation protocols required for disputes over safeguarding practice.

Recommendation C29: The Minster should consolidate all victim and survivor support resources and information into a single, unified and searchable webpage. This will provide a more accessible, seamless experience for those seeking help.

Recommendation C30: The Minster must standardise its safeguarding response to ensure all individuals who have experienced harm receive appropriate care and formal apologies where desired. Support frameworks must also transition to an adaptive model that accounts for how vulnerability and trauma evolve over time.

Recommendation C31: The Minster should ensure that all missing fields within the version control matrix of the Survivor Engagement Protocol are complete, to ensure full administrative traceability and document compliance.

Recommendation C32: The Minster should ensure the Survivor Engagement Protocol clearly defines the formal process, timelines, and specific frequency for reviewing survivor support packages to provide clear guidance on how they will be maintained.

Recommendation C33: The Minster should partner with the DBF to host Diocese-wide listening events, providing an additional platform to hear from a diverse range of voices to inform local safeguarding practice.

Recommendation C34: The Cathedral should develop a formal process for evaluating the impact of safeguarding learning beyond attendance and participant feedback. This should include consideration of how learning influences behaviour, decision-making, culture and safeguarding practice across the Cathedral.

Recommendation C35: The Cathedral should formalise support arrangements for those undertaking safeguarding responsibilities, including clergy, staff and volunteers. This should include opportunities for reflective discussion, wellbeing support and access to guidance following complex or emotionally demanding safeguarding matters.

20 Appendix 3 – Glossary of Abbreviations

ADSO	Acting Diocesan Safeguarding Officer
AI	Artificial Intelligence
CCTV	Closed-Circuit Television
CMS	Contact Management System
CofE	Church of England
COO	Chief Operating Officer
CSMG	Cathedral Safeguarding Management Group
CSO	Cathedral Safeguarding Officer
CSP	Church Safety Plan
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSAP	Diocesan Safeguarding Advisory Panel
DSO	Diocesan Safeguarding Officer (Head of Safeguarding)
DST	Diocesan Safeguarding Team
FTE	Full-Time Equivalent
GDPR	General Data Protection Regulations
HR	Human Resources
IICSA	Independent Inquiry into Child Sexual Abuse
LADO	Local Authority Designated Officer
LLR	Lessons Learned Review
MoU	Memorandum of Understanding
NHS	National Health Service
NSCMS	National Safeguarding Case Management System
NSPCC	National Society for the Prevention of Cruelty to Children
NST	National Safeguarding Team
PCC	Parochial Church Council

PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
RE	Religious Education
RSL	Regional Safeguarding Lead
SCIE	Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SLA	Service Level Agreement
SMT	Senior Management Team
SNEM	Senior Non-Executive Member
TBC	To Be Confirmed

Date of Publication: 31/07/26

Version: 1.0

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