Independent Safeguarding Audit of York Diocesan Board of Finance and York Minster

2025

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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 Diocese 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 York DBF and York Minster, this involved the following:

- Over 580 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.
- 585 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, York Minster and parishes.
- Seven focus groups.
- A confidential contact form being made available via a dedicated webpage.
- In total, the Audit undertook 47 separate engagement sessions reaching 136 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, York DBF and Part Two, York 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 York Minster.

Part One - York Diocesan Board of Finance

2 Context

2.1 The Diocese of York, under the Archbishop of York and part of the Province of York, is geographically the second largest diocese in England. It covers 2700 square miles, including all or parts of North Yorkshire, East Riding of Yorkshire, City of Hull, City of York, Middleborough, Redcar and Cleveland. Organised into three archdeaconries and 21 deaneries, it encompasses 442 parishes and benefices with 597 places of worship. This diverse region hosts a mix of urban and rural areas and is home to a varied population.

2.2 The Diocese encompasses a broad landscape, ranging from the North Yorkshire coastline and moors to the agricultural areas of East Yorkshire. Its primary population centres are the cities of Middlesbrough, Hull, and York, where there are stark contrasts between affluence and deprivation. Indeed, this Diocese includes some of the most and least deprived parishes in the country. Housing pressures are significant, particularly the shortage of affordable housing and the increasing prevalence of tourist accommodation. Furthermore, the Diocese is becoming more culturally and ethnically diverse with the arrival of migrant and refugee populations.

2.3 The Diocese of York has an estimated population of around 1.45 million, comprising 637,500 households. The most recent annual mission statistic returns for the Diocese of York indicates that average weekly church attendance is 16,400 adults and 1,900 children and young people (under 18). The region provides 122 CofE primary and secondary schools, alongside sixth form colleges in major towns and universities.

3 Progress

3.1 In total, the SCIE safeguarding audit and PCR2 made 29 considerations / recommendations for the DBF in York. These addressed a range of issues, including case management, safer recruitment, capacity and how to support and engage children, young people, victims and survivors. The Audit was reassured that the initial actions in response to these processes had been met, with several being incorporated into the DBF's dedicated action plan or superseded by national developments, such as the implementation of parish dashboards and adoption of the national case management system. The Audit was informed that despite change in the Diocesan Safeguarding Advisor / Officer (DSA / O) post, consistent oversight has been maintained throughout by the Diocesan Safeguarding Operational Group (DSOG) and through reporting to the Diocesan Safeguarding Advisory Panel (DSAP).

3.2 The SCIE audit, published in October 2016, resulted in 20 considerations for the DBF to address, all of which were accepted. The Audit heard that the former Diocesan Safeguarding Officer (DSO) took the lead in implementing the actions arising from the SCIE report. This work, the Audit was told, was overseen by the DSOG and reported to the DSAP. Whilst these actions were being progressed, the Diocese of York was also subject to a case review by the Independent Inquiry into Child Sexual Abuse (IICSA).

3.3 The PCR2 resulted in nine recommendations for the DBF. The Audit was informed that the learning from this review was integrated into a broader two-year action plan. This plan was reviewed at most DSAP meetings and referenced within the Diocesan Safeguarding Strategy, with an emphasis on a commitment to improving the safeguarding culture.

3.4 The DBF has demonstrated a commitment to ongoing improvement, as evidenced by its

approach to learning from past cases, refining risk assessments, and strengthening existing procedures. National policy feedback provided by the DSA / O has further informed these efforts, while ongoing support for victims / survivors remains a priority. To ensure accountability and promote continuous learning, the DSAP maintains oversight of these areas.

3.5 The DBF monitors parish safeguarding compliance through the Dashboard and Safeguarding Hub and has completed reviews of Safer Recruitment and DBS processing procedures. Recognising past structural shortcomings in engaging with children and young people, the DBF has implemented new mechanisms and a 12-month engagement plan to address this gap. Notably, the DBF's partnership with IDAS and the development of the "Building Hope" resource have been identified as significant strengths in their safeguarding approach.

4 Culture, Leadership and Capacity

DBF Culture

4.1 The Audit of the Diocese of York revealed a discernible cultural shift, with significant feedback indicating a growing recognition of safeguarding, not merely as a procedural requirement but as a fundamental aspect of Christian life, underpinned by a more integrated theological understanding.

4.2 This evolution is evidenced by participants demonstrating a heightened awareness and commitment to safeguarding principles, with many parishes, supported by their Parish Safeguarding Officers (PSOs) and the Diocesan Safeguarding Team (DST), proactively embedding safeguarding into their core Church activities.

4.3 Across the Diocese, there was a clear sense of progress and growing confidence in the safeguarding culture. A majority within both workforces and worshipping communities reported improvements in safeguarding arrangements, and a significant majority in both the Diocesan Board of Finance (DBF) and Parish workforces stated that safeguarding is now embedded within their practices.

4.4 Critically, the confidence to raise safeguarding concerns without fear of reprisal was evident in the responses from the majority of those engaged, and overwhelmingly so within the parish worshipping community.

4.5 Furthermore, positive individual experiences, such as opportunities for direct engagement with senior leaders on safeguarding matters, and initiatives like the dedicated safeguarding week, were welcomed and considered a strength, particularly amongst PSOs.

4.6 While feedback from focus groups, individual discussions, and the Audit's survey was predominantly positive, revealing a culture in transition with leadership actively working to improve safeguarding practices and understanding, a notable minority expressed negative views linked to past accountability and complaint handling. It was clear that beyond local engagement and lived experience within the Diocese, views were often influenced by events at a national level, not least by unresolved legacy issues. This is particularly relevant to a Diocese led by an Archbishop and has the potential to erode growing local confidence if not transparently addressed.

Leadership

4.7 The Diocese of York presents unique leadership challenges, stemming primarily from the Archbishop of York's dual role, which encompasses both diocesan and provincial responsibilities, alongside his significant national engagement and influence. This inherent complexity can impact local diocesan leadership and is further compounded by broader national Church issues, particularly past failings and concerns regarding the Church's future direction.

4.8 A key line of enquiry for the Audit has therefore been the Archbishop's capacity to manage such a diverse range of responsibilities while maintaining a focus on safeguarding. Specifically, the Audit considered whether he has sufficient time to meet local diocesan needs alongside leading the wider Church.

4.9 In order to address the capacity challenges he faces, he has delegated various diocesan leadership and administrative functions to Suffragan Bishops. This includes the designation of the Bishop of Selby as Lead Suffragan, located in Bishopthorpe to ensure continuity of oversight. While this system (in operation since November 2024) is relatively new, initial signs are positive.

4.10 Notwithstanding the fact that the Archbishop has supported the Bishop of Hull's active involvement in safeguarding, he is clear that this is an area (along with discipline) that he cannot delegate. He was adamant that he retains absolute oversight, responsibility, and accountability for safeguarding and discipline across the Diocese. Indeed, the Audit saw and heard evidence of him taking direct authoritative action on a number of contemporary safeguarding matters.

4.11 The Archbishop was well-regarded by the majority of those involved in the Audit, with significant support evident within his leadership team and across the Diocese. That said, a number of individuals, both locally and nationally, have expressed and, in some cases, continue to publicly share concerns about his leadership. During detailed discussions with auditors, it was clear that he has learnt lessons from previous safeguarding matters. He also appeared personally reflective regarding recent criticism linked to nationally prominent issues, stating clearly his determination that both he and the wider Church learn from these experiences.

4.12 The Archbishop is supported by an experienced Diocesan Secretary, who understands and ably articulates the necessity for clear lines of accountability regarding safeguarding responsibilities, the need for an appreciation of Church dynamics and the ability to constructively challenge. He provides effective support to the Diocesan Safeguarding Advisor / Officer (DSA / O), the DST, and broader safeguarding activities. The Archbishop and Diocesan Secretary are committed to supporting and strengthening safeguarding arrangements within the Diocese's financial constraints and support the professional development of the DST and during discussion were not averse to the adoption of a Director of Safeguarding (dealt with as a recommendation, later in this report).

4.13 The DSA / O has a credible background in former statutory roles within the criminal justice and education settings. The Audit found him to be reflective, considered, fundamentally

focused on approachability and demonstrated strong engagement with the frontline of safeguarding in parishes. He is an asset to the DBF and parishes he serves.

4.14 Archdeacons work effectively with the DSA / O and DST. They help to address capacity issues (which places additional demand on them) and enhance safeguarding awareness during their formal and informal visits throughout their archdeaconries.

4.15 The Archdeacons currently employ a pre-visitation sheet, completed by church wardens, to guide their safeguarding inquiries. This approach (amongst other activities) includes specific safeguarding questions, and during visits, Archdeacons verify several key elements: the presence of PSOs, the display of safeguarding information, the completion of safeguarding training, and the status of Disclosure and Barring Service (DBS) checks. This is good practice.

4.16 However, the Audit identified several challenges that Archdeacons face in fulfilling this aspect of their role. These challenges include high workloads, for example, one Archdeacon is responsible for 51 Church buildings within a single deanery, the administrative burden associated with detailed pre-briefings, and limited capacity for in-depth pre-visit research.

4.17 That said, the Audit noted that Archdeacons were receptive to a more structured approach to pre briefings. To support such a process, the Audit make the following recommendations:

Recommendation D1:

1. Establish quarterly meetings with the DSO to ensure structured information sharing. These meetings should be underpinned by enhanced safeguarding briefs, debriefs, and reporting of outcomes and any necessary remedial actions.

2. Collaborate with the DSA / O, DST and parish representatives (potentially with oversight from the Diocesan Safeguarding Advisory Panel (DSAP)) to create a framework for focused engagement at the Deanery and parish level. This framework should include a formatted pre-visit briefing document provided by the DST, containing up-to-date information (as per the current pro-forma) and a specific Archdeacons' brief covering:

    a) The number of safeguarding agreements.
    b) Parish engagement levels and areas for specific, in-depth verification of safeguarding dashboards.
    c) Any relevant historic safeguarding issues.
    d) Details of recent or active Core Groups.

3. Submit a formal report of findings to the DSA / O / DST following each visit, outlining any remedial safeguarding requirements and the expected timeframe for response.

4.18 Currently, Archdeacons participate in Core Group meetings but do not hold the Chair. Given their extensive insight across their geographical areas and their enhanced safeguarding knowledge, the Audit takes the view that, with appropriate training and support, they are well-placed to assume this role. Their number ideally positions them to ensure independence, mitigating potential geographical or relational conflicts of interest. Furthermore, their seniority would enable them to facilitate and moderate professionally curious and challenging discussions effectively. Their safeguarding expertise would also help ensure appropriately focused outcomes. Additionally, adopting this approach could provide greater uniformity.

4.19 During discussions with the auditors, an Archdeacon raised the potential value of including a suitably qualified external independent expert in such groups. This idea clearly has merit, as it could help quality assure the process and offer independent insight and challenge.

Considering the potential policy, practice, and legal implications, the Audit will refer this suggestion to the NST for further consideration.

Recommendation D2:

1. Archdeacons should receive specific training and support to effectively chair Core Group meetings, ensuring a uniform approach and providing sufficient options to avoid any perceived conflict of interest.
2. To further enhance their safeguarding practice, Core Group training should be extended to other routine participants and consideration be given to hosting annual workshops with neighbouring Archdeacons to help develop good practice. This would provide additional added value and the opportunity to participate / lead cross diocesan groups when an issue involves more than one area.

Ministerial Development Reviews (MDRs)

4.20 Based on feedback, there is a view that MDRs are often perceived as performance-focused rather than developmental. MDRs are valued by participants and facilitators alike and in the opinion of the Audit ,could be further strengthened by expanding the composition of mentors / supervisors, how they focus their interaction and capitalise on opportunities for external and internal experiential development.

Recommendation D3:

1. Broaden the MDR review panel to include the Bishop, Archdeacon, and a trained lay person or retired clergy member, moving beyond the current structure to facilitate richer, more developmental conversations.
2. Shift the emphasis from retrospective performance review to a forward-looking developmental reflection, considering past experiences, assessing current skills (particularly in safeguarding), and identifying capabilities needed for future ministry focus.

3. Establish a process to identify and facilitate relevant internal or external developmental opportunities, such as visits or short secondments (e.g., with a youth justice team, food bank, or shadowing the DSAP Chair), tailored to support the individual's growth in their current and future roles.

Clergy (Blue) Files

4.21 Blue files are efficiently administered and stored, staff ensure a templated (checklist) approach and the Bishop's Chaplain follows up when blue files are delayed.

4.22 That said, greater clarity is required concerning how the files are received, examined and Clergy Current Status Letters (CCSLs) verified by the most appropriate senior person. The adoption of the recent delegated approach and relocation of a Suffragan Bishop to Bishopthorpe Palace and the recruitment of a further chaplain, will assist in ensuring better practice in this regard.

Recommendation D4: Blue files require examination by the territorial Bishop and the DSO promptly after receipt.

Recommendation D5: Introduce fireproof storage:

1. Procure certified fireproof cabinets or chests (meeting standards like UL Class 350 for paper).
2. Store these containers in a secure, restricted-access location.
3. Transfer blue files to the fireproof storage once examinations are complete.
4. Maintain an inventory of files held in fireproof storage.
5. Regularly review storage capacity and consider secure digital archiving for appropriate files.

Governance

4.23 The DBF operate a range of appropriate governance oversight meetings related to safeguarding. These reflect the expectations of the Church and relevant regulatory requirements, such as those issued by the Charity Commission.

4.24 Whilst the DSO is able to attend senior leadership team meetings (he is not a member of SLT), this does not always occur. The Audit recognises this is a capacity issue rather than a lack of desire on the part of the DBF leadership or DSO.

4.25 While the DSO can attend management and director structure meetings within the DBF and meets monthly with the Chief Executive (the Diocesan Secretary - their line manager), direct representation at the most senior leadership level is absent. Reasons cited for this include discussions around the effective use of the DSO's time and the belief that the safeguarding voice is adequately heard through other channels, such as an Archdeacon chairing an operational group and the Bishop of Hull and Chief Executive sitting on DSAP. That said, the Audit takes the view that none are dedicated safeguarding professionalsand that capacity permitting (up to and until a Director of Safeguarding is adoptioned - see Recommendation D8), the DSO should attend all leadership meetings.

Recommendation D6: The Audit team strongly recommend that the DSO should attend all senior leadership team meetings. It is considered crucial for a dedicated safeguarding professional to be present in these key decision-making forums. The safeguarding perspective is vital in discussions across a range of strategic areas, including housing, Church growth initiatives, international partnerships, and staffing / HR matters, where safeguarding implications may be significant but not immediately apparent to those without specialist expertise.

While the DSO recognises the potential value of this direct involvement and seeks to influence culture through existing meetings, the Audit concludes that reinforced capacity to facilitate formal inclusion at the senior leadership table is necessary to ensure proactive identification and mitigation of safeguarding risks at the highest level.

To deliver this enhancement, the DSO should become a standing member of the senior leadership team (YDLT). This should be supported by clear terms of reference outlining the DSO's role and expected contributions in this context.

The Diocesan Safeguarding Advisory Panel (DSAP)

4.26 DSAP and its operational sub-group are notable strengths, largely attributable to their membership and expert chair. The Chair possesses a keen understanding of the unique challenges within a diocese led by an Archbishop, including the public's tendency not to differentiate between a provincial leader's national engagement and their diocesan responsibilities.

4.27 Crucially, the panel's approach is well-structured, focusing on key safeguarding areas, including national standards, and they actively monitor actions, providing challenge and feedback on progress.

4.28 The DSAP benefits from robust internal representation across the Diocese, encompassing clergy members, key Church officers, and external members from the Local Authority, North Yorkshire Police, a domestic abuse advocacy organisation, and a representative from the Roman Catholic Diocese of Middlesbrough. York Minster is also represented.

4.29 Evidence reviewed by the Audit indicates that the Chair effectively challenges members at all levels, promoting accountability and scrutiny beyond mere discussion. This is considered good practice. Reassuringly, the Chair was able to cite instances where they

had observed the Archbishop actively promoting accountability, encouraging challenge, and demonstrating an appropriate willingness to learn - which is also good practice.

4.30 A review of the Quality Assurance Subgroup's oversight and resulting outcomes, which identify learning for the DST has evidenced appropriate challenge, focused learning, and effective action plans. Evidence further indicates that these plans have been effectively driven by the DSO and monitored by both the DSAP and the QA Subgroup.

Capacity

4.31 Based on the Audit findings, the DST is assessed as being well led with some complementary skill sets among its current personnel (DSO, ADSA, Admin Support Officer, Trainer). However, the team's present size is insufficient to effectively manage its workload, extractions or unforeseen contingencies.

Recommendation D7:

The DBF should increase the DST's capacity by adding two additional Assistant Diocesan Safeguarding Advisors (ADSAs). This expansion would allow for a portfolio-based approach, enabling specialisation by geographic area (potentially aligned with Archdeacons) and crucial safeguarding specialities such as victim/survivor support, offender management, and training.

While additional cost is inherent, two main options for achieving this expansion are identified for consideration:

1. **Option 1: Recruit Two New ADSAs** - This involves creating and recruiting two entirely new ADSA posts to add directly to the existing team structure.
2. **Option 2: Phased Recruitment and Role Reconfiguration** -This potentially more strategic option links recruitment to the consideration of establishing an autonomous

Diocese-wide safeguarding directorate. It involves a review of current roles to identify opportunities for strengthening the team with less initial investment.

This model would entail recruiting one new ADSA and reconfiguring existing roles: the current training post would become an ADSA role with geographic and specialist training portfolio responsibilities, and the administrator's role would be realigned into a Safeguarding and PSO Support Coordinator role, focusing on call management and filtering, dashboard compliance and reporting, annual audits, training evaluation, communications, and targeted parish support. This added value approach will require additional training and appropriately enhanced remuneration.

In any expansion or reconfiguration that enhances specialist safeguarding resources, consideration should be given to formally assigning one of the ADSAs as Deputy DSO. This individual would hold responsibility for a principal geographic area and a specialist portfolio (e.g., risk assessment and safety planning), thereby providing essential continuity and resilience during absences.

4.32 Recruitment for any new ADSA roles should seek to introduce complementary skills, rather than replicating those skills already evident in the team. Therefore, any recruitment exercise (notwithstanding due process) should target appropriately qualified and experienced social workers or former police officers with public protection backgrounds.

4.33 Looking ahead strategically, consideration should also be given to a more fundamental restructuring by establishing a dedicated Safeguarding Directorate led by a professional Director of Safeguarding. This would significantly strengthen the safeguarding function's authority and influence across the Diocese and the strategic nature of advice, guidance and direction to the Archbishop. Furthermore, while not recommending the subsumption

of the Cathedral Safeguarding Advisor / Officer into the DST at this time, it is recommended that the Memorandum of Understanding (MOU) between the Cathedral and the DBF be reviewed and redrafted as a formal Service Level Agreement (SLA) to enhance mutual support and shared services.

Recommendation D8: To significantly strengthen safeguarding, ensuring operational independence without undermining governance oversight, the Minster and the DBF should establish an operationally autonomous Safeguarding Directorate, headed by a Director of Safeguarding. This Directorate would consolidate all safeguarding resources, providing comprehensive and consistent support and direction to the Archbishop of York, DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the ability, authority and autonomy to:

a) Provide expert advice, robust oversight and ultimate direction on all safeguarding matters.

b) Challenge senior clergy and Church bodies when necessary, ensuring accountability.

c) Escalate concerns directly to higher authorities, including the National Director of Safeguarding at the NST without undue influence.

To ensure the effectiveness and influence of this structure, the following are required:

a) The Director should attend and report directly to, key decision-making bodies, including the DBF, Bishop's Council, Chapter, and the Archbishop / Bishop's / Senior Leadership Team (YDLT).

b) A comprehensive MoU / SLA between the DBF, Parish PCCs, and the Minster should clearly define the Director's authority and responsibility. This includes providing safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the geography of the Diocese.

c) The Directorate should be adequately resourced and staffed, incorporating all professional safeguarding personnel (including those currently based at York Minster).

Note: This recommendation should be read in conjunction with the Safeguarding Directorate section in the Independent Safeguarding Audits Annual Report (2024/2025).[2]

[2] https://ineqe.com/churchofengland/

5 Prevention

5.1 The DBF and the wider Diocese demonstrate strong safer recruitment practices. They adhere to the House of Bishops' guidance (Safer Recruitment and People Management), and processes align with relevant legislation. A range of measures underpin this important area of work, including training for key personnel, the establishment of role descriptions, supporting for and promotion of the Parish Dashboards, reference gathering, and role-specific vetting and barring checks. There is a well-defined procedure for assessing and acting upon 'positive' returns on DBS checks. Furthermore, specialist advice on criminal record checks is available from a contracted Disclosure and Barring (DBS) provider, and there is a process in place to support parishes that are unable to fulfil the position of Lead Recruiter.

5.2 One area for improvement within safer recruitment is advertising. The Diocese is missing opportunities to reinforce key messages about safeguarding in all job adverts. This is a helpful way to establish expectations from the outset of employment and sends a clear message of deterrence.

Recommendation D9: The DBF should ensure its commitment to safeguarding is embedded into all job adverts published by the DBF.

5.3 The DBF provides safeguarding governance and safer recruitment tools to parishes through the Parish Dashboards and Safeguarding Hub. The DBF is committed to supporting, encouraging and mentoring parishes in adopting and embedding this tool. The DBF offers support through various methods, including explainer videos, presentations to parishes, and other engagements with parish officers.

5.4 The DST has proactively worked to ensure the DBS system configuration effectively meets

the Diocese's needs. A key improvement has been the segmentation of a large, centralised DBS administration account into smaller, dedicated accounts for different categories of individuals. This change was primarily implemented to enhance data protection, improve system resilience, and better address the specific requirements of various user groups. This is considered good practice.

5.5 The Audit is of the opinion that the current responsibility for DBS administration, held by the DST, would be more appropriately located within the HR team. This should include a clear process for information sharing with the DST, particularly when a DBS check reveals relevant information. This realignment would free up administrative capacity within the DST to offer more proactive outreach and support to parishes.

Recommendation D10: The DBF should transfer DBS administration from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

5.6 Safeguarding is embedded within the operational structure of the DBF, evidenced by its consistent inclusion as a standing agenda item in all leadership team meetings. Furthermore, the active participation of leadership team members in the DSAP and the Diocesan Safeguarding Oversight Group (DSOG) ensures they play a central role in crucial safeguarding discussions. Direct accountability is further reinforced through quarterly one-on-one safeguarding meetings between the DSO and the Archbishop. Beyond formal meetings, meaningful engagement and dialogue on safeguarding are developed through various initiatives, including Safeguarding Sunday, Safeguarding Week, regular bulletins, PSO forums, and PSO drop-in sessions.

5.7 The Regional DSA and CSA meetings offer opportunities for networking and the sharing of best practice in response to current trends. The close working relationship with the

Catholic Diocese of Middlesbrough has strengthened both strategic thinking and practical implementation. Shared membership of DSA representatives on each other's boards and sub-groups has facilitated the exchange of knowledge and expertise, particularly in areas such as communication strategies, job descriptions, and PSO induction and support materials.

5.8 A scheme is being developed to promote PSO ambassadors, with the aim of fostering local networking and support among PSOs. While this initiative is still being rolled out, it has already been established in some areas.

5.9 As a member of the East Riding Safeguarding Adults Board, the DSO strives to contribute actively to its meetings, although participation has occasionally been limited due to capacity constraints.

5.10 Raising awareness of different types of abuse and promoting appropriate responses are fundamental to strong safeguarding practice. The DBF is committed to raising awareness of the different types of abuse and harm that can affect children, young people and adults. To achieve this, it utilises a range of effective communication methods, including newsletters, PSO drop-in sessions, forums, face to face events and the Safeguarding Week initiative. The improved data on newsletter recipients has enabled more tailored and targeted communications, such as the 'Bulletin Extra' edition, and has informed more intentional approaches to face-to-face engagement.

5.11 The Diocese's website presents a strong, modern theme that loads quickly, performs well with search engine optimisation (SEO) and is mobile-responsive. The 'safeguarding' section is prominently displayed and is easily accessible. It provides guidance directing users to internal assistance, external support, safeguarding training, and a range of DBS guides, tools and video explainers on how to use the Parish Dashboard. In respect of social

media, the DBF has issued guidelines advising churches to embrace these platforms to connect with their communities and share their message. For church representatives, the guidelines emphasise responsible online behaviour, transparency, and awareness of safeguarding, legal, and privacy issues. Specific information is included for interactions with children, young people, and vulnerable adults, prioritising consent, appropriate boundaries, and safety protocols. This is good practice.

5.12 The DBF takes into account those with additional communication needs. For example, subtitles and transcripts are now provided for video content, enhancing accessibility for a wider audience. Furthermore, PowerPoints and other resources are produced using high-contrast colour schemes to assist individuals with visual impairments and neurodiversity. A briefing session on "Understanding Neurodiversity" was held during Safeguarding Week in 2024. The Audit notes that the DBF is currently developing a job description for a diocesan disability advisor. The Audit supports this initiative and an ongoing focus on the diverse communication needs of all audiences.

5.13 As part of the Audit, the Children and Youth Enabler was engaged. They explained their active collaboration with colleagues across other dioceses through conferences and regional meetings, and their contribution to the survivor voice working group. Furthermore, they are involved in developing resources for schools and churches in partnership with young people.

Recommendation D11: The DBF should undertake a review to map the types of activities involving children and young people that take place within parishes, the primary focus of these activities and to identify any examples of good practice and / or potential areas for improvement.

5.14 All churches are required to conduct risk assessments for activities that take place within their buildings, including the physical layout. To support parishes in meeting this

requirement, the DST delivered two training sessions on the risk assessment process in 2024, with ongoing focus on this issue planned for the 2025. The DST's recent presentation on parish risk assessments during Safeguarding Week 2024 and this topic being referenced in the 2025 Safeguarding Bulletin have both been positive.

5.15 The DBF has policies and procedures in place to help make people safer when lone working. The recent update to the Lone Working policy was disseminated via the DBF newsletter, accompanied by a directive to consult the CofE's Code of Safer Working Practice (which outlines appropriate boundaries for preventing misunderstandings and reducing risks).

6 Recognising, Assessing and Managing Risk

6.1 The DBF's Risk Register covers key corporate issues. There is a dedicated section on safeguarding where concerns are thoroughly documented. This allows for a specific focus on safeguarding and is considered good practice. Appropriate oversight is in place, with recorded review dates, and in-depth examination at executive level. That said, to facilitate more targeted analysis, tailored mitigation strategies, and clearer accountability, the Audit recommends the following.

Recommendation D12: The DBF should create a separate Risk Register specifically for operational safeguarding risks. This will allow for the effective identification, assessment, and management of potential issues within the organisation.

6.2 Safeguarding concerns are appropriately assessed, triaged and prioritised with the DSO sensibly setting their threshold at a low level to encourage contact. This is supported by a Low Level Concerns Policy that highlights the importance of developing an environment where all concerns are openly shared and addressed, even if they don't meet the threshold for harm. This approach recognises that this is as much about providing advice and guidance as it is about building trust and relationships with those in safeguarding roles. This helps to create an environment where concerns are more likely to be passed on to the DST, providing a clear view of issues where the person reporting may not fully understand the level of risk. This approach is considered good practice.

6.3 For those cases referred to the DST, outcomes typically involve one or more of the following:

a) Onward referrals to statutory authorities

b) The management of individuals within the worshipping community

c) The provision / signposting to support

d) The initiation of disciplinary processes, such as Clergy Disciplinary Measures (CDM)

e) Initiation of the Safeguarding Case Management procedure (commonly referred to as Core Groups).

6.4 There is good awareness about how and to whom concerns can be reported, supported by website signposting, published email addresses, and a direct telephone number. Positively, the Audit's survey across the Diocese found that most respondents are aware of who the safeguarding leads are within their setting and how to report a safeguarding concern.

6.5 The DST uses the CPOMS case management system, and the team is preparing to transition to the National Safeguarding Case Management System (NSCMS) in Spring 2025. For the three-year period leading up to the Audit, the system recorded 280 concerns as safeguarding incidents, alongside 70 instances documented as contacts solely for safeguarding advice. Of the concerns referred to the DST within the last 12 months, 24 subsequently resulted in referrals to statutory authorities.

6.6 Within these cases, the Audit observed a robust approach to safeguarding, with evidence of effective responses to both routine and emergency contacts. This included collaboration with statutory and support agencies, the convening of safeguarding case management groups, conducting risk assessments and providing support to those involved.

6.7 Risk assessments undertaken by the DST are initiated in response to safeguarding concerns involving church officials, members of the religious community, or individuals from specific high-risk categories seeking participation in Church events or services. These assessments are well documented, and prioritise the safety of victims, potential victims, vulnerable individuals and the respondent.

6.8 The Audit found effective use of Safety Plans by the DST to manage risks posed by convicted offenders and others within Church settings. 34 active Safety Plans were in place during the Audit. The DST, working with the incumbent and relevant statutory agencies, regularly reviews these plans. The Audit noted that Safety Plans include specific prohibitions and are subject to documented, in-person reviews, which strengthens the process's rigor and importance. This is considered good practice.

6.9 The Audit team met with an incumbent and a respondent subject to a Safety Plan. The respondent demonstrated knowledge of the plan's conditions and, importantly, openly acknowledged the ongoing risk they pose. The incumbent clearly understood the requirement to consult with the DST regarding any proposed changes to the Safety Plan arrangements. A good professional relationship between the two parties was evident.

6.10 To assist incumbents in having meaningful conversations with respondents about the risks they pose, the following is recommended.

Recommendation D13: The DBF should develop a set of standardised prompts for incumbents to use in discussions with respondents subject to Safety Plans. These prompts should go beyond general inquiries (e.g., "how are you?") and will be designed to explore and identify any new concerns and promote understanding of the respondent's life in the context of the risk they pose.

6.11 The Audit recommends enhanced training for those individuals who work directly with this cohort of offenders (beyond the DST). The provision of bespoke, localised training is addressed in more detail in the Learning, Supervision and Support section of the report.

6.12 The Audit found evidence of the effective use of Safeguarding Case Management Groups (SCMGs) in managing complex cases involving church officers. The Audit noted a collaborative approach within these meetings, characterised by professional curiosity and

constructive challenge, which contributed to actions that mitigated risk. The DSO currently chairs these meetings, and the Audit confirmed that Core Groups were actively considering the support requirements of all parties, ensuring plans were trauma-informed and sensitive.

6.13 The DBF is a registered charity with a statutory requirement to submit Serious Incident Reports (SIRs) to the Charity Commission. Support and practice guidance is available nationally regarding SIR referrals. The Audit was informed that four cases had met the threshold for a SIR in the last three years

6.14 The DBF has several national information sharing agreements (ISAs). These include a data sharing agreement with the police and a CofE National Safeguarding Information Sharing Agreement.

6.15 The DBF has a Service Level Agreement (SLA) in place with IDAS (Independent Domestic Abuse Services) for the provision of Independent Sexual Violence Advisor (ISVA) support to individuals who have experienced abuse by someone within the York Diocese. Furthermore, a Memorandum of Understanding (MoU) exists between the Chapter of York and the DBF, articulating the agreed framework for collaborative efforts in delivering effective safeguarding arrangements, consistent with Church of England guidance and governance structures. This agreement encompasses strategic and operational cooperation and is subject to annual review. A resolution process is defined for disagreements, commencing with the DSO and CSO, and escalating to the NST's Regional Safeguarding Lead and the Chair of the DSAP if necessary.

6.16 The complexities of managing safeguarding issues can lead to differing opinions among decision makers. The DBF has addressed this by establishing a Safeguarding Complaints

Policy which details the steps for escalation.

6.17 Monthly case discussions between the DSO and ADSO support the oversight and supervision of ongoing cases. Additionally, independent professional supervision, provided by qualified experts, offers valuable support to both the DSO and ADSO. This supervision covers practical casework and broader safeguarding issues. For the DSO specifically, it provides a space to examine case management decisions, discuss risk mitigation, identify potential oversights, and seek guidance on strategic and organisational matters. The supervision structure is currently in transition, with the DSO now engaging with the RSL from the NST.

6.18 Measures are in place to ensure that personal information is stored and shared in compliance with the Data Protection Act 2018 and relevant regulations, including GDPR. These measures include national ISAs, use of non-personal email addresses, the use of a secure case management system and staff training on GDPR and personal data.

7 Victims and Survivors

7.1 For some within the Diocese of York community, the impact of past safeguarding failures by the Church has been profound. The enduring legacy of trauma and pain remains, brought into sharp focus by the publication of the Makin review and the subsequent mandate for an independent review concerning David Tudor. The priority now must be to build a future founded on trust and accountability by continuing to listen to the voices of victims and survivors.

7.2 For many victims and survivors, living with the abuse they have suffered can be deeply traumatic. Disclosing this to others can be an incredibly difficult experience. Victims and survivors may feel overwhelmed by the processes involved and the potential for re-traumatisation or anxieties about the outcome. In this context, it is crucial for Church bodies to create and maintain a supportive environment where victims and survivors feel heard, supported and protected, whilst also learning from their experiences.

7.3 In evaluating the DBF's response to this key standard of safeguarding practice, the Audit obtained feedback from victims and survivors from across the Diocese through an anonymous online survey. Additionally, the Audit had the opportunity to listen to the authentic voice of a survivor through a face-to-face discussion.

7.4 The DBF follows the House of Bishop's policy, 'Responding Well to Victims and Survivors of Abuse' and signposts to the Church's 'Responding Well to Victims and Survivors of Abuse' leaflet. Despite this adherence, 60% of respondents to the Audit's victim / survivor survey were unaware of this guidance. To improve visibility, accessibility and commitment to the full guidance, and to make better use of the helpful video explainers, the Audit makes the following recommendation.

Recommendation D14: The DBF should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

a) Including a statement of commitment on its 'Victim and Survivor Support' webpage.

b) Providing a direct link to the 'Responding Well to Victims and Survivors of Abuse' section of the Safeguarding e-manual.

7.5 The Diocesan website effectively serves as a central resource for those needing support. Its clear and accessible language, along with readily available contact information for the DST, makes it easy for individuals to find help. The prominent "Report a Concern" button, which links to safeguarding reporting procedures, and the comprehensive list of support resources (including Safe Spaces, IDAS-Building Hope, MACSAS, and Survivors Voices), ensures users have access to a wide range of support options.

7.6 The Diocese of York's Safeguarding Week produced a valuable collection of resources, which the Audit reviewed, including recordings and online materials. The Bishop of Hull's open discussion about the realities of abuse and the need for trauma-informed care was particularly impactful.

7.7 The Diocese faces significant challenges in supporting individuals with mental health needs due to the reliance on self-referral systems. These can be inaccessible to those in crisis, with widespread digital poverty also limiting access to online services. However, this situation presents an opportunity to enhance the mental health literacy of the workforce and community, enabling earlier recognition of crises. Furthermore, establishing partnerships with local charities could provide both additional support resources and a platform for educating the public on identifying mental health symptoms and offering appropriate assistance.

Recommendation D15: To address the challenges of self-referral barriers and digital poverty in mental health support, the DBF should prioritise workforce and community education on recognising mental health crises and establish strong partnerships with local charities to enhance outreach and support.

7.8 The Survivor Voice Working Group (SVWG), initially established following the Past Cases Review 2 (PCR2), is now a permanent subgroup within the DBF's safeguarding structure. This group focuses on ensuring victim / survivor needs are met, recommending improvements to the DSOG, DSAP, and York Minster Chapter. The SVWG develops resources, support pathways, and communication strategies, evidenced by successful collaborations and resources like 'Building Hope' (the name given to the service provided through the SLA with IDAS). The group co-produced a leaflet advertising the remit of the 'Building Hope', which has been widely publicised via the Diocesan website and within safeguarding bulletins. More recently, the group has worked with the NST to create a feedback form for individuals who have used this support. This is good practice, and the Audit commends this approach.

7.9 The Audit recognises and supports the SVWG's independent leadership and diverse membership, which includes those with lived experience, supporting organisations, and statutory agencies. Acknowledging this inclusive approach, the Audit identifies an opportunity for the DBF to further enhance its support for victims and survivors by increasing its engagement with and learning from a broader range of experiences. Consequently, the Audit makes the following recommendation.

Recommendation D16: To improve accessibility and ensure wider participation, the Audit recommends that the DBF partner with the Minster to host diocese-wide listening events, thereby providing additional platforms for hearing from a diverse range of voices.

7.10 The SVWG advises the DBF on how to effectively support victims and survivors. To ensure adequate support for victims and survivors, the SVWG evaluated staffing levels and suitability of the DST. This assessment led to a partnership with IDAS. Since August 2022, the Diocese of York has partnered with the IDAS through a SLA. This agreement allows the DBF to directly refer victims and survivors of abuse to IDAS for specialist support, including access to Independent Sexual Violence Advisors (ISVAs) and trained supporters. The IDAS has successfully supported numerous individuals connected to the Church who have experienced abuse, both in childhood and in intimate relationships.

7.11 The Audit notes the Archdeacon of the East Riding's extensive support for a victim / survivor, which includes long-term coordination and proactive planning for ongoing care. This serves as a positive example of a person-centric and tailored approach to providing support.

7.12 The Audit acknowledges the DBF's work in supporting survivors and its efforts to improve safeguarding in this context. Recognising that rebuilding trust is a continuous process, the DBF is committed to building a future where safeguarding is paramount and healing is prioritised.

8 Learning, Supervision and Support

Learning

8.1 There is clear evidence that the DBF is dedicated to embedding a culture of learning across the Diocese. The DBF benefits from an experienced safeguarding trainer, whose delivery is consistently supported by a group of approximately 12 volunteers (training co-chairs). While these co-chairs do not deliver training, their presence in sessions helps to create safe and reflective learning environments. They are available to listen to concerns and respond appropriately to disclosures, providing an additional layer of pastoral and safeguarding support during training.

8.2 The DBF is heavily reliant upon a single trainer, which limits the capacity to scale and / or diversify the training offer. There are also vulnerabilities to the programme, that the trainer themselves acknowledges and supports the development of contingency arrangements. The Audit suggests that these contingency arrangements could involve equipping co-chairs or another suitable individuals to step into delivery roles when necessary.

Recommendation D17: The DBF should train volunteer co-chairs or other suitable individuals to offer additional options for delivery of training.

8.3 In the longer term, the DBF should continue to build resilience within its safeguarding learning offer by embedding training delivery and oversight within the safeguarding team structure itself. The proposed expansion of the DST to include an additional ADSA, as outlined in the Culture, Leadership and Capacity section of this report, would allow one ADSA to hold a dedicated training portfolio. This would ensure that training development, delivery, and evaluation are closely aligned with operational safeguarding practice, providing enhanced stability and continuity as the programme grows.

8.4 The DBF benefits from a well-structured training programme, with a clear strategy that includes contributions from trusted external partners and a dedicated internal training resource. A number of courses are delivered, including sessions on the National Safeguarding Standards, as well as bespoke training in partnership with North Yorkshire Police on harassment and stalking, and with the Mothers' Union on domestic abuse awareness. Training on the use of the Safeguarding Dashboard and Parish Hubs is delivered by the Clearly Simpler team.

8.5 The NST may be developing national materials on managing individuals who pose a risk, such as known sex offenders who may require a formal agreement or safety plan. Until this guidance is available, it is essential that the DBF provides interim training for clergy, parish officers, and safeguarding leads. This should cover recognising concerning behavioural patterns, understanding risk management responsibilities, and ensuring staff are equipped to implement, monitor, and review safeguarding agreements effectively.

Recommendation D18: The DBF should deliver interim training on managing individuals who pose a risk, including the use of safeguarding agreements and recognising concerning behavioural indicators.

8.6 Record-keeping is thorough, and any outstanding training requirements are followed up promptly. That said, training evaluation is limited. While the current focus is primarily on collecting feedback about leadership training, there is an opportunity to ensure feedback mechanisms are consistent across all training types through automation and regular review.

Recommendation D19: To ensure training feedback is gathered routinely and not delayed due to staff availability, the DBF should introduce automated post-session emails or collect in-person feedback forms.

Recommendation D20: The DBF should broaden the existing training evaluation process to capture not only immediate feedback but also longer-term impact, embedding mechanisms to assess how well training is influencing safeguarding culture and practice over time.

8.7 It is positive to note that some training is adapted to specific contexts, such as Mustard Seed, where safeguarding leadership training is tailored for those who experience barriers to accessing conventional training and learning, and Holy Rood House in Thirsk, a retreat centre supporting people with lived experience of abuse. Exemptions to training are appropriately made for those with lived experience of abuse while ensuring essential information is still provided.

Clergy Support

8.8 There is a clear commitment to supporting clergy wellbeing. Clergy who are survivors of abuse or trauma and those subject to an allegation are directed to appropriate sources of support through Link Person brochures and informational leaflets. Where further support is needed, clergy can contact the DST directly, who can make referrals to external agencies, including those able to offer financial support for counselling or therapeutic services.

8.9 In addition, the Diocesan Advisor for Pastoral Care is a qualified counsellor and is available for confidential referrals, either initiated by the DST or through clergy self-referral.

8.10 In some MDRs, safeguarding is a standing item, and the Audit noted clear examples of safeguarding being used constructively to support both reflective practice and professional development. However, one clergy member who has been in post for five years has only had one MDR in this time. The MDR they did participate in only covered safeguarding in relation to compliance matters such as training. The Audit is aware that the DBF is

reviewing its processes and practices in relation to MDRs - frequency, topics covered (incorporating safeguarding) etc.

Recommendation D21: The DBF should strengthen MDR processes to support consistency, accountability and ongoing development, and ensure that all clergy receive regular MDRs that have safeguarding as a standard item, covering both compliance and reflective practice.

8.11 The DBF also ensures there is a focus on safeguarding as part of the clergy induction process, which is held regularly throughout the year. While the content is reviewed on a periodic basis, the process itself is not subject to formal evaluation.

Recommendation D22: The DBF should implement a formal annual review of the clergy safeguarding induction process to ensure it remains aligned with best practice and national guidance.

Supervision and Support of Safeguarding Roles

8.12 Members of the DST benefit from a support structure that includes access to the Employee Assistance Programme offering mental health services, such as talking therapies. The DBF has trained three mental health first aiders, providing further internal support. The DSO and ADSO have both undertaken CPD on Sexual Violence Risk Factors and are encouraged to identify further training opportunities through external or private providers. CPD offers from local safeguarding boards, the National Safeguarding Team, and other partner agencies are also available.

8.13 The DST's trainer maintains a strong commitment to professional development, regularly attending NST trainer sessions and participating in the national trainers' network and associated development groups. This ensures training can be adapted to the local context and allows the DBF to remain aligned to national developments and good practice. This

commitment should also be factored into any future contingency planning to ensure standards are maintained during periods of trainer absence or transition.

8.14 Independent professional supervision is in place for both the DSO and ADSO. This is provided by individuals with significant experience in the criminal justice and youth justice sectors. Further therapeutic support can also be accessed via the Diocesan Advisor for Pastoral Care. This layered approach to supervision is considered good practice.

9 Conclusion

9.1 The Diocese of York presents unique leadership challenges, stemming primarily from the Archbishop of York's dual role, which encompasses both diocesan and provincial responsibilities, alongside his significant national engagement and influence.

9.2 While feedback was predominantly positive, revealing a culture in transition with leadership actively working to improve safeguarding practice, a notable minority expressed negative views linked to past accountability and complaint handling.

9.3 That said, evidence accessed by the Audit revealed a clear sense of progress and growing confidence in the safeguarding culture, with significant feedback indicating a mounting recognition of safeguarding, not merely as a procedural requirement but as a fundamental aspect of Christian life. Positively, the Audit found that the confidence to raise safeguarding concerns without fear of reprisal was evident in the majority of engagements via surveys, focus groups and one-to-one interviews.

9.4 There are a number of reasons for this linked to leadership support and the hard work of many volunteers in the frontline, but the foundation upon which this improvement in safeguarding culture and practice is built and delivered is undoubtedly the DST.

9.5 The DST in York is well led by a reflective and considered DSO who, supported by the small but committed team, focuses on supporting safeguarding and those who provide it in parishes. This hard work has resulted in safeguarding being proactively embedded into core Church activities.

9.6 Leadership and governance structures demonstrate an appropriate focus on safeguarding,

and the DSAP, a particular strength, is well-structured, effectively providing challenge, focused on key safeguarding standards.

9.7 From a practice perspective, the Audit saw and heard evidence of good practice. This ranged from (amongst other issues) safer recruitment, a commitment to accessibility, lone working and digital outreach. The approach to managing risk was also judged to be good. The Audit saw effective use of Safety Plans containing specific, relevant prohibitions, underpinned by regular and appropriately managed reviews.

9.8 The DBF's work in support of victims and survivors is delivering significant progress. The Survivor Voice Working Group (SVWG), initially established for a case review, is now a permanent subgroup within the DBF's safeguarding structure and presents a strength, focusing on ensuring victim / survivor needs are met.

9.9 That said, for some within the Diocese and further afield, the impact of past safeguarding failures by the Church has been profound. The enduring legacy of trauma and pain remains and was brought into sharp focus by the publication of the Makin review shortly before the Audit commenced. This is particularly relevant to a diocese led by an Archbishop and has the potential to erode growing local confidence if not transparently addressed.

9.10 The recommendations within this report are designed to further accelerate and enhance the improvement journey York is on, to aid reflection on what is working and encourage action to reinforce what could be done better. That must begin by addressing capacity issues within the DST and consideration of how operationally independent safeguarding can be delivered.

Part Two – York Minster

10 Context

10.1 York Minster, constructed between 1225 to 1472, is notable as England's largest medieval Cathedral by volume. Its architectural significance is profound, encompassing the full spectrum of English Gothic styles. The Minster's 160-metre length and 76-metre width dominate the north-western part of the city centre, marking a site with a rich history. It superseded Norman and Saxon predecessors, with the Norman relocation to the Roman Principia site in the 1070s symbolising their ascendancy. While showcasing the evolution of Gothic styles, York Minster developed its own distinctive regional interpretation, setting it apart from other major Cathedrals.

10.2 The historic city of York, a cultural hub and popular tourist destination, enjoys a picturesque location between the Yorkshire Dales and the North York Moors. York Minster stands as a testament to the city's rich heritage, and with over 200,000 residents, York offers a unique blend of urban and natural beauty. The city has a substantial student population of 48,779, and York Minster welcomes up to five school visits per week.

10.3 Despite its renowned educational institutions and the high quality of life experienced by many residents, the city does contain areas facing significant deprivation. Its ranking of 259th out of 316 in the UK's income deprivation index, considering its resources, is a cause for concern. This statistic reveals that approximately 5% of York's population live in areas characterised by entrenched poverty, ranked amongst the most deprived in England and Wales.

10.4 York Minster regularly hosts a variety of events, including religious services, choir recitals, and an upcoming heavy metal music concert featuring York Minster’s Grand Organ. As of November 2024, York Minster reported having received 27,458 general admission visitors and 7,259 regular worshippers each month.

11 Progress

11.1 The Social Care Institute for Excellence (SCIE) audit of York Minster, published in March 2019, resulted in 36 ‘considerations’. The Diocesan Past Cases Review 2 (PCR2) resulted in 10 recommendations.

11.2 York Minster accepted all the SCIE considerations, with a defined action plan setting out a range of activity. This plan was owned by Chapter and led by the Cathedral Safeguarding Officer (CSO). Both outstanding and ongoing SCIE actions, along with themes emerging from PCR2, were factored into the development of the Cathedral’s Safeguarding Strategy.

11.3 In terms of evidenced progress, the improvement work undertaken following the SCIE audit and PCR2 has led to the successful implementation of numerous recommendations. Notable areas include the modification of training to enhance accessibility by using plain English for British Sign Language (BSL) users. Areas that naturally requiring ongoing attention include record keeping, case management and safer recruitment practice. Systems are now in place for the oversight of volunteers, and the staff database remains a work in progress.

11.4 The Audit received evidence of various learning activities, which included an internal safeguarding summary report and recommendations in relation to a safeguarding case and the undertaking of departmental safeguarding audits. These audits, facilitated by the Safeguarding Working Group using the National Safeguarding Standards Cathedral workbook, specifically evaluated safeguarding practices in the aftermath of the COVID-19 pandemic. In March 2024, York Minster underwent a peer review conducted by colleagues from Liverpool and Herefordshire, which was considered a positive experience. Further, the Audit was informed that the CSO intends to develop a broader action plan aligned with the National Safeguarding Standards.

12 Culture, Leadership and Capacity

Culture

12.1 The Cathedral's culture is largely seen as welcoming, supportive, inclusive, and respectful, with the workforce confident in raising concerns without fear of reprisal. However, this confidence isn't fully shared by some of the regular worshipping community, where less than half of the survey respondents felt comfortable reporting issues. Although expressed by a small group (fewer than twenty), this sentiment was reflected in a number of discussion groups and one-to-one engagements during the Audit process. Concerns about the culture being cliquey, defensive, and outdated were also raised by a small number of individuals, alongside reports of dismissive behaviour and a perception, for some, that the Dean can appear distant.

12.2 Many in the senior leadership team, including the Dean, had a realistic understanding of these challenges and the work required to address barriers such as perceived or real deference, the privilege of exception, breaking down silos across departments, and enhancing face-to-face engagement with all staff and volunteers.

12.3 The Dean recognises that the symbolic nature of his role, and the personal qualities that inform his leadership, can inherently create a sense of deference. He acknowledged that this can be intimidating to some. While finding it challenging to eliminate entirely, he has taken steps to reduce hierarchical barriers and increase approachability through informal interactions, symbolic gestures like giving up his office, and consciously calibrating his communication style. The Audit makes a number of recommendations to support him in this regard.

12.4 The Audit saw and heard evidence that many of the challenges including non-recent issues have been, or are being, systematically addressed through training, clearer protocols,

social engagement, and better embedding of York Minster values.

12.5 Many acknowledged the progress made and the importance of being people-centric, with one senior manager stating, "…it's the people who make the Minster special, not just the building".

12.6 This work needs to continue, and specific efforts should be made to address the concerns reflected in this report. To this end, the Audit makes the following recommendations.

Recommendation C1: Drive an open, inclusive, and accountable culture through visible and engaged leadership that actively reduces hierarchical barriers, encourages challenging discussions, and prioritises continuous improvement directly linked to feedback mechanisms and overseen by Chapter via its SMG subcommittee. To facilitate accurate monitoring:

a) Design survey questions specifically to measure the perceived approachability of leaders, comfort levels in raising challenging issues or concerns with them, and the overall sense of inclusivity within the organisation. Use clear scales (e.g., Likert scales) for consistent data collection.
b) Utilise workshops led by independent facilitators to assess and monitor the feedback on the nature and impact of culture / deference.
c) Ensure senior leaders include reflections in their supervision sessions on how they can enhance culture, facilitate better communication and mitigate deference within their area of influence.
d) Such surveys / activity should be carried out once per year for the next three years. Information from these activities should be anonymised, consolidated and shared as part of a cultural health check and form part of current performance processes.

e) A uniform approach should be adopted, without exception and regardless of rank or role, regarding the provision, application, and use (in keeping with data protection regulations) of technology or other equipment or material provided for a work-based purpose.

Leadership

12.7 York Minster is a complex and intricate entity, essentially representing a micro-community. It is a place where people visit, live, learn, worship, and work, developing skills and building internal services and businesses to meet its needs. For example, it has its own police service, a heritage skills development programnme and facility with apprentices training alongside highly skilled stone masons and other craft skills to maintain its incredible structure. Within that context, it presents a number of challenges and some significant opportunities.

12.8 Cathedral leadership is a unique environment - few leaders will have the opportunity to serve in such a role, and fewer still will arrive immediately equipped to 'hit the ground running'. This is primarily because there's no specific training or dedicated succession planning currently in place for the individual who leads it: the **Dean**. For example, the current Dean, who most people thought had managed the move well, came from a parish church background. While he had experience working in another jurisdiction (the United States), the transition from a local parish church system to leading a complex, multifaceted Cathedral environment can be challenging. This complexity stems from the Cathedral's own ecosystem and its diverse professional teams, which encompass areas such as communications, HR, finance, and the vital maintenance and restoration of its stonework. Leading and getting the best out of a high-performing senior leadership team, such as the one at the Minster, is therefore of critical importance.

Recommendation C2:

1. A structured programme of learning and mentoring should be established, primarily for the Dean's role (and in a wider sense for the consideration of the CofE National Church Institutions (NCIs)). This program could also bring potential benefit for the wider SET.
2. This programme should facilitate access to mentoring from individuals with significant and complex leadership portfolios outside the traditional Cathedral or Church structure. Examples could include Chief Executives of Local Authorities or leaders of other large, intricate organisations. The focus of this mentoring should be on navigating complex organisational ecosystems, strategic leadership, managing diverse professional teams, and adapting leadership skills to a unique environment. This initiative would provide invaluable external perspective, support professional growth, and enhance the strategic capabilities of the leadership team.

12.9 When it comes to safeguarding, the Dean unambiguously accepts his responsibility and accountability for it, both within and across the Minster. In the opinion of the Audit, he leads a highly competent team of senior leaders, all of whom were able to explain their role and responsibilities in the context of safeguarding, and it was clear that they individually and collectively ensure oversight via a critical and collective safeguarding lens.

12.10 The experienced and highly capable Chief Operating Officer (COO) directly line manages the Cathedral Safeguarding Officer (CSO). While the COO possesses outstanding leadership skills, they are not a safeguarding professional. That said, in the absence of a suitably qualified Director of Safeguarding (which would be the ideal position), this current structure is seen as both a strength and an acknowledgement of the CSO's crucial role and their operational independence.

12.11 Safeguarding is further enhanced via the leadership of the Chapter Safeguarding Leads (CSL) and the Canon Precentor, all of whom demonstrated a deep understanding of safeguarding in the context of Minster life. The Audit saw and heard evidence of appropriate challenge and authoritative practice by all those with a safeguarding responsibility at the Minster.

12.12 The Audit acknowledges that many of the senior leaders are working to cultivate a more professional, strategic, and values-driven environment, striving to maintain warmth and accessibility while embedding safety and organisational values.

12.13 The CSO has been a leader in their field and been pivotal to the development of safeguarding arrangements across the Minster and via their wider influence at a national level. Their upcoming retirement will be a loss to the Minster and a potential risk regarding continuity.

12.14 The Audit welcomes the acknowledgement of this by the SET and Chapter and the work they are undertaking to mitigate the potential over-reliance on key individuals, in this case the CSO, by incorporating a succession and support plan that includes systematising knowledge and processes to ensure resilience and consistency.

Governance

12.15 The Cathedral operates a range of appropriate governance oversight meetings. These reflect the expectations of the Church and relevant regulatory requirements, such as those issued by the Charity Commission.

12.16 The Audit welcomed the opportunity to attend a Chapter Meeting. This is a highly effective forum populated by credible and safeguarding focused trustees who bring a wide range of experience to the boardroom. The presence of a non-executive with a background in

strategic leadership in the education sector, acting as Chapter Safeguarding Lead (Lay), further strengthens Chapter. The inclusion of the CSO at all such meetings is welcomed and, in the absence of a Director of Safeguarding, represents good practice. The Audit commends Chapter for its approach in this regard.

12.17 The Cathedral currently operates a Safeguarding Working Group (SWG). The SWG operates informally, tasked with translating the safeguarding strategy into operational practice. Its membership comprises senior individuals from across the Minster, including key stakeholders such as the Canon for Nurture and Congregational Discipleship, Director of People, Chief Finance Officer (CFO), CSO, and the Music Department Designated Safeguarding Lead (DSL).

12.18 This group serves as a mechanism for discussing operational safeguarding practices, ensuring collaboration between different departments, implementing safeguarding standards, and ultimately operationalising the broader safeguarding strategy.

12.19 In the opinion of the Audit, this approach could be strengthened and the safeguarding structure better formalised if this work was consolidated within a subcommittee of Chapter.

12.20 This committee would provide a structured approach to discussing and managing safeguarding risks, creating a more robust mechanism to link Cathedral and Diocesan safeguarding efforts. Key stakeholders should be invited to participate, including, for example, the Director of People, CFO, CSA, Police Sergeant, Canon Precentor, DSO, CSO, and the DSAP Chair. Where possible, representatives of the wider community in which York Minster is situated, including those from the business and charitable sectors, should also be involved.

12.21 As a subcommittee of Chapter, it would ideally be chaired by an independent lay person

with credible safeguarding experience to ensure robust oversight and have the ability to create focused task and finish groups for specific pieces of work.

Recommendation C3: A formal Safeguarding Management Committee (SMC) should be established as a subcommittee of Chapter to provide a structured approach to discussing, managing and escalating safeguarding risks and a mechanism for linking Cathedral, community and Diocesan safeguarding efforts.

a) The SMC should be formally constituted as a subcommittee of Chapter, deriving its authority from it.

b) Key stakeholders should be represented on the SMC, including the Director of People, CFO, CSL, Police Sergeant, Canon Precentor, DSO, CSO, and DSAP Chair. Where possible, representatives from the wider community, including business and charitable sectors, should also be included.

c) The SMC should ideally be chaired by an independent lay person to ensure robust oversight.

d) The committee's scope should include providing a structured approach to discussing and managing safeguarding risks, linking Cathedral and Diocesan safeguarding efforts, and having the ability to create focused task and finish groups for specific pieces of work.

Capacity

12.22 York Minster has a unique footprint and faces a range of challenges in relation to scale, footfall, event management and other issues related to its micro community. The role of the CSO is therefore pivotal.

12.23 The Audit recognises that the current (outgoing) CSO is nationally recognised as the first Cathedral Safeguarding Advisor and is actively involved in national safeguarding networks. They are rightly respected for the work they have done which has led to significant local and national improvements.

12.24 Notwithstanding the range of support available across the Minster, the Cathedral Safeguarding Officer (CSO) is recognised as the only person with professional safeguarding experience, and their role is exceptionally demanding, representing a significant workload for one individual. This creates a potential risk to continuity and the ability to fully replicate the comprehensive approach required. While steps are being taken to mitigate this through added hours and systematising knowledge, the inherent pressures necessitate further support to ensure adequate capacity.

Recommendation C4: It is recommended that a part-time Assistant Cathedral Safeguarding Officer (ACSO) support person be appointed. This role would provide essential capacity and support to the CSO, enhancing the overall resilience and effectiveness of the wider Cathedral safeguarding functions.

12.25 The Audit welcomes the succession plan currently in place and acknowledges the strength of the wider safeguarding-aware team around and across the Minster as well as the work of the York Minster Police.

York Minster Police

12.26 The York Minster Police provides a 24/7 police presence within the Minster's micro-community, often regarded as a significant asset and contributing to a tangible perception of safety. This diverse team brings value to safeguarding efforts through their constant presence.

12.27 The Police Sergeant has indicated a desire to further professionalise the York Minster Police and has taken steps to begin that process. He has developed excellent relationships with North Yorkshire Police (NYP) and other agencies, as well as participating in high-profile multi-agency events and exercises, including those related to counter-terrorism.

12.28 To support the development of this unique entity and enhance its safeguarding contribution, the Audit makes a number of recommendations.

Recommendation C5:

1. The York Minster Police should pursue externally accredited safeguarding training (e.g., Level Three) to professionalise its operations and validate its standards. This is a level of training provided by most safeguarding children partnerships to multi-agency safeguarding partners. The attendance at such a course would build both knowledge and contacts and develop networks.
2. A dedicated safeguarding specialist role should be developed within the York Minster Police team to enhance expertise and focus in this critical area. This should include short term observational visits to other external police and multi- agency safeguarding organisations.
3. Regular joint training exercises, beyond counter terrorism, for example, missing children and potential critical care incidents within the precints of the Cathedral, should be conducted with external police forces, such as NYP, Fire and Ambulance services to improve collaboration and share best practices.
4. They should review and update existing training and complete a refreshed training needs analysis based on the recommendations from this audit, ensuring their current Constabulary curriculum is fit for purpose. This should focus on, but not be limited to, areas such as legal powers, safeguarding protocols, and the development of consistent policing approaches. To this end, the Minster could:
    a) Consider bringing in a senior serving police officer with public protection experience, on secondment for a fixed period, to consult on and help develop the service's basic and advanced training curriculum.
    b) Engage with the Police College and / or advertise the leadership and development opportunity to police services (including the British

Transport Police) and further education establishments with a policing curriculum or focus.

5. Clearly define and document the legal boundaries of the York Minster Police's policing role to ensure all officers understand their powers regarding actions such as arrest and detention.
6. Create clear pathways for progression within the York Minster Police to support professional development and retention.
7. Explore opportunities to align with and provide mutual assistance across the three Cathedrals that have similar constabulary provisions, sharing knowledge and resources.

12.29 In a range of other dioceses, the Audit has considered the relationship between the DBF and Cathedral with regards to consolidating the provision and oversight of resources. This primarily included integrating the CSO (whilst located in the Cathedral) within the DST and placing them under the direct supervision of the DSO. Given the unique environment and the developed safeguarding provisions, the Audit has not considered this approach (i.e., the CSO being supervised by the DSO) appropriate at this time.

12.30 That said, the Audit maintains the view that operationally independent safeguarding can be achieved within the Diocese and Minster by creating a consolidated safeguarding directorate. This directorate would bring together all professional safeguarding resources across the Diocese's geographical area. It should be led by a Director of Safeguarding, to whom both the Cathedral Safeguarding Officer (CSO) and the Diocesan Safeguarding Officer (DSO) would report. This structure would ensure a clear division between operational (casework / early help) and strategic responsibilities.

12.31 The Safeguarding Director would serve as the ultimate authority on safeguarding matters,

removing any perception that safeguarding decisions are influenced or directed by clergy. However, the Director of Safeguarding would remain accountable to each of the relevant governing bodies.

12.32 To this end, the Audit makes the following recommendation:

Recommendation C6: To significantly strengthen safeguarding, ensuring operational independence without undermining governance oversight, the Minster and the DBF should establish an operationally autonomous Safeguarding Directorate, headed by a Director of Safeguarding.

This Directorate would consolidate all safeguarding resources, providing comprehensive and consistent support and direction to the Archbishop of York, DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the ability, authority and autonomy to:

a) Provide expert advice and robust oversight and ultimate direction on all safeguarding matters.
b) Challenge senior clergy and Church bodies when necessary, ensuring accountability.
c) Escalate concerns directly to higher authorities, including the National Director of Safeguarding at the NST without undue influence.

To ensure the effectiveness and influence of this structure, the following are required:

a) The Director should attend and report directly to, key decision-making bodies, including the DBF, Bishop's Council, Chapter, and the Archbishop / Bishop's / Senior Leadership Team (YDLT).

b) A comprehensive MoU / SLA between the DBF, Parish PCCs, and the Minster should clearly define the Director's authority and responsibility. This includes providing safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the geography of the Diocese.

c) The Directorate should be adequately resourced and staffed, incorporating all professional safeguarding personnel (including those currently based at York Minster).

Note: This recommendation should be read in conjunction with the Safeguarding Directorate section in the Independent Safeguarding Audits Annual Report (2024/2025).[3]

Chorister Safeguarding

12.33 There is a demonstrably strong safeguarding culture around the choristers at York Minster, one that is both visible in day-to-day practice and echoed in feedback from staff, choristers themselves, and the small number of parents who engaged with the Audit. Safeguarding is not simply seen as compliance, but as an embedded part of daily practice. Choristers operate across both St Peter's School and York Minster itself, with safeguarding oversight reflecting this dual context.

Information Sharing

12.34 The Chorister Liaison, who is also the school's Director of Music, plays a key role in bridging the two settings, using both school and Minster email systems to maintain clear and consistent communication. While this arrangement is effective and well-regarded, it does create a degree of reliance on a single individual. This is mitigated to some extent by the presence of a Designated Safeguarding Lead (DSL) within the music department - a

[3] https://ineqe.com/churchofengland/

structure that mirrors the school's own safeguarding framework and helps to ensure continuity and clarity across both contexts.

12.35 Although the Audit is satisfied that low-level concerns are handled appropriately, staff agreed that the introduction of a low-level concerns log would support earlier identification of potential issues. This would help staff spot patterns, record emerging worries, and ensure appropriate action can be taken in a timely and proportionate way. It would also provide an additional layer of protection for both the children and the adults working with them.

Recommendation C7: The music department should introduce a low-level concerns log, accessible to all staff in direct contact with choristers, to support early identification of patterns and enhance safeguarding oversight across both contexts.

Scheduling and Wellbeing

12.36 Wellbeing is prioritised by staff, with clear evidence that efforts have been made to ensure the chorister schedule is not only manageable but conducive to broader development. Adjustments have been made to allow choristers to take part in sports and other extracurricular activities to help them maintain a sense of balance. There is also a commendable focus on vocal health, ensuring that the physical demands of choral singing are met with appropriate care and expertise. The 'Chorister Cake Breaks' offer a relaxed and age-appropriate space for children to share their thoughts or concerns and is reflective of a culture that listens and adapts.

Parent and Chorister Views

12.37 Few parents engaged directly with the Audit process, but those who did gave largely positive feedback about the safeguarding and support in place. There are already a number of ways for parents to engage, including forums, social events, and open lines of

communication with staff across both the school and the Minster. Even so, there appears to be an opportunity to strengthen how the safeguarding framework is shared with families, supporting a fuller understanding of the work already taking place. A recommendation will be made to introduce a start-of-term meeting or similar, to help ensure that all parents feel equally included, informed, and confident in the systems surrounding their child. It may also be helpful to introduce an annual anonymous parent survey to gather broader feedback and monitor perception over time.

Recommendation C8: York Minster should introduce a start-of-term parent meeting or implement an annual anonymous parent survey or similar method of feedback, to support shared understanding, inclusion, and confidence in the safeguarding arrangements.

Chaperoning

12.38 Supervision arrangements for choristers are well structured. There is close coordination between Minster Police and choir staff regarding chorister movements into and out of the Minster. Drop-off and pick-up systems are clearly defined and supported by the use of parent lanyards and appropriate adult-to-child ratios.

Other Safety Provisions

12.39 Within the Song Room at York Minster, child friendly safeguarding posters are clearly displayed to offer choristers an additional reminder of where they can seek help. Dedicated chorister toilets are also available to reduce the need for them to mix with the public. This is good practice.

12.40 The Audit recommend the installation of CCTV in the organ loft to improve oversight in this hard-to-monitor area. The CCTV should cover the loft, its ground floor, and the adjacent library, given the layout of the space. While no specific concerns have been raised, the

measure would enhance visibility and act as a deterrent, aligning with good practice in safeguarding environments.

Recommendation C9: Install CCTV in the organ loft, including its ground floor and adjoining library space, to improve visibility in this area and provide an additional layer of safeguarding oversight.

12.41 Concerns had previously been raised by some parents about the effectiveness of evacuation and invacuation arrangements. The Minster has acted on this feedback and reviewed its procedures. However, choristers have not yet taken part in a full practice drill. Planning and preparation are in place and as such, no formal recommendation is made at this stage, but it is understood that these drills will be scheduled and completed as a matter of priority to ensure children are prepared and confident in an emergency situation.

Training

12.42 All key staff involved with the choristers complete safeguarding training through both the school and the Minster. This dual approach enables staff to operate confidently across the two safeguarding contexts. Staff have expressed a desire to align behaviour management strategies more formally between the school and Minster, to ensure consistency in response and expectations.

Recommendation C10: The Minster should seek to align its approach to behaviour management with that of St Peter's School to support consistency for choristers across both settings. This could be achieved through training delivered by school staff, a shared statement of practice, or a collaboratively developed behaviour policy.

Policies

12.43 The chorister safeguarding policy is robust and represents a clear strength. The Audit views this as a positive and proactive document, as it links directly to St Peter's individual

safeguarding policies and explains how to access them, while also incorporating York Minster's additional safeguarding policies. It includes external signposting to resources and support - this is good practice.

13 Prevention

13.1 Safer recruitment policies and practices are crucial for fostering safer environments, discouraging unsuitable individuals from joining an organisation, and preventing the abuse of children, young people, and vulnerable adults. York Minster demonstrates its commitment to safer recruitment through several measures. These include requiring all applicants to complete a confidential declaration, undertaking DBS checks (based on role criteria) with repeat checks as necessary, and obtaining references. Furthermore, York Minster has specific policies in place such as a policy for under 18s volunteering in the Minster. Upon appointment, all new candidates are required to complete Basic Awareness and Foundations safeguarding training.

13.2 It is important for the Minster to set out its expectations and commitment to safeguarding within its recruitment process. As with the DBF, there are opportunities to consistently reinforce such messaging within job advertisements and job descriptions. The Audit makes the following recommendation in this regard.

Recommendation C11: York Minster should continue to ensure its commitment to safeguarding is included in all job descriptions and also embedded in all job advertisements.

13.3 The Minster takes steps to ensure good safeguarding practices are developed, adopted, and shared. For example, to ensure the safer livestreaming of services, the Minster has some volunteers who are under 18 years old, and therefore parental consent is obtained for them. Furthermore, guidance for school visits is provided, including a risk guidance document to assist school trip leaders in drafting their own risk assessments.

13.4 The Minster undertakes appropriate awareness raising activities to promote the profile of

safeguarding. For example, posters for the Independent Domestic Abuse Service (IDAS), Childline, and Safe Spaces are prominently displayed throughout the Minster. To support the workforce, a comprehensive Public Information folder is located on the shared network drive, accessible to the floor team, York Minster Police, chaplains, vergers, and other support personnel. This digital resource offers up-to-date information and relevant links, designed for immediate use when individuals need support, advice, or signposting to relevant services. Furthermore, hard copies of these resources are readily available at the welcome desks, the Vestry, and with the York Minster Police team. The overarching aim is to improve awareness of these issues and available services among both staff and volunteers, while also providing them with practical materials to respond effectively to situations as they arise. Topics covered encompass a range of services, including the Independent Domestic Abuse Services (IDAS), York Drug and Alcohol Services, homelessness and rough sleeping support, mental health crisis support, refugee support, IDAS information in alternative languages, and an accessible IDAS pictorial leaflet.

13.5 The Audit findings support the Minster's plans to enhance safeguarding awareness, specifically by increasing information regarding contemporary issues such as online safety, Modern Slavery and Human Trafficking, and County Lines. Furthermore, the Minster intends to improve the integration of safeguarding themes with its broader Programming and Liturgical planning, aiming for a more unified focus and consistent messaging throughout the year. This alignment presents an opportunity to use the Cathedral space for impactful installations that further raise awareness and understanding of safeguarding matters.

13.6 Safeguarding is regularly discussed at York Minster in various meetings and forums. The CSO holds formal briefings at staff and volunteer team meetings and has informal conversations during walk-rounds. Some examples where safeguarding was seen to be

discussed included the November 2024 Host briefings, the October 2024 Critical Incident Training on procedures for missing children or vulnerable adults, a September 2024 Police team meeting attended by the CSO, a June 2024 Critical Incident Training session and a Vergers meeting covering safeguarding processes and pastoral care. Safeguarding was also discussed at the May 2024 Collections and January 2024 Retail team meetings.

13.7 Safeguarding considerations are also integrated into more specific contexts, such as with the Bell Ringers at York Minster. This includes the Bell Steering Group, which convenes three times annually and maintains safeguarding as a standard agenda item. Furthermore, all visiting bell ringers are required to familiarise themselves with the information provided on the Safeguarding page of the York Minster website, and all new bell ringers undergo an induction. This induction is typically delivered by a Volunteer Advisor and incorporates safeguarding protocols.

13.8 York Minster adheres to the House of Bishops' Safeguarding Policy, 'Promoting a Safer Church', and makes its safeguarding policy readily accessible and visible on its dedicated webpage.[4]

13.9 York Minster's website provides a fully mobile responsive experience for users and performs well with search engine optimisation (SEO). The 'safeguarding' section is easily accessible through the primary navigation menu and provides users with relevant signposting and resources. Information is made available in a clear and logical format.

13.10 Robust practice was seen in the day-to-day functioning of the Cathedral and the work undertaken to ensure those who visit and worship are made safer. Whenever an activity is likely to involve or affect children or vulnerable adults, risk assessments are carried out.

[4] https://yorkminser.org/about-us/safeguarding/

These assessments are the responsibility of the event organiser, who completes them in consultation with the CSO. Examples of these risk assessments include regular reviews for organ visits, the St Williams Singers, unaccompanied worshippers under the age of 18, the refugee week picnic, and a Minster Mice picnic.

13.11 In terms of the arrangements to ensure that Cathedral staff and volunteers are sufficiently safeguarded and potential risks mitigated, the Cathedral has a Lone Working Policy. Additionally, there is guidance for visiting choirs and several documents related to visiting bellringers, including an Agreement, a Safeguarding leaflet, an Information leaflet, and an Under 18s policy.

13.12 Understanding and maintaining appropriate boundaries is key for professionals and volunteers. In this respect, the volunteer handbook contains a Code of Behaviour, and staff policies and procedures make mention of professional boundaries.

13.13 To ensure staff and volunteers are aware of safeguarding risks associated with the Cathedral's layout, several measures are in place. These include issuing staff and volunteers with maps of the Cathedral layout, such as the one found in the volunteer handbook. Furthermore, staff and volunteers receive briefings about the building's layout during their induction and in relation to specific activities. Volunteer chaplains are also instructed to engage with individuals pastorally within the main body of York Minster, in full view of others, rather than in any enclosed or private areas.

14 Recognising, Assessing and Managing Risk

14.1 The Cathedral maintains its own safeguarding risk register, where concerns and control measures are well documented. This demonstrates that safeguarding is a key organisational priority.

14.2 As detailed in Part One of this report, a Memorandum of Understanding (MoU) exists between the Chapter of York and the DBF, articulating the agreed framework for collaborative efforts to deliver effective safeguarding arrangements, consistent with CofE guidance and governance structures. This agreement covers both strategic and operational cooperation and is reviewed annually. A process for resolving disagreements is in place, commencing with the DSO and CSO, and escalating to the NST's Regional Safeguarding Lead and the Chair of the DSAP as necessary.

14.3 Whilst there are no safeguarding information sharing agreements with external organisations, the Audit was informed that to manage data exchange for York Minster's adoption of the NSCMS, a dedicated information sharing agreement will be established with the DBF. This is good practice.

14.4 York Minster has a dedicated CSO who oversees all safeguarding matters and and attends each Chapter and SET meeting. Case management is led by the CSO. The Audit was advised that there have been 17 safeguarding incidents recorded in the last 3 years on CPOMs. In the last 12 months, six were held or referred to statutory authorities.

14.5 The current safeguarding processes at the minster facilitate the effective triage of referrals. The current CSO assesses reports to determine if they are a safeguarding concern. Allegations involving Church Officers or worshippers with connections to other churches

are escalated for discussion with the DSA, who then collaborates with the CSO to decide the most appropriate course of action. Depending on who leads (CSO or DSA), the DST provides reciprocal support. For highly complex or serious matters, the NST may take the lead or assist in coordinating the necessary actions.

14.6 The Audit found evidence that the Minster acts promptly to address safeguarding concerns, with issues being resolved and plans put in place efficiently. Furthermore, the Audit pointed to the presence of a clear process, including referral pathways, for determining whether an issue falls under safeguarding, HR or a combination of both.

14.7 Similar to the support provided to the DSO, the CSO receives professional supervision from the NST's RSL.

14.8 During the Audit, there were two Safety Plans in place at the Minster. The findings regarding Safety Plans are addressed in Part One of this report and are equally applicable to the Cathedral.

14.9 The Audit was advised that one Safeguarding Case Management Group (SCMG) meeting had been initiated at the Cathedral in the last year. The broader effectiveness of case management by the DST and the convening of SCMGs is set out in Part One of this report.

14.10 York Minster is a registered charity and therefore has a legal requirement to submit Serious Incident Reports to the Charity Commission. The Audit was informed that one case had met the threshold for a safeguarding SIR in the last 12 months. The referral to the Charity Commission aligned with national guidance and the NST was appropriately informed.

14.11 Personal information relating to safeguarding cases is held by York Minster on CPOMs and is compliant with UK data protection legislation, including the UK General Data

Protection regulations (UK GDPR). The MoU between the Minster and DBF sets out clear parameters governing the legal and best practice requirements for information sharing. All staff and clergy are required to complete Data Protection training via the iHASCO system. Volunteers receive Data Protection information during their induction, and while additional training is available via their Better Impact account, this is not compulsory. For work purposes, staff and clergy use Microsoft 360 and Outlook for email addresses and work phones are also issued to staff where appropriate for their role.

15 Victims and Survivors

15.1 The Audit was informed that the Cathedral follows the House of Bishops' guidance as set out in 'Responding Well to Victims and Survivors of Abuse'. To improve accessibility and make use of the helpful video explainers, the Audit recommends linking the full guidance document in the Safeguarding e-manual.

Recommendation C12: York Minster should provide a direct link to the 'Responding Well to Victims and Survivors of Abuse' section of the Safeguarding e-manual.

15.2 York Minster's Safeguarding webpage features a Victims and Survivors Charter, a visual pledge ensuring victims receive dignity, respect, compassion, and support. While the charter promises case updates, survey feedback indicates a need for clearer and more consistent communication practices.

15.3 York Minster's Safeguarding webpage provides appropriate reporting routes in the form of contact information for the CSO and signposting to the Victim and Survivor Support webpage. York Minster has also produced an advice leaflet, containing relevant information about what to do in an emergency, along with contact details for the CSO, Pastoral Lead, the Minster Police, and York Social Care. The leaflet also signposts to external support services such as Safe Spaces, NAPAC, the National Domestic Abuse Line, NSPCC and Childline. To enhance the accessibility of leaflet's valuable information, a clearer title is required.

Recommendation C13: To ensure those who require help can easily find information, York Minster should rename their advice leaflet to 'Victim and Survivor Support: External Resources'.

15.4 To combat domestic abuse and modern slavery / human trafficking, York Minster's Safeguarding webpage provides resources and encourages action. Users can report suspected modern slavery or human trafficking via the Clewer Initiative's 'Report It' feature or by contacting the CSO. The site clearly states that domestic abuse is a crime that can happen to anyone and urges individuals to seek help by contacting the police, the CSO, or IDAS.

15.5 York Minster observes Safeguarding Sunday with a dedicated service and sermon. The Audit heard of post-service discussions taking place, further facilitating open dialogue about current safeguarding topics. To better demonstrate solidarity with victims and survivors, the Audit recommends the Minster expands its initiatives. Cathedrals like York Minster offer unique opportunities to provide sanctuary and raise awareness through visible, themed events.

15.6 The Audit received positive feedback regarding the Cathedral Safeguarding Officer (CSO)'s interaction with victims and survivors, and saw evidence of pastoral support being provided by senior staff members. That said, the Audit also heard feedback from a few individuals about what they perceived as a lack of appropriate trauma-informed care. This highlights the need to continuously reflect on both individual and collective practice when engaging with and supporting victims and survivors. To support such an approach, the Audit makes the following recommendation.

Recommendation C14: York Minster should conduct a Training Needs Analysis to identify specific requirements for trauma-informed practice training across all roles. This will help determine which roles require further specialist training and support.

Recommendation C15: Following the Training Needs Analysis, a tiered training programme should be developed (idealy co-produced) and implemented:

- All staff and volunteers should receive lighter-touch briefings on creating trauma-informed settings. This foundational training will help promote a general understanding of trauma and its impact.
- Key staff, particularly those in roles most likely to interact with individuals who have suffered abuse, should receive more intensive, role-specific trauma-informed practice training and support. This tailored approach aligns with national initiatives to roll out trauma-informed practice training to certain roles.

15.7 York Minster collaborates with the DBF to respond to victims and survivors, such as through the co-convening of the Survivor Voice Working Group (SVWG). The Chapter Safeguarding Lead for clergy (CSL) and CSO both sit on this group, and its outcomes are formally reported to Chapter. The DBF and York Minster also jointly commission "Building Hope", an independent service for victims and survivors for church-based abuse through the IDAS. Posters and leaflets for the Building Hope service and IDAS are widely distributed throughout communications.

15.8 Following the Makin Review, the Dean addressed the congregation, staff and volunteers both through verbal and written communication. Whist this is positive, a small number were disappointed in this response. The impact of this review on the wider Church has been profound, as such, the Audit recommends that York Minster actively engages with survivor groups to listen to a broader range of voices and work to rebuild trust and deliver meaningful change.

Recommendation C16: York Minster should prioritise rebuilding trust by actively listening to the voices of victims / survivors and those impacted by abuse through the implementation of diocese-wide listening events co-facilitated with the DBF.

15.9 The Audit was told that victims / survivors and others presenting with vulnerabilities, such as mental ill health or homelessness, are regularly prayed for in services and in the daily hourly prayer delivered by chaplains. Given the presence of children, it is essential that these prayers are delivered in a sensitive and age-appropriate way.

16 Learning, Supervision and Support

Learning

16.1 There is clear evidence that York Minster is committed to safeguarding learning and development as part of a wider culture of improvement. Safeguarding is a strategic priority within the York Minster 2030 Plan, with a refreshed training strategy and action plan due for implementation in 2025.

16.2 Training is well-structured, with both Basic and Foundation level courses delivered online and, where appropriate, in person. Notably, training is contextualised to address regional issues and specific roles, such as for staff in the Works Department, where issues like behaviour and social media use are tailored to the reality of supervising apprentices. This is good practice that is clearly having a positive impact, as highlighted by the vast majority of respondents to the Audit's survey who indicated that the training they received was relevant to their role.

16.3 Looking ahead, the Minster's focus will shift to embedding role-specific learning beyond core pathways, including training on domestic abuse and critical incident response (e.g., missing children). This evolution reflects a maturing culture of safeguarding learning.

16.4 Leadership training is delivered in partnership with the DBF, with further sessions on domestic abuse and safer recruitment provided through a blended model. York Minster demonstrates strength in this area through its follow-up briefings, which help participants to apply the learning to their specific context and allow safeguarding staff to assess if a participant has been adversely affected by the content.

16.5 Training records are clear and well maintained. Systems such as Cezanne and Better Impact have strengthened monitoring and compliance.

16.6 The evaluation of training takes place via one-to-one meetings and PDRs, though there remains an opportunity to ensure feedback mechanisms are consistent across all training types, through automation and regular review.

Recommendation C17: York Minster should ensure training feedback is gathered routinely by implementing automated post-session emails or collecting in-person feedback forms.

Clergy Support

16.7 Clergy at York Minster are supported through both established processes and emerging pastoral strategies. All clergy (apart from the Dean who is reviewed by the Archbishop of York) undertake MDRs through the DBF's arrangements (see *Learning, Supervision and Support* section of the DBF report).

16.8 Safeguarding is covered during clergy induction, which takes place face-to-face with the CSO for all senior and key roles, including new Chapter members, police colleagues, and key volunteers. These meetings include a conversation about safeguarding, responsibilities, and role-specific risks. The People Team lead on induction materials, with oversight and input from the CSO. This induction process is regularly reviewed. This is good practice.

16.9 There is also a developing strategy for pastoral support, alongside practical resources such as a dedicated wellbeing room.

Supervision and Support of Safeguarding Roles

16.10 The Cathedral has invested well in the supervision and support provided to those in safeguarding roles. The Cathedral Safeguarding Officer (CSO), who was seconded to the IICSA 1 and 8 project as Cathedral Lead User, receives structured reflective supervision every six weeks. This supervision is provided by the National Safeguarding

Team (NST)'s Regional Safeguarding Lead and utilises the 4x4x4 model. The CSO has also completed training in this model, which helps ensure their full and active engagement in the process.

16.11 Internally, the CSO meets monthly with both lay and clergy Chapter Safeguarding Leads, providing a structured rhythm for oversight, updates and issue escalation.

16.12 Additionally, York Minster's CSO plays an active national role by co-facilitating the Cathedral Safeguarding Network, contributing to NST training pathways, and leading on the IICSA 1&8 project as part of the NST Development Team. These roles ensure national learning informs local practice and it is clear that this is having a demonstrably positive impact.

16.13 Relationships with statutory partners, including North Yorkshire Police, Local Authority Designated Officer (LADO), and probation services, are also well-established. The CSO and Chapter Safeguarding Leads are members of strategic forums such as the DSAP, the DSOG, and the Survivor Voice Working Group. This is good practice.

17 Conclusion

17.1 York Minster is a complex and intricate entity, essentially representing a micro-community. It is a place where people visit, and where others live, learn, worship, and work, developing skills and building internal services and businesses to meet the needs of its community. For example, it has its own police service and a specialist construction company with apprentices training alongside highly skilled stone masons to maintain its incredible structure. Within that context, it presents a number of challenges and some significant opportunities.

17.2 The current Dean leads a highly competent team that capitalises on the significant strengths of its current CSO, COO, CSL, and Canon Precentor.

17.3 Governance is delivered by a well-balanced, engaged, and safeguarding-focused Chapter, to whom the CSO reports directly. This is good practice, and the Chapter is to be commended in this regard. They ensure regular expert feedback, and the CSO is present at every meeting.

17.4 The role of the CSO is recognised as being very demanding, representing a significant workload for one individual. The current CSO is due to retire, and it is appropriate to acknowledge their professional contribution to safeguarding at the Minster and beyond. As the first ever CSO, they have helped to develop and shape national responses to safeguarding. Their well-earned retirement therefore represents a significant loss to the Church of England's safeguarding efforts at both a local and national level.

17.5 That said, appropriate succession planning and contingency measures are sensibly in place, and there are plans to further incorporate the safeguarding support provided by their

dedicated in-house, 24/7 attested police service: the highly credible York Minster Police.

17.6 The CSO and other staff and volunteers undertake appropriate awareness-raising activities to promote the profile of safeguarding, including the use of digital resources with up-to-date information and signposting for individuals in need of support and advice. Safeguarding for choristers was identified as a particular strength within York Minster, with clear prioritisation given to their wellbeing and support.

17.7 They are also actively involved in future-proofing activity by increasing access to information regarding online safety, modern slavery (human trafficking), and county lines. They participate in a range of safeguarding-focused events, providing guidance for visiting choirs and bellringers, and have adopted a 'safer by design' approach to the Cathedral's layout. Recently, their outreach extended to hosting multi-agency critical incident training on site.

17.8 Safety plans are well managed, and safeguarding processes at the Minster are effectively triaged, with decisions recorded on the current case management system.

17.9 York Minster collaborates with the DBF to respond to victims and survivors, co-convening the Survivor Voice Working Group (SVWG), in which the Chapter Safeguarding Lead for clergy (CSL) and CSO both participate. They also jointly commission (with the DBF) ‘Building Hope’, an independent service for victims and survivors of church-based abuse via IDAS.

17.10 Furthermore, the Audit saw evidence of positive feedback regarding the CSO’s interaction with victims and survivors and the pastoral support provided by senior staff members. That said, other feedback indicated that some individuals engaged by the Minster did not receive appropriate trauma-informed care. This highlights the need for more work to be

done to embed a trauma-informed approach in practice and culture.

17.11 The culture in the Cathedral is undoubtedly improving, and a majority of those engaged by the Audit chose phrases such as welcoming, supportive, inclusive, and respectful to describe it.

17.12 However, a minority adopted a much less positive position, highlighting concerns that the Dean can appear distant and dismissive. While the majority of people in the Cathedral workforce felt confident they could raise concerns without fear of reprisal, less than half of those from the worshipping community who participated in the Audit (fewer than twenty) agreed. That said, these challenges are recognised at the highest leadership levels, and work is ongoing to address them.

17.13 The recommendations within this report are designed to help enhance their safeguarding practice, support and strengthen engagement with victims, address the residual concerns regarding culture, and facilitate the opportunity the Minster has to consolidate its safeguarding-aware SET, support their new CSO, and further integrate the work of the York Minster Police into its safeguarding provision.

Appendices

18 Appendix 1 – DBF Recommendations

Recommendation D1:

1. Establish quarterly meetings with the DSO to ensure structured information sharing. These meetings should be underpinned by enhanced safeguarding briefs, debriefs, and reporting of outcomes and any necessary remedial actions.
2. Collaborate with the DSA / O, DST and parish representatives (potentially with oversight from the Diocesan Safeguarding Advisory Panel (DSAP)) to create a framework for focused engagement at the Deanery and parish level. This framework should include a formatted pre-visit briefing document provided by the DST, containing up-to-date information (as per the current pro-forma) and a specific Archdeacons' brief covering:

    e) The number of safeguarding agreements.

    f) Parish engagement levels and areas for specific, in-depth verification of safeguarding dashboards.

    g) Any relevant historic safeguarding issues.

    h) Details of recent or active Core Groups.

3. Submit a formal report of findings to the DSA / O / DST following each visit, outlining any remedial safeguarding requirements and the expected timeframe for response.

Recommendation D2:

1. Archdeacons should receive specific training and support to effectively chair Core Group meetings, ensuring a uniform approach and providing sufficient options to avoid any perceived conflict of interest.
2. To further enhance their safeguarding practice, Core Group training should be extended to other routine participants and consideration be given to hosting annual

workshops with neighbouring Archdeacons to help develop good practice. This would provide additional added value and the opportunity to participate / lead cross diocesan groups when an issue involves more than one area.

Recommendation D3:

1. Broaden the MDR review panel to include the Bishop, Archdeacon, and a trained lay person or retired clergy member, moving beyond the current structure to facilitate richer, more developmental conversations.
2. Shift the emphasis from retrospective performance review to a forward-looking developmental reflection, considering past experiences, assessing current skills (particularly in safeguarding), and identifying capabilities needed for future ministry focus.
3. Establish a process to identify and facilitate relevant internal or external developmental opportunities, such as visits or short secondments (e.g., with a youth justice team, food bank, or shadowing the DSAP Chair), tailored to support the individual's growth in their current and future roles.

Recommendation D4: Blue files require examination by the territorial Bishop and the DSO promptly after receipt.

Recommendation D5: Introduce fireproof storage:

1. Procure certified fireproof cabinets or chests (meeting standards like UL Class 350 for paper).
2. Store these containers in a secure, restricted-access location.
3. Transfer blue files to the fireproof storage once examinations are complete.
4. Maintain an inventory of files held in fireproof storage.

5. Regularly review storage capacity and consider secure digital archiving for appropriate files.

Recommendation D6: The Audit team strongly recommend that the DSO should attend all senior leadership team meetings. It is considered crucial for a dedicated safeguarding professional to be present in these key decision-making forums. The safeguarding perspective is vital in discussions across a range of strategic areas, including housing, Church growth initiatives, international partnerships, and staffing / HR matters, where safeguarding implications may be significant but not immediately apparent to those without specialist expertise.

While the DSO recognises the potential value of this direct involvement and seeks to influence culture through existing meetings, the Audit concludes that reinforced capacity to facilitate formal inclusion at the senior leadership table is necessary to ensure proactive identification and mitigation of safeguarding risks at the highest level.

To deliver this enhancement, the DSO should become a standing member of the senior leadership team (YDLT). This should be supported by clear terms of reference outlining the DSO's role and expected contributions in this context.

Recommendation D7:

The DBF should increase the DST's capacity by adding two additional Assistant Diocesan Safeguarding Advisors (ADSAs). This expansion would allow for a portfolio-based approach, enabling specialisation by geographic area (potentially aligned with Archdeacons) and crucial safeguarding specialities such as victim / survivor support, offender management, and training.

While additional cost is inherent, two main options for achieving this expansion are identified for consideration:

1. **Option 1: Recruit Two New ADSAs** - This involves creating and recruiting two entirely new ADSA posts to add directly to the existing team structure.
2. **Option 2: Phased Recruitment and Role Reconfiguration** -This potentially more strategic option links recruitment to the consideration of establishing an autonomous Diocese-wide safeguarding directorate. It involves a review of current roles to identify opportunities for strengthening the team with less initial investment.

This model would entail recruiting one new ADSA and reconfiguring existing roles: the current training post would become an ADSA role with geographic and specialist training portfolio responsibilities, and the administrator's role would be realigned into a Safeguarding and PSO Support Coordinator role, focusing on call management and filtering, dashboard compliance and reporting, annual audits, training evaluation, communications, and targeted parish support. This added value approach will require additional training and appropriately enhanced remuneration.

In any expansion or reconfiguration that enhances specialist safeguarding resources, consideration should be given to formally assigning one of the ADSAs as Deputy DSO. This individual would hold responsibility for a principal geographic area and a specialist portfolio (e.g., risk assessment and safety planning), thereby providing essential continuity and resilience during absences.

Recommendation D8:

To significantly strengthen safeguarding, ensuring operational independence without undermining governance oversight, the Minster and the DBF should establish an operationally autonomous Safeguarding Directorate, headed by a Director of Safeguarding.

This Directorate would consolidate all safeguarding resources, providing comprehensive and consistent support and direction to the Archbishop of York, DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the ability, authority and autonomy to:

a) Provide expert advice, robust oversight and ultimate direction on all safeguarding matters.
b) Challenge senior clergy and Church bodies when necessary, ensuring accountability.
c) Escalate concerns directly to higher authorities, including the National Director of Safeguarding at the NST without undue influence.

To ensure the effectiveness and influence of this structure, the following are required:

a) The Director should attend and report directly to, key decision-making bodies, including the DBF, Bishop's Council, Chapter, and the Archbishop / Bishop's / Senior Leadership Team (YDLT).
b) A comprehensive MoU / SLA between the DBF, Parish PCCs, and the Minster should clearly define the Director's authority and responsibility. This includes providing safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the geography of the Diocese.

c) The Directorate should be adequately resourced and staffed, incorporating all professional safeguarding personnel (including those currently based at York Minster).

Note: This recommendation should be read in conjunction with the Safeguarding Directorate section in the Independent Safeguarding Audits Annual Report (2024/2025).[5]

Recommendation D9: The DBF should ensure its commitment to safeguarding is embedded into all job adverts published by the DBF.

Recommendation D10: The DBF should transfer DBS administration from the DST to the HR team and establish a clear protocol for information sharing between HR and the DST, particularly concerning safeguarding implications arising from DBS check results.

Recommendation D11: The DBF should undertake a review to map the types of activities involving children and young people that take place within parishes, the primary focus of these activities and to identify any examples of good practice and / or potential areas for improvement.

Recommendation D12: The DBF should create a separate Risk Register specifically for operational safeguarding risks. This will allow for the effective identification, assessment, and management of potential issues within the organisation.

Recommendation D13: The DBF should develop a set of standardised prompts for incumbents to use in discussions with respondents subject to Safety Plans. These prompts should go beyond general inquiries (e.g., "how are you?") and will be designed to explore and identify any new concerns and promote understanding of the respondent's life in the context of the risk they pose.

Recommendation D14: The DBF should reinforce its commitment to 'Responding Well to Victims and Survivors of Abuse' by:

a) Including a statement of commitment on its 'Victim and Survivor Support' webpage.
b) Providing a direct link to the 'Responding Well to Victims and Survivors of Abuse' section of the Safeguarding e-manual.

[5] https://ineqe.com/churchofengland/

Recommendation D15: To address the challenges of self-referral barriers and digital poverty in mental health support, the DBF should prioritise workforce and community education on recognising mental health crises and establish strong partnerships with local charities to enhance outreach and support.

Recommendation D16: To improve accessibility and ensure wider participation, the Audit recommends that the DBF partner with the Minster to host diocese-wide listening events, thereby providing additional platforms for hearing from a diverse range of voices.

Recommendation D17: The DBF should train volunteer co-chairs or other suitable individuals to offer additional options for delivery of training.

Recommendation D18: The DBF should deliver interim training on managing individuals who pose a risk, including the use of safeguarding agreements and recognising concerning behavioural indicators.

Recommendation D19: To ensure training feedback is gathered routinely and not delayed due to staff availability, the DBF should introduce automated post-session emails or collect in-person feedback forms.

Recommendation D20: The DBF should broaden the existing training evaluation process to capture not only immediate feedback but also longer-term impact, embedding mechanisms to assess how well training is influencing safeguarding culture and practice over time.

Recommendation D21: The DBF should strengthen MDR processes to support consistency, accountability and ongoing development, and ensure that all clergy receive regular MDRs that have safeguarding as a standard item, covering both compliance and reflective practice.

Recommendation D22: The DBF should implement a formal annual review of the clergy safeguarding induction process to ensure it remains aligned with best practice and national guidance.

19 Appendix 2 – York Minster Recommendations

Recommendation C1: Drive an open, inclusive, and accountable culture through visible and engaged leadership that actively reduces hierarchical barriers, encourages challenging discussions, and prioritises continuous improvement directly linked to feedback mechanisms and overseen by Chapter Via its SMG subcommittee. To facilitate accurate monitoring:

f) Design survey questions specifically to measure the perceived approachability of leaders, comfort levels in raising challenging issues or concerns with them, and the overall sense of inclusivity within the organisation. Use clear scales (e.g., Likert scales) for consistent data collection.

g) Utilise workshops led by independent facilitators to assess and monitor the feedback on the nature and impact of culture / deference.

h) Ensure senior leaders include reflections in their supervision sessions on how they can enhance culture, facilitate better communication and mitigate deference within their area of influence.

i) Such surveys / activity should be carried out once per year for the next three years. Information from these activities should be anonymised, consolidated and shared as part of a cultural health check and form part of current performance processes.

j) A uniform approach should be adopted, without exception and regardless of rank or role, regarding the provision, application, and use (in keeping with data protection regulations) of technology or other equipment or material provided for a work-based purpose.

Recommendation C2:

1. A structured programme of learning and mentoring should be established, primarily for the Dean's role (and in a wider sense for the consideration of the CofE National Church Institutions (NCIs)). This program could also bring potential benefit for the wider SET.
2. This programme should facilitate access to mentoring from individuals with significant and complex leadership portfolios outside the traditional Cathedral or Church structure. Examples could include Chief Executives of Local Authorities or leaders of other large, intricate organisations. The focus of this mentoring should be on navigating complex organisational ecosystems, strategic leadership, managing diverse professional teams, and adapting leadership skills to a unique environment. This initiative would provide invaluable external perspective, support professional growth, and enhance the strategic capabilities of the leadership team.

Recommendation C3: A formal Safeguarding Management Committee (SMC) should be established as a subcommittee of Chapter to provide a structured approach to discussing, managing and escalating safeguarding risks and a mechanism for linking Cathedral, community and Diocesan safeguarding efforts.

e) The SMC should be formally constituted as a subcommittee of Chapter, deriving its authority from it.

f) Key stakeholders should be represented on the SMC, including the Director of People, CFO, CSL, Police Sergeant, Canon Precentor, DSO, CSO, and DSAP Chair. Where possible, representatives from the wider community, including business and charitable sectors, should also be included.

g) The SMC should ideally be chaired by an independent lay person to ensure robust oversight.

h) The committee's scope should include providing a structured approach to discussing and managing safeguarding risks, linking Cathedral and Diocesan safeguarding efforts, and having the ability to create focused task and finish groups for specific pieces of work.

Recommendation C4:

It is recommended that a part-time Assistant Cathedral Safeguarding Officer (ACSO) support person be appointed. This role would provide essential capacity and support to the CSO, enhancing the overall resilience and effectiveness of the wider Cathedral safeguarding functions.

Recommendation C5:

8. The York Minster Police should pursue externally accredited safeguarding training (e.g., Level Three) to professionalise its operations and validate its standards. This is a level of training provided by most safeguarding children partnerships to multi-agency safeguarding partners. The attendance at such a course would build both knowledge and contacts and develop networks.
9. A dedicated safeguarding specialist role should be developed within the York Minster Police team to enhance expertise and focus in this critical area. This should include short term observational visits to other external police and multi- agency safeguarding organisations.
10. Regular joint training exercises, beyond counter terrorism, for example, missing children and potential critical care incidents within the precints of the Cathedral, should be conducted with external police forces, such as NYP, Fire and Ambulance services to improve collaboration and share best practices.
11. They should review and update existing training and complete a refreshed training needs analysis based on the recommendations from this audit, ensuring their current

Constabulary curriculum is fit for purpose. This should focus on, but not be limited to, areas such as legal powers, safeguarding protocols, and the development of consistent policing approaches. To this end, the Minster could:

c) Consider bringing in a senior serving police officer with public protection experience, on secondment for a fixed period, to consult on and help develop the service's basic and advanced training curriculum.

d) Engage with the Police College and / or advertise the leadership and development opportunity to police services (including the British Transport Police) and further education establishments with a policing curriculum or focus.

12. Clearly define and document the legal boundaries of the York Minster Police's policing role to ensure all officers understand their powers regarding actions such as arrest and detention.
13. Create clear pathways for progression within the York Minster Police to support professional development and retention.
14. Explore opportunities to align with and provide mutual assistance across the three Cathedrals that have similar constabulary provisions, sharing knowledge and resources.

Recommendation C6: To significantly strengthen safeguarding, ensuring operational independence without undermining governance oversight, the Minster and the DBF should establish an operationally autonomous Safeguarding Directorate, headed by a Director of Safeguarding.

This Directorate would consolidate all safeguarding resources, providing comprehensive and consistent support and direction to the Archbishop of York, DBF, parishes, and the Cathedral.

The Director of Safeguarding would have the ability, authority and autonomy to:

a) Provide expert advice and robust oversight and ultimate direction on all safeguarding matters.
b) Challenge senior clergy and Church bodies when necessary, ensuring accountability.
c) Escalate concerns directly to higher authorities, including the National Director of Safeguarding at the NST without undue influence.

To ensure the effectiveness and influence of this structure, the following are required:

a) The Director should attend and report directly to, key decision-making bodies, including the DBF, Bishop's Council, Chapter, and the Archbishop / Bishop's / Senior Leadership Team (YDLT).
b) A comprehensive MoU / SLA between the DBF, Parish PCCs, and the Minster should clearly define the Director's authority and responsibility. This includes providing safeguarding advice, support, and ultimate authoritative operational decision-making on any safeguarding-related matter across the geography of the Diocese.

c) The Directorate should be adequately resourced and staffed, incorporating all professional safeguarding personnel (including those currently based at York Minster).

Note: This recommendation should be read in conjunction with the Safeguarding Directorate section in the Independent Safeguarding Audits Annual Report (2024/2025).[6]

[6] https://ineqe.com/churchofengland/

Recommendation C7: The music department should introduce a low-level concerns log, accessible to all staff in direct contact with choristers, to support early identification of patterns and enhance safeguarding oversight across both contexts.

Recommendation C8: York Minster should introduce a start-of-term parent meeting or implement an annual anonymous parent survey or similar method of feedback, to support shared understanding, inclusion, and confidence in the safeguarding arrangements.

Recommendation C9: Install CCTV in the organ loft, including its ground floor and adjoining library space, to improve visibility in this area and provide an additional layer of safeguarding oversight.

Recommendation C10: The Minster should seek to align its approach to behaviour management with that of St Peter's School to support consistency for choristers across both settings. This could be achieved through training delivered by school staff, a shared statement of practice, or a collaboratively developed behaviour policy.

Recommendation C11: York Minster should continue to ensure its commitment to safeguarding is included in all job descriptions and also embedded in all job advertisements.

Recommendation C12: York Minster should provide a direct link to the 'Responding Well to Victims and Survivors of Abuse' section of the Safeguarding e-manual.

Recommendation C13: To ensure those who require help can easily find information, York Minster should rename their advice leaflet to 'Victim and Survivor Support: External Resources'.

Recommendation C14:

York Minster should conduct a Training Needs Analysis to identify specific requirements for trauma-informed practice training across all roles. This will help determine which roles require further specialist training and support.

Recommendation C15: Following the Training Needs Analysis, a tiered training programme should be developed (idealy co-produced) and implemented:

- All staff and volunteers should receive lighter-touch briefings on creating trauma-informed settings. This foundational training will help promote a general understanding of trauma and its impact.
- Key staff, particularly those in roles most likely to interact with individuals who have suffered abuse, should receive more intensive, role-specific trauma-informed practice training and support. This tailored approach aligns with national initiatives to roll out trauma-informed practice training to certain roles.

Recommendation C16: York Minster should prioritise rebuilding trust by actively listening to the voices of victims / survivors and those impacted by abuse through the implementation of diocese-wide listening events co-facilitated with the DBF.

Recommendation C17: York Minster should ensure training feedback is gathered routinely by implementing automated post-session emails or collecting in-person feedback forms.

20 Appendix 3 – Glossary of Abbreviations

Abbreviations and Acronyms	Meaning
ADSA	Assistant Diocesan Safeguarding Adviser
ADSO	Assistant Diocesan Safeguarding Officer
AEC	Association of English Cathedrals
CCSL	Clergy Current Status Letter
CCTV	Closed-circuit TV
CDM	Clergy Discipline Measure
CofE	Church of England
COO	Chief Operating Officer
CPD	Continuing Professional Development
CSA	Cathedral Safeguarding Advisor
CSL	Cathedral Safeguarding Lead
DBF	Diocesan Board of Finance
DBS	Disclosure and Barring Service
DSA	Diocesan Safeguarding Advisor
DSAP	Diocesan Safeguarding Advisory Panel
DSO	Diocesan Safeguarding Officer
DST	Diocesan Safeguarding Team
GDPR	General Data Protection Regulation
HR	Human Resources
IICSA	The Independent Inquiry into Child Sexual Abuse
ISA	Information Sharing Agreement
IT	Information Technology

LADO	Local Authority Designated Officer
LLR	Learning Lessons Reviews
MDR	Ministerial Development Review
MOSOVO	Management of Sexual Offenders and Violent Offenders
MoU	Memorandum of Understanding
NAPAC	National Association for People Abused in Childhood
NPCC	National Police Chiefs' Council
NSCMS	National Safeguarding Case Management System
NST	National Safeguarding Team
PCC	Parochial Church Council
PCR2	Past Cases Review 2
PSO	Parish Safeguarding Officer
PTO	Permission to Officiate
RSL	Regional Safeguarding Lead
SCIE	The Social Care Institute for Excellence
SCMG	Safeguarding Case Management Group
SEO	Search Engine Optimisation
SET	Senior Executive Team
SIR	Serious Incident Report
SLA	Service Level Agreement
SLT	Senior Leadership Team
SMG	Safeguarding Management Group

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