NORTH YORKSHIRE FIRE & RESCUE SERVICE

Safeguarding

Final Internal Audit Report: 6.24/25

28 May 2025

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Appendices

AUDIT OUTCOME OVERVIEW

In line with our scope, included at Appendix B, the overview of our findings is detailed below.

Background: We have undertaken an audit of Safeguarding for North Yorkshire Fire and Rescue Service (the Service) as part of our Internal Audit Plan for 2024/25. The objective of this review was to assess how and to what extent the Service adequately responds to safeguarding concerns, and whether it has embedded safeguarding processes in place that are complied with.

Following changes to the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975, the Service has been working to ensure that all Wholetime and On Call firefighters are subject to DBS checks, and has been actively monitoring completion of such checks. Safeguarding referral case notes are maintained within a secure Sharepoint site accessible to members of the Safeguarding team. Mandatory e-Learning Safeguarding training modules are in place and compliance with these is being monitored. Governance and oversight of the Safeguarding process is undertaken through the Service Leadership Team, the Safeguarding Compliance Meeting, and monthly Managing Allegations and Safeguarding Meetings.

Conclusion: A robust Safeguarding Policy and Procedure is in place which includes adequate coverage of expected policy areas, although we have noted a low priority finding to ensure evidence of approval of the Policy is retained. Through our sample testing of new starter firefighters, we confirmed the process for completion of DBS checks was complied with in each instance. Similarly, through our review of a sample of 20 safeguarding referrals, we confirmed that details of each referral had been adequately recorded and tracked within a restricted Sharepoint folder, using standard documentation.

We identified a further low priority finding, relating to the signing of information sharing agreements in place by the Service. While the content of mandatory training, and of the information sharing agreements in place, was adequate, we noted a concern in that there was a low level of compliance with mandatory safeguarding training (49% for Safeguarding Level 1 and 50% for Safeguarding Adults and Young People) as of the 31 March 2025 completion deadline (note – this had increased to 75% and 72% respectively by mid May 2025). Other awareness and understanding mechanisms for staff are in place to offset the level of risk associated with the low training compliance. Governance and reporting arrangements are in place through the Safeguarding Compliance Meeting, the Strategic Leadership Team, and the monthly Managing Allegations and Safeguarding meeting. However, these are un-minuted which means while training is a standing agenda item, there is no evidence around the scrutiny relating to such low training compliance levels. With the other mitigations in place, we have agreed a medium priority action to understand the root cause of the poor compliance and improve compliance for further iterations of the safeguarding training cycle.

Internal audit opinion:

Taking account of the issues identified, the Force can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).

Audit themes:

Policies and Procedures.

The Service has a comprehensive Safeguarding Policy and Procedure, version-controlled via Sharepoint and reviewed every three years. However, there is no documented evidence of formal review and approval by the SLT and representative bodies. The Policy covers all expected areas and is accessible to relevant staff. **(Low)**

Training.

As of the 31 March completion deadline, only 49% of applicable staff had completed the LearnPro Safeguarding Level 1 mandatory module and 40% had completed the Safeguarding Adults and Young People Mandatory module. While we confirmed that reminder notices had been issued prior to this date, the low level of compliance with mandatory safeguarding training creates a significant risk that staff may not be adequately prepared to identify and respond to safeguarding concerns. This lack of training could potentially lead to failures in protecting vulnerable individuals, thereby exposing the organisation to legal and reputational risks. Additional context was provided, detailed in the finding below, that provides confidence around the approach in place for staff awareness and training. Therefore, we have agreed a medium priority action in relation to this area. **(Medium)**

Information Sharing Agreements.

We confirmed that the Information Sharing Protocol was reviewed and approved in January 2025, with clear guidelines and responsibilities for Partner Agencies. However, only four of the 17 Partners had dated signatures. Similarly, the Safeguarding Information Sharing Agreement for the City of York, which includes data sharing arrangements, processes, and data retention and deletion policies, was missing 15 out of 21 required signatures, including from the Fire and Rescue Service. **(Low)**

Roles and Responsibilities.

While the Chief Fire Officer's safeguarding responsibilities are delegated to the Deputy Chief Fire Officer (Deputy CFO) and documented in the accountability framework, the Deputy CFO's job description lacks reference to this. The CFO highlighted that to make any amendments to the DCFO role profile, it would have to be done through the Mayoral Combined Authority (MCA) via full consultation with the Deputy CFO. It was considered by the CFO therefore that the

risk is mitigated through the York & North Yorkshire Constitution, which sets out delegation arrangements from the CFO to the Deputy CFO for statutory responsibilities, one of which would include safeguarding. Therefore, no further action has been agreed.

Policies and Procedures.

While we have noted an issue with formal review and approval of the Safeguarding Policy and Procedure above, through review of the document, we did note that it included thorough coverage of all expected areas, such as the code of ethics, GDPR, social media policies, and more. It is also clearly aligned with relevant legislation and is accessible to relevant staff via Sharepoint and the Service intranet portal.

DBS Checks.

From a sample of 20 new starter firefighters, we confirmed that 19 had completed DBS checks, with details recorded in the Service's DBS tracker. One individual, who had been previously suspended, had not completed the check but was currently on modified duties without public contact. All checks were performed at the correct level, with one exception due to a policy change, and were completed before the individual's start date, with refresh dates recorded.

Recording of Safeguarding Cases.

We confirmed that access to the Sharepoint referrals folder was appropriately restricted to a small number of staff with valid reasons for access. Although several IT users had system admin access to CFRMIS, the risk was minimal as no sensitive safeguarding information was recorded there. A review of 20 referrals from the past three months showed all cases were properly recorded and filed in CFRMIS and Sharepoint with all referral forms completed correctly.

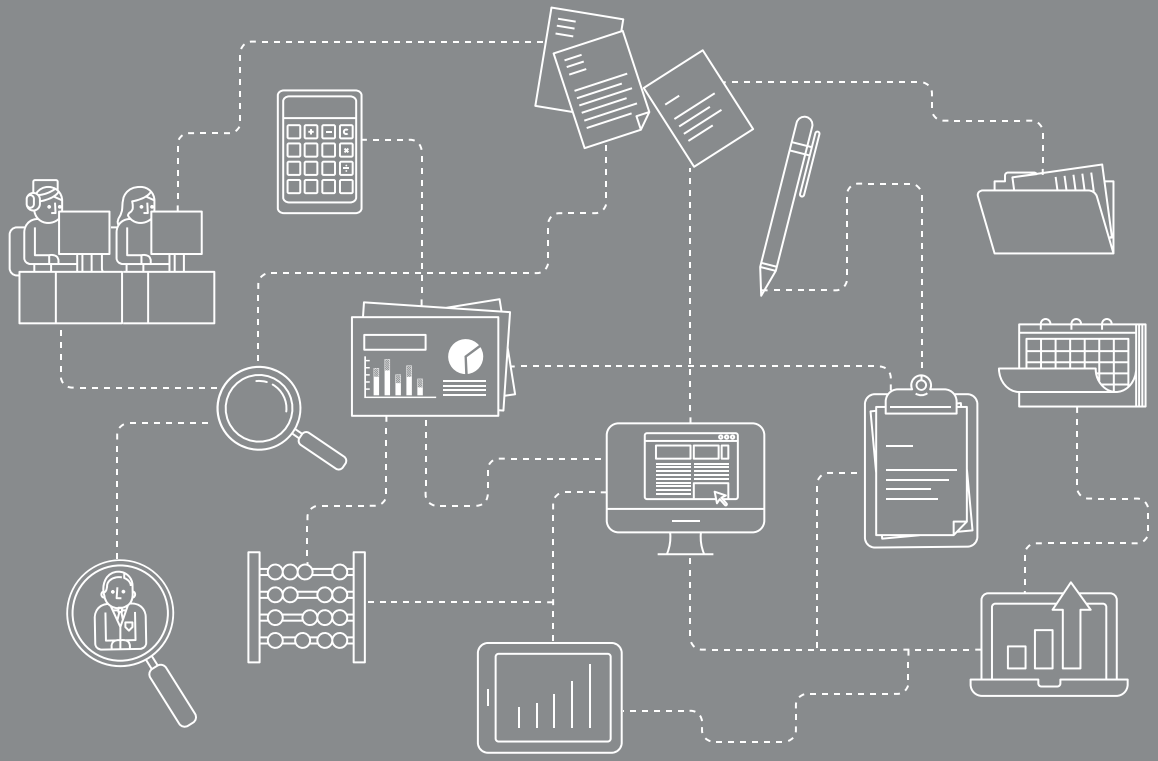
Governance and Reporting.

The terms of reference for the Safeguarding Compliance Meeting clearly document its purpose in providing assurance around safeguarding compliance. The group's accountability and reporting arrangements include six-monthly reporting to the Strategic Leadership Team and annual reporting to the Executive Board. The meeting frequency, membership, and quorum requirements are recorded, with the document updated in September 2024. Quarterly meetings were confirmed through inspection of standard agendas, which covered dashboard reporting of safeguarding cases, information sharing, standards updates, training, and DBS updates.

An actions and decisions log is used to track and review actions raised during meetings. Additionally, an allegations tracker maintained by the Safeguarding Team is discussed at monthly Managing Allegations and Safeguarding Meetings. Safeguarding update papers were reported to the Service Leadership Team in February and October 2024, with detailed updates on compliance actions following legislative changes, and adequate evidence of review, challenge, and scrutiny was confirmed through review of SLT meeting minutes. However, in tandem with the Training key finding above, the Service may wish to evaluate the effectiveness of these groups to challenge, escalate and ensure compliance with mandatory training.

Summary of Actions for Management

01



SUMMARY OF MANAGEMENT ACTIONS

The action priorities are defined as*:

High	Medium	Low
Immediate management attention is necessary.	Timely management attention is necessary.	There is scope for enhancing control or improving efficiency.

Ref	Action	Priority	Responsible Owner	Date
1	We will ensure that approval and endorsement of the Safeguarding Policy and Procedure through the Safeguarding and Compliance meeting is clearly documented.	Low	Director of Capabilities, Community Risk and Resilience	*Complete*
2	Lessons learned from the introduction of the E-Learning module in January 2025 will be evaluated, and any identified improvements will be made to the awareness and completion of the e-learning module in 2025/26. Chasing of staff who have not completed the module will commence prior to 31 March for 2025/26 to increase completion percentages before this date.	Medium	Director of Capabilities, Community Risk and Resilience	*31 August 2025*
3	We will ensure that the Service has signed and dated all Safeguarding Information Sharing Agreements to which it is party.	Low	Director of Capabilities, Community Risk and Resilience	*31 August 2025*

* Refer to Appendix A for more detail

Detailed Findings and Actions

02

DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all audit testing undertaken.

Safeguarding Policy and procedures			
Control	The Service has a Safeguarding Policy and Operating Procedure in place which is accessible to relevant members of staff via Sharepoint, as well as to the public via the Service's website. The document is reviewed on a three-year cycle and was last reviewed in September 2024. The Policy and Procedure includes guidance on key safeguarding processes including, but not limited to: • roles and responsibilities; referral procedures; safeguarding training; supervision; leadership, governance and accountability.	**Assessment:** **Design** ✓ **Compliance** ×	
Findings / Implications	We confirmed that the Service has a Safeguarding Policy and Procedure in place. The document is version-controlled through Sharepoint with a three-year review cycle, and was last reviewed by the Head of Safeguarding in September 2024. We were advised that the document is additionally sent to the Senior Leadership Team (SLT) Safeguarding and Compliance meeting and representative bodies for formal review and approval at each review cycle; however, no documented evidence is retained of this approval. Without documented evidence of formal review and approval by the SLT and representative bodies, there may be a lack of accountability and assurance that the Safeguarding Policy and Procedure has been properly vetted and endorsed. We did confirm, however, that the documented included adequate coverage of the areas expected, including: the code of ethics; GDPR and information sharing; social media policies; PREVENT; training; roles and responsibilities; governance; supervision; and referral procedures. The Policy was also clearly aligned to and linked with relevant legislation throughout. We confirmed through inspection that the Policy was available to relevant staff via Sharepoint and the Service intranet portal. Update: Prior to the finalisation of this report, the Director of Capabilities, Community Risk and Resilience confirmed that the agreed action was now complete. While our audit has not independently validated this, we have marked the date as complete to support internal follow up of this low priority action at the earliest opportunity.		
Management Action 1	We will ensure that approval and endorsement of the Safeguarding Policy and Procedure through the Safeguarding and Compliance meeting is clearly documented.	**Responsible Owner:** Director of Capabilities, Community Risk and Resilience	**Date:** Complete **Priority:** **Low**

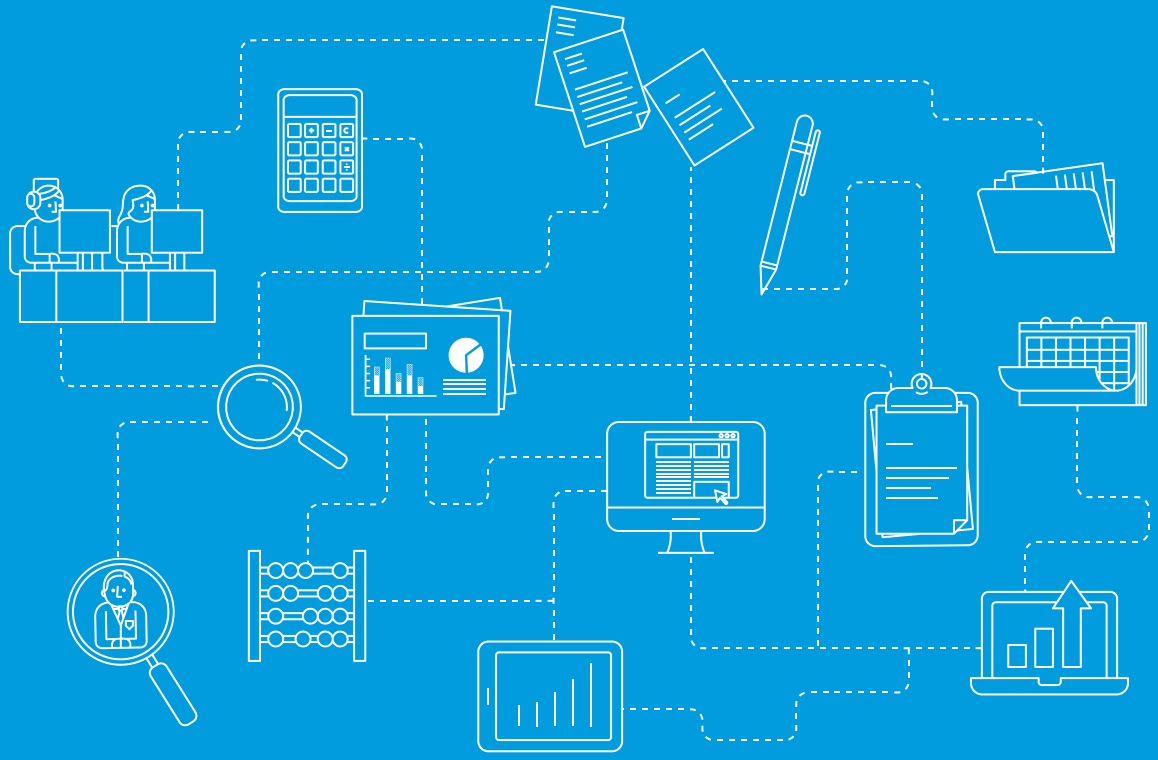
Training			
Control	All Service staff are required to completed two mandatory eLearning modules: 'Safeguarding Adults' and 'Safeguarding Children', and to refresh this training annually or sooner if directed by the Service. Completion of training by staff is monitored through the Firewatch system, which includes expiry dates and reminder dates for training refreshers.	**Assessment:** **Design** **Compliance**	 ✓ ×
Findings / Implications	We confirmed through discussion with the Safeguarding Manager and inspection of the LearnPro learning platform that all Service staff are currently required to complete two mandatory eLearning modules: 'Safeguarding Adults' and 'Safeguarding Children'. This training must be refreshed annually or sooner if directed by the Service. We compared a listing of Wholetime and On Call active firefighters to the following reports of Safeguarding passes, to identify any current firefighters without passes in the safeguarding eLearning modules: • LP Safeguarding 1; • LP Safeguarding Adults and Young People. As of the 31 March 2025 deadline, only 49% of applicable staff had completed LP Safeguarding 1, and 50% had completed LP Safeguarding Adults and Young People. There is an increased risk of failures in protecting vulnerable individuals, potentially exposing the organisation to legal and reputational risks. Following feedback of this finding, a number of additional mechanisms were highlighted that provide the organisation with greater assurance around this training. Notably, these were: • The e-learning module was introduced and made mandatory for this year, and so prior to this training module, there were a number of mechanisms that staff received safeguarding information and knowledge. Given this is the first year it is being used, lower compliance is expected, for example, where non-operational staff were not clear it was applicable to them. • There are no comparison figures to demonstrate compliance levels in 2024 due to the training module not existing previously, but having it in place for this year is a positive step which will allow continuous improvement going forward. • HMICFRS act as a further independent source of assurance that commended safeguarding at the Service previously. This e-learning is building on what was in place then. While we cannot comment on the coverage HMICFRS undertook to reach their conclusion, we have included this here as context. • Other mechanisms of awareness around safeguarding are established at the Service, such as posters and newsletters which we evidenced. Therefore, the Service is not raising staff awareness exclusively through completing the training. • While this falls outside of the audit period, the Service have been able to demonstrate that while compliance was low on 31 March 2025, their escalation controls show marked improvement in that circa 75% of operational staff had completed the two modules by 19 May 2025, alongside 72% of all staff. There is an exercise ongoing to better categorise the population numbers too, as the current number includes all staff, such as those who are on career breaks and secondments are removed.		
Management Action 2	Lessons learned from the introduction of the E-Learning module in January 2025 will be evaluated, and any identified improvements will be made to the awareness and	**Responsible Owner:**	**Date:** 31 August 2025	**Priority:** **Medium**

Training				
	completion of the e-learning module in 2025/26. Chasing of staff who have not completed the module will commence prior to 31 March for 2025/26 to increase completion percentages before this date.	Director of Capabilities, Community Risk and Resilience		

Information Sharing Arrangements				
Control	The Service has an Information Sharing Protocol in place with the purpose of ensuring that information is shared with partners lawfully, appropriately, and in compliance with best practice. The document was last reviewed and approved by the Data Protection Officer (DPO) in January 2025, and is due for next review in April 2026. The document is signed by signatories from relevant parties to the Protocol agreement. Information Sharing Agreements (ISAs) are in place with relevant third parties. These include key Safeguarding contacts for each organisation signed up to the agreement, and clear contractual criteria for the sharing of information in relation to Safeguarding.	**Assessment:** **Design** ✓ **Compliance** ×		
Findings / Implications	We confirmed the first draft of the Information Sharing Protocol was reviewed and approved in January 2025 by the DPO, Information Compliance Officer, and the Partnerships Manager. The Protocol is next due for review in April 2026, and annually thereafter. The Protocol clearly set out its aims and objectives, including the agreement of standards, guidance on the lawful sharing of information, and protecting Partner Agencies from allegations of wrongful use of data. The specific roles and responsibilities of Partner Agencies with respect to information sharing were clearly outlined. Both routine and ad hoc information sharing arrangements and processes were documented. Security arrangements were recorded, as was the duty of confidentiality for all Partner Agencies. Key contacts for Partner Agencies were appended to the Protocol. Although an appendix was included to record the signatures of all signatories to the Protocol, only four of the 17 Partners had any evidence of dated signatures. The lack of dated signatures from the majority of Partner Agencies on the Information Sharing Protocol poses a risk of non-compliance with legal and best practice standards, potentially leading to unauthorised data sharing and legal repercussions. We additionally confirmed that a Safeguarding Information Sharing Agreement was in place for the City of York Safeguarding Children Partnership, dated December 2024 with a two-yearly review cycle. Partners to the agreement, together with their contact details, were listed. The responsibilities of the partners to the agreement were set out in detail, including data sharing arrangements and processes, and data retention and deletion policies. However, we noted the documented was missing 15 out of 21 required signatures from the parties to the agreement. In particular, we note the document was not signed by the Fire and Rescue Service. As above, there is a risk of non-compliance with legal and best practice standards.			
Management Action 4	We will ensure that the Service has signed and dated all Safeguarding Information Sharing Agreements to which it is party.	**Responsible Owner:** Director of Capabilities, Community Risk and Resilience	**Date:** 31 August 2025	**Priority:** **Low**

Appendices

03



APPENDIX A: CATEGORISATION OF FINDINGS

Categorisation of internal audit findings

Low

There is scope for enhancing control or improving efficiency.

Medium

Timely management attention is necessary. This is an internal control risk management issue that could lead to: Financial losses which could affect the effective function of a department, loss of controls or process being audited or possible reputational damage, negative publicity in local or regional media.

High

Immediate management attention is necessary. This is a serious internal control or risk management issue that may lead to: Substantial losses, violation of corporate strategies, policies or values, reputational damage, negative publicity in national or international media or adverse regulatory impact, such as loss of operating licences or material fines.

The following table highlights the number and categories of management actions made as a result of this audit.

Risk	Control design not effective*	Non-compliance with controls*	Agreed actions		
			Low	Medium	High
Organisation safeguarding compliance	0 (7)	3 (7)	2	1	0
		Total	**2**	**1**	**0**

* Shows the number of controls not adequately designed or not complied with. The number in brackets represents the total number of controls reviewed in this area.

APPENDIX B: SCOPE

The scope below is a copy of the original document issued.

Scope of the review

The scope was planned to provide assurance on the controls and mitigations in place relating to the following risk:

Objective of the risk under review	Risks relevant to the scope of the review	Risk source
This review will consider how the Service responds to concerns of safeguarding and liaises with external parties. We will focus on how the Service has embedded and ensures adherence to safeguarding processes, including how staff are trained to recognise and respond to safeguarding concerns.	8658 - Organisational safeguarding compliance	Strategic Risk Register

When planning the audit, the following were agreed:

Areas for consideration:

- There is an internal process to record safeguarding cases once identified by staff, contractors and / or volunteers.
- The Service is responsible for proactively responding and reducing the risk of abuse, harm and neglect to those who are the most vulnerable in its community and also those inside its own organisation. Our review will determine whether the Service has effective processes in place to ensure it complies with safeguarding legislation / guidance and Fire Standard. In particular, we will consider the following:
    - The Service has strategies and procedures in place which conform with safeguarding legislation, are up to date, approved, and available to staff.
    - The Service has a named and accountable strategic lead for safeguarding and this is clearly documented and communicated with staff.
    - Safeguarding training has been provided to all relevant staff and the training has been provided by an accredited individual / organisation. We will confirm the training provided has been aligned with the Service's Community Risk Management Plan.
    - Safeguarding training is refreshed at required intervals and is aligned to the NFCC's Safeguarding Guidance for Children, Young People and Adults.
    - The Service has implemented a process that minimises the risk of employing people who may be unsuitable to work with those who are vulnerable. We will confirm that appropriate checks are performed on staff, refreshed at required intervals, and concerns identified are escalated.
    - Review of how safeguarding concerns are identified and reported with other parties.
    - The Service maintain effective and efficient two-way information sharing arrangements to ensure data relates to those who are vulnerable is available to those who need it.
    - Continued improvement of safeguarding is shared internally and externally.

Limitations to the scope of the audit assignment:

- The review is not intended to replicate or predict the outcome of a regulatory inspection.
- We will not comment on whether all safeguarding guidance has been captured, only whether there is a framework in place to capture the guidance.
- Our work is only designed to review the systems and internal controls in place to ensure safeguarding risks are appropriately mitigated.
- We will undertake an assessment of the adequacy of selected key aspects of the control framework (as stated in the areas for consideration above).
- Any testing undertaken during the audit will be performed on a sample basis only.
- Our review will not consider the entire policy and procedural framework available regarding safeguarding other than to confirm that such documentation is available to staff.
- We will not comment on the suitability of the leads for safeguarding adults and children, only that the role is in place and responsibilities have been established.
- Our audit does not seek to replicate advice provided by external, third parties in relation to the safeguarding referrals and / or any resultant actions, only that any actions have been completed.
- We will not comment on the applicability of the DBS check.
- We will not comment on the appropriateness of the DBS checks, in particular whether a standard or enhanced check should be undertaken for specific roles.
- We will not comment on the completeness of the documentation the Service retains in relation to safeguarding cases.
- We will not verify the accuracy of the Service's safeguarding reports, both internally or externally.
- The review will not provide an opinion in relation to the design and operation of the IT systems used in the process.
- The results of our work are reliant on the quality and completeness of the information provided to us.
- Our work will not provide an absolute assurance that material errors, loss or fraud do not exist.

Please note that the full scope of the assignment can only be completed within the agreed budget if all the requested information is made available at the start of our fieldwork, and the necessary key staff are available to assist the internal audit team. If the requested information and staff are not available we may have to reduce the scope of our work and/or increase the assignment budget. If this is necessary we will agree this with the client sponsor during the assignment.

To minimise the risk of data loss and to ensure data security of the information provided, we remind you that we only require the specific information requested. In instances where excess information is provided, this will be deleted, and the client sponsor will be informed.

Debrief held	13 March 2025
Draft report issued	12 May 2025
Revised draft report issued	27 May 2025
Responses received	28 May 2025
Final report issued	28 May 2025

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