Believe in children
Barnardo's
Training and Consultancy

Independent Review of Safeguarding Arrangements in St Thomas Philadelphia Church

26 February 2024

Linda Richardson and Jane Sarre, Safeguarding Consultants
Barnardo's Training and Consultancy

This report has been moderated by Julie Dugdale, Head of Business,
Barnardo's Training and Consultancy

We are grateful to the individuals who contributed voluntarily to this independent review and shared with us their experiences, observations, and insights about safeguarding arrangements in St Thomas Philadelphia church. These conversations helped us understand where safeguarding arrangements are working well and where improvements are needed to strengthen and improve safeguarding practice within the Church.

Executive Summary

Safeguarding all children and adults and protecting them from harm is everyone's responsibility, and all organisations, including church and faith communities have an important role to play in addressing these responsibilities.[1] Charity trustees are responsible for ensuring that those benefitting from, or working with or on behalf of their charity, are not harmed in any way through their contact with it.[2]

This report relates to an independent review of the current safeguarding arrangements in St. Thomas Philadelphia Church (the '**Church**') undertaken by Barnardo's Training and Consultancy.

Barnardo's were commissioned by the Diocese of Sheffield, to undertake two stages of work; the first being an independent investigation into a complaint made by an individual about the Church. The complainant, had alleged some aspects of practice within the Church in 2014, especially around Prayer Ministry, had caused him harm and his well-being had not been addressed or safeguarded by the Church at the time.

The first stage of work culminated in a report which was completed in November 2023 and was shared with the Diocese of Sheffield and the Yorkshire Baptist Association (the '**Core Group**')[3] and MD; the review team upheld all four aspects of the complaint.

Given the complaint related to what happened in the Church almost a decade ago, the Core Group agreed that a second stage of work was necessary to review current safeguarding arrangements in the Church. The review team was asked to consider to whether these arrangements were in line with safeguarding practice and procedures in the Diocese of Sheffield; the extent to which the Church met Charity Commission requirements was also considered.

Linda Richardson, and Jane Sarre, Safeguarding Consultants from Barnardo's undertook this review and were mindful of the need to give careful consideration as to what constitutes

[1] *https://www.gov.uk/guidance/safeguarding-duties-for-charity-trustees; https://www.gov.uk/government/publications/working-together-to-safeguard-children*
[2] *https://www.gov.uk/government/publications/strategy-for-dealing-with-safeguarding-issues-in-charities*
[3] [3] *The purpose of a core group is to oversee and manage the response to a safeguarding concern or allegation in line with House of Bishops' policy and practice guidance, ensuring that the rights of the victim/survivor and the respondent to a fair and thorough investigation can be preserved. Practice Guidance: Responding to, assessing, and managing safeguarding concerns or allegations against church officers. Church of England 2017*

appropriate and proportionate safeguarding arrangements for the Church in line with its charitable status and best practice.

The Church now makes clear that it neither permits nor endorses prayers which seek to change a person's sexual orientation and Prayer Ministry teams are not permitted to refer to or discuss a person's sexual identity. A Prayer Ministry protocol has been developed which make this clear. In this respect, student and Prayer Ministry is now, the review team was told, delivered much more safely and with greater awareness than it has been in the past and Church leaders seek to ensure that all individuals regardless of their faith, beliefs or sexuality are welcomed and accepted into the Church community.

In response to all the findings from this review, a number of recommendations have been made which highlight areas where important changes are needed and identifies other areas where longer term strategic changes, if implemented, would strengthen safeguarding arrangements in the charity. The recommendations are listed below:

Recommendation 1: The learning from this review should be shared with [redacted].

Recommendation 2. As a matter of priority, Board of Trustees should ensure that all emails which refer to any individual safeguarding concern reported to the SfgT and/or SSO in the last three years are copied and stored securely in individual case files; each case file should be prefaced with a chronology of events and actions taken.

We would advise that in respect of this investigation, a Complaint file for MD should be opened and all the documents shared with Core Group, with ourselves as reviewers and with MD should be stored or uploaded into the file, alongside copies of Stage 1 and Stage 2 reports.

Recommendation 3. A formalised system should be agreed whereby the SfGT and the SSO meet on a regular basis to discuss safeguarding arrangements, issues, and plans, where these have been agreed by the Board - how these are working and what barriers, if any, may be preventing progress. These meetings should be minuted and stored electronically within the appropriate safeguarding folder with clear details as to who can access this information.

Recommendation 4. The roles and responsibilities of the SfGT and SSO should be made explicit in role profiles and relevant job descriptions.

Recommendation 5. Trustees should have specific training around their safeguarding roles and responsibilities. This should be additional to and separate from Trustee training on their legal responsibilities and should be outsourced to specialists in the field.

Recommendation 6: The Board should adopt a more formal approach to managing and improving safeguarding practice in the Church, so it is better able to evidence good governance, openness, and accountability. Safeguarding should be a standing agenda item for Board meetings. Where there are no incidents or updates to bring to the table this should also be recorded in the minutes. The SfGT should ensure that the Board receives safeguarding reports on a regular basis using a format which includes, anonymised updates on incidents/ allegations, data to show themes and trends of reporting, progress of the strategic plan and updates on actual or emerging risks and risk mitigation.

Recommendation 7: A safeguarding strategy and implementation plan outlining the Church's ambition for its safeguarding arrangements and the goals it hopes to achieve should be developed and once agreed, signed off by the Board of Trustees.

Recommendation 8: The Board of Trustees should develop a more robust safeguarding structure in which individuals with key safeguarding roles collaborate as a team to strengthen safeguarding arrangements within the Church.

Recommendation 9: The Church website should have a safeguarding page which has links to key safeguarding documents, and which explains how safeguarding arrangements work in the Church. Details should be provided about how to report a concern and to whom, with contact details being provided for more than one person.

Recommendation 10: The full suite of policy documents which relate or are linked to safeguarding should be revised as part of a longer-term strategy so that NCS policies are aligned, standardised, have clear version control, and contain up to date and accurate information and references.

Recommendation 11: The Board of Trustees should ensure that the Church develops and maintains a data management system which can be used to record all incidents, concerns, and complaints and which can be used to draw down reports for scrutiny by the Board. Access to this system should be restricted but sufficient to allow legacy and handover should current members of the team move on. The contents of the database should be reviewed regularly to inform the direction of safeguarding work and to identify any patterns of behaviour or areas of concern.

Recommendation 12: The Church should ensure that a safeguarding message in terms of what to report and when is regularly communicated through all channels in the Church and everyone including those in the congregation know how to report concerns and are confident that their concerns will be taken seriously and actioned with the appropriate level of information and confidentiality.

Recommendation 13: Consideration should be given to producing a more detailed document around safer working practice and what constitutes appropriate and safe behaviours for adults who work for or on behalf of the Church.

Recommendation 14: A safeguarding risk management policy and risk management plan which includes the creation and maintenance of a safeguarding risk register should be developed and implemented.

Recommendation 15: The Prayer Ministry protocol should be shared with the Diocese and the Yorkshire Baptist Association and in the light of MD's complaint, critical reflection sought on its content. A revised document should include:

- reference to the requirements of the Charity Commission in terms of all beneficiaries of the Church, not just those who may fall under the legal definition of an adult at risk (Care Act 2014).
- how the Church will ensure that Prayer Ministry sessions, including those which may take place in settings other than the Church, are delivered in line with the Church's Prayer Ministry protocol
- information about how any concerns relating to Prayer Ministry can be reported and to whom.

Recommendation 16: Those administering Prayer Ministry should have not only a spiritual approach to Prayer Ministry but should be able to demonstrate, through training, a trauma-informed approach which understands that, however carefully managed, prayer sessions can re-trigger past traumas, and this can leave a person vulnerable.

Recommendation 17: If extended Prayer Ministry is to be reinstated, the Church needs to carefully consider how it will ensure that all sessions are delivered in ways which safeguard and protect the individual for whom the prayers are being said.

Recommendation 18: The Church should ensure that it regularly reviews it safeguarding practice, processes, and procedures, including how it delivers Prayer Ministry, through routine audits undertaken in partnership with external partners. Any findings should be publicised on the Church's website.

Recommendation 19: As part of the overall development of safeguarding in the Church, a member of staff should hold responsibility for the development of a safeguarding training plan which should include keeping records of training attended including date and content and details of trainer.

Recommendation 20. The Board of Trustees should consider how it can better evidence that its decision-making processes are well-informed, and that effective risk assessment and management systems are in place, fit for purpose, and regularly reviewed. The Board should also consider what steps it will take to audit its own performance on an annual basis.

Recommendation 21: The Church should seek discussion with the Diocese and the Yorkshire Baptist Association to share the learning from this review and explore what steps could be taken to enhance and consolidate partnership working even further to avoid similar situations occurring in the future.

Recommendation 22: Given we have advised that the Management of Allegations policy should be revised, the issue of contact with the LADO should be clarified so the Church can be confident in making contact with the LADO in future.

Contents

Overview

i. Barnardo's was commissioned to undertake a two-part investigation relating to a complaint made by an individual about the Church. The complainant, MD alleged that some aspects of practice within the Church in 2014, especially around Prayer Ministry, had caused him harm and his well-being had not been addressed or safeguarded by Church at the time. A report into the first stage of that investigation was shared in November 2023 with the Diocese of Sheffield and Yorkshire Baptist Association ('the **Core Group'**)[4] and MD, with all four aspects of the complaint being upheld.

ii. A second stage of the work requested by the Church involved an independent review of its current safeguarding arrangements. This was so that the Church could evidence that student and Prayer Ministry was now delivered much more safely than it had been in the past and all individuals, regardless of their sexual orientation were welcomed and accepted into the Church community. The report relates to the findings from the second stage.

iii. The word 'orthodox' is a contested term when it comes to issues of human sexuality. The Church at the heart of this investigation designates its position as 'Orthodox' and 'Evangelical', by which they mean that they have a conservative or traditional perspective on same sex relationships. We have chosen to adopt this designation in the report but acknowledge that other churches and individuals will describe themselves as 'Orthodox' and/or 'Evangelical' but have a different perspective on same sex relationships and some other areas of theology and practice.

iv. Linda Richardson and Jane Sarre, both Safeguarding Consultants with Barnardo's, undertook both the initial investigation into the historic complaint and the wider safeguarding review of current practice. They took a decision to use pronouns such as 'we' and 'us 'throughout this report and made use of key lines of enquiry (KLEs) taken from the terms of reference, to structure the review.

[4] *The purpose of a core group is to oversee and manage the response to a safeguarding concern or allegation in line with House of Bishops' policy and practice guidance, ensuring that the rights of the victim/survivor and the respondent to a fair and thorough investigation can be preserved. Practice Guidance: Responding to, assessing, and managing safeguarding concerns or allegations against church officers. Church of England 2017*

1. Background and Context

1. The Philadelphia Network Limited, known locally as Network Church Sheffield ('**NCS**') is a Christian Church with Anglican, Baptist, and House Church expression; it is a charity registered in England and Wales and operates from two sites, the Kings Centre, and St Thomas Philadelphia church (the **'Church'**). The aim of NCS is to share the gospel through the movement of missionary disciples, working in communities with vulnerable adults, students, youth, and children's groups in and around Sheffield.[5]

2. NCS is part of the Yorkshire Baptist Association and the Diocese of Sheffield, and although there have been moves and intentions in the past to strengthen and formalise partnership arrangements between all three parties, there is no Local Ecumenical Partnership[6] currently in place. We were told however, by all parties, that the Church adopts and works to Diocesan safeguarding policies and procedures.

3. Under section 5 of the Safeguarding and Clergy Discipline Measure 2016, 'all authorised clergy, bishops, archdeacons, licensed readers and lay workers, churchwardens and PCCs must have 'due regard' to safeguarding guidance issued by the House of Bishops (this will include both policy and practice guidance). A duty to have 'due regard' to guidance means that the person under the duty is not free to disregard it but is required to follow it unless there are cogent reasons for not doing so. ('Cogent' for this purpose means clear, logical, and convincing.) Failure by clergy to comply with the duty imposed by the 2016 Measure may result in disciplinary action.'[7]

4. Barnardo's was commissioned in early 2022 by the Diocese of Sheffield to undertake a two-stage independent investigation into the complaint made by MD, who had been a volunteer with the Church between 2013 and 2016. MD alleged he was discriminated against by the Church because of his sexuality and that he had been subject in 2014, to what many would describe as form of exorcism, in an attempt to change his sexual orientation.

5. At the time the complaint was received, in November 2019, the Church had eight Trustees on its Board one of whom was the non-executive safeguarding Trustee ('**SfgT**.'); the Church also had an

[5] *Charity Commission Register Charity Number 1134973*
[6] *In https://en.wikipedia.org/wiki/EnglandEngland and Wales, a local ecumenical partnership (or LEP) is a formal and legal arrangement to develop unity between churches of different denominations.*
[7] *https://www.churchofengland.org/safeguarding/policy-and-practice-guidance*

executive Senior Safeguarding Officer ('SSO'), referred to [redacted] in the Stage 1 report, [redacted].

6. MD had submitted his complaint to the Diocese at the same time it was sent to the Church. After undue delay, compounded by the Covid pandemic, the Diocese took a decision in February 2021, that aspects of the complaint raised concerns about safeguarding practice within the Church, thus prompting the Diocese to set up a Core Group to consider these concerns further. A decision was later taken to commission an independent investigation into the complaint and the Church was informed of that decision in May 2021. Barnardo's was approached to undertake the work.

7. Although [redacted] as the Church's safeguarding lead at the time would have been the most appropriate person to liaise with the Core Group, he was not in a position to do so and the Board of Trustees requested that [redacted], took over the SSO role as an interim measure.

8. [redacted] queried the rationale behind the decision to deal with this complaint as a safeguarding matter. He sought answers from the Diocese as to the implications on this process for data protection and information-sharing and was advised in an email by the Diocese to seek legal advice on this issue.

9. [redacted] also requested that the Diocese confirm in writing why the Core Group had concluded that the complaint was a safeguarding matter, so he could share the information with the SfgT and seek further legal advice around information sharing. A written response was duly provided by the Diocesan Safeguarding Officer.

10. Although Barnardo's had already been commissioned by the Diocese to undertake the independent investigation and data sharing agreements had been signed, the Church insisted that additional data sharing agreements were needed, and this required further consultations with the legal advisors for all parties. Data sharing agreements were eventually put in place, but the process incurred further delays and the investigation, consequently, did not commence until June 2023. We have recently been provided with some documentation and emails that were shared between [redacted] and the Board of Trustees in relation to the investigation, evidencing that the Board was kept informed about what was happening.

11. The work undertaken in relation to Stage 1 of the investigation of the complaint concluded with all four aspects of the complaint being upheld and the final report was shared with MD, and the Core Group in November 2023.

12. At this point, as reviewers, we were given permission to commence the second stage and review the Church's current safeguarding arrangements. This work began in December 2023, with us visiting the Church in early January 2024 to undertake some face-to-face conversations with named individuals and with those who volunteered to meet with us.

13. This second stage of the work was important. Almost a decade had passed since MD had left the Church feeling distressed and isolated by his experiences and the Trustees and Senior Church Leaders advised us that they wanted to be able to demonstrate, going forward, that some positive changes had taken place in the intervening years and, furthermore, that the Church and its leaders were responsive and willing to examine where further improvements were needed to strengthen safeguarding arrangements. Consequently, embarking on the second stage of what was described not as an investigation but a review of safeguarding arrangements, felt much more of a collaborative journey with the Church than we had experienced when undertaking the initial investigation.

14. Once the first stage of the investigation was concluded we were able to begin working with the current Senior Church Leader who had taken over the role of SSO in late 2022 but who had not been previously involved as he was named in the original complaint. We experienced a constructive approach and a willingness to work with us to examine safeguarding arrangements in the Church and highlight where policies, procedures, and practice, going forward needed to change or be strengthened.

2. Methodology

15. As reviewers, we carefully considered how best to undertake this review, given its purpose was to comment on current safeguarding arrangements whilst also focusing on key areas identified in the terms of reference. We adopted an approach which used key lines of enquiry, and these were discussed and agreed in conversations with the Church and the Diocese prior to the commencement of this review; they are listed below:

General: A review of the Church's safeguarding arrangements

KLE1: In relation to all aspects of student and Prayer Ministry, to what extent do current arrangements safeguard people from potential harm?

KLE2: In what way are members of the LGBTQ+ community and others who hold different theological perspectives from the Church safeguarded from any potential harm arising from their contact with the Church or any of its activities?

KLE3: To what extent are individuals who work for or on behalf of the Church safely recruited and appropriately trained to understand their safeguarding responsibilities and know how to report safeguarding concerns?

KLE4: To what extent is there robust managerial oversight and scrutiny of safeguarding arrangements from Trustees and Church leaders.

KLE5: How well does the Church liaise and work collaboratively with partners to continually improve safeguarding arrangements in the Church?

16. We were well supported throughout the review process by the Senior Church Leader who at the time of the review was the Chair of the Board of Trustees and also the named SSO for the Church. We were provided with key documents where they existed, and these were reviewed as part of a desktop exercise prior to our visit. No formal case records were available but recruitment and selection records, including references and application forms, were sampled when we were on site.

17. We met with the following individuals on a one-to-one basis or as part of a focus group:

- SSO
- Deputy SSO, Finance and Commercial Director, (previously the CEO).
- Curate with overall responsibility for Streetwise[8]
- Trustee with a designated safeguarding remit (SfgT)
- Three additional Trustees including one newly appointed to the Board.
- Senior Administrator in the Church
- Team Leader for Under 5s
- Team Leader for Children and Families
- Team Leader for Youth Work
- Student Intern developing a strategy for developing and supporting Interns.
- Three focus groups involving 12 volunteers and members of the Church congregation.
- Diocesan Safeguarding Advisor ('DSA')
- Safeguarding Adviser for Yorkshire Baptist Association.

[8] *Streetwise offers a more informal place of worship to individuals within the Sheffield community who seek or need a more relaxed church service.*

- Local Authority Designated Officer. ('LADO')

18. These conversations were important in that they allowed us to understand the Church from both a strategic and operational perspective. Some conversations also helped us to explore some '*what if'* scenarios and this provided for a realistic picture to emerge of day-to-day practice and helped us to identify, where additional guidance or direction could be of benefit.

19. We were introduced to 'ChurchSuite', a management tool used by many churches, and which provides features for staff, leadership teams, and church members to access and share information. ChurchSuite provides different modules and can be customised to meet church size and needs.

3. Review of Safeguarding Arrangements

20. As reviewers we were looking for a clearly defined infrastructure in which key strategic and operational roles and responsibilities are well-defined and understood and there are safeguarding systems in place which support and promote best practice. We looked for evidence of good governance and accountability, with robust management oversight to ensure that all individuals who worked for or on behalf of the Church in any capacity understand their safeguarding responsibilities and know how to report concerns when they arise.

21. This high-level overview covers five areas of practice, some aspects of which are also considered in specific detail in the KLE sections:

- Leadership, Governance and Culture
- Policies and Procedures
- Safe Working Practice
- Managing Concerns and Incidents
- Risk Management

Leadership, Governance and Culture

What we were looking for:

22. Demonstrable top-level appropriate and proportionate commitment from Trustees and Senior Church Leaders which evidences that the safety and well-being of children and adults is a governance priority and Trustees promote an open and positive culture and ensure everyone feels able to report concerns, confident that they will be heard and responded to.

Findings and Recommendations

23. The Church now has around 9 employees, and over 80 volunteers, eight of whom are Trustees and who provide managerial oversight of the charity. The Church is currently moving through a period of transition with [redacted], our remit was to focus only on safeguarding arrangements in the Church and the activities it delivers in the local community.

24. The lessons from this review do however bring into sharp focus the need for [redacted], best practice would be that the learning from it is taken forward by the Trustees and staff [redacted].

    Recommendation 1: *The learning from this review should be shared with* [redacted].

25. In a positive safeguarding culture the welfare of children, adults and vulnerable others is given a high priority, work is continually underway to prevent abuse from occurring and action is promptly taken when safeguarding concerns are reported and there is an understanding that safeguarding is everyone's responsibility. Actions and mitigating steps are also taken to identify where a person may present a risk to others.

26. Safe and healthy cultures do not, however, happen by accident, they are purposefully developed and carefully nurtured, influenced to a significant extent by the actions and attitudes of senior leaders. The organisational response to safeguarding should not just be

about the mechanics of implementing and adhering to policies and procedures, it is also about creating a '*culture of vigilance'* and engaging hearts and minds from the leaders down to everyone within the church community.[9]

27. In our conversations with individuals, both on a one-to-one basis and in group situations, we heard about the Church's nurturing, supporting and caring culture which was clearly a source of pride for many. Individuals spoke of their involvement with the Church as being akin to being part of large family which meant looking out for everyone and being there when support was needed. Most individuals with whom we spoke said they understood safeguarding and their responsibility to report safeguarding concerns, but we found that knowing what to report, how and to whom varied significantly.

28. Many individuals who met with us had experience of safeguarding in either former roles or their current profession and brought their knowledge, skills, and ways of working to their volunteer or employee role within the Church. We were also told by the SSO on several occasions that whilst safeguarding is a thread that now runs through every aspect of the Church and its activities, there was a recognition that more could be done to strengthen practice within the Church. We were told on several occasions by different people that what happened ten years ago [in relation to MD's complaint] was 'then', but the Church now has a different [and better] 'feel' under the current church leader. This was explained by reference to previous church leaders who were described as being more orthodox in their approach and teachings. One individual said that a past leader did not understand safeguarding and was not inclined to engage in discussions about the Church's safeguarding responsibilities.

29. Charity trustees in the UK are required to take active steps to protect everyone who comes into contact with their organisation from harm[10] and this includes:

- ensuring safeguarding policies, procedures and measures are fit for purpose and up to date.
- making sure everyone in the organisation is aware of their safeguarding responsibilities and knows how to respond to concerns.
- having a lead trustee for safeguarding and child/adult protection

[9] *https://www.iicsa.org.uk/reports-recommendations/publications/investigation/roman-catholic-church/part-k-role-roman-catholic-church-leaders-safeguarding/k3-embedding-culture-safeguarding-and-one-church-approach.html*
[10] *Charity Commission for England and Wales, 2019*

- challenging any decisions which adversely affect anyone's wellbeing.
- managing allegations of abuse against someone involved in the organisation.
- reporting serious incidents to statutory agencies and the Charity Commission as and when necessary.

30. The SfgT has held the role for over two years, and we were told, meets regularly with the SSO to discuss safeguarding matters and any reported concerns. There are however no notes taken of these meetings and we were told that any decisions or actions taken, are confirmed in emails, and shared with others as and when the need arises. It was encouraging to note that regular meetings take place between the SfGT and the SSO, but without any notes or minutes, we found it difficult to determine how effective these meetings were and how key decisions were made and why.

31. It is of some concern that the notes of discussions, whilst available in the form of email exchanges, some of which we have seen, are not stored on a formal data management system and are therefore not easily accessible for audit or review, neither do they provide the means by which actions and decisions can be tracked and monitored through carefully constructed chronologies. There has been, in our view, a lack of accountability and managerial scrutiny at Board level in how safeguarding concerns are identified, addressed, and managed.

Recommendation 2. *As a matter of priority, Board of Trustees should ensure that all emails which refer to any individual safeguarding concerns reported to the SfgT and/or SSO in the last three years are copied and stored securely in individual case files; each case file should be prefaced with a chronology of events and actions taken.*

We would advise that in respect of this investigation, a Complaint file for MD should be opened and all the documents shared with Core Group, with ourselves as reviewers and with MD should be stored or uploaded into the file, alongside copies of Stage 1 and Stage 2 reports.

32. The Board should also ensure that all safeguarding meetings are placed on a more formal footing, with any plans, decisions and actions, and the rationale for these, being clearly recorded. Without such a system in place, there is limited accountability, and it becomes virtually impossible for Trustees or indeed anyone, to understand, question or challenge what plans are in place, what progress is or is not being made to improve practice and what decisions have been taken and why.

Recommendation 3. *A process should be agreed whereby the SfGT and the SSO meet formally on a regular basis to discuss safeguarding arrangements, issues, and plans. These meetings should be minuted and stored electronically within the appropriate safeguarding folder with clear details as to who can access this information.*

33. The SfGT clearly takes an active interest in how safeguarding should and does work in the Church. The role and how its '*check and challenge'* function should be discharged would benefit from being made more explicit by way of a role profile, so the role and the responsibilities associated with it are clearly defined and well understood by everyone at every level in the Church. This would include ensuring that more formal safeguarding structures and processes are in place, and these are regularly reviewed.

34. It would also be helpful if there was greater clarity around the SSO role and responsibilities, especially given that the current SSO also has a raft of other responsibilities in his substantive role as Senior church leader. We understand that those holding previous safeguarding roles in the Church have never had specific safeguarding responsibilities included in their job descriptions and neither have any role profiles for the SSO been formalised and agreed. There is a wealth of information and guidance on safeguarding roles and responsibilities online and available on the Diocese and Sheffield Safeguarding Children Partnership websites which the Church might find useful to access.

35. Alongside his other roles as Senior church leader, the SSO sits on the FCT Board of Trustees and was at the time of the review, the Chair of the Board of Trustees for the Church. It has since been recognised that the SSO's chairmanship of the Board conflicted his role as SSO in that as a member of staff he was accountable to the Board of which he was the chair. This issue has now been addressed and the SSO is no longer Chair of the Board of Trustees

Recommendation 4. *The roles and responsibilities of the SfGT and SSO should be made explicit in role profiles and relevant job descriptions.*

36. We found no evidence that informative safeguarding reports are formally produced and shared with Trustees, but neither it would seem have they been requested. Every Trustee needs to have clear oversight of how safeguarding and protecting people from harm is managed within the Church. This means that Trustees need to monitor their own performance not just using statistics, but ensuring they are provided with qualitative reports to promote discussions and enhance understanding. This would help Trustees identify risks and gaps so they can ensure they are addressed. As reviewers, we were not confident that every Trustee fully understood

their safeguarding responsibilities and far more needs to be done to address this issue. We were told at a meeting with the Trustees that training around their responsibilities as Trustees has been commissioned from the Church's legal advisors. This training is necessary, but care should be taken to ensure that training around the detail and intricacies of the Trustee safeguarding responsibilities is delivered by experienced individuals with specialist safeguarding knowledge.

Recommendation 5*. Trustees should have specific training around their safeguarding roles and responsibilities. This should be additional to and separate from Trustee training on their legal responsibilities and should be outsourced to specialists in the field.*

37. The Board holds regular meetings throughout the year with additional meetings called to respond to specific issues. The Trustee Board is made up of eight members and we were told this means there is no capacity to set up sub- groups with delegated powers to progress and manage business, although we would suggest that there are other volunteers who met with us who could be co-opted onto any work group established by the Board. We understand that some Board members lead on specific areas of work and meet with one or two other Trustees before reporting back to the Board.

38. We were repeatedly told during this review that safeguarding within the Church was managed on a relational basis, through informal conversations and 'talking' groups rather than sub-groups or sub committees. In terms of safeguarding however, it would appear there are no records (other than some email trails) of discussions and decisions taken. We found Board minutes to be so minimal that we were unable to determine, from a safeguarding perspective, what information was shared with the Board and what discussions took place. This leaves the Board, however committed it might be to keeping people safe, unable to demonstrate good governance; it also leaves the SfGT and the SSO inappropriately carrying sole responsibility for safeguarding in the Church. In terms of safeguarding and sharing information, we were also of the view that a fear and lack of understanding about data protection breaches actually inhibits sound safeguarding practice.

Recommendation 6*: The Board should adopt a more formal approach to managing and improving safeguarding practice in the Church, so it is better able to evidence good governance, openness, and accountability. Safeguarding should be a standing agenda item for Board meetings. Where there are no incidents or updates to bring to the table this should also be recorded in the minutes. The SfGT should ensure that the Board receives safeguarding reports on a regular basis using a format which includes, anonymised updates on incidents/ allegations,*

data to show themes and trends of reporting, progress of the strategic plan and updates on actual or emerging risks and risk mitigation.

39. The Board of Trustees does not currently have a safeguarding strategy or plan in place which outlines the Church's vision and ambition in terms of its safeguarding arrangements and what it hopes to achieve in the coming year. Safeguarding work is bound by guidance and procedure, but sustainable and ongoing improvements are more likely to be effective if the Church has a safeguarding plan which sets direction and priorities, informs decision-making, and provides the means by which progress can be monitored and measured by Board members. The SSO advised us that the recommendations from this report will, going forward, form the basis of a safeguarding plan.

Recommendation 7: *A safeguarding strategy and implementation plan outlining the Church's ambition for its safeguarding arrangements and the goals it hopes to achieve should be developed and once agreed, signed off by the Board of Trustees.*

40. Feedback from conversations with individuals and with external partners have welcomed the approach of the current SSO, who has been described as being accessible, providing a good listening ear and, importantly, being committed to improving and strengthening safeguarding practice within the Church. This has also been our experience, as reviewers.

41. The SSO is supported in his role as Senior Church Leader by members of his leadership team, all of whom, we found, have experience of working with children, families and adults who need support at different times in their lives. We were advised that this team meets on a weekly basis to share information and discuss emerging and current issues and, although not documented, safeguarding issues are discussed as and when they arise.

42. Members of the team advised us that they each have responsibilities to respond to and manage safeguarding concerns when they are reported and although each person was confident in their working practice and how they responded to concerns, it was recognised that more could be done to ensure there is a more consistent approach across the team as to how concerns are managed, reported, and recorded.

43. Speaking to these members of staff, it was evident that these individuals, wanted to do the very best for the children and adults with whom they worked and had ideas about how the safeguarding reporting and recording system could be improved. Given their roles and experience, we would recommend that alongside their substantive roles, these staff members should be formally recognised as the 'Safeguarding Team'. This would provide the SSO with a team around his safeguarding role and the means by which safeguarding plans could be

progressed. Furthermore, it would utilise the skills and knowledge of the existing team and ensure wider access to safeguarding support and advice throughout the Church.

44. The previous SSO, currently holds the Deputy SSO role for the Church [redacted] we would suggest it may be timely to consider which member or members of staff in the Church should now step into the Deputy SSO role and work more closely with the SSO.

45. We acknowledge this may at first appear to be increasing workloads of some staff but having spoken with those who could effectively form part of a safeguarding team, we are confident that the benefits of formalising these arrangements would serve only to strengthen current arrangements and contribute to a more effective safeguarding structure. The reviewers discussed with the SSO how this might realistically be achieved and were encouraged by a response which acknowledged that going forward, there was a need to work differently.

46. With the support of the SfGT, progress on a safeguarding improvement plan could be shared across a team of trained and committed individuals albeit as part of their current substantive roles. This would not detract from or replace the working relationship with the Diocese or the Yorkshire Baptist Association but would demonstrate that safeguarding was a governance priority for the Church and steps were being taken to build an improved safeguarding structure.

Recommendation 8: *The Board of Trustees should develop a more robust safeguarding structure in which individuals with key safeguarding roles collaborate as a team to strengthen safeguarding arrangements within the Church.*

Policies and Procedures

What we were looking for:

47. A clear description of what the Church does to keep children and adults safe and well and evidence of robust procedures to ensure that all concerns are reported and handled in line with best practice and in ways which support everyone involved.

Findings and Recommendations

48. Good practice both dictates and highlights the importance of a clear safe organisational framework that includes clear policies and procedures for safeguarding in relation to both children and adults. Accessible and robust policies demonstrate an organisational culture that is concerned with promoting best practice in accordance with guidance and legislation, as well as providing a clear framework within which staff can practice and be confident about their

safeguarding roles and responsibilities. Policies also provide the means by which practice, and compliance can be audited and reviewed. Organisations should make explicit their commitment to safeguard vulnerable groups not only through the production of policies and procedures but also through a policy statement which is on the website, is on public display and is also adopted throughout the organisation and embedded into practice. The Church's links with statutory agencies should also be made explicit.

49. The Church's website states clearly that all safeguarding concerns should be reported to the 'Safeguarding Officer.' A telephone number and an email address are listed, but if a caller needed to speak to someone urgently or could not reach the SSO, it would be helpful if there were other contacts listed, perhaps the details of the safeguarding team were that to be established. Details reminding people of who to contact if a child or adult was believed to be at urgent risk of harm should also be on the web page and although this information is included on the front page of the safeguarding policy, people need to know where to look to access the necessary details. Many of the Church's activities take place at different times so providing an out of office contact number might also be useful. There is no information on the website pertaining to Complaints and Whistleblowing Policies.

Recommendation 9: *The Church website should have a safeguarding page which has links to key safeguarding documents, and which explains how safeguarding arrangements work in the Church. Details should be provided about how to report a concern and to whom with contact details being provided for more than one person.*

50. We are aware that the Safeguarding Children and Vulnerable Adults policies were shared with the Diocesan Safeguarding Advisor who indicated these documents were good enough but required updating and further review. Notwithstanding these comments, it is our view that much more work is needed to ensure these policies are as good as they need to be. Putting in place the necessary suite of safeguarding policies and procedures and ensuring they are all linked, up to date and of good quality is time consuming and requires a good understanding of the purpose of these documents and how safeguarding processes work in practice. This work could be part of a longer-term strategy.

51. A number of other policies and documents were shared with us, some of these appear to have been reviewed in 2023 but not all were dated or signed off by the Board, however many do not 'flow', align in terms of advice and direction given, or contain up to date information. There is clearly no standardised format for these documents; the status of many is unclear, there are no

titles or dates on some and they do not form a coherent suite of safeguarding documents. It seems likely that some of these documents have evolved over time, and some have been produced by copying and pasting sections from different organisations or settings. Copying from elsewhere and avoiding having to 'reinvent the wheel' makes sense but it is vitally important that what is copied is well-considered and carefully reviewed to ensure what is included in any policy document is appropriate and relevant to the Church and its activities.

52. There are a range of resources available to help faith communities develop these documents, but it should be stressed that the process of co-producing these policies with staff and volunteers is just as important as securing sign off by the Board for the finished document. We do appreciate, from the Church's perspective, there is a need to liaise with the Diocese on some of these documents but the responsibility for producing quality and fit-for- purpose policies lies with the Trustees in line with not only best practice but also the requirements of the Charity Commission.

53. Having looked in some detail at the Management of Allegations Policy and the Recruitment and Selection procedures we would advise that further revisions are necessary, and both should be produced as stand-alone policy documents with clear and explicit links to the Safeguarding Children and Safeguarding Adults policies.

54. In our view, it would be helpful if there were an overarching standard set of NCS safeguarding documents which are used as templates for the Kings Centre, and St Thomas Philadelphia, especially given that some volunteers, staff and Trustees also hold roles across both sites. This would ensure a far more consistent approach to safeguarding practice and serve to strengthen safeguarding arrangements in NCS. It would also mean skills and expertise could be shared.

Recommendation 10: *The full suite of policy documents which relate, or are linked, to safeguarding should be revised as part of a longer-term strategy so that NCS policies are aligned, standardised, have clear version control, and contain up to date and accurate information and references.*

Managing Concerns

What we were looking for:

55. Evidence that everyone who works for and on behalf of the Church knows when to act and what to do if they are worried about the safety and welfare of any child or adult. The Church has, and understands the need for, a clear and robust system which ensures that all concerns and the actions taken to respond to these are carefully recorded, appropriately monitored, and securely stored.

Findings and recommendations

56. All of the individuals with whom we spoke confirmed that if they were concerned about the safety or welfare of any individual, child, or adult, they would share that concern with the SSO, sometimes by way of a conversation or an email and sometimes it would be raised at weekly team meetings. The Safeguarding Children's policy does refer to the need to report any concerns using the '*Significant Conversation Form'*, but we were not shown any completed forms or any log of those which had been forwarded to the past or present SSOs. The SSO was of the view that these forms are not in common use as most individuals if they want to make contact will do so via email.

57. In the four years since MD made the complaint there was still no formalised recording system which captured what safeguarding concerns or complaints had been made, how these had been addressed and by whom. It was acknowledged in some discussions that it was possible, although unlikely, that some individuals in the wider Church may have responded to and managed concerns which were not brought to the attention of the SSO or recorded on any system.

58. Good relationships clearly need to be at the heart of the Church responses to local needs and whilst almost everyone with whom we spoke knew how to report and respond to reported concerns, the issue of what to record and where was less clear., with many saying they would drop an email to the SSO if needed. The absence of any system to log, record and manage complaints and concerns, build chronologies, and identify patterns or trends was of concern to us. Using only emails as a way of recording concerns and how they are managed fails to provide a system whereby plans, interventions and outcomes can be easily monitored, reviewed, and scrutinised.

59. It would appear that when concerns or complaints are reported, they are each dealt with on an individual basis either by a team leader or by the SSO; and the information does not generate the opening of a 'case file' so ongoing actions and outcomes can be clearly seen. This means that managerial oversight cannot be assured and the tracking of how concerns or complaints are being addressed relies on memories or notes in individual emails. The reporting and recording of safeguarding concerns, how they are assessed and what decisions are consequently taken are crucial processes which must be carefully managed in order to properly safeguard everyone and improve effectiveness.

60. Without a case management system in place, we were unable to view any case records and were informed that there had been relatively few safeguarding concerns or complaints reported in recent years. This is most unusual in an organisation of this size and especially one located in a relatively disadvantaged area. The lack of reported safeguarding concerns or complaints could suggest any of the following: the reporting process is not well known or staff and volunteers fear using it, that there are complaints or concerns, but they are not reported to leaders or managers or there are reported concerns, but they are not recognised as being related to safeguarding.

61. The Church has in the past taken a somewhat restrictive approach to safeguarding, tightly applying legal definitions of vulnerability and need and using thresholds regarding those at risk as opposed to the more nuanced and contextual application often used in social care and not including the all-encompassing safeguarding requirements of the Charity Commission. This could also account for there being so few reported safeguarding concerns.

62. We had sight of email exchanges which related to one safeguarding matter, but the emails had been so heavily redacted it was difficult to understand who said and did what. Talking through that concern, it was clear that contact with the appropriate authorities had been made but we were only able to determine this through reading the emails between the SSO and a team member. The individual was clearly well known in the Church. No other cases or complaints were shared with us.

Recommendation 11*: The Board of Trustees should ensure that the Church develops and maintains a data management system which can be used to record all incidents, concerns, and complaints and which can be used to draw down reports for scrutiny by the Board. Access to this system should be restricted but sufficient to allow legacy and handover should current members of the team move on. The contents of the database should be reviewed regularly to*

inform the direction *of safeguarding work and to identify any patterns of behaviour or areas of concern.*

63. We understand that there are safeguarding posters displayed in the communal buildings but there were none on show, that we could see, in the office. Although we were told that staff and volunteers did attend external safeguarding events there was little to evidence any regular newsletters or safeguarding updates are circulated to remind staff about their safeguarding responsibilities.

Recommendation 12: *The Church should ensure that a safeguarding message in terms of what to look out for, what to report and when, is regularly communicated through all channels in the Church and everyone including those in the congregation know how to report concerns and are confident that their concerns will be taken seriously and actioned with the appropriate level of information and confidentiality.*

Safe Working Practice

What we were looking for:

64. Trustees, Staff and Volunteers in all settings and in all contexts are given clear advice and guidance on appropriate and safe behaviours when working with children, young people and any adult needing support. It is important that all adults working for or on behalf of the Church understand that the nature of their work and the responsibilities related to it, place them in a position of trust.

Findings and recommendations

65. Research and national enquiries[11] highlight the importance of all organisations, especially faith communities whose function brings them into any form of contact with vulnerable groups, being mindful that there are adults who will deliberately seek out, create, or exploit opportunities to abuse children and/or vulnerable adults. This requires organisations to not only apply due diligence standards when employing or recruiting adults to work for them or on their behalf but to also ensure that everyone working for or on behalf of the Church know what is expected of them in relation to their behaviour, interactions and contact with others.

[11] *https://www.iicsa.org.uk*

66. All adults who come into contact with children, young people and adults at risk have a duty of care[12] to safeguard and promote their welfare and the vast majority of adults who work with or on behalf of vulnerable groups act safely and responsibly. However, it is recognised that in this area of work, tensions and misunderstandings can occur. It is here that the behaviour of adults can give rise to allegations of abuse being made against them. Clear and specific codes of conduct for everyone working for or on behalf of an organisation are therefore key components of robust safeguarding practice.

67. Although there are references in the safeguarding policies to codes of behaviour, the Church would be advised to produce a more detailed document outlining expected codes of behaviour and clearly explaining how adopting safer working practices can minimise the chance of allegations being made where actions have possibly been misinterpreted. More clearly defined codes of behaviour should be linked to the management of allegations, so staff and volunteers also know how and when to report concerns about adults with whom they work.

Recommendation 13: *Consideration should be given to producing a more detailed document around safer working practice and what constitutes appropriate and safe behaviours for adults who work for or on behalf of the Church.*

Risk Management

What we were looking for:

68. How the Church identifies and understands safeguarding risks and how these are managed and recorded.

Findings and recommendations

69. Charity trustees should regularly review and assess the risks faced by their charity in all areas of its work and plan for the management of those risks. Risk is an everyday part of charitable activity and managing it effectively is essential if Trustees are to achieve their key objectives and safeguard not only their charity's funds and assets but also the safety and welfare of all the charity's beneficiaries.

[12] *Duty of care means to safeguard from harm and promote the wellbeing of those in your responsibility. Any person in charge of or working with children and adults at risk in any capacity is considered both legally and morally, to owe them a duty of care.*

70. We understand that the Church does not have a risk management policy and this issue should be addressed. A risk management policy would offer clarity around when and how the more general day to day risk assessments should be undertaken and clarify what risks should be reported to the SSO and Trustees.

71. The Charity Commission advises that some charities elect to establish a risk framework to help them make decisions about the levels of risk that can be accepted on a day-to-day basis and what matters need to be referred to them for decisions. Being clear about how safeguarding risks are identified and explaining how they are managed is a key responsibility not just for the SfGT and the SSO but for all Trustees.[13] Without any form of risk register and no obvious strategy in place to manage risk, other than recourse to legal action or advice, decision-making around risk management is more likely to be reactive and ad-hoc and left to individuals rather than to the Board of Trustees. This is not an appropriate approach to manage safeguarding risks.

72. Any identified risks arising from both stages of this investigation ought to be considered and reflected in a risk assessment and risk management plan.

Recommendation 14: *A safeguarding risk management policy and risk management plan which includes the creation and maintenance of a safeguarding risk register should be developed and implemented.*

[13] *https://www.gov.uk/government/publications/charities-and-risk-management-cc26/charities-and-risk-management-cc26#knowing-the-requirements---the-risk-management-statement*

4. Key Lines of Enquiry

73. These KLEs are lines of enquiry and relate specifically to the wider and contextual aspects of MD's complaint, and which were included in the terms of reference. For ease of reference the link between the terms of reference and the agreed lines of enquiry are listed below:

This review was to consider:

- whether all reasonable actions …. '*have been undertaken within the areas of student ministry and Prayer Ministry at the church'* (KLE1)
- whether members of the LGBTQ+ community, or those who do not hold the same theological position as the church in regard to human sexuality are safeguarded from any potential harm. (KLE2)
- volunteer recruitment and management, employee recruitment, whistle blowing policy and equal opportunities policies within the Christian ministry activities at the church. (KLE3)
- management activities that pertain to monitoring, accountability, and recording] in these areas of ministry. (KLE4)
- A fifth line of enquiry was agreed which related to the extent to which the Church works collaboratively with other partners. (KLE5)

KLE1: In relation to all aspects of student and Prayer Ministry, to what extent do current arrangements safeguard people from potential harm?

What we were looking for.

74. A clear description of what the Church does to ensure its student and prayer ministries are delivered safely and in line with best practice and there are processes in place to ensure that any concerns are reported and handled in line with best practice and in ways which support everyone involved. We were looking for evidence that the Church has an understanding of the impact Prayer Ministry might have on individuals with significant vulnerabilities in their personal lives, either current or historical.

Findings and Recommendations.

75. In order to better understand the operation of Prayer Ministry within the Church we met with some current members of the Prayer Ministry team as a separate focus group. Other members of the team also contributed to the review via the congregational and volunteer focus groups.

76. Most of the Prayer Ministry team had very longstanding associations with the Church, [redacted]; they therefore had a clear understanding of changes in the approach to ministry since MD attended the Church, especially in relation to different leadership styles.

77. Although we were unable to observe how Prayer Ministry is delivered, we were assured that practice has changed significantly in recent years. We were told there is now far greater awareness, through training and discussions, of how directed prayer session can impact on individuals and the importance of Prayer Ministry teams being attuned to past and current vulnerabilities of those for whom they pray.

78. The individuals who currently form the Prayer Ministry team were invited to become leaders in August 2023 and attended a training session delivered by the SSO in September 2023. Going forward, no -one delivering Prayer Ministry is permitted to do so without attending this training and signing to indicate they have read and understood the Prayer Ministry protocol.

79. We were told that the type of prayer session described by MD in his complaint no longer took place. Views were offered that what happened to MD was more likely to have been linked to the personal belief system of the Prayer Ministry team at the time although it was pointed out that even when it was reported the Church's response was less than supportive. If upon hearing what

had happened to MD, the Church had demonstrated concern and taken a different course of action, there may have been a more positive outcome for MD.

80. Prayer Ministry ceased after the pandemic in 2020 and was only resumed in September 2023; it now only takes place at the front of the Church after services. A Prayer Ministry Protocol has been co-produced with church leaders and volunteers. It was clear to us that this protocol has evolved as various people have contributed to it, but further changes are still needed to the current version, (5.3) the document still refers i for example, to outdated guidance (No Secrets 2000) and it has not been shared with partner agencies.

81. It was encouraging to learn that the document has been subject to consultation in the Church and that the Prayer Ministry team were active contributors to its development. The current document includes clearer guidance on the 'laying on of hands', deliverance prayers and touches on issues relating to sexuality and sexual identities.

82. Deliverance ministry is subject to the House of Bishops' pastoral guidance and to the Safeguarding Code of Practice set out in Safeguarding Children, Young People and Vulnerable Adults (2021) [14] the protocol states that ' *Where there is a question of possible spiritual oppression with the person being prayed for, the Prayer Ministry Leaders should seek the assistance of the church leadership. Action is not permitted in these situations without the involvement of the senior leader who will work within the guidelines of the accountable organisations'*. Those individuals with whom we spoke clearly understood the difference between deliverance prayers and prayers for healing.

83. At present extended Prayer Ministry, which are prayer sessions held in the home or at various times outside of church services, has not been reinstated and we understand there are currently no plans to do so. It was evident that some individuals were keen to offer extended prayers but had been advised by Senior Church Leaders that more discussions were needed to ensure these sessions could be delivered safely and in line with the evolving Church protocol. From our perspective, it is vital that the risks of offering extended prayers outside of Church settings are well understood so that appropriate mitigation plans can be put in place.

84. We were told that the Church now has no contact with the School of Inner Healing and Deliverance. The last intern programme FORM intake took place in 2018/2019 and although the Church is considering a new Intern programme, the programme described by MD no longer

[14] *https://www.churchofengland.org/safeguarding/safeguarding-e-manual/safeguarding-children-young-people-and-vulnerable-adults-1*

operates. Encounter with God weekends no longer take place, and we were told that interns are not required, and would not in future be required, to share deeply personal information about their past experiences and vulnerabilities as previous interns, including MD, had been asked to do.

85. The Prayer Ministry team advised that they have regular training sessions. Some individuals who met with us were not surprised to learn of what had happened to the complainant, they attributed what took place as being more to do with 'certain' individuals' way of delivering ministry in a way that would not now be endorsed by the Church. Some expressed sadness that any of their previous colleagues had behaved in ways which caused distress to any individual. They were however able to acknowledge the vulnerabilities of some of the individuals who came forward to ask for prayers and were aware of their responsibility to act with care and compassion towards to anyone regardless of their lifestyle or sexual orientation.

86. These discussions highlight the importance of the Church ensuring that all individuals who offer or deliver Prayer Ministry understand their role, are appropriately trained and they follow the Church's policy on Prayer Ministry. They should also understand they are individually and collectively accountable for their actions and should always be able to evidence how the safety and welfare of those for whom they pray, is safeguarded. The Church recognises its responsibility to ensure that anyone who delivers Prayer Ministry does so in ways which safeguard and protects the person for whom the prayers are being said.

Recommendation 15*: The Prayer Ministry document and related procedure should be shared with the Diocese and the Yorkshire Baptist Association and in the light of MD's complaint, critical reflection sought on its content. A revised document should include:*

- *reference to the requirements of the Charity Commission in terms of all beneficiaries of the Church, not just those who may fall under the legal definition of an adult at risk (Care Act 2014).*
- *reference to current guidance and legislation, including terms and definitions.*
- *how the Church will ensure that Prayer Ministry sessions, including those which may take place in settings other than the Church, are delivered in line with the Church's Prayer Ministry protocol*
- *information about how any concerns relating to Prayer Ministry can be reported and to whom.*

Recommendation 16: *Those administering Prayer Ministry team should have not only a spiritual approach to Prayer Ministry but should be able to demonstrate, through training, a trauma - informed approach which understands that, however carefully managed, prayer sessions can re-trigger past traumas, and this can leave a person vulnerable.*

Recommendation 17*: If extended Prayer Ministry is to be reinstated, the Church needs to carefully consider how it will ensure that all sessions are delivered in ways which safeguard and protect the individual for whom the prayers are being said.*

87. It remains unclear how the Church will, going forward, ensure that prayer sessions are delivered in line with the Prayer Ministry protocol and that individuals, whatever their personal beliefs, comply with the Church's policy and procedures on this issue. The Church should ensure that it regularly reviews it safeguarding practice, processes, and procedures, including how it delivers Prayer Ministry, through routine audits undertaken in partnership with external partners. Independence scrutiny, by these means can help to rebuild trust if things have gone wrong and also allows any systemic barriers around safeguarding to be identified and addressed so future concerns/complaints can be handled better.

Recommendation 18*: The Church should ensure that it regularly reviews it safeguarding practice, processes, and procedures, including how it delivers Prayer Ministry, through routine audits undertaken in partnership with external partners. Any findings should be publicised on the Church's website.*

88. People who contribute to the life of faith-based communities and places of worship have an important role to play in keeping people safe and they play a vital role in responding effectively and compassionately when someone comes forward to share concerns or disclose abuse.

.

KLE2: In what way are members of the LGBTQ+ community and others who hold different theological perspectives from the Church safeguarded from any potential harm arising from their contact with the Church or any of its activities?

What we were looking for.

89. The extent to which the Church does in fact welcome people of all faiths and beliefs as described in their belief statement[15] and takes action to ensure everyone is made welcome in the Church and not in any way harmed by contact with it.

Findings and Recommendations

90. Many of the people we spoke to, including volunteers, employed persons and congregation members had very long-standing associations with the Church and described how the Church had changed over the years under different leaders. All those who contributed to the review emphasised that the Church welcomes everyone and we were given examples of people from different faiths attending church associated activities and told that the congregation included individuals from all walks of life, some who were openly gay and some who lived in same sex relationships.

91. We do not know if any of the individuals who met with us fell into any of these categories and neither did we purposefully seek out members of the congregation who could share with us their experiences of being part of the Church community. We understand from those who did meet with us that they had responded to an open request from the SSO to meet and talk with the 'review team'.

92. Many expressed views that there had been material change in the leadership of the Church and by implication in its direction and acceptance of people from LGBTQ+ communities. Discussions ensued as to whether it was commonly known that individuals who chose not to live in accordance with biblical teaching or who publicly challenged the Church's views on marriage and human sexuality, would not be permitted to hold leadership positions in the Church. There was agreement that if individuals did not believe and could not endorse the Church's values and beliefs, they should not hold or be invited to hold leadership positions in the Church. It was mentioned during one conversation that the Church adopts the Evangelical Alliance position on Human Sexuality which states that those who have committed themselves to chastity by

[15] *NCS Statement of Belief undated. Attached to the confirmation letter to Volunteers.*

refraining from sexual activity should still be eligible for leadership within ministry as it is recognised that' '*that they can bring invaluable insights and experience to the sphere of Christian pastoral ministry*'.

93. In our discussion with various groups and individuals, we were encouraged by their willingness to talk about these issues with honesty and reflection. The point was made by one individual that in their experience, asking questions and holding conversations now about the Church's view on sexual identities is not discouraged in the way it perhaps had been in previous years under different Church leaders. Views were also expressed that any verbal assaults or disrespect shown to individuals who held different beliefs would be challenged. We were told, as with a Muslim family who came to the Church, that people come to the Church because they felt welcomed and '*part of something*' no matter their faith, sexual orientation, or belief system.

94. It was clear that whilst church attendees with views that differ from the orthodoxy of the Church are welcome to attend, those who spoke to us felt that it was still unlikely that they would attain positions of leadership in the Church. Whilst it was still not clear how new members of the congregation would be made aware of this, the welcome letter sent to new volunteers does include the NCS Statement of Belief which makes reference to what is expected of new recruits and by implication, church leaders.

95. It was observed by some contributors that those looking for a church in Sheffield would be aware of the theological position of St Thomas Philadelphia or would be able to determine that position from the materials posted on the website. It was also pointed that whilst discrimination on the grounds of sexual orientation is prohibited by the Equality Act 2010, the Church is permitted to exclude individuals from participation in certain activities or from holding specific roles because of its religious aims, or to avoid offending people who share its religious aims.

96. What was recognised by those who met with us, however, was that prayers, or indeed any actions, which seek to change a person's sexuality is not accepted by Church leaders today in the way it may have been ten years ago. We heard no evidence to suggest that people from different faiths or from the LGBTQ+ community would not be made welcome by the Church or would be subject to harassment or rejection by its members without challenge from church leaders.

KLE3: To what extent are individuals who work for or on behalf of the Church safely recruited and appropriately trained to understand their safeguarding responsibility and know how to report safeguarding concerns?

What we were looking for*:*

97. The means by which the Church ensures its staff and volunteers are safe and competent to carry out their safeguarding responsibilities.

Findings and Recommendations

98. The Church's human resource (HR) function is managed, alongside [redacted] other duties, by [redacted] We had sight of a Single Central Record, maintained on an Excel spreadsheet, which recorded staff and volunteer appointments, references, and details of background checks. The system also recorded when DBS checks are needed and when they should be renewed. Individuals or staff, we were told, cannot take up posts until DBS checks, references and background checks have been completed.

99. The Church has access to Thirtyone: eight guidance on safer recruitment of staff and volunteers, and this includes advice on application for DBS checks and how concerning content should be managed. The recruitment process for volunteers is also kept on a spreadsheet where renewal dates for DBS checks are also noted.

100. There are records in place which indicate which staff have read the required safeguarding policies and who has completed the e. learning safeguarding induction programme made available through the Diocese. Some contributors were of the opinion that the case studies used in the eLearning did not accurately reflect the situations which might be experienced by the Church and would like something more bespoke. However, the e. learning programme is very much an introduction to safeguarding and is useful as a base upon which the Church could develop its own training sessions which could be made more relevant to the Church and its activities. Some of those with whom we spoke had attended safeguarding training sessions with other employers or as part of volunteer roles with different charities.

101. There is currently no training development plan although we were told that staff and volunteers can attend any of the Diocese safeguarding events or those provided by Yorkshire Baptist Association, but there is no expectation or requirement that staff or volunteers attend these programmes and no record maintained of courses they have attended.

102. There is some expertise in regard to safeguarding available within the volunteer network. A number of individuals who contributed to this review held (or had held) front facing roles working with children and /or adults at risk in their professional lives and told us they brought their knowledge and experience to their roles within the Church. These individuals might be well placed, if they were willing, to support not only the development and implementation of a regular safeguarding training programme, but also to contribute, going forward, to the introduction and implementation of safeguarding improvements in the Church.

103. Volunteers who support organisations can struggle to find the time to take part in formal training and since faith-based communities are often made up of many smaller groups in different locations, implementing a clear training plan can be challenging. However, but it is vital to invest in the frontline by providing effective safeguarding training, management, and regular reviews of safeguarding practice. There is however no- one within the staff team who has responsibility for training on policy and practice, nor for holding records of what training staff and volunteers have received. We felt it unlikely that the SSO, given his existing responsibilities, would have capacity to undertake this responsibility.

104. The Church could perhaps make more use of available resources (Church portal/Dashboard) which takes churches through what is needed in terms of safeguarding and offers templates and guidance documents. For example useful sources may include the House of Bishops website, Sheffield Safeguarding Children Partnerships, Sheffield Adult Safeguarding Board, and the offer from the Yorkshire Baptist Association for staff and volunteers to access the Baptist Union of GB Excellence in Safeguarding in-personal training. The National Safeguarding Team for the Church of England also has a training framework which has reference to a raft of different training programmes and clear expectations as to who should attend which programmes.

105. The review found evidence that the Church has procedures in place which ensure that staff, volunteers, including Trustees are safely recruited. Further work is required to ensure that staff and volunteers are kept well informed about their safeguarding responsibilities and how to report concerns and they have access to ongoing learning opportunities to ensure their knowledge and practice is kept up to date.

Recommendation 19: *As part of the overall development of safeguarding in the Church, a member of staff should hold responsibility for the development of a safeguarding training plan which should include keeping records of training attended including date and content and details of trainer.*

KLE4: To what extent is there robust managerial oversight and scrutiny of safeguarding by Trustees and Church leaders.

What we were looking for

106. Evidence that in terms of reported safeguarding concerns or complaints systems are in place which demonstrate that Trustees and Senior Church Leaders understand the importance of management oversight and scrutiny of safeguarding practice.

Findings and Recommendations.

107. The way in which the complaint made by MD was handled, for example, over a four-year period has brought into sharp focus that safeguarding procedures in the Church were not in line with the Charity Commission regulations which state that Trustees of charities must manage any risk of harm to beneficiaries that might *arise from the charities activities including the effective management of complaints, whistleblowing and allegations relating to child protection or adults at risk*.[16].

108. The complaint made by MD was not well-managed; there was an absence of scrutiny perhaps also lack of understanding that safeguarding, as it applies to charities, is far wider than what is generally understood by those offering legal advice. There should have been a better understanding of safeguarding in its broadest sense and a willingness to heed the advice of those with significant expertise, rather than relying so heavily on legal advisors for advice and guidance.

109. We were unable to identify any clear system or process by which the Board can demonstrate robust managerial oversight or scrutiny of its safeguarding arrangements. Whilst the Board is supported by the SfGT and the SSO, it is the Board in its entirety that is collectively responsible for governance and auditing practice and ensuring it is kept well-informed as to how things are working and what lessons are being learnt during the course and in the aftermath of safeguarding incidents being reported and addressed.

Recommendation 20*. The Board of Trustees needs to consider how it can better evidence that its decision-making processes are well-informed and effective risk assessment and*

[16] *Safeguarding and protecting people for charities and trustees 2017.[updated 2023]* *https://www.gov.uk/guidance/safeguarding-duties-for-charity-trustees#full-publication-update-history*

management systems are in place, fit for purpose, and regularly reviewed. The Board should also consider what steps it will take to audit its own performance on an annual basis.

KLE5: How well does the Church liaise and work collaboratively with partners to continually improve safeguarding arrangements in the Church?

What we were looking for.

110. In terms of safeguarding, evidence that the Church does not work in isolation but strives to work collaboratively with other parties, charities, and external agencies to continually revise and improve its safeguarding arrangements. Partnership and collaborative working are the cornerstone for good safeguarding practice.

Findings and Recommendations.

111. The Philadelphia Network Limited (NCS) is a charity which operates from the Church and the Kings Centre. [redacted].

112. The working partnership between the charities does however bring into sharp focus the value of ensuring that safeguarding procedures are aligned and largely uniform, so any staff and Trustees working for and across [redacted] NCS know they are working to the correct procedures and know how to report concerns and to whom. We would advise, whilst acknowledging that this is outside of our remit, that some consideration is given as to whether the findings from this safeguarding review may helpfully be applied to the Kings Centre [redacted] so there is consistency in practice and processes.

113. NCS, and therefore the Church, is part of the Yorkshire Baptist Association and the Diocese of Sheffield, but there are currently no formal partnership arrangements in place between all three parties. We understand that discussions took place several years ago about establishing a Local Ecumenical Partnership (LEP)[17] but this work did not progress. There are, of course, practical challenges that arise in relation to churches with different policies, procedures, and denominational requirements and these are particularly heightened when it comes to safeguarding, with the need to communicate and manage what can be sensitive matters between members of the clergy, paid and volunteer officers and church members.

[17] *In https://en.wikipedia.org/wiki/EnglandEngland and Wales, a local ecumenical partnership (or LEP) is a formal and legal arrangement to develop unity between churches of different denominations*

114. We were, from the outset, concerned about the delay in us being able to start work on this investigation in 2022 as originally planned. We became aware of tensions within the Core Group established to investigate MD's complaint, when the Church challenged the authority of the Diocese to act on their behalf and we noted also the frustrations expressed by the Diocese when the Church disagreed that MD's complaint was a safeguarding matter and relied so heavily on legal advice about how to proceed; this was a key factor , not the only factor but an important one, which in our view, contributed to the lengthy delay before our work could commence.

115. We cannot know for certain if a Local Ecumenical Partnership (LEP) would have helped in this situation, but it might well have done so in that all partners would have been legally bound to follow the safeguarding procedures agreed when the LEP was first established. The delay in being able to commence this investigation not only sparked media coverage causing damage to the Church, which arguably could have been avoided, it also caused distress to the MD and for a brief time, as far as we could see, adversely impacted on the relationship between the Diocese and the Church.

116. There is however learning from this situation, and we are reassured by the response of the Church to this review and the willingness to consider what changes need to be made going forward to improve and strengthen safeguarding arrangements in the Church.

Recommendation 21: *The Church should seek discussion with the Diocese and the Yorkshire Baptist Association to share the learning from this review and explore what steps could be taken to enhance and consolidate partnership working even further to avoid similar situations occurring in the future.*

117. During this review we spoke with the Safeguarding Advisor from the Diocese and the Yorkshire Baptist Association, both of whom confirmed their ongoing commitment to work with the Church and support any plans to improve safeguarding arrangements.

118. We also spoke with the Local Authority Designated Officer (LADO) who similarly expressed the view that the LADO team were there to offer any advice or guidance in terms of dealing with allegations or concerns about the behaviour of staff or volunteers in the Church. A point which was stressed to us was the need for the Church to inform and consult with the LADO within 24 hours of any allegations or concerns and that the Church should not always wait until contact with the Diocese before reporting to the LADO. If the allegation relates

to a Baptist accredited minister or recognised pastor, these should also be reported to the Yorkshire Baptist Association without delay.

Recommendation 22: *Given we have advised that the Management of Allegations policy should be revised, the issue of contact with the LADO should be clarified so the Church can be confident in making contact with the LADO in future.*

119. NCS is a charity operating from two sites, the Kings Centre, and St Thomas Philadelphia. It is a complex organisation, which states that it looks to the Church of England for advice and support in regard to safeguarding whilst maintaining its independence through a Board of Trustees.

120. As mentioned previously some the work undertaken by the Church [redacted] to ensure that safeguarding practice [redacted] is robust and in line with best practice.

121. This review has evidenced that the Church can and does work in partnership with other organisations and is willing to explore how partnership working with the Diocese and Yorkshire Baptist Association could be further developed so safeguarding arrangements in the Church can continue to evolve an improve.

6. Concluding Comments

122. It is vital that all Trustees, senior leaders, staff, and volunteers understand the need for safeguarding to be an integral and essential element of all church activities. There was some evidence from this investigation that until recently safeguarding was seen more as an administrative function in the Church rather than as a 'golden thread' running throughout the Church and its activities.

123. Even in organisations with small numbers of staff, there is a need for robust safeguarding systems and processes without which the needs and safety of some children and adults can

be left unrecognised and unreported leaving them vulnerable and possibly at risk. We also know from our experience that by improving safeguarding arrangements in an organisation, the number of reported concerns increase as confidence in knowing what to report, how and to whom grows, so the need for safer working practices becomes even more important.

124. The Church has recognised that it can do more to improve its safeguarding arrangements and even prior to this report being finalised, it has begun to make some important changes. Accountability and transparency around safeguarding practice is supported by independent scrutiny, routine audits, and the publication of findings; we would urge the Church to carefully consider how it will publicise the learning from this review. We have been encouraged by the Church's readiness to support the development of a more robust approach to safeguarding and this is to be welcomed.

7. Summary of Recommendations

Recommendation 1: The learning from this review should be shared with [redacted]

Recommendation 2. As a matter of priority, Board of Trustees should ensure that all emails which refer to any individual safeguarding concern reported to the SfgT and/or SSO in the last three years are copied and stored securely in individual case files; each case file should be prefaced with a chronology of events and actions taken.

We would advise that in respect of this investigation, a Complaint file for MD should be opened and all the documents shared with Core Group, with ourselves as reviewers and with MD should be stored or uploaded into the file, alongside copies of Stage 1 and Stage 2 reports.

Recommendation 3. A process should be agreed whereby the SfGT and the SSO meet formally on a regular basis to discuss safeguarding arrangements, issues, and plans. These meetings should be minuted and stored electronically within the appropriate safeguarding folder with clear details as to who can access this information.

Recommendation 4. The roles and responsibilities of the SfGT and SSO should be made explicit in role profiles and relevant job descriptions.

Recommendation 5. Trustees should have specific training around their safeguarding roles and responsibilities. This should be additional to and separate from Trustee training on their legal responsibilities and should be outsourced to specialists in the field.

Recommendation 6: The Board should adopt a more formal approach to managing and improving safeguarding practice in the Church, so it is better able to evidence good governance, openness, and accountability. Safeguarding should be a standing agenda item for Board meetings. Where there are no incidents or updates to bring to the table this should also be recorded in the minutes. The SfGT should ensure that the Board receives safeguarding reports on a regular basis using a format which includes, anonymised updates on incidents/ allegations, data to show themes and trends of reporting, progress of the strategic plan and updates on actual or emerging risks and risk mitigation.

Recommendation 7: A safeguarding strategy and implementation plan outlining the Church's ambition for its safeguarding arrangements and the goals it hopes to achieve should be developed and once agreed, signed off by the Board of Trustees.

Recommendation 8: The Board of Trustees should develop a more robust safeguarding structure in which individuals with key safeguarding roles collaborate as a team to strengthen safeguarding arrangements within the Church.

Recommendation 9: The Church website should have a safeguarding page which has links to key safeguarding documents, and which explains how safeguarding arrangements work in the Church. Details should be provided about how to report a concern and to whom with contact details being provided for more than one person.

Recommendation 10: The full suite of policy documents which relate or are linked to safeguarding should be revised as part of a longer-term strategy so that NCS policies are aligned, standardised, have clear version control, and contain up to date and accurate information and references.

Recommendation 11: The Board of Trustees should ensure that the Church develops and maintains a data management system which can be used to record all incidents, concerns, and complaints and which can be used to draw down reports for scrutiny by the Board. Access to this system should be restricted but sufficient to allow legacy and handover should current members of the team move on. The contents of the database should be reviewed regularly to inform the direction of safeguarding work and to identify any patterns of behaviour or areas of concern.

Recommendation 12: The Church should ensure that a safeguarding message in terms of what to look out for, what to report and when, is regularly communicated through all channels in the Church and everyone including those in the congregation know how to report concerns and are confident

that their concerns will be taken seriously and actioned with the appropriate level of information and confidentiality.

Recommendation 13: Consideration should be given to producing a more detailed document around safer working practice and what constitutes appropriate and safe behaviours for adults who work for or on behalf of the Church.

Recommendation 14: A safeguarding risk management policy and risk management plan which includes the creation and maintenance of a safeguarding risk register should be developed and implemented.

Recommendation 15: The Prayer Ministry document and related procedure should be shared with the Diocese and the Yorkshire Baptist Association and in the light of MD's complaint, critical reflection sought on its content. A revised document should include:

- reference to the requirements of the Charity Commission in terms of all beneficiaries of the Church, not just those who may fall under the legal definition of an adult at risk (Care Act 2014).
- reference to current guidance and legislation, including terms and definitions.
- how the Church will ensure that Prayer Ministry sessions, including those which may take place in settings other than the Church, are delivered in line with the Church's Prayer Ministry protocol
- information about how any concerns relating to Prayer Ministry can be reported and to whom.

Recommendation 16: Those administering Prayer Ministry should have not only a spiritual approach to Prayer Ministry but should be able to demonstrate, through training, a trauma-informed approach which understands that, however carefully managed, prayer sessions can re-trigger past traumas, and this can leave a person vulnerable.

Recommendation 17: If extended Prayer Ministry is to be reinstated, the Church needs to carefully consider how it will ensure that all sessions are delivered in ways which safeguard and protect the individual for whom the prayers are being said.

Recommendation 18: The Church should ensure that it regularly reviews it safeguarding practice, processes, and procedures, including how it delivers Prayer Ministry, through routine audits undertaken in partnership with external partners. Any findings should be publicised on the Church's website.

Recommendation 19: As part of the overall development of safeguarding in the Church, a member of staff should hold responsibility for the development of a safeguarding training plan which should include keeping records of training attended including date and content and details of trainer.

Recommendation 20. The Board of Trustees needs to consider how it can better evidence that its decision-making processes are well-informed, and that effective risk assessment and management systems are in place, fit for purpose, and regularly reviewed. The Board should also consider what steps it will take to audit its own performance on an annual basis.

Recommendation 21: The Church should seek discussion with the Diocese and the Yorkshire Baptist Association to share the learning from this review and explore what steps could be taken to enhance and consolidate partnership working even further to avoid similar situations occurring in the future.

Recommendation 22: Given we have advised that the Management of Allegations policy should be revised, the issue of contact with the LADO should be clarified so the Church can be confident in making contact with the LADO in future.

Appendix 1

Terms of Reference: Part 2 [18]

Part 2 cannot be undertaken until Part 1 is completed.

Regardless of the findings of Part 1 of the investigation, the investigator will undertake an assessment into whether all reasonable actions (subject to point i) have been undertaken within the areas of student ministry and Prayer Ministry at the church, to ensure members of the LGBTQ+ community, or those who do not hold the same theological position as the church in regard to human sexuality are safeguarded from any potential harm. The scope of the assessment will be the [practices, policies, training, and people management activities that pertain to monitoring, accountability, and recording] in these areas of ministry.

The review will consider [volunteer recruitment and management, employee recruitment, whistle blowing policy and equal opportunities policy] within the Christian ministry activities at the church.

i. The assessment will take due regard of the church's right, established in law, to hold a theological position in regard to human sexuality and make decisions based on this right, and other theological perspectives, that in another context might be considered discriminatory, unlawful, or unethical.

The assessment will make recommendations for where further actions could be implemented to improve practice. Such recommendations must:

ii. Be clear and specific.
iii. Be supported with a justification for the recommendation based on the information reviewed (see point i) (together with a rationale for inclusion or disregard of such information as required).
iv. Explain the necessity for the recommendation to be carried out.

[18] *Copied from original contract between Barnardo's and the Diocese of Sheffield acting on behalf of the Core Group*

The church will be presented with any initial recommendations, each of which will meet points i – iv. Once any initial recommendations have been presented, the church and the Core Group, will have the right to, within 5 working days make representations based on points i – iv. but not the recommendations themselves. The investigator will consider these representations and address them in the final report, outlining how they have taken these representations into account or their rationale for disregarding them.

The church will make reasonable endeavours to support the investigator in their review, providing all directly related policies, files, and correspondence, subject to information and other legislation, but cannot compel people to engage with the review. For the avoidance of doubt, information that could be subject to legal privilege will generally not be provided to the investigator.

The final report to be sent to the Right Reverend Pete Wilcox, Bishop of Sheffield.

MD will be informed that this assessment is being undertaken by Barnardo's and will be informed of any recommendations that become Bishop's Final Recommendations (see below), together with a note on their implementation or otherwise.

Following both Parts of the Investigation:

The Bishop of Sheffield (The Bishop), having received both Parts of the investigation, will meet with representatives of the church to discuss the findings (Part 1) and recommendations (Part 2), together with any action he proposes to take in light of these. The Bishop will give written notification of any action they propose to take and the reasons for such action. Within 15 working days of receiving this notification the church can make written submissions in relation to The Bishop's proposals and The Bishop must share these with the DSA and the Chair of the Diocesan Safeguarding Advisory Panel. The Bishop having reviewed their proposed actions in light of the submissions, must decide what action to take and give written notification of the decision and reasons for it (these being the "Bishop's Final Recommendations"). In deciding this action the Bishop must pay due regard to the advice of the Diocesan Registrar, the DSA, and the Chair of the Diocesan Safeguarding Advisory Panel

A copy of both Parts of the investigation will be held securely within the safeguarding records of both the Diocese of Sheffield and the Yorkshire Baptist Association. Access to these is restricted to the safeguarding teams of each denomination and may be shared with the National Safeguarding Teams of either denomination as appropriate.

Appendix 2

Information about Barnardo's Training and Consultancy

Barnardo's is a leading UK children's charity with over 150 years of history and experience in supporting the most vulnerable children, young people, and families across the country. In 2022/2023 Barnardo's supported work with over 370,000 children young people, parents, and carers across 811 services and partnerships throughout the UK.[19] From day one, Barnardo's ambition has remained the same: to achieve better outcomes for more children and young people and ensure no child is left behind, regardless of their circumstances.

Barnardo's Training and Consultancy

Within Barnardo's, our Training and Consultancy is a well-established and experienced provider of Consultancy activities. Informed by our extensive expertise and in line with Barnardo's core mission and corporate strategy, our objective is to provide independent consultancy advice and support to other organisations to promote improvements and encourage best practice in safeguarding children, young people, and adults at risk. On a daily basis we are concerned with supporting other agencies to continuously improve.

Our team undertakes independent time-limited reviews and audits to help other organisations understand what is working well and what needs to change or improve; we are skilled in not just identifying areas of improvements but also in helping others understand why changes might be needed and making suggestions as to how best to achieve the change needed. Our focus is on ascertaining whether safeguarding arrangements are sufficiently robust or not, and in identifying what changes are necessary to enable progress and achievement of good practice.

We also undertake reviews of policy, procedures, and practice, historic and current, as well as independent investigations; this work helps us understand what can go wrong and ensures our

[19] *Barnardo's Annual Report 2022/2023 https://www.barnardos.org.uk/sites/default/files/2022-11/Impact%20Report%202021-22.pdf*

delivery and audits of arrangements today is informed by lessons learnt. Ultimately, the focus of our activities is on ensuring organisations can continuously improve their practice and embed a safeguarding culture to achieve better outcomes for any children and young people. Our team are highly experienced and have backgrounds in managing and advising on child protection. Each review and consultancy project we undertake is unique but what remains the same is our commitment to listen to the voices of those affected.