

NSPCC Consultancy Services

Safeguarding review of Plymouth Diocese case records

September 2011

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1. INTRODUCTION

- 1.1. The Bishop of the Roman Catholic Plymouth Diocese commissioned the National Society for the Prevention of Cruelty to Children (NSPCC) Consultancy Services (Child Protection Consultancy Division) to undertake an independent review of the Diocese's safeguarding practices. The intended outcome of this project is to promote improved safeguarding awareness and practises, to identify lessons to be learned within Plymouth Diocese, and to ensure that children and vulnerable adults are safeguarded. This is part of a number of measures the Bishop has taken, in conjunction with his Independent Safeguarding Commission, to ensure that a safe environment exists for all in the church.
- 1.2. This followed the knowledge that Mr Christopher Jarvis, who had been a fully qualified social worker employed as the Diocesan lead for safeguarding since 2002, had been accessing abusive images of children (category 4/5 5 is the highest level and constitutes the most serious offence) and distributing these. The Bishop immediately suspended Mr Jarvis and subsequently dismissed him from his position for gross misconduct, after Mr Jarvis admitted to the offences. From the outset the church fully co-operated with police to bring Mr Jarvis to justice, and he has been charged, bailed, and will attend a further court hearing later this month (September 2011).
- 1.3. The Diocese of Plymouth covers three Counties with six Local Authorities: Devon, Cornwall, Plymouth, Torbay, Dorset and Bournemouth. The Plymouth Diocese has a Safeguarding team with a Safeguarding Co-ordinator, part-time safeguarding officer and an administrative worker. This team has been the professional core of the organisation and has worked with the parishes and other diocesan agencies for the purpose of ensuring effective organisational safeguards. There is currently an Interim Safeguarding Co-ordinator in post to ensure that work continues.
- 1.4. In addition, and following the Nolan Report (2001), the Diocese of Plymouth has an Independent Safeguarding Commission (ISC) which in summary provides:

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support, governance, and independent challenge and scrutiny of safeguarding practice within the diocese. It is chaired by an independent person, and members include representatives from statutory and voluntary bodies including Devon and Cornwall Police, Devon and Cornwall Probation Service, the NSPCC (Services for Children and Families Division) and Plymouth Adult and Children's Services. Pastoral input is provided by church representatives to ensure that faith issues are an integrated part of the ISC approach.

- 1.5. The NSPCC safeguarding review has been divided into two phases. Phase one has been completed during July/August 2011 and the findings are represented in this report. This first phase involved reviewing all church case files over the past three years which Mr Jarvis was involved with, to assess the extent to which policies/procedures have been complied with, and to ensure that any safeguarding concerns have been appropriately responded to, and if not, to ensure that action is taken to address this. Practice during this phase was reviewed against the Catholic Safeguarding Advisory Service (CSAS) policies and procedures (standards), Working Together to Safeguard Children (2010), and The Children Act 1989 and 2004, as relevant.
- 1.6. Phase two will follow in due course, and include examination of safeguarding policies, procedures and training provision, and advice will be given on areas where this could be improved. Full details of the purpose, scope and methodology of the review are attached as appendix 1. We have made recommendations in this report only where we consider this will be helpful to assist future practice.
- 1.7. The following terms for the purpose of this report are used to mean:
 - 'Safeguarding' includes primarily child protection, as well as broader situations where children and/or vulnerable adults may be at risk
 - 'Children'- includes all children and young people who have not yet reached their 18th birthday

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- 'Vulnerable adult' is a person who is/maybe, in need of community care services because of mental disability or other disability, age or illness, and who is/maybe unable to take care of themselves or unable to protect themselves against significant harm or exploitation.
- 1.8. We wish to thank all Diocese of Plymouth Safeguarding Office staff for their cooperation, assistance, and support, without which, phase one of this review could not have been completed.

2. METHODOLOGY

2.1. Choosing cases for the review. Two NSPCC Senior Consultants reviewed 111 church cases and included cases from across the three Counties and six local authorities covered by the diocese. The scope of the review was to assess practice recording for cases that had been opened and/or closed during the preceding three years as it was known that offending behaviour by Mr Jarvis had occurred during this period. In fact this meant that files involving a number of complex cases dated back earlier than this timeframe e.g. one case dated back to 1994 and records were accessed fully back to 2002 (when Mr Jarvis was appointed). For the purpose of reporting, cases have been categorised by the type of case or nature of presenting safeguarding concern - identified in table 1 below. The age of the children, vulnerable adults, and alleged offenders involved in the cases audited are wide ranging.

Table 1: Files reviewed using the case review audit tool which captures information regarding the quality of recording practice

Type of case or nature of presenting safeguarding concern	Number and overall findings
Alleged/convicted sex offenders	31 (of these, twelve related to convicted sex offenders attending church – two convicted re abusive images of children, nine involved allegations of sexual abuse against parishioners – one involved a parishioner accessing abusive images of children, and seven involved allegations regarding

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	members of the clergy – one former priest had convictions for sexual offences). Two sex offenders are now deceased Findings Overall, these cases were robustly responded to and child protection procedures adhered to. Where appropriate Covenants of Care were/are in place. There are areas where practice could be improved and this is elaborated later in the report
Disclosure by adult of alleged historical sexual abuse when a child	8 (seven related to allegations of sexual abuse, of these three involved alleged perpetrators within the family or by a stranger, and four were allegations against persons in a position of trust – two related to members of the clergy. The one remaining case involved an allegation of physical abuse by a carer) Findings Responses given and referral out to the relevant local authority were appropriate. Practice was proportionate to the presenting concern and did not compromise child/ren's or vulnerable adults safety
Alleged physical abuse of children by an adult	3 (of these, all were about child/ren at risk of suffering harm e.g. one involved a safeguarding representative raising concern about the impact of domestic violence on children in a family, one related to behaviour of a teacher (a parishioner) towards children, and one was about an 'incident' involving a parishioner) Findings All were responded to appropriately and child protection procedures adhered to
Concerning behaviour of adult/child	23 (of these, four related to concerns about priests, three involved parishioners involved in ministry, fourteen were concerning the behaviour of parishioners, and two related to concerns about the behaviour of children)

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	Findings Advice given and action taken was proportionate to the presenting concern e.g. one case about the behaviour of a teacher led to a multi-agency strategy meeting being convened where contributions were given and actions and decisions appropriate
Vulnerable adult	3 (all related to concern about presenting behaviour of parishioners considered to be vulnerable adults within church) Findings Appropriate advice given and action taken
Support/advice sought	4 (of these, one involved a safeguarding representative who had welfare concerns about children, one was from a parishioner whose children had been taken into care, one related to a parishioner who had assaulted an adult and worked with children, and one was a parishioner seeking advice about accommodation and financial assistance) Findings Appropriate advice given and action taken within the remit of role and where necessary signposted/referred to other agencies
Notification/alert to the diocese about risky adults	22 (the majority of these related to high risk adults who may have contact with the diocese, and alerts were received from a range of sources e.g. other diocese, COPCA, CSAS, LSCB's) Findings The majority were to provide information only and no further action was necessary. Where action was needed e.g. contribution to a strategy meeting this was provided appropriately
Blemished disclosure (re individuals seeking involvement in ministry e.g. this could be a	16 (of these, ten progressed to perform ministry within church environment, and six stepped down from making an application)

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historical conviction for driving while under the influence of alcohol)	Findings Responses and decisions considered to be proportionate to the presenting risk, and reports to ISC made as necessary
Complaint	1 (this was a complaint made by a headteacher about the diocese CRB process) Findings A response was given to the individual and the situation resolved in accordance with CSAS policy
TOTAL	111

2.2. Multi-agency protocol for sharing information. An agreement was drawn up between NSPCC and Plymouth Diocese, to ensure that there was a clear and understood process in the event that any safeguarding/child protection concerns arose during the auditing of cases, particularly in relation to the practice of Mr Jarvis. This protocol was also shared with Police and Children's Services and signed by all relevant agencies. In the event, no cases were identified which warranted use of this protocol. That said, a number of cases did require further action and follow up by the diocese in order to satisfy itself that potential risk is being effectively and proportionately managed, and reference to these cases can be found at section 7 of this report.

3. SUMMARY OF KEY FINDINGS

3.1. Strengths

- (i) On the basis of written records, assurance that safeguarding practice is sound and overall compliant with CSAS standards and legislative frameworks.
- (ii) Overall, a good quality of recording which supports safeguarding practice and demonstrates professional accountability.
- (iii) Good evidence of partnership working with diocese safeguarding representatives/others, and a strong commitment to multi-agency working to optimise the best outcomes for children and vulnerable adults as far as Plymouth Diocese can influence.

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- (iv) Good examples which demonstrate action taken to ensure children and vulnerable adults are safeguarded and protected.
- (v) Good examples of the implementation of strategies proportionate to manage risk/potential risk.
- (vi) Evidence that the potential vulnerabilities of specific individuals within the church environment have been identified and responded to as would be reasonable to expect.
- (vii) Overall, good scrutiny and challenge, as necessary, supported via discussion and decisions at Independent Safeguarding Committee meetings.

3.2. Areas for improvement and development

- (i) Overhaul and implementation of an effective filing and recording system, ideally via an electronic database, fit for purpose, to assist easy retrieval of information, support staff/organisational accountability, in addition to supporting quality standardisation processes.
- (ii) Any new recording system could include review of existing forms and templates used to support effective recording practices, which avoid duplication and includes recording the rationale for decision making.
- (iii) A clear process clarifying when a case should be opened and closed in order to demonstrate parameters of responsibility and accountability.
- (iv) The process for systematic prompting/planning forthcoming reviews on cases where potential risk is being managed/monitored needs to be reviewed to ensure timely and effective reviews are consistently undertaken.
- (v) Better evidence of supervision decisions and management oversight, scrutiny, and direction in case recording.
- (vi) Further exploration of how risk is assessed in cases may be beneficial. For example, development of a template/checklist to guide practitioners to gather and assess information, which could assist in analysing risk factors and informing judgements about risk.

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(vii) Consideration of a process for the implementation of case auditing through the management line in order to quality assure local practice on an on-going basis.

4. FILING SYSTEM AND RECORDING

- 4.1. Overall, review findings show a good quality of recording which supports safeguarding practice and demonstrates professional accountability. For example, recording was conducted promptly, files provided evidence of planned and purposeful work. Recording demonstrates a commitment to multi-agency practice with effective communication and information sharing in the majority of cases. For example, attendance at and contribution to strategy meetings was evident in cases that warranted this.
- 4.2. All indications from written records are that Mr Jarvis was able to differentiate between his professional practice, and that of criminal offending behaviour, with the exception of using his work laptop to access abusive images on some occasions during work time at the office base. In other respects Mr Jarvis appears to have worked professionally in accordance with safeguarding policies and procedures, and we found evidence of robust challenge and scrutiny of others when necessary. However, this finding of itself does not mean that he does not present a potential risk to children and vulnerable adults, as evidence has been found to the contrary by his offending behaviour. It is of significance that his offending behaviour, and use of a work laptop, represents a serious breach of professional trust bestowed upon him in his role as Safeguarding Coordinator and it is important not to minimise this.
- 4.3. In this context, the safeguarding team are aware of the need to update and implement a new system for filing and recording case information and are already taking positive steps to progress this. The current system has served its purpose but is now out of date, and involves the maintenance of hard copy files with day to day contacts/records being hand written. This has been supported by a manual list of cases on a spread-sheet which identifies cases by number and name. In

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the review we identified some inconsistencies and inaccuracies in this system e.g. two unrelated cases having the same identifying case number, and numbering in the case list being out of sequence delaying the ability to retrieve and access information in specific cases. There is a need for each case to have its own file (hard copy or electronic), as currently some smaller cases are identified as 'miscellaneous' and grouped together until a file is full, and 'alerts/notifications' from other agencies are kept together in a 'red' folder. In our view cases should be recorded in one central place, the type of case recorded, and opened and closed as appropriate. Examples of chronologies in some more complex cases were found and assisted the reader in obtaining an overview of the 'story', and it would be helpful to have a simple chronology at the beginning of each case file to obtain a quick overview of the circumstances of the case. In our view, findings support that a new system, fit for purpose, is required and a recommendation is made in this regard.

Recommendation

The Bishop of Plymouth Diocese should ensure the commissioning, review and implementation of an effective filing and recording system, ideally via an electronic database, which is fit for purpose, to assist easy retrieval of information, support staff/organisational accountability, in addition to supporting quality standardisation processes. This would include review/revision of standard recording templates.

4.4. It would be beneficial to clarify when a case should be opened and closed in order to demonstrate parameters of responsibility and accountability. For example, one case remained open and had been for many months with no activity, and another case was closed yet it appeared that all actions had not been completed. Instances such as this could lead to the diocese being open to scrutiny and challenge in the future with questions about which agencies are responsible and accountable for actions. We make a recommendation to assist future clarity about when a case should be opened and closed. This may be symptomatic of a wider issue about management oversight, scrutiny, auditing arrangements and

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will be explored further in phase two of this project when interviews and focus groups are undertaken.

Recommendation

The Bishop of Plymouth Diocese should ensure that the Interim Safeguarding Co-ordinator of Plymouth Safeguarding Office puts a clear process in place for opening and closing cases to ensure that the parameters of responsibility and accountability for cases is clear and understood by staff.

4.5. Reviews are relevant in cases where written and signed agreements are in place (often Covenants of Care) e.g. with alleged/convicted offenders about the conditions of their contact with the church and restrictions to mitigate any potential risks to others. There was evidence in many cases of regular reviews taking place appropriately to manage/monitor risk. However, in the context of an increased workload following the departure of Mr Jarvis, a decision was made to postpone some reviews and we found three examples showing this as reviews were outstanding or not completed within set timescales (several months outside of timescale). In our opinion, risk was managed satisfactorily in these cases. While staff are aware of cases where reviews are needed and are/have addressed this, it may assist staff to implement a system for prompting/planning forthcoming reviews on relevant cases to reduce the potential for future delays. The issue of resources is being addressed currently with the appointment of an Interim Safeguarding Co-ordinator, and this will be explored further in phase two of this project.

Recommendation

The Bishop of Plymouth Diocese should ensure that the Interim Safeguarding Co-ordinator of Plymouth Safeguarding Office implements a systematic process to plan forthcoming reviews on cases where potential risk is being managed/monitored to ensure timely and effective reviews are

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consistently undertaken (this could be included in the functionality of a new electronic database).

5. ASSESSMENT OF RISK

- 5.1. With the exception of one case (a historical case involving practice in the 1980's whereby concern does not relate to the actions of Mr Jarvis), assessments of risk are considered to have been proportionate to the presenting concern and did not compromise child/rens or vulnerable adults safety. Evidence was found of the Bishop commissioning specialist assessments when identified as required and these instances involved cases where allegations of abuse had been made in relation to members of the clergy.
- 5.2. Examples were evident of Mr Jarvis writing 'special' reports on individuals who were/are the subject of concern and presenting them at Independent Safeguarding Commission meetings. However, in some instances it was not clear from case file records what decisions/actions were agreed at such meetings because minutes of the meeting are not placed on individual's case files where information would have been relevant. There has recently been a national direction from CSAS about a change in policy, so that now the expectation is that relevant minutes of ISC meetings will be placed on individual case files. This change in practice should ensure that actions and decisions made on a multiagency basis at ISC meetings about how to manage risk will be evident on relevant case files.
- 5.3. There were some cases where it was unclear how risk had been assessed, and it may be beneficial (as part of reviewing/compiling new templates as recommended at 4.3 above), for the Bishop/Safeguarding Office to consider developing a template/checklist to guide practitioners to gather and assess information, which could assist in analysing risk factors and informing judgements about risk.

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6. MANAGEMENT AND SUPERVISION

- 6.1. It is not yet clear what the level and quality of supervision, management oversight, and general support has been and is available to staff and this will be explored in phase two of this project when staff currently in post will be interviewed. For example, a significant proportion (more than a quarter) of cases involve work with alleged or convicted sex offenders and managing/monitoring risk/potential risk in this complex area can be demanding on staff and this will need to be explored.
- 6.2. It is a finding from case recording that, supervision actions, decisions, and the rationale for this, has not, in the majority of cases been evident. This is an important element of quality assurance and demonstration of organisational accountability through the management line. Lord Laming (2003, 2009) suggests that supervision should focus on the quality of decisions; good risk assessment and analysis; and improving outcomes for children (this also applies to vulnerable adults). Alongside, supervision is particularly important when working with high risk individuals, as Lord Laming (2003) emphasised 'supervision should be actively supportive of social workers practical and emotional needs'. The NSPCC (2010) also notes the need for supervisors to 'address the impact on practitioners of working with other people's pain and distress' (p.5) as well as monitoring practice. A recommendation is made about recording actions and decisions.

Recommendation

The Bishop of Plymouth Diocese should ensure, with immediate effect, that actions, decisions, and the rationale for decision making, is recorded on individual case files.

6.3. However, there are a number of examples showing evidence of management oversight and direction on cases where there were specific risks apparent e.g. discussions with the Bishop and representations made at ISC meetings (evidenced in the minutes of such meetings).

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7. CASE FOLLOW UP

- 7.1. Of 111 cases reviewed, four were identified as cases of particular concern whereby the diocese needed to reconsider the need for further action. The Acting Safeguarding Co-ordinator was already aware of two of the cases and action had been taken to progress matters. Three of the four cases related to priests and the remaining case about a man no longer permitted to be involved with the church. All involved historical allegations of sexual abuse, and the current issue was about assessment and management of risk/potential risk to children and/or vulnerable adults. One case was reconsidered and concluded that given all the facts the individual does not currently pose a risk, and the file has been updated to this effect. Two cases are the subject of further enquiry by the Safeguarding Office to be able to inform a risk assessment. In the remaining case, the diocese share concerns and following a number of actions the matter is being taken to the September ISC meeting for consideration and decision about how to pursue.
- 7.2. A further eight cases were bought to the attention of the diocese for consideration, six involved queries as there is no explicit conclusion on file or no clear record showing that all actions have been completed. Two needed clarity about whether any further action could be taken or not. We are satisfied following feedback from the Interim Safeguarding Co-ordinator that all possible actions have now been completed or are progressing and files updated so this is evident in recording.
- 7.3. As identified at 4.5. of this report, three cases were identified with outstanding reviews and these have since been addressed.
- 7.4. In view of gaps present in supervision recording and also some cases identified requiring further clarity and risk assessment, it could be beneficial to implement a process of random case auditing through the management line in order to quality assure local practice on an on-going basis. Audit offers the opportunity to check what is being done and consider whether it could be done better. It is a method of checking against defined standards and assists with planning change and

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setting priorities (Munroe, 2004). This can be explored further as part of phase

two of this project.

8. RECOMMENDATIONS

8.1. The Bishop of Plymouth Diocese should ensure the commissioning, review and

implementation of an effective filing and recording system, ideally via an

electronic database, which is fit for purpose, to assist easy retrieval of information,

support staff/organisational accountability, in addition to supporting quality

standardisation processes. This would include review/revision of standard

recording templates.

8.2. The Bishop of Plymouth Diocese should ensure the Interim Safeguarding Co-

ordinator of Plymouth Safeguarding Office puts a clear process in place for

opening and closing cases to ensure that the parameters of responsibility and

accountability for cases is clear and understood by staff.

8.3. The Bishop of Plymouth Diocese should ensure the Interim Safeguarding Co-

ordinator of Plymouth Safeguarding Office implements a systematic process to

plan forthcoming reviews on cases where potential risk is being

managed/monitored to ensure timely and effective reviews are consistently

undertaken (this could be included in the functionality of a new electronic

database).

8.4. The Bishop of Plymouth Diocese should ensure, with immediate effect, that

actions, decisions, and the rationale for decision making, is recorded on individual

case files.

Wendy Noctor & Kevin Ball

NSPCC Senior Consultants

28 September 2011

APPENDIX A

PURPOSE AND SCOPE

Project task (intended outcome of this review):

To promote improved safeguarding awareness and practices, and to identify lessons to be learned within Plymouth Diocese, for the purpose of ensuring children and vulnerable adults are safeguarded.

Project objectives (intended objectives):

- 1) Review church case files where CJ has had involvement (previous 3 year period) to assess, the extent to which policies/procedures have been complied with, and to ensure that any safeguarding concerns have been appropriately responded to, and if not, to ensure that action is taken to address this.
- 2) Review the Diocesan safeguarding practice as an organisation to assess what works well and identify areas for improvement and make any recommendations in order that children and vulnerable adults are safeguarded.
- 3) Examine the interface between Plymouth Diocesan organisational safeguarding practice and the Plymouth Independent Safeguarding Commission and their relationship with the national safeguarding organisation of the Roman Catholic Church (and any relevant statutory bodies), to assess the effectiveness of the safeguarding function as a whole. This will focus on assessing the effectiveness of inspection, audit and governance as it applies to Plymouth Diocese.

In order to achieve these three objectives the NSPCC consultancy services are proposing a phased approach:

<u>Phase One</u>: this involves consultancy to review approximately 130 church case files to assess the quality of safeguarding practice (in accordance with relevant policies and procedures), identify any outstanding concerns, and ensure that action is taken to address them (if any are apparent).

<u>Phase Two</u>: this includes assessing the quality of Diocesan organisational safeguarding practice including the interface with inspection, audit and governance, and the wider Roman Catholic Church, as relevant to Plymouth Diocese safeguarding practice, to ensure that children and vulnerable adults are safeguarded in future practice as far as possible.

Phases will follow numerically (phase one is priority in terms of needing to complete this in a timely manner), and phase two will follow and have partly been informed by findings from phase one.

Project scope and methodology for Phase One:

This phase involves NSPCC reviewing practice of CJ for the preceding 3 years via accessing church files in matters he has had involvement.

This will involve NSPCC Consultants in the following activities:

• Accessing and familiarising themselves with the *Catholic Safeguarding Advisory* (*CSAS*) *procedures* for safeguarding children and vulnerable adults;

- Developing an *audit tool* for the purpose of gleaning relevant information this will be completed for each file reviewed. This audit tool will *need to be agreed with the Diocese* prior to review commencing. The tool will provide an audit trail of work undertaken and provide data for analysis and reporting (agreed 19 July 2011);
- Writing a protocol for working together, sharing information, and reporting any concerns
 during the course of work. This will need to be agreed/signed across agencies (NSPCC,
 Diocese, Local Authority, and Police) prior to review commencing. This protocol will
 apply to both phase one and phase two (signed off 19 July 2011);
- Convening a professionals meeting between relevant agencies for the purpose of making introductions, sharing information, and agreeing parameters prior to review commencing (held 19 July 2011);
- Making themselves (two or three consultants) available to access and review church files at a suitable Plymouth Diocese venue (from 20 July onwards, with a view to concluding this part of the work by end of July 2011 if feasible). Advice and support relating to vulnerable adults will be obtained (as considered necessary) through a linked Consultant contracted by the NSPCC. The NSPCC consultants will focus upon safeguards for children and young people as our expertise does not extend to adult protection services, although the values and principles underpinning both areas of practice are shared (completed by end of July 2011);
- **Communication strategy** agreeing the wording of any media statement by Plymouth Diocese which makes reference to NSPCC involvement in this matter, following liaison and agreement with NSPCC media team (signed off August 2011);
- Briefing NSPCC National Helpline staff to the involvement of the NSPCC in this review
 in readiness for them to respond to any relevant calls from the public and refer out to
 appropriate agencies, alongside informing NSPCC Consultants (Wendy Noctor and/or
 Kevin Ball). Consultants will collate an overview of this information and report back to
 Plymouth Diocese appropriately, which is intended to support a joined up approach to
 safeguarding children and vulnerable adults (arranged prior to audit commencing in July
 2011);

NSPCC National Adult Helpline number is: 0808 800 5000

NSPCC ChildLine number is: 0800 1111

• Compiling a **summary report**, reporting key findings from the review of files, and share this with Plymouth Diocese, initially in draft for the purpose of checking for accuracy and fairness only, and subsequently finalising the report. It is expected that this report will become a public document (September 2011).

Project scope and methodology for Phase Two:

This phase involves examination of current arrangements within Plymouth Diocesan for safeguarding children and vulnerable adults. This will entail undertaking an independent review of the organisation's safeguarding policies, procedures, supporting guidance/resources, training/learning provision and safeguarding practices. Alongside, the interface between safeguarding practice, and inspection, audit, and governance arrangements (September

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onwards - timescales yet to be agreed).

It should consist of the following:

- Establish a *reference group* with representation of key personnel from the Diocese to
 ensure the expertise of those with knowledge and experience locally (including where
 appropriate specialist vulnerable adult expertise) to inform an action plan for phase two
 and implementation thereafter;
- Senior consultant desk top review of the Diocese safeguarding policy and procedures, and allied policies/procedures that link to safeguarding in collaboration with the reference group, which is needed to ensure that policies and procedures are fit for purpose. This is likely to include -
 - Supporting guidance
 - Safeguarding protocol/information sharing agreements
 - Disciplinary procedures
 - Recruitment and Selection policy
 - Training plans
 - Arrangements for inspection/audit/governance

Comment, suggested amendments and feedback will be provided electronically using Microsoft Word track changes facility. The aim will be to ensure that the policy and supporting resources are accessible for key stakeholders (and resonate with appropriate language and the context of the church community), reflect best practice, and are consistent with UK legislation and guidance;

- Interviews with key personnel including -
 - The Bishop
 - Chair of Independent Safeguarding Commission
 - Trustees (x 2)
 - Interim Safeguarding Co-ordinator
 - Safeguarding Advisor
 - Administrator
 - Director of Catholic Safeguarding Advisory Service (CSAS)
 - Others considered necessary

Support will be required from the Diocese in scheduling these interviews - telephone discussions are proposed in order to keep costs for travel to a minimum;

- Focus groups x 3 (one in each of the three Counties) with:
 - Identified Diocesan senior staff
 - Identified members of the clergy and ministers
 - Others considered necessary (to be identified and agreed);
- A **survey** for completion by wider members of the Diocese e.g. parishioners;

The interviews, focus groups, and survey results will provide the reviewers with information about the level of awareness and understanding, and learning and support needs, what works well and areas where change is needed, and issues relating to implementation and effectiveness;

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Analysis and reporting – analysis of review findings and compilation of an overview report identifying key themes about organisational safeguarding practice, including areas of strength, as well as areas where change is needed. Findings will not be attributed to individuals to ensure that the confidentiality of individuals is respected and protected. The only exception to this will be where concerns arise which require action to be taken to protect and child/vulnerable adult and where this is the case the child/vulnerable adult concerned will be the paramount consideration. This will be shared with Plymouth Diocese, initially in draft for the purpose of checking for accuracy and fairness only, and subsequently a final report will be provided.

The emphasis in this phase will be for the Senior Consultant to lead this discrete piece of work, together with support and guidance from the reference group.

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