Te Aromatawai mo nga Paerewa Tiaki Tikanga

An Assessment of the Implementation of the Safeguarding Culture Standards of the Catholic Church in Aotearoa New Zealand

FINAL REPORT

31 July 2024

SUMMARY VERSION

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Summary Version of Final Assessment Report

INTRODUCTION

GCPS Consulting was appointed by Te Rōpū Tautoko (TRT) on behalf of the bishops and congregational leaders and the National Safeguarding and Professional Standards Committee (NSPSC) to undertake an assessment of the implementation and suitability of the Safeguarding culture standards of the Catholic Church in Aotearoa New Zealand. The assessment was undertaken between December 2023-April 2024 by a GCPS team of four consultants (2 male, 2 female). This report and annexes address Part A and Part B of the Terms of Reference (https://tautoko.catholic.org.nz/assessment/). The report on the Case Review is confidential and not for publication. The assessors have ensured the key learning from the Case Review is included and referred to as such in this report.

METHODOLOGY

Building on the TOR's objectives, GCPS engaged with key stakeholders to ensure a planned and inclusive approach that would be appropriate to and honour the traditions, culture, and context of Aotearoa New Zealand.

The safeguarding assessment team used several methods to assess NZ Church safeguarding response and prevention:

i) A detailed document review was conducted of 450 relevant safeguarding policies, procedures, and other documents

ii) A case review of selected complaints received by NOPS from 2020 to 2023 was made. This was a desk review conducted by two team members experienced in investigations, to look at all associated documentation. over 500 in total.

iii) Semi-structured interviews and focus groups were held with key stakeholders, including members of the clergy, NOPS team members, NSPSC members, all diocese safeguarding leads, staff and volunteers of the three dioceses visited, survivors, Māori, Pacific peoples, people with disabilities and children. At least 47 face-to-face interviews/meetings with 128 persons were conducted during the assessment visit by two members of the team to Aotearoa New Zealand in February 2024, with 20 additional online interviews.

iv) Observational assessments were conducted during visits in dioceses/parishes to observe the practical application of safeguarding measures and to identify any potential gaps or risks in real-time.

The findings for each safeguarding standard are presented below using four areas: compliance, effectiveness, appropriateness and improvement. These areas focus on

overarching questions that seemed to be important to TRT in the TOR and our briefing which included:

1. **To what extent are the standards being met and does the level of compliance present a risk?**
2. **Are the standards working in practice? To what extent are they keeping everyone safe?**
3. **Are the standards relevant and do they fit with the realities of the Church in Aotearoa New Zealand at this time?**
4. **Areas of improvement or change**

It should be noted there were delays in the reporting stage of the assessment that led the project to overrun slightly. The assessment team took significantly longer than anticipated to produce the first draft and further editing of the final draft resulted in the report being delayed by around six weeks.

Hearing Hard Truths

The findings and interim reports of the 2018 Royal Commission of Inquiry into Abuse in Care (inquiry) were being published during the period covered by this assessment (2020-2023). The publication of the Inquiry's final report (recommendations) is pending (end July 2024) as this report is being written.

This created a difficult, emotional backdrop to the GCPS assessment. Survivors had become vocal in their expectations of what the Royal Commission would deliver whilst we also heard from some in the Catholic Church that, although they had asked to be part of the Inquiry, they now felt there had been a disproportionate focus on the Church. Many said they were shocked and had not previously comprehended the cumulative extent of abuse perpetrated by their own clergy, members of congregations, and institutions.

However, the TORS provided GCPS with a specific brief and whilst this assessment will be seen in light of the outcomes of the Royal Commission, it is not related and is a 'snapshot' of current policy/practice.

PART A - FINDINGS

Standard 3. Responding to Complaints or Concerns

The standard:

"Church entities have clear procedures and practices to respond to and manage concerns, allegations and complaints."

Background

According to the report of the National Safeguarding Professional Standards Committee (NSPSC) November 2023, during the period 2019 to 2023, the National Office of Professional Standards (NOPS) received 141 complaints alleging sexual abuse or sexual misconduct involving clergy and religious and completed 80 investigations. The remaining 61 cases/investigations are either on-going/incomplete or referred to other parties as they were deemed not within the mandate of APTH.

1. Standard 3 - COMPLIANCE

Criteria 1: *has a planned approach to ensure a prompt response and fair process.*

At NSPSC/NOPS level

The complaints of sexual abuse and sexual misconduct by clergy and religious are addressed by the APTH protocol, managed by NOPS[1], whilst other types of abuse are addressed within the dioceses and congregations. There is evidence at national level to indicate strong compliance. There are publicly available protocols and there is evidence of activity aimed to improve compliance in plans and priorities.

NOPS has a strategic plan, priorities, budget, and team with a key function to manage sexual abuse and sexual misconduct claims relating to clergy and religious. The Director reports on a regular basis to the NSPSC. In January - February 2024 (time of assessment) NOPS had six staff (three of whom started in 2023). Several of these staff are involved in case management as reflected in their Job Descriptions.

Evidence that these commitments are followed through is that NOPS submitted a draft "*Complaints Protocol*" to the NSPSC and Mixed Commission. At the time of writing, we do not know if the decision on its acceptance has been made.

At diocesan and parish level

The team reviewed the 3-year plans for Christchurch (2021), Auckland (2022) and Dunedin (2023). The plans include activities to improve compliance with standard 3.

[1] The National Office of Professional Standards (NOPS), established by the National Safeguarding Professional Standard Committee (NSPSC), aims to centralize the management of concerns regarding sexual abuse involving clergy and religious, a task previously undertaken by Protocol Committees at the diocesan level. Its primary goal is to support and ensure consistency ("one Church approach") across dioceses.

The dioceses have identified individuals to fulfil the responsibilities of a Complaint Officer. Arrangements vary with the responsibilities assigned to the Chancellor, the General Manager or to a specific role of Policy and Complaint Officer or to the Safeguarding lead as the Compliance Officer or Manager.

The parishes do not appear to have written Safeguarding plans, but they have established roles for the Safeguarding and Complaint Officers (generally a volunteer).

Considerable work has been invested in promoting plans to ensure compliance and this was found across the safeguarding system. Safeguarding leads have been appointed in each diocese. There are monthly meetings between these diocesan safeguarding leads with the NOPS Director to spread understanding and consistency across the dioceses.

There are some inconsistencies in how compliance manifests at parish level due to the level of interest or accountability of the priest, but this could be supplemented by a committed Safeguarding lead with enough time to work with other officers in the parish.

All plans reviewed were internal. Despite some examples of good practice, the team saw little intention to link plans with other functions within/across the church or to be transparent and share plans at national and local level.

Criteria 2: *Clear systems in place for people to raise concerns regarding the safety of children, young persons and vulnerable adults***.**

There are several reporting channels for individuals to raise their concern(s) directly to NOPS (online, email or phone). However, although much work has been done to promote the available channels for reporting, communication materials displayed in parishes visited were primarily in English, focus on sexual abuse and sexual misconduct by clergy and religious and do not make it clear that the system is also for other safeguarding complaints.

In addition, these systems are not fully accessible for some, for example the Deaf and Māori communities – some Deaf people may have technical access issues and there is a need to increase contact points for Māori community members.

People can report their concerns through the online reporting channel available via the diocese website or directly to the bishop/parish priest, the Complaints Officer, whose contact information is often displayed or disseminated in the parish (in announcements or via the NOPS posters) or the Safeguarding Officer.

Additionally, dioceses provide ethnic chaplaincies. These chaplaincies play a pivotal role as key contact persons for their respective communities. These chaplaincies also serve as frontline focal points for safeguarding within their communities.

However, there is often a lack of engagement with children, youth, and adults, particularly those with disabilities.

Whilst there are materials on the NOPS website in relevant languages, the team noted that most posters in parishes were in English. Even for those with English as a first language and in spite of clearly written and accessible promotional materials, it

seemed, based on feedback from a number of interviewees, that safeguarding was not always fully understood by them and/or what the implications were for their roles.

Criteria 3: *has written procedures that direct all claims of sexual abuse or misconduct involving members of the clergy or religious congregations be referred immediately to the National Office for Professional Standards*

All dioceses and congregations have adopted the APTH protocol for responding to cases of sexual abuse involving clergy and religious. Clergy and parishioners interviewed all had a clear understanding of their responsibility and how to refer to NOPS and or the police.

Congregations have their own protocols and procedures for managing complaints that do not fall under the scope of APTH ("non-APTH" complaints).

The team saw examples of complaints involving members of religious congregations reported and managed by NOPS through APTH and reviewed the safeguarding documentation of the congregations visited (Society of Mary and Sisters of Mercy). This indicated some elements of good practice were in place but further work was still required to fully develop their safeguarding measures. Others recognized they still need to contextualise the APTH protocol, in areas such as the initial assessment of concerns, the process of case resolution, survivors' assistance and longer-term support, the implementation of safety plans for respondents, or the internalization of lessons learned from these complaints.

Criteria 4: *Written processes to manage all other concerns and complaints*.

''All other concerns and complaints'' refer to concerns and complaints that are not under the scope of APTH. From interviews and mapping of documents available on the diocesan website, it seems that at least three dioceses have developed written procedures, which are published, for handling concerns not involving sexual abuse by clergy or religious.

Dioceses and congregations are committed (through Bishop and Congregational Leader signature) to the church's' "Safeguarding Policy". The Policy refers to procedures on how people can make a complaint but doesn't give the details.

Some parishes do not have their own written procedures for dealing with issues that do not fall under the scope of APTH, but most appear to follow the NOPS flow diagram *''What to do if you receive a call or visit about abuse or harm?*".

Some parishes' officers reported they are still challenged by the 'grey areas' of concerns i.e. how to assess the level of significance with regards to safeguarding.

It was reported that that in many parishes the parish priest with his parish council (including those responsible for complaints, safeguarding) would resolve the day-to-day concerns or complaints (about the running of the church) and they would refer all other concerns and complaints to the bishop and police authorities (if relevant) e.g. sexual misconduct by a lay person, spiritual, emotional, or physical harm or neglect by a priest. There does not seem to be a consistent, written set of procedures to guide

responses or a common understanding of the pathology of abuse and not all procedures seen are up to date.

Whilst accessible online on the national safeguarding website, it is unclear how the existing procedures have been shared with more 'difficult to reach' communities. We did not see these materials about procedures and reporting mechanisms displayed in the dioceses/parishes.

Congregations tend to have fewer active ministries under their direct control and follow their own procedures, as determined by the nature of the work undertaken.

Criteria 5: *Access to appropriately trained personnel to respond to the complainant and respondent in a manner that is timely and considerate of needs*.

All NOPS personnel are recruited to ensure they have relevant experience in safeguarding and case management, are from a variety of backgrounds and receive regular supervision and team support.

NOPS staff, bishops and priests as well as safeguarding leads have received training on safeguarding, through enrolment in the SCCANZ self- study online training (3 months) and this has been completed by all SG leads. We were informed by NOPS that not all Bishops and congregational leaders had completed the SCCANZ course at the time of the assessment. This training provides an overview of abuse and its impact on people, the law (Church, civil and criminal) and appropriate behaviours (for more details see section on standard 5).

NOPS also developed a training for priests, on the standards-based document "Integrity in Ministry" (code of conduct for priests) which includes behaviours expected when responding to concerns.

The diocesan SG leads also have opportunities to learn from one another during their monthly meetings with the NOPS Director. Safeguarding staff can access online resources in NOPS and dioceses websites.

All safeguarding personnel involved in receiving and responding to complaints, while they have undergone some level of training, the assessors believe that further support is needed to deepen and increase their understanding of providing on-going survivor-centred support to complainants and that the current training needs to be further developed to achieve this.

Complainants [2] who choose to access the Accident Compensation Corporation (ACC) claims process[3] may be referred to expert counsellors. We were made aware of cases where dioceses have established connections to external groups and expert support. There are specialist experienced counsellors throughout the Church, but it is recognised that given they are perceived as 'the Catholic Church' they may not in the circumstances be viewed as appropriate supports, especially by survivors. However,

[2] Note reference to complainant/survivor in terminology above. ACC and APTH refer to 'complainants' whilst we are using 'survivor' in this report.

[3] Most people in New Zealand are covered by this no-fault scheme if they've been injured in an accident. The cover ACC provide helps pay for the costs. https://www.acc.co.nz/

their experience could be drawn on to develop materials, train and coach safeguarding officers within the church.

There was reference to other external resources that may be used e.g. counsellors, therapists but we did not see evidence of budgets that are allocated to resource this support, nor was it clear how survivors might be signposted to access appropriate support. The case review and feedback from survivors interviewed is that those involved in the complaints process were not always sensitive to their needs. It was not possible to ascertain if respondents had similar issues.

Criteria 6: *Works with Māori to ensure provision of appropriate pastoral care and support*.

Dioceses have developed different strategies to reach diverse ethnic groups and/or people from different backgrounds, for example by adapting the training material, working with secular expert organisations or using key persons within the communities to deliver key messages.

Māori, Samoan, and Tongan people are under-represented within the NSPSC, NOPS, CAC, diocesan safeguarding leads and investigator roles, which creates issues of trust and barriers to reporting for members of these communities who do not see 'people like us' within such Church institutions, according to feedback from some interviewees. The process is predominantly led by individuals of European descent, both within the Catholic Church and its associated entities. For Māori individuals, lodging a complaint goes beyond seeking redress; it encompasses deeper spiritual values, notably *mana* to recognize and honour the sacred nature of the survivor, their family, and their community as creations, thus reinforcing *Tapu* ("sacrosanct nature")

From the case review we found that, although the NOPS' acknowledgement letter asks if there are any specific cultural considerations to be taken into consideration, there is little documentation or indication that Māori or Pasifika survivors were offered specific considerations during the investigation or case management process.

It appeared that the NOPS process of investigator appointment might match investigators to geographical location where possible but not necessarily with cultural understanding.

Criteria 7: *has clear processes to comply with the Privacy Act (Updated in 2020) and for the secure storage of information and record-keeping.*

The case review found that the Privacy Act (updated in 2020) is incorporated in protocols, contracts, access to data.

Confidentiality is a guiding principle of the NOPS investigations and in general appears to be adhered to at diocese level. Survivors sign consent forms agreeing to NOPS using their information in line with the Privacy Act 2020.

The team heard that some survivors feel the implications of what they are signing are not fully explained to them, and expressed concerns that there could be breaches of confidentiality, which could also reflect the need to better explain to survivors what

confidentiality means in the process and the steps taken by the case management team to ensure breaches do not occur.

2. Standard 3 - EFFECTIVENESS

There are clear documented processes and procedures to report complaints or concerns and these are widely publicised and known. Cases escalated to NOPS are recorded and monitored centrally. There are trained and supported staff within the NOPS system to respond. Cases that are assessed to be either not of a sexual nature and/or not involving clergy or religious congregations are referred to or managed by members of the diocese/parish and the response is variable with weaker recording and less understanding of safeguarding.

According to records provided for this assessment, the NOPS office has received 141 concerns in the last 5 years. The case completion rate is 57% of the cases and the average duration of the process 14 months, illustrating the challenge of resolving cases, especially historical cases.

According to the case review, the average duration of the *completed* investigations is 8 months although 3 investigations are still ongoing after 15 months. The average time to complete a case is 11.5 months (although three are still open after 17 months and can be as long as 3 years 9 months).

Almost half the cases are of a historical nature relating to the time period from 1960-1990. Interviews with investigators, CAC and NOPS confirmed the challenges of investigating historical cases. Recognising that the survivors we heard from had personal concerns with the APTH/NOPS process, most survivors and their network representatives believed the process had failed to adhere to the principles of the APTH.

Some felt they had been further harmed, due to the process not being sufficiently culturally sensitive and survivor-centred, transparent, accountable, and independent to enable justice to take its course. The assessment has identified some evidence to support this. However, the team did receive positive feedback from a member of a support association who had accompanied two survivors through the APTH process that was described as 'complex'. The reflection was that the process had been respectful, and the survivors were happy with the results.

Based on the case review and interviews with survivors who have experienced the complaints procedure, the process for making a complaint is not as easy or accessible as it could be, and the response process is not perceived to be 'prompt' or 'fair'. In addition, it is not as 'survivor centred' as international standards require, nor its own aspirations (APTH protocol) would expect.

There is currently no nationally agreed protocol or process on how non-APTH complaints are handled or monitored. This increases the likelihood of ad hoc and inconsistent practices and could hamper the monitoring of the kind of issues arising and learning on how well they are managed.

The team found evidence of only three dioceses having written and published procedures and these do not describe in detail how different stakeholders are involved in the case management, their roles, and responsibilities.

A recent commissioned audit of safety plans highlighted a lack of consistency and monitoring within and across dioceses, insufficient written records, or documentation on how decisions are made to implement or not implement a plan.

The overall training strategy lacks the specification and implementation for all levels of the organisation. It is therefore not possible to easily assess the quality, effectiveness, or impact of the strategy. While all volunteers and employees of the dioceses receive a mandatory 2-hour safeguarding workshop, the other main vehicle for more in-depth safeguarding training appears to be the Safeguarding in the Catholic Church in Aotearoa New Zealand (SCCANZ) online training course developed by NOPS for all those involved in ministry in the Catholic Church, whether in a paid or voluntary role.

The assessment team did not review the content of the course but it appears to be a laudable attempt to provide a widely accessible and reasonably comprehensive introduction to safeguarding. For some, it will need to be complemented by more specific, in-depth training e.g. detection and reporting with practical, contextual case scenarios and tailored to the specific functions of the stakeholder.

We did not identify specific training on case management for those involved with non-sexual cases at parish/diocese levels. Whilst some interviewees had been trained on trauma related responses there was a lack of understanding (but not opposition) to what might constitute a survivor centred approach at each stage of the process.

NOPS work with independent investigators who are often former police officers. Whilst they themselves have good experience and are trained in conducting investigations into sexual crimes, the investigators interviewed would welcome more specific training and guidelines on investigations. From interviews with survivors and the case review, the range of investigation skills need to be broadened to include survivor-centred approaches to investigation.

3. Standard 3 - APPROPRIATENESS

Standard 3 is commonly used in secular and faith-based organisations and appropriate for safeguarding in the church. For the Church, this standard is a prerequisite to demonstrate Church commitments to gospel values, religious teachings, priests' vows of celibacy/chastity and fidelity to Doctrine, "Integrity in Ministry", the Church's Safeguarding Policy, etc.; and align with Church canonical and legal obligations on duty of care, protection of people and harm prevention. Implementation is intended to ensure an environment of trust and credibility where anyone can raise a concern about harmful behaviours and be sure it will be taken seriously, investigated thoroughly and appropriate action taken to address wrongdoing and provide justice for survivors.

Consultations on appropriate, safe channels for reporting need to be regularly reviewed to build trust and remove barriers e.g. for people with disabilities, for children.

The case management process involves several entities and stakeholders who receive details of the case. Survivors noted that it is difficult for them to understand who knows the details of their abuse and it is difficult to "navigate the system alone".

Survivors have consistently raised the concern that the members of CAC are anonymous and there could be conflicts of interest if the same persons are members of

the NSPSC and NOPS. The assessors did not identify any apparent duplication of roles. Nevertheless, some interviewees informed the assessors of what they understood to be connections between CAC members based on their professional backgrounds. This may or may not be the case, and in any event would not necessarily create conflicts of interest (unless there were any duplication of roles within the various bodies) but the lack of transparency is creating mistrust and leading to perceptions of, or speculation on, conflicts of interests/and or duplications for some groups, especially survivors.

This lack of transparency also led to expressions from some interviewees of their lack of trust in the process and also concerns that the people making decisions were of a certain type and not necessarily representative of the Church or them. Although there may be no or little basis to this, it is important the Church appreciates the impact of its processes and the way in which these are experienced, especially when some areas of decision-making and influence are very opaque.

At the same time, structures within the system are kept isolated from each other. For example, the church entity is not obliged to inform NOPS on whether it accepts and implements a CAC recommendation. The lack of visibility is also true for the Church when it comes to 'non-APTH' complaints.

The enforcement of the standard depends on the understanding and genuine interest of the church authorities and congregation leaders, their personal commitment and engagement rather than a structure that holds its leaders accountable. Secular organisations would generate this accountability through, for example, performance management and key performance indicators (KPI).

Summary

Strengths

- Reporting & Response system and protocol in place for escalating
- NOPS is clearly responsible for managing allegations of sexual abuse committed by clergy and religious
- Staff and consultants involved in case management have good skills and capacity
- Access to informed investigation companies
- Access to support for survivors is in place (counselling funded by the Church)
- Confidentiality and privacy of survivors, respondents and witnesses respected
- Complainants continuing to report cases (historical and current)

Progress has been made on compliance and increasing awareness, establishing structures and developing procedures and guidance that are appropriate to respond to and investigate allegations of sexual abuse involving the clergy. Procedures for responding to other safeguarding complaints are less clear and understood. There are areas for urgent improvement particularly with regards to the timeliness of responses, clarity on leadership accountabilities and responsibilities within the structures and ensuring consistently compassionate, survivor centred approaches.

4. Standard 3 - IMPROVEMENT

KEY PROPOSED IMPROVEMENTS – STANDARD 3

The following are some examples of the recommendations developed by GCPS Consulting based on the above findings, for consideration by the Church in regard to its procedures and practices to respond to and manage concerns, allegations and complaints:

A. Capacity Building

a. The capacity of individuals involved in case management should be further strengthened through developing additional guidance for addressing "grey area" concerns and facilitating sessions with parish safeguarding personnel that include real-life case scenarios, comprehensive training including training on survivor-centred approaches, detection, reporting, and understanding the signs and impacts of abuse.

b. Investigation guidelines that cover trauma informed and survivor-centred approaches should be developed for investigators and these topics covered in training.

c. Consideration should be given to drawing on additional external expertise, e.g. psychiatrist, therapist, counselling from outside as well as within church entities.

B. Reducing Barriers to Reporting

a. Dioceses could engage in consultations to identify existing barriers to reporting and improve the accessibility of reporting channels and empower the leaders of Ministries for youth, the elderly, or people with disabilities, including the Deaf Ministry, Māori and ethnic communities, to raise awareness and facilitate the detection and reporting of concerns.

b. Each diocese and congregation should contextualise the APTH protocol, ensuring clarity and understanding of current process and roles in receiving, assessing, referring to NOPS, survivors support, case resolution and implementing the final decisions.

c. Each diocese should develop or update and disseminate written complaint procedures for addressing of “non-APTH” concerns, establish a register to track all reported concerns and design relevant communication strategies and material to inform parishioners about the reporting channels alongside the professional conduct standards.

C. Keeping people safe

a. The key recommendations of the recent TRT audit of safeguarding/safety plans must be addressed, implemented, and actions documented within a clearly defined timeframe. This includes recommendations for more and better risk assessment, and developing national guidelines to ensure information is shared between the church and entities.

D. Survivor-centred safeguarding system.

a. There is a pressing need for constructive dialogue between the Church and survivor representatives, as the current level of distrust is detrimental to survivor healing.

b. Survivors and ethnic minorities should be represented or participate within Church entities involved in case management, such as NOPS, CAC, and investigator teams, and be part of the process of designing the Complaint Protocol recently presented to the NSPSC.

c. Survivor support needs should be identified and documented early in the complaint process, and support extend beyond basic pastoral and therapeutic care. This support should be survivor centred and provide culturally sensitive options from services within and outside the church with a single point of contact (supporter) for the survivor. When made, apologies need to be culturally appropriate, such as an *ifoga* (Samoan ceremony of apology), involving the survivor, his/her family, and the community, with an expectation for a direct apology from the bishop.

E. Timely informed responses

a. The Church/system needs to become more responsive, providing timely solutions for investigations that extend beyond 3 to 6 months.

b. The Church authority should document the consultations with the respondent and the survivor and share the final decisions to NOPS more systematically and in a time bound way.

c. Survivors should be better informed of the option to request a review.

F. Learning at an institutional level

a. There is a call for increased focus on documenting the lessons learned and recommendations from each incident. The investigation report should include (as

a separate document) the learning and recommendations from the case, including observations on any aspects of Church culture or other factors that might have enabled or prolonged the abuse.

G. Receiving Complaints

a. Expand the existing channels for reporting complaints to NOPS with relevant languages, use of other media to make the system more accessible youth, people with disabilities, and those who cannot read. Provide information and contact names for reporting complaints that do not concern sexual abuse or sexual misconduct by clergy and religious.

b. Improve understanding and awareness of the internal referral system that allows a church entity that receives a complaint in error to re-route it (with consent of the individual) to the relevant authority (to streamline process and prevent unnecessary re-traumatising of the complainant).

c. Improve understanding and capacity of recipients of complaints (or those to whom the complaint is referred) to assess whether the behaviours described are indicative of patterns of abuse. This is an important factor in preventative interventions.

H. Initial Assessment

a. Ensure there is clarity on who and how decisions are being made and these are documented.

b. An initial assessment of the survivor's physical and emotional needs should be made and addressed at this point.

c. A timeframe for managing the case should be identified at this point with oversight of any modification as the case proceeds.

I. Decision Making

a. The survivor centred approach requires consultation with the survivor before deciding how to proceed with the complaint.

b. Whilst respecting confidentiality, key stakeholders should be informed of safeguarding/ safety plans as they will be required to monitor the plan. (This is one response to the recommendations from the safeguarding/safety plan audit October 2023)

J. Reporting on Outcomes

a. In the proposed annual public accountability report, performance timelines for case management should be included. With regards to a timeline for responding to new complaints (APTH related or at diocese level) it is good practice to establish specific response times for each stage of case management.

K. Decision Making

a. Increase the numbers of CAC members or reduce the quorum to ensure that investigation reports are considered in a timely manner and the rationale for recommendations is included in the CAC report to the Church Authority.

b. Survivors should be informed of the option to request a review at the time when they receive the result of their complaint (in writing and/or verbally). Given this can be emotionally charged, a follow up call and written information (including the 6-month period to request a review) should be made.

c. The review of a case should enable verification that each step of the process has been respected and assess the consistency between the findings, the recommendations, and the final decisions as the current decisions are made by three different entities.

L. Disposal /Closure

a. Ensure that the lessons learned stage in case management are fully documented and ensure these lessons are always communicated back into the safeguarding system to improve prevention and response.

Standard 4. Monitoring Compliance with National Policy

The standard:

"Church entities develop a plan of action to assure compliance with the standards."

Clarification:

In our interviews we noted that questions about the existence of ''Safeguarding Plans'' in the dioceses, parishes and congregations were understood at times to refer to the individual safety plans for respondents to allegations of abuse and not a comprehensive strategic timebound plan for implementing activities. These are two different plans and purposes and the team has tried to specify which is being referred to.

Standard 4 - COMPLIANCE

Criteria 1 - *Church entity will have a planned approach to ensure and evaluate its compliance with the safeguarding standards. The plan is reviewed annually*[4]

At National Level:
NOPS has a clear monitoring mandate and has put in place a robust monitoring system, with annual surveys, self-assessments and audits. There are good levels of compliance with monitoring requirements across the church system.

NOPS monitors safeguarding through monthly meetings with the diocesan Safeguarding Leads, the self-assessments (if shared), periodic audits and regular reports to the NSPSC that, in turn reports annually to the Mixed Commission. Minutes of meetings record decisions but transparency of how decisions are reached by the Mixed Commission is not clear in terms of the rationale of some decisions or the key points of the discussion.

Bishops and Congregation leaders are required to be informed on an annual basis by the Safeguarding Lead or officer responsible of the results of the self-assessment /review against standards. Most bishops seem to rely on delegation to NOPS and the SG leads to ensure that safeguarding expectations are fulfilled but it was less clear from the assessment how closely bishops monitor their progress.

As noted in Standard 3, it is less clear how decisions are made and when congregations are monitored. An example of good practice and coordination is when diocesan Safeguarding Leads provide technical support and annual forums are held to include SG Leads in religious congregations.

NOPS tracking lists are maintained with the number of audits completed from 2019 - 2023. Deloitte's review in 2021 noted the need to assess progress for these religious congregations and the number audited by NOPS post 2021 reflects implementation of

[4] For the purposes of conciseness and reducing repetition, GCPS has merged two indicators (4.1, 4.4)

this recommendation. With regards to how religious congregations are supported to implement the audit recommendations, the Mixed Commission Minutes 2022 included mention of special support (unspecified) for one congregation unable to address issues identified in their audit.

At Diocese level
Each Diocese has the position of a Safeguarding Lead (currently 3 females, 3 male) reporting to the general/business manager or directly to the bishop and these positions are tasked with coordinating safeguarding activities.

The Safeguarding leads are a reference point and conduit for NOPS and meet with the NOPS Director monthly. Plans were seen in all dioceses visited and focused on ensuring compliance, primarily that all staff and volunteers are police vetted, attend training (2 hour) on the basics of safeguarding and the 2-person rule and recorded as induction and refresher training. Planning to accompany parishes to complete the annual self-assessments were also seen. Congregations visited had completed or were in the process of completing the self-assessment that forms the basis of these plans. Consolidated reports by NOPS to the NSPSC demonstrate good progress in implementation with a high level of compliance. All dioceses either have, or are in the process of developing, long term safeguarding plans.

The dioceses have diverse arrangements and dynamics that may not reflect an assessment of safeguarding need and workload, or the time needed to share learning. There appears to be a correlation between the amount of time dedicated to the safeguarding role and the effectiveness of safeguarding within the different dioceses.

In all locations, even where there is a Safeguarding full-time position, there appear to be some delays in timeframes for annual self- assessment and 3-yearly audits. However, the assessments have potential as a tool to assess quality (not just compliance) as some entities explained they were taking time to complete the self-assessment and using the opportunity to reflect in-depth on their practices.

Business Managers (named General Managers) are appointed in dioceses and have good oversight of the compliance requirements and plans. There is evidence they support good practice and assist leadership in monitoring and progressing the safeguarding agenda.

A planned approach to compliance requires planned resourcing and how this is achieved was less clear. We did not see a budget report on safeguarding or levels of investment in prevention and response. We heard that there have been resources for safeguarding materials and content on diocese websites, for case management/redress, training, and support to parishes for self-assessment but it was less clear how the safeguarding budget is planned and determined.

There appeared to be limited practice of including safeguarding in risk assessments. Notable examples of where this was happening was when the Safeguarding Lead or

youth group leader had a background or capacities in risk management and when an individual safeguarding/safety plan was being put in place.

At Parish level:
Plans, practices and skills vary across parishes, which is partly a reflection of subsidiarity, the demographics of the parishes, the prioritization of budget i.e. volunteer or remunerated. We heard deep regret of what had been reported in the Royal Commission, observed a strong commitment to ensure robust safeguarding at a parish level but a need for more in-depth understanding of safeguarding. We heard observations that some safeguarding leads were not skilled or not appropriate for the position.

Good examples were seen in one parish where there is a Safeguarding Officer, a Complaints Officer and a Parish Secretary as members of a Safeguarding Committee led by the Priest. Plans have been developed in collaboration with the SG lead and NOPS (National Office for Professional Standards) and informed by self-assessments and external reviews. Whilst it is recognized that most parishes will not have this level of resources and proximity of expertise (NOPS), we did observe how some parishes access NOPS resources and post them on their own websites. These models can be adapted and learned from.

Criteria 2 - *Undertakes an annual self-review of safeguarding practices*.

Our assessment found an estimated 100% level of compliance on completing the self-assessment but also heard of challenges with regards to completing it annually with any level of consultation. Some Safeguarding Leads have spent time sitting with key personnel in the parishes to help them understand the requirements in the self-assessment and this has proved valuable orientation to increase understanding of the scope of safeguarding. It was reported that subsequent self-assessments have required less accompaniment. However, the team heard from one safeguarding lead in a religious congregation that he had completed the assessment himself without any consultation with other stakeholders.

The time resourcing required for the self-assessment process is significant but if seen as a learning investment, it is efficient. The team heard of an example where discussions in one parish had led to including safeguarding requirements in contracts for the hiring of premises and one safeguarding lead has developed an internal process for scoring parishes so they can see they are addressing and improving practice in their annual reviews.

In cases where a second or third self-assessment has been conducted, it appears there has been more consultation with functional leads, but we did not hear of any plans to make the consultation wider and more inclusive of iwi, young people, parishioners, or survivors. This appeared to be due to not having thought about it rather than opposition to the principle. If the process is to become more inclusive and consultative, there will be a need for the SG lead to accompany the process and for the church leadership to ‘champion’ the process.

As the self-assessments are repeated, it will be important to move from a purely compliance exercise to a perception of the tool as also the basis for a conversation within the entity and its leadership, rather than simply a duty of the leadership. This seems important as leaders need to develop listening and communication skills on safeguarding and a deeper understanding of what it means to people on daily, practical basis.

Criteria 3 - *Meets its own designated reporting requirements*.

Reporting upwards is well documented through NOPS procedures and all interviewees were aware of what is required.

Some priests and the bishops interviewed assured that they take an active interest and receive regular reports from the Safeguarding Leads and ensure safeguarding is a regular agenda item at diocesan meetings, the NSPSC and Mixed Commission.

The Standard requires the bishop or congregation leader to be informed in writing of the level of compliance found in the annual self-review but accountabilities for action are less clear. This applies to both general safeguarding measures and for cases that are not sexual abuse involving clergy.

In cases that are assessed by CAC, the recommendation is referred back to the bishop or congregation leader but there is no accountability, transparency or timescale on how decisions are made, and action taken. This lack of transparency within the structures contributes greatly to survivors' dissatisfaction with the Church's processes and seems a disproportionate barrier that could be easily removed without compromising confidentiality.

There appeared to be some lack of clarity or consistency from our interviews regarding 'cases'. We were told there were no new cases, but subsequent discussion suggested that there is confusion in categorizing ''complaints'' or ''cases'' and cases seemed to be terminology associated with only sexual abuse perpetrated by clergy/religious rather than other forms of abuse that are addressed at diocese or parish level.

Whilst there was general support from the bishops for the continuation of collating of data (as completed by TRT for the Royal Commission 2022) this appeared to be perceived to be for internal information and management rather than transparency. The team heard of little appetite from leadership for transparency in publicly reporting the incidence of cases (new, ongoing, completed) even at a national level.

Publishing data at a national level that is compliant with national legislation is now a standard accountability and trust building practice for many international organisations, the private sector, and other faiths. Some national Catholic churches publish data on complaints/cases and the team found a good deal of support for this from those interviewed.

Criteria 4 - *Engages with the National Office for Professional Standards who will carry out an independent review of the entity's safeguarding practice with established frequency and including an independent review of NOPS itself.*

NOPS has built a highly professional team that is respected across the Church, including congregations. Between 2019-2023 it conducted 19 thorough reviews of church and religious entities and appears to have followed the recommendation made in the 2021 Deloitte's Review to adopt a risk-based approach in prioritising Church entities for review and more consistency.

NOPS has developed several (undated) practical guidelines to support practice (as is appropriate for a professional standards body) and been the main body to receive and assess complaints and implement and manage investigations. There have been capacity issues as its brief and mandate has increased with more responsibilities for training and monitoring the implementation of all standards, not just Standard 3. Minutes from the NSPSC and Mixed Commission show there have been resourcing issues, but we were told that additional funding was obtained in 2023 for staff time to follow up on audit recommendations and more consultancy time to conduct audits.

The diocese safeguarding leads have a network and regular meetings where they share practices and in some dioceses, the safeguarding lead (especially in full time positions) organises annual safeguarding meetings/forums inviting all priests and congregation leaders to foster knowledge and common understanding.

Summary

The Church has detailed planning processes that are widely known, followed, and reviewed, if not fully understood. The assessors found high levels of compliance in the dioceses visited and recognise that compliance may be less consistent at parish level and amongst religious congregations but anticipate the plans will reflect this going forward.

2. Standard 4 – EFFECTIVENESS

The implementation of some aspects of the National Policy is successful and is a positive step in contributing to a reduction of potential harm. The requirement for police vetting of staff and volunteers is a measurable indicator that appears to have been accepted consistently across the church (even if not always understood) and there is wide compliance with the 2-person rule.

Generally, albeit with a few exceptions, staff and priests of the parishes visited knew who to take their concern to. The parishioners coming to the Church have access to NOPS posters that indicate who to report to, which in some parishes also included the contact details of the parish complaints officer. However, it is less clear that there is a consistent understanding of how the culture needs to change and complying with the standards alone does not encourage this understanding.

Meeting the reporting requirements needs to be achieved through more openness, inclusion and consultation with youth, people with disabilities, survivors and not just by obeying rules and prohibitions. Moving beyond basic compliance will only happen when safeguarding plans become more strategic, longer term and with secured investment.

The NOPS convened monthly meetings of the diocesan Safeguarding Leads, their informal network, the annual forums, and reflection meetings are good opportunities for learning and best practice to be shared between and across parishes and dioceses. However, more systematic sharing of plans and good practice including between leadership in the parishes/diocese would be an effective way to promote improved safeguarding.

There is a lack of transparency and accountability for Individual safety plans, so it is difficult to assess their effectiveness and relevance. Whilst confidentiality needs to be respected, it is not clear how these plans are identified, monitored, reviewed, or assessed or how the restrictions or prescriptions they impose on the priest, or other individuals, affect them.

3. Standard 4 – APPROPRIATENESS

Standards are a good tool used widely in secular organizations and the monitoring procedures are at an appropriate level to monitor compliance. However, these processes are only as good as the quality assurance and ownership that should accompany them. The team heard inconsistent views on who ‘’owns’’ the standards - generally it was seen as a NOPS tool.

The team heard that ‘’subsidiarity is a strong principle unless it involves safeguarding when it needs to be centralized and regulated by NOPS’’. This may be appropriate for the size of the Catholic Church in Aotearoa New Zealand, but safeguarding capacities still need to be developed at parish and diocese levels as this is where the prevention and initial response needs to be located. Whilst there are strong upward accountabilities, a ‘’pinch point’’ appeared to be a lack of clarity on what NOPS is responsible for and what Church leaders (bishops, congregational leaders, key staff, and advisers) are responsible for.

Dioceses and parishes have developed safeguarding skills and approaches that reflect the level of competence and time allocated by the Safeguarding Leads. A baseline has been established but there is a lack of shared, consistent vision on what needs to happen next on the safeguarding journey and understanding of using risk to assess prevention. For example, unequal resourcing of safeguarding will impact negatively on smaller dioceses or congregations.

The lack of inclusion of iwi and consultation with other groups e.g. people with disabilities and especially youth, does not seem appropriate for a church in current times. Aotearoa New Zealand is an increasingly multi-cultural society, and the Catholic

Church is welcoming clergy from other countries. Whilst there may be issues to address with regards to traditions of clericalism, this could also be seen as an opportunity to promote more consultation and engagement on safeguarding. One parish team described their ‘’My Parish, My home” approach that is particularly helpful for people to understand safeguarding.

Summary

Strengths

- Dioceses and parishes signed up to safeguarding standards
- Good level of monitoring is being implemented (scope and detail). Minimum of one round of the Self-Assessment process everywhere (some 3 times), minimum of 19 NOPS audits completed.
- Plans based on recommendations from reports, adapted to different contexts and evidence they are part of management plans, and meeting agendas at diocese level
- Resourcing is available for safeguarding
- Religious congregations have own safeguarding leads and are engaged in safeguarding processes incl. Self-assessments

Centralizing the safeguarding system at the national level (development of procedures, tools, monitoring, training) is appropriate for the size of the church in New Zealand but more clarity is needed on roles and responsibilities at specific levels. This is particularly true for NOPS, that is managing a range of expectations (at times unrealistic and may increase as a result of implementing the recommendation from the Royal Commission). In clarifying roles and responsibilities, more attention should be given to consultation with and inclusion of those who are currently excluded e.g. Māori, immigrant communities.

4. Standard 4 – IMPROVEMENT

KEY PROPOSED IMPROVEMENTS – STANDARD 4

The following are some examples of the recommendations developed by GCPS Consulting based on the above findings, for consideration by the Church in regard to its plans of action to assure compliance with the standards:

A. Resourcing based on needs assessment.

a. Develop a medium to long term national strategic plan with budget based on an assessment of meeting standards.

b. Ensure the allocation of resources for safeguarding measures reflects an assessment of need through robust monitoring of the safeguarding plans at regular business or management meetings.

c. Consolidate and track investment in SG at national level to identify the balance between spending on prevention and response and to develop a multi-year plan.

d. Consider investment in a nationwide information/case management system to improve the consistency of data and ability to track trends whilst recognising the effectiveness of these systems is dependent on maintaining trained personnel to manage the system.

B. Monitoring Risk

a. Implement with a tight timeline (reflecting the current level of risk) the recommendations of the recent audit of individual safety plans (whether case pending or concluded).

b. Introduce more risk-based assessments for long term safeguarding (not just for an event e.g. RAMS)

C. Monitoring performance

a. To generate clearer accountabilities, include key performance indicators (KPI) for safeguarding in performance management processes.

b. Increase consultation/inclusion in developing and monitoring plans.

c. Increase the monitoring of survivor centred perspectives: Engage with survivors and their networks to better understand (listen and learn) the impacts of their

disclosures and case management. These responsibilities do not have to be undertaken by the priest or congregation leader, but the listening and learning should inform how safeguarding is implemented.

D. Transparency

a. Follow other faith-based institutions and secular organisations by publishing an annual complaints/accountability report at national level that includes feedback from clergy, parishioners, congregation members, survivors on monitoring progress: 'How are we doing?''

E. Learning

a. Improve learning and build on best practice through peer-to-peer learning for bishops, priests, and others, as well as Safeguarding Leads. The former might encourage the bishops to share what they have learned from responding to cases and inform prevention and safeguarding plans and budgets.

STANDARDS 1, 2, and 5

Strengths

- Dioceses implementing Safeguarding measures
- SG leads in each diocese, pro-active with good practices
- Messaging on response across many entities (NOPS posters)
- Examples of multiple languages communications on NOPS and dioceses websites
- Consistency of basic Safeguarding practices (Police vetting, 2-person rule, 2-hour SG induction workshop)
- Reports that safeguarding part of church discussion and discourse
- Training programmes available and uptake good – e.g. SCCANZ review

Standard 1 – Communicating the Church's Safeguarding Message

The standard:

"Church entities appropriately communicate the Church's safeguarding message."

1. Standard 1 – COMPLIANCE

NOPS has developed communication material (posters and flowchart) on current contact and reporting mechanisms (Cf. section standard 3) that were clearly on display during GCPS' visit. NOPS posters are accessible on the website with translation (but a Māori version of APTH was not seen) and Safeguarding Leads are responsible for identifying and disseminating materials at diocese level (NOPS report to NSPSC Nov 23).

All dioceses have safeguarding plans that include some communication activities e.g. 2-hour workshops, safeguarding fora delivered by the Ministry leaders.

Communications between the different structures within the safeguarding framework (cross referenced with governance) needs to be developed and reviewed. For example, the bishops do not systematically communicate their final decisions to NOPS (cf. standard 3 section).

2. Standard 1 – EFFECTIVENESS

The people we interviewed are aware of Safeguarding, even if they see it through the lens of the NOPS response to sexual abuse involving clergy/religious and not the prevention aspects and responses to non-sexual abuse concerns. The Safeguarding Culture Standards were less familiar but not new to interviewees. The Safeguarding Leads have been instrumental in raising awareness and have "put Safeguarding into the

discussion" to the point that there appears to be a reasonable level of confidence that if someone saw something wrong and wanted to report it, he/she would be able to find information on who to tell and how and know who will follow up on the concern or complaint.

Traditional communication patterns need to change, and the communication skills of the clergy improved to build trust and transparency. The abuse impacts not only on those most closely involved but also on congregation and parishioners e.g. the impact of the standing down of a priest and these matters can be talked about without compromising confidentiality. There appears to be confusion between confidentiality and secrecy, and we recognise talking about these matters requires specialized skills that not everyone has but there is an absence of learning from each other across clergy, parishes and dioceses.

3. Standard 1 – APPROPRIATENESS

The safeguarding communication by entities focuses on how to report on sexual misconduct and what response to expect. It is less detailed on prevention and other types of abuse, yet these are included and defined in the Safeguarding Policy 2018. Most of the communication material is accessible to adults who can read but weak on accessibility e.g. persons with disabilities. There is poor communication with children and young people.

Currently there are no "child voice" resources available from NOPS but we note it is included in the 2024 Strategic Plan. This is a major gap, especially as it has long been recognised that children who are made aware of the commitments to keep them safe and what to do if they are harmed or feel at risk of harm are more likely to seek protection. As a consequence some children may have remained in abusive or highly risky situations due to a lack of knowledge or encouragement to speak up. It should be recognised that this area of development has been planned for some time and various impediments have delayed progress.

However, the church is now looking to safely gather the views of children and young people in order to develop appropriate resources. There is also a vast amount of excellent existing material available externally for working with children and young people on all aspects of safeguarding that the church can make good use of.

There might be a need for different communication materials for overseas priests as part of their "induction". Similarly, there is a growing new community of migrant parishioners with their own understanding and practices. We heard several comments that immigrant communities have different understandings and priests are too clerical and understand pastoral care differently. This seems to be a communication/understanding issue rather than a lack of commitment to keep everyone safe.

4. Standard 1 – IMPROVEMENT

KEY PROPOSED IMPROVEMENTS – STANDARD 1

b. The Church should plan to develop a more comprehensive, principle-based communication strategy that recognizes its hierarchical structure and local differences but is based on ways to listen and communicate with congregations inside and outside the church.

c. The Bishop Conference should consider agreeing and monitoring safeguarding performance indicators for dioceses and parishes to enhance leadership and accountability of the bishops, priests & congregational leaders.

d. Develop greater consultation and engagement between parishioners and congregants to enhance communicating on safeguarding, its implementation and consequences.

e. Efforts to be more transparent and accountable and communicating within and outside the church could be by improved by consolidating data collection and publishing top-line information at national level on the numbers of complaints received (sexual and non-sexual) and resolution. Accompany this with learning, recommendations, and specific measures.

f. Build on the use of social media and online communications and ensure there are audience specific safeguarding messages for prevention as well as reporting.

g. Consider more listening and consultation on creating a secure and supportive environment (prevention) and safeguarding with the wider church community including survivor networks. Communicating with survivors and regularly bringing them into the conversation and development of safeguarding measures can contribute to reducing the current polarization and adversarial approach.

Standard 2 – Safe Practices

The standard

"Church entities provide environments that are welcoming, nurturing and safe. Members respect, protect and enhance the spiritual, physical, emotional, intellectual and social development of children and vulnerable adults."

1. Standard 2 – COMPLIANCE

There is a high level of compliance on police vetting and implementing the 2-person rule but less evidence of people knowing why they are doing it or how to adapt if there is lack of physical space when e.g. visiting the elderly or sick.

There is a digital media policy for volunteers, staff, youth leaders and reflects Safeguarding with reference to the Harmful Digital Communications Act 2015.

Safeguarding is part of the Risk Register held at the management level in some dioceses. Safeguarding risk assessments are done as part of the Safety and Security Plan for special events. The Risk Analysis and Management Systems (RAMS) includes a component on "Behaviour / Disputes including Harassment, Bullying, Cyberbullying, Discrimination".

As a result of completing the NOPS Self-assessment, entities are becoming increasingly aware of the need to include safeguarding considerations into their activities and plans e.g. hiring premises.

2. Standard 2 – EFFECTIVENESS

According to documentation received, safeguarding is not mentioned in some key leadership or management roles in many dioceses.

The term Safeguarding is not apparent in the voluntary agreement and employee contract or volunteering contract (for all).

Parishes/entities do not conduct safeguarding risk assessments for regular church activities (separate to mandatory Health and Safety and Privacy assessments) that should form the basis of safeguarding plans for activities and events.

There appears to be a lack of proactive, systematic planning for events to accommodate children/ young persons with vulnerabilities or disabilities and adapt to their needs to ensure inclusion and safety. There appeared to be little insight into assessing safeguarding risks between children and young people and no consultation with them about safeguarding measures.

3. Standard 2 – APPROPRIATENESS

Dioceses must stretch resources and consistency is a concern combined with staff/volunteer turn-over and a lack of child protection/safeguarding expertise. We met some highly competent volunteers but also heard examples of volunteers being given safeguarding responsibilities when clearly not appropriate.

We heard mixed messages about how overseas clergy are identified and how they move between different jurisdictions. NOPS has developed forms for Bishops/Leaders to sign but there appeared to be gaps with regards to acculturalization of overseas priests or any in-depth appreciation of what the priest's culture might bring to making environments safer.

The recent audit findings on how individual safety/safeguarding plans contribute to a safe environment are referred to above with recommendations for improvement. We understand that the NSPSC does not have a risk register and no evidence that the Mixed Commission owns safeguarding responsibilities within the NZCBC/CLCANZ ''corporate'' risk register.

Whilst it appears the need for a RAMS assessment is understood, there is no consultative process. For example, digital/social media is referred to in the guidance but might need to be more nuanced and reflective of trends e.g. Artificial Intelligence (AI).

In examples of the Code of Conducts seen, reference is made to sanctions if there is a breach of behaviour, but we were not made aware of what these might be and who would impose them.

The codes do not include the obligation to create a safe environment free from any form of abuse – this and a 'zero tolerance' approach to abuse is commonly enshrined in institutional codes of conduct or ethics.

4. Standard 2 – IMPROVEMENT

KEY PROPOSED IMPROVEMENTS – STANDARD 2

a. More robust practices are needed in terms of safe recruitment. All JDs should mention the post's responsibilities for safeguarding.

b. Attention is required to ensure NZ safeguarding policy and approach is understood by migrants and overseas priests. This requires more robust, culturally appropriate inductions on safeguarding.

c. Consider enhancing oversight by NSPSC (and perhaps Mixed Commission) by developing and managing a safeguarding risk register. This would ensure timely implementation of recommendations e.g. audit on safeguarding plans.

d. Consider whether NOPS should take a more active assurance role, including to be part of the NOPS review system, in relation to facilities operated by other church entities from diocesan-owned properties, especially those being used for residential care purposes.

e. Improvements are needed in all aspects of consultation with children and youth, and people with disabilities. With a few exceptions, we found an unrealistic view of what children and young people might think and do that was out of step with the actual capabilities of children and young people.

Standard 5 – Formation and Training

The Standard:

"Church personnel are trained and supported in all aspects of safeguarding relevant to their role, to develop and maintain the necessary knowledge, attitudes and skills to safeguard and protect children and vulnerable adults."

1. Standard 5 – COMPLIANCE

Formation and training are core activities for NOPS, church entities and safeguarding leads, and seminary staff. Following the periodic NOPS review at diocese and congregational level, follow up recommendations include capacity building/training.

The National Safeguarding Guidelines 2017 commits the Church to provide training for all those who are involved in ministry with children, young people and adults who are vulnerable. The updated Course was launched in 2021 with NOPS responsible for the content and Te Kupenga for its delivery. A consultative review of the substantive training programme (SCCANZ) was conducted in July 2023 by a team comprising an independent consultant, a canon lawyer, 2 representatives of Te Kupenga and 2 representatives of NOPS.

NOPS has developed or made accessible and used capacity building materials:

- An online training "Safeguarding Culture in the Catholic Church of Aotearoa New Zealand" (SCCANZ)
- 2 hour safeguarding workshop for all dioceses, delivered by the SG team on a regular basis
- A training on "trauma-informed education in NZ catholic church" and links to online Webinar on trauma (https://www.skylight.org.nz/web-series/working-with-trauma/webinar-1-understanding-trauma).
- Several inductions on Safeguarding for School principals, a training on "Integrity in Ministry" for priests which has some case scenario, and on the "2 persons rule".

One diocese has very informative videos with the facilitators from local secular organisations accessible to the public on their website, and one diocese has adapted and translated the training material into Māori and made the links between Safeguarding and spiritual values. In another diocese, the SG coordinator has initiated an annual SCCANZ Kickstart day (first held in 2020), where attendees work through aspects of the course in one day with an external facilitator from NOPS.

2. Standard 5 – EFFECTIVENESS

The 2-hour general safeguarding induction programme (including 2-person guidance) plus the SCCANZ course (a 3-month online course for the individual) are the foundations of the safeguarding training. SG Leads have initiated other types of training and safeguarding discussions. It was notable that counselling support is available to SG Leads.

While the SCCANZ course was reviewed in 2023, some interviewees shared with the assessment team that they felt, while it is thorough, it was too complicated and theoretical and they were not aware of any inputs from survivor networks and felt there were few opportunities for discussion with others. It is understood from other sources that some survivors were involved in the review process.

We were informed by NOPS that not all Bishops and congregational leaders had completed the SCCANZ course at the time of the assessment. The SCCANZ course in the seminary is conducted with group discussions and external speakers.

Understandably the 2-hour workshop introduction delivered by the SG lead is generic. The sessions on "*Integrity in Ministry*", aimed to support clergy, delivered by NOPS is more comprehensive and has interesting case scenarios for discussion and, subject to the skills of the facilitator, does open the discussion to the links between spirituality, theology and safeguarding.

3. Standard 5 – APPROPRIATENESS

A few interviewees talked about the good training materials they had seen (online or programmes delivered within congregations).

Now that a baseline of understanding on safeguarding has been established and the Catholic Church has systems to respond to the urgency of historical and current case management, different training and reflection materials will be needed to continue its safeguarding journey. Ongoing mapping and sharing of effective training/capacity building materials could be one way to do that, especially material that adapts safeguarding training to minorities (ethnic groups, or people with specific needs)

4. Standard 5 – IMPROVEMENT

KEY PROPOSED IMPROVEMENTS – STANDARD 5

a. Staff at NOPS, investigators, members of the Complaints Assessment Committee, SG leads, and clergy are working with people who have experienced physical and psychological trauma within the church. Training and mentoring to understand the impacts of trauma and it ongoing effects is a requirement to ensure an appropriate professional response and care to those who engage with 'A Path to Healing' and other complaint processes.

Continue supporting this training to relevant individuals involved in case management and response.

b. Ongoing assessment of the quality of the training and formation inclusive to survivors and the survivors networks to ensure their views are included and the material is sensitive to their needs and is survivor-centred in its approach.

c. NOPS has plans for youth focused safeguarding proposed by a member of the NSPSC member that is sensible and de-mystifies working with children and young people and it will be important to recognize the amount of knowledge, technical expertise and training materials that already exist in the external environment.

d. Develop a more detailed & graduated training strategy, with clear needs assessments, that targets specific training needs of different individuals and groups across the safeguarding system to allow people to develop and deepen their safeguarding understanding and skills, in line with their safeguarding roles and responsibilities.

Part B - FINDINGS

Assess whether the current system in place to implement the guidelines (including the National Safeguarding Policy) the standards, and the various Catholic entities engaged to do the implementation, are appropriate to fulfil the principles of the National Safeguarding Guidelines and adequately support those impacted by abuse and to achieve the commitment to keep those in care safe from harm.

The assessment team was asked to reflect on the following questions and provide conclusions.

1. Has the structure had adequate means to address conflicts, irregularities, bias and complaints about processes of any sort?

Current context and perception

NOPS receives and assesses complaints of abuse (historical and current) in the dioceses and religious congregations. As illustrated in our assessment of Standard 3, the response within the diocese is unclear and can vary greatly due to a lack of understanding of what the first signs of abusive behaviour or abuse of power and authority might be. The response by NOPS to complaints is more systematic and documented.

However, it operates under the Church's canon law and the instructions of the Dicastery for the Doctrine of the Faith, so is not perceived by many survivors/complainants to be independent. The Church is perceived to control the process and, therefore, the investigation cannot be independent i.e. "investigating their own'. This dependence on the church being the only entity to address survivor complaints is exacerbated by the fact that the recourse to the justice system is often not an option for historical cases e.g. if the respondent is deceased the case will not be considered.

Survivors believe that there are conflicting objectives, and *"the set-up is wrong"*, especially because the bishops make the final decision *alone* once a complaint has been assessed and recommendations made by Complaints Assessment Committee (CAC). The decision maker may have a professional, spiritual, or personal relationships with and authority over the respondent and the survivor. The lack of transparency and accountability for these decisions is combined with the sad reality that priests, bishops, and leaders in the Aotearoa New Zealand Church have been found to have committed abuse. This has led to a lack of confidence and trust in the system.

Adequate means to address survivors' needs.

The pastoral support, redress payments offered, or the public apology made by the church have been important and sufficient for some survivors but not for others. Whilst there are skilled individuals within the system and some of the case management we

read and heard of is professional, sensitive and understanding of need, the current system appears unable to truly listen and respond to the needs of survivors and read testimonies that they felt the Church had been unable to listen and respond fully to survivor needs when they are hurt and were angered by the Church's (often delayed) actions and response.

Survivors accessing support through the Accident Compensation Corporation (ACC) for both redress and support has proved effective in some cases but is unrelated to support provided by the Church as survivors self-refer to access support from ACC. Whilst unable to verify, we did hear of some survivors' understanding that if they accepted ACC payments, they would not be eligible for redress from the Church. This may indicate a need to be more clearly communicate to address such perceptions or concerns.

There may be situations where modest financial support by the Church at the initial assessment of a complaint could help the survivor to steady his/her life and find the legal and social support needed.

The lack of independent, systematic, and documented needs assessment at the initial stage of the complaint process with guidelines for survivor support, make it difficult for the Church to ensure that the level and type of support provided to the survivor has been appropriate or sufficient.

Adequate means to support the survivors.

It is positive to see the commitment to and availability of support to survivors. Funding is made available for a counsellor or professional support nominated by survivor, although NOPS has made direct appointments for survivors where necessary. Counsellor invoices are often paid by NOPS to make it simpler for the survivor and counsellor – and then NOPS arranges for on-charging to the relevant church authority behind the scenes.

A Path to Healing speaks of a counsellor or supporter being offered to accompany the survivor through the process, and the team saw some evidence of survivors being asked by NOPS if they want to be accompanied. Direct survivor feedback to NOPS has expressed resistance to being provided with/referred to a counsellor and it is recognised that broaching support with survivors is sensitive but making the offer of support (without being directive) would communicate a proactive recognition of the survivor's need for support.

At times there appears to be a lack of understanding or comprehension that the pastoral care and support systematically offered by dioceses and congregations to survivors might replicate the circumstances, i.e. pastoral care, in which the abuse occurred and, therefore, is inappropriate.

We read and heard of examples of good practice where church people and entities did provide long term, appropriate care and support to survivors, but we also read of defensive responses. In some cases, it appeared that once the investigation was completed, the assumption was ‘’case closed".

Means to ensure timely, sensitive, and meaningful investigation and review.

Investigations are funded by the diocese or congregation, and although the team did not have access to the allocated budget for investigations, there could be budget constraints on timely investigations.

The NOPS case review found the average duration of completed investigations is 8 months with several investigations still under investigation after 15 months and up to 2 years. Data is not available on the time taken and how dioceses respond to "non-NOPS" complaints.

Investigation into historical complaints is complex. We understand from the investigators contracted by NOPS that they may record interviews, but we found no evidence that two investigators were allocated in any of the cases reviewed, as stated in Section 3 of APTH. Having two investigators as a minimum is a common standard in administrative investigations as it contributes to reducing the risk of assumptions and bias.

The NSPCS, whose role is to define strategies, is encouraged to proactively identify ways to reduce unacceptable delays in the investigations.

Means to support and monitor the respondent.

The NOPS team makes a professional judgement on how to respond at the point of receipt of the information and initial assessment of the complaint i.e. it constitutes a case to be addressed through APTH or needs to be referred to the diocese or congregation. How (and when) these decisions are made needs to be documented to track patterns of abuse and speed of response.

NOPS does not have the authority or the capacity to make decisions on what actions are taken concerning respondents. The Church authority is responsible for supporting or stepping down the respondent pending investigation or placing the respondent under a Safeguarding/Safety Plan.

Survivors told of occasions when respondents were not stood down or were not put under a Safeguarding/Safety Plan but there is no way to validate this information other than when facts come to light.

Whilst the Royal Commission identified the historical practice of removing clergy to other parishes or countries as a solution to unresolved allegations, there is limited evidence that countries now sending priests and seminarians to Aotearoa New Zealand have records of allegations of abuse amongst clergy available to them. However, we would encourage more person-to-person verbal references to check information. Recruitment practices should include at least one verbal reference as a follow up to, two or ideally three written references.

Means to reflect and learn collectively:

The striking point is that there is a global body of knowledge and reflection from across the Catholic Church and secular organizations to guide what is needed in an effective response system. Aotearoa New Zealand also has survivor networks and individuals who are willing to share and contribute to learning, yet somehow the positions between the Church and survivors have become polarized, which is obstructing much needed dialogue.

Means to ensure survivors' participation, mobilization, and dialogue:

The assessors have noted above that survivors, Māori and others are not sufficiently represented, consulted with or heard. It is the view of the assessors that their voices should influence the design of the policies, protocols, procedures, and support systems. It is useful to remind ourselves that survivors were and could still be parishioners and part of the congregation.

A constructive dialogue with survivors and congregations/members of the community, particularly those who are marginalized due to being young or persons with disabilities or for other reasons such as general disconnection with the church, must be possible and measures to address the power imbalance included e.g. consultation when NSPSC and NOPS designing and being held accountable for their strategies, plans and budget and protocols.

Resources to centralise and publish data:

Given the context of distrust and increased call for transparency, the Church is encouraged to consider publishing high-level data on the number of cases reported, under investigation and categories of cases. This data now exists because of a request from the Royal Commission and Church entities should now build on this as a confidence inspiring move towards greater accountability and increased transparency.

Means to hold the church authorities accountable:

The safeguarding system (NOPS, NSPSC and CAC) is part of the church's structure, and it exists because the church authorities and entities have decided it should exist. It has shared principles, standards and practices that can contribute to its effectiveness in keeping people in the church safe from harm. Most organizations, institutions and governments will have their own professional standards and bodies to self-regulate and maintain standards.

However, the lack of accountability between the church entities within the system and the level of 'secrecy' within which it operates is different. NOPS, CAC and survivors have very limited, if no means at all, to hold bishops, parish priests or leaders of congregations accountable for their decisions, actions or non-actions. Equally, other leaders do not have the ability to hold other leaders to account – for example, a bishop can find it difficult to hold a religious congregation to account or a bishop to hold another bishop accountable.

2. Has the structure a suitable operational capacity and appropriate governance to implement the guidelines?

Safeguarding policies, guidelines, standards, and self-assessments have established the expectations of a safeguarding culture at a national level, the "*One Church Approach*". The Royal Commission of Inquiry and media coverage has provided an impetus for the bishops and leaders to show leadership, but the risk now is that complacency and the '*NOPS will do it*' attitude sets in. A lot of attention and communication is also still about "sexual abuse by clergy/religious leaders" rather than including all aspects of abuse.

Currently it appears a significant proportion of national funding for safeguarding is allocated to NOPS. To move to the next safeguarding level on improving prevention, funds may need to be allocated according to the need of dioceses and/or congregations and be clearly identified for different aspects of the system e.g. investigations (including for non-sexual/clergy cases), survivor support, communication, training.

Leadership at national level

NOPS reports to the NSPSC which in turn reports to the Mixed Commission but the specific accountabilities are not clear and there is no mechanism for NOPS to hold the bishops and leaders accountable for their decisions, action, or inaction.

The NOPS Director has oversight of case management for historical and current cases involving sexual abuse by clergy and religious, the management of services provided by CAC and the level of compliance with the standards across dioceses/parishes and within all church entities. In effect, NOPS has the leadership and responsibility for safeguarding but accountabilities upwards and downwards are not clear with appointments to structures lacking transparency.

As previously noted in this assessment, interviews with some clergy suggested that '*NOPS will handle it*' and their decisions to allocate more funds to increase NOPS capacity might appear to be an abrogation of responsibility, especially when dioceses and parishes need more capacities and resources.

Resources are effectively organized, managed, and deployed with solid leadership at diocese level (bishop, safeguarding team in place).

There is no clarity on resources allocated to safeguarding at diocese level. In the three dioceses visited, there are different structures in place and variations exist in the other diocese not visited. Each has a SG lead position (varying time allocated), and the Complaints Officer role is covered respectively by the Chancellor and the General Manager. The SG lead develops and presents a plan, liaises with SG focal persons in religious congregations and presents progress reports on a regular basis to the diocesan board or management meeting. Oversight of the budget dedicated to Safeguarding response and prevention would facilitate analysis and be an indicator of effective leadership.

Risk Management:

Although some risk mitigation measures are in place to address certain safeguarding risks, there is no evidence of consistent and effective risk management at a strategic and systematic level that operates across the church as a whole. To our knowledge, NSPSC does not have an overall risk register which is an essential element of safeguarding oversight, leadership and risk management. The team found an inconsistent understanding of risk at all levels. Assessing risk through open, consultative processes is a key part of governance. Safeguarding risks need to be documented, held by named individuals at all levels and managing and monitoring of these forms a key part of leadership and governance.

There are platforms/opportunities for listening and participation.

Church entities need to allow space for people to feel confident to speak up. The team heard examples from priests and chaplains and complaints officers about how members of the congregation do speak up and do complain about masses, services etc. The point for reflection is whether people feel able to speak up to those who hold power about behaviours that make them uncomfortable and whether they believe they would be listened to. Specific consideration needs to be given to how Māori, youth and people with disabilities are listened to.

Adequate experience, skills/knowledge, diversity, and learning across the church.

We heard about the varying levels of safeguarding skills and competency across the parishes and the congregations. How to source and retain relevant skills if no budget is allocated may not be the same problem in the Catholic church as it is in a secular organisations, but it was noticeable that the quality of safeguarding practices and innovation increased in line with the profile of the SG lead and their time allocated.

There was seemingly an absence of peer-to-peer learning and sharing of best practice between dioceses.

A further inconsistency identified was the lack of expertise, knowledge or application in child protection and consulting with children and youth.

Does the system allow it to sanction a diocese/parish which is not making progress or is not proactive?

The team was not able to identify a specific process that would kick in if a parish was not implementing the safeguarding improvement plan or review recommendations. We heard that there are still some parishes and congregations that have no follow up plan on review recommendations. NOPS has recently funded a post to track follow up, but we heard from a number of interviewees that the most effective way to secure compliance is to 'have a word with the bishop'. Whether this accurately reflects reality or is the perception of a few, it may indicate the need for more clear and transparent monitoring processes and clearer accountability within decision making processes. Whilst this approach is not unusual in a secular management structure, the absence of other checks and accountability mechanisms could mean this is more problematic in the Catholic Church.

3. Are the principles of the National Safeguarding Guidelines and the corresponding protocols, policies, and procedures, appropriate to the context and culture of Aotearoa New Zealand and achieve the commitment to keep those in care safe from harm?

A more inclusive process to consult with survivors, ethnic minorities, youth and persons with disabilities to design and review the protocols, policies and procedures would better ensure a reflection of the context and culture of Aotearoa New Zealand. This inclusion would contribute to building ownership and trust in the system and structure. An opportunity might be the current draft of the "complaints protocol" that NOPS has presented to the NSPSC. The survivor networks are well organised and could be interlocutors to inform the church of survivors' perspectives.

We understand that work remains through the audit process on how the current protocols, procedures, policies and resources allow the church to effectively monitor compliance and accountability of the congregations to the safeguarding standards.

The Catholic Church in Aotearoa New Zealand has made a good start in developing and socializing its safeguarding structures and practice, but it needs to do more to make the system accountable with independent oversight at points in the process. Currently the church is managing its own systems with no independent oversight. Australia, and England and Wales have addressed this challenge by professionalizing and ensuring part of the system is independent of the church.

At the beginning of this assessment, we were told it was likely that the recommendations from the Royal Commission would be for an independent body to be established. In the meantime, the change of government may affect this recommendation with a hybrid of possible structures. A wise approach would be for the Catholic Church in Aotearoa New Zealand to make what changes it can (on the back of this assessment) to make the Church as safe as it can be, regardless of what is taking place in the external environment.