Catholic Safeguarding Standards Agency

Survivors' experience of the Catholic Church: A thematic review of safeguarding in England and Wales – Full Report

July 2026

Content warning

This report contains accounts of abuse and its impact on survivors. It includes discussion of disclosures of abuse, safeguarding concerns, and the ways in which Church bodies have responded to those affected.

We recognise that reading this material may be distressing, particularly for survivors and those supporting them. Readers are encouraged to engage with the report in a way that feels safe for them and to seek support if needed.

Free, independent, confidential support for adults affected by church-related abuse is available from Safe Spaces England and Wales at www.safespacesenglandandwales.org.uk and 0300 303 1056.

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1. Introduction

1.1 Coming forward about abuse can be profoundly difficult. Survivors may face a range of personal, emotional, and practical barriers when considering whether to disclose their experiences, including feelings of shame, fear of not being believed, concerns about consequences for themselves or others, and the lasting impact of trauma. In many cases, survivors do not disclose abuse at the time it occurs and may only feel able to speak about their experiences years, and sometimes decades, later. The final report of the Independent Inquiry into Child Sexual Abuse noted that "child sexual abuse is often very difficult for children to talk about and can go unreported or even unidentified for many years"[1]. For many survivors, the decision to disclose requires considerable courage and strength. How survivors are received when they come forward, whether they are listened to, believed, and supported, can therefore have a lasting impact on their wellbeing, sense of safety, and trust in institutions.

1.2 For survivors, engagement is experienced not through policies or written commitments alone, but through everyday interactions. How disclosures are received, how communication is handled, whether survivors feel respected and believed, and whether support is sustained over time all shape how survivors experience safeguarding responses. Where institutional responses fail to recognise the needs and experiences of survivors, harm can be compounded. Survivors and researchers have described this additional harm arising from institutional responses as "secondary abuse".

1.3 Safeguarding developments within the Catholic Church in England and Wales have been shaped by a series of significant reviews over the past two decades. Each has highlighted the importance of placing victims and survivors at the centre of safeguarding practice and ensuring that institutional responses recognise the experiences and needs of those who have been harmed.

1.4 The Nolan Report, *A Programme for Action*[2], published by the Catholic Bishops' Conference of England and Wales in 2001 following concerns about safeguarding practice within the Church, marked a significant step in establishing

[1] Independent Inquiry into Child Sexual Abuse, *The Report of the Independent Inquiry into Child Sexual Abuse*, 2022, The Report of the Independent Inquiry into Child Sexual Abuse p.442
[2] Nolan, Lord Michael, *A Programme for Action*, 2001, Nolan report

formal safeguarding structures and accountability. The report emphasised that safeguarding arrangements must prioritise the protection of children and vulnerable people. The review recommended the development of consistent safeguarding policies and structures across the Catholic Church in England and Wales.

1.5 The Cumberlege Review, *Safeguarding with Confidence*[3] examined how effectively the Nolan recommendations had been implemented. The review reaffirmed the importance of listening to victims and survivors and ensuring that safeguarding responses recognised the profound impact of abuse. It stated the need for the church to respond sensitively and compassionately to the needs of children, young people and vulnerable adults and to ensure they are protected from harm. (p. 26). The review also highlighted the need for safeguarding systems that can earn the trust and confidence of victims and survivors as well as the wider Catholic community.

1.6 The Independent Inquiry into Child Sexual Abuse (IICSA), chaired by Alexis Jay, examined institutional responses to child sexual abuse across England and Wales, including the Roman Catholic Church. Through the Truth Project[4], the Inquiry provided an opportunity for victims and survivors to share their experiences and have their voices heard. The Inquiry heard from thousands of survivors and highlighted the lifelong impact of abuse, as well as the importance of institutions responding with transparency, accountability, and compassion.

1.7 The Inquiry's investigation into the Roman Catholic Church[5] identified significant institutional failings in the Church's historical response to child sexual abuse. The Inquiry heard from many victims and survivors who described not being listened to or believed when they disclosed abuse. It concluded that in some cases the Church prioritised the protection of its reputation over the welfare of children and that allegations were sometimes handled internally rather than reported to statutory authorities. The Inquiry also found that institutional responses could compound the harm experienced by victims and survivors and highlighted inconsistencies in safeguarding practice across dioceses and religious congregations.

[3] Cumberlege, Julia, *The Cumberlege Commission Report: Safeguarding with Confidence*, 2007, Cumberlege report

[4] Independent Inquiry into Child Sexual Abuse, *I will be heard: Victims and Survivors' experiences of child sexual abuse in institutional contexts in England and Wales*, 2002, I will be heard | IICSA

[5] Independent Inquiry into Child Sexual Abuse, *The Roman Catholic Church Investigation Report*, 2020, The Roman Catholic Church Investigation Report | IICSA

1.8 Following continued concerns regarding safeguarding governance and accountability, the Catholic Church commissioned the *Independent Review of Safeguarding Structures and Arrangements within the Catholic Church in England and Wales*, commonly referred to as the Elliott Review[6]. The review emphasised the importance of safeguarding arrangements that are independent and transparent, stating that "to provide an effective safeguarding service, it is imperative that the voice of those that have been harmed through their involvement with the Church is heard and learnt from."

1.9 Alongside these formal reviews, research has also explored the wider impact of the abuse crisis within the Catholic community. The Cross of the Moment study[7], emerging from the *Boundary Breaking* research project led by Durham University's Centre for Catholic Studies, examined how child abuse in the Catholic Church in England and Wales has affected the wider Catholic community. The study suggested that aspects of Church culture and practice were implicated in how clerical abuse occurred and in how institutional responses were experienced by victims and survivors. Victims and survivors participating in the research described experiencing further trauma arising from institutional responses, referring to this harm as "secondary abuse".

1.10 Despite growing recognition of the importance of survivor voice in safeguarding development, there has historically been no single national survivor body or representative forum within the Catholic Church in England and Wales through which survivors can collectively contribute to safeguarding policy or practice. Survivor engagement has therefore often taken place through individual disclosures, informal relationships, independent advocacy groups, or participation in specific reviews and consultations, rather than through a structured national mechanism for survivor representation.

1.11 In the absence of a national survivor forum, approaches to survivor engagement have often developed at a local level. Some dioceses and religious life groups[8] have established their own methods for engaging with survivors, including consultation exercises, survivor listening initiatives, or local support arrangements. However,

[6] Elliott, Ian, *Independent Review of Safeguarding Structures and Arrangements within the Catholic Church in England and Wales*, 2020, Elliott report

[7] Jones, Pat, Pound, Marcus, and Sexton, Catherine, *The Cross of the Moment: A Report from the Boundary Breaking Project*, 2024, The Cross of the Moment report

[8] The term 'religious life group' is not found in canon law but used in this report as a generic term for all religious orders.

these approaches have developed independently and vary considerably in structure and consistency. As a result, survivor engagement across the Church has often depended on local initiatives rather than a coordinated national framework.

1.12 Safeguarding reforms across the Catholic Church in England and Wales have also been shaped by the principle often referred to as the "One Church approach". The Nolan Report introduced the concept of a unified safeguarding framework operating across dioceses and religious congregations. The Cumberlege Review later referred explicitly to safeguarding operating through a "One Church approach", recommending that the Catholic Bishops' Conference of England and Wales and the Conference of Religious[9] commit to a shared safeguarding model (Cumberlege Review, p. 114).

1.13 IICSA also examined how safeguarding governance operated across the Catholic Church in England and Wales. The Inquiry noted that while safeguarding structures had been in place for a number of years, embedding a consistent safeguarding culture across the Church remained an ongoing challenge. The Inquiry observed that although nearly two decades had passed since the Nolan Report and national safeguarding bodies had been established, embedding the "One Church" approach remained "work in progress"[10].

1.14 The Catholic Bishops' Conference of England and Wales formally accepted both the IICSA recommendations and the recommendations of the Elliott Review following their publication in 2020. As part of the Church's response, a Lead Bishop for Safeguarding was appointed to provide national leadership on safeguarding matters. The role description approved by the Bishops' Conference states that the Lead Bishop is to work collaboratively with the Lead Safeguarding Religious "to ensure and to model a 'One Church' strategy to Safeguarding in the Church in England and Wales"[11].

1.15 The Action Plan accompanying the Church's response also recognised that the aim of a "One Church" approach had not been achieved sufficiently robustly following the Nolan and Cumberlege reports, and that differences of approach

[9] The Conference of Religious in England and Wales represents the leaders of religious life by encouraging collaboration on the major issues facing religious today and by addressing issues from a Catholic perspective on their behalf. Conference of Religious

[10] Independent Inquiry into Child Sexual Abuse, *The Roman Catholic Church Investigation Report*, p.113

[11] Catholic Council for the IICSA, *Recommendations Action Plan*, 2021, IICSA Recommendations Response Paper, p.4

continued across the institutions that make up the Catholic Church in England and Wales. It outlined a series of structural reforms intended to strengthen national consistency, including the establishment of the Catholic Safeguarding Standards Agency (CSSA), the development of national safeguarding standards, and the creation of structures intended to support Church-wide implementation.

1.16 Safeguarding governance arrangements have continued to evolve since that time. However, within the scope of this thematic inspection, no single publicly available national strategy document has been identified setting out in detail how the "One Church" safeguarding approach is currently implemented across dioceses and religious life groups.

1.17 This continuing emphasis on national consistency alongside local responsibility provides important context for understanding how survivor engagement is organised and experienced across the Church.

1.18 While many of the historical reviews referenced above focused primarily on child sexual abuse within the Church, the scope of this thematic inspection is broader. This thematic inspection considers the experiences of survivors of any form of abuse known to Church bodies, recognising that safeguarding practice and survivor engagement must respond to a wide range of harms and individual circumstances. In parish contexts, safeguarding concerns may also arise where individuals seek advice or support in relation to abuse occurring outside Church settings, such as domestic abuse. The Catholic Church is often approached as a place of pastoral support and a point of safe contact for individuals experiencing harm, and safeguarding responses may therefore involve listening, support, and appropriate signposting to statutory or specialist services.

1.19 The Catholic Safeguarding Standards Agency (CSSA) undertook this thematic inspection to examine how Catholic dioceses and religious life groups in England and Wales engage with and support survivors of abuse currently. The inspection forms part of CSSA's role in inspecting the implementation of safeguarding standards, providing independent scrutiny, and supporting learning and improvement across the Catholic Church.

1.20 While the inspection focuses on safeguarding responses during a defined review period, it recognises that survivors may disclose abuse many years or decades after it occurred. Church bodies may therefore be responding to both

recent and non-recent abuse[12] within the review period, and the inspection considered how those responses were experienced by survivors regardless of when the alleged abuse took place.

1.21 Following these reviews, safeguarding arrangements within dioceses and religious life groups have continued to develop. CSSA's baseline audits[13] have provided a foundation for understanding safeguarding structures, governance, and policy across the Church. This thematic inspection builds on that work by examining in greater detail how survivor engagement and support are currently understood and delivered in practice. Focusing on a defined review period, the inspection considers how disclosures are received and responded to, how support is accessed and sustained, how responses are tailored to individual survivor needs, and how survivor feedback is gathered and used.

1.22 There is no single statutory definition of survivor or victim-centred engagement in the United Kingdom. However, national safeguarding and victim-focused frameworks consistently emphasise that engagement must prioritise safety, dignity, transparency, and choice, and must be capable of influencing policy and practice rather than being limited to one-off consultation or information-gathering. In this thematic inspection, survivor engagement is understood as the ethical and meaningful involvement of survivors in shaping safeguarding policies, practices, and responses, in ways that prioritise autonomy, respect, and demonstrable impact. Survivor engagement is therefore treated not as a discrete activity, but as an integral part of survivor-centred safeguarding, accountability, and cultural change within the Church.

1.23 Hearing directly from survivors was central to this work. Survivors were invited to contribute through surveys, interviews, and a public call for information. These opportunities were designed to offer survivors choice and control over how they participated, recognising that survivors are best placed to determine whether and how they wish to share their experiences. Survivors' perspectives provide essential experience about how safeguarding arrangements operate in practice and whether commitments to survivor-centred practice are reflected in day-to-day interactions

[12] There is no precise universally agreed definition of non-recent abuse. In the context of this report it should be taken to refer to abuse that occurred in the past but has been disclosed, reported or otherwise come to light at a later date. The term recognises that survivors may disclose abuse many years after it occurred and that its impact may remain ongoing.
[13] Baseline audit reports of dioceses and religious life groups can be accessed at catholicsafeguarding.org.uk

and decision making.

1.24 This report presents a thematic overview of survivor engagement across the Catholic Church in England and Wales. It highlights areas of effective practice, identifies gaps and inconsistencies, and explores systemic factors that influence how survivor engagement is understood and delivered. The report does not assess or compare the performance of individual dioceses or religious life groups, nor does it seek to reinvestigate individual cases. Examples used throughout the report are anonymised and are intended to illustrate broader patterns rather than reflect the practice of any specific location.

1.25 The purpose of this thematic inspection is to support reflection, accountability, and learning across the Catholic Church in England and Wales, with the aim of strengthening survivor-centred safeguarding practice and ensuring that the dignity, voices, and experiences of survivors remain central to safeguarding development.

1.26 The CSSA recognises that this learning applies not only to dioceses and religious life groups, but also to CSSA's own work. In undertaking this thematic inspection, CSSA acknowledges that further improvement is needed in engagement with survivors. This report seeks not only to identify learning for church bodies, but also to support reflection and improvement within CSSA, including how survivors are engaged with, listened to, and involved through inspection and safeguarding related work.

2. Methodology

2.1 Research Design and Scope

2.1.1 This thematic inspection used a mixed-methods approach to assess current practice in Catholic dioceses and religious life groups in England and Wales in relation to survivor engagement and support. The inspection was conducted in accordance with Terms of Reference that establish its purpose, objectives and scope, and are included as Appendix 7.1.

2.1.2 The methodology combined both quantitative and qualitative sources of evidence, including two national surveys, survivor follow-up interviews, documentary review, meetings and interviews with Church personnel, and the review of safeguarding case information.

2.1.3 The inspection focused on a defined 12-month review period beginning on 1 July 2024, in order to examine survivor engagement and safeguarding practice as it currently operates. The defined review period relates to the safeguarding responses and engagement undertaken by Church bodies during this timeframe rather than the date on which abuse is alleged to have occurred. Survivors may disclose abuse many years or decades after the event, and safeguarding personnel may therefore be responding to concerns relating to both recent and non-recent abuse. The inspection therefore considered how Church bodies responded to survivors during the review period regardless of when the alleged abuse took place. While participants were not restricted in what they could share, evidence was assessed against this timeframe for formal inclusion within the analytical sample.

2.1.4 The thematic inspection also drew upon information gathered through CSSA's baseline diocesan inspections. These inspections were undertaken prior to the defined review period and were used to provide contextual information about safeguarding governance, policy, and practice across the Church. Dioceses were invited to confirm whether any information previously recorded had changed since the baseline inspections. This information supported triangulation of evidence across multiple sources.

2.1.5 Evidence gathered through surveys, interviews, documentary review, and case information was analysed collectively. Findings were developed through triangulation across these sources in order to identify recurring themes, patterns, and areas of consistency or divergence in practice.

2.2 Terminology and Definitions

2.2.1 For the purposes of this thematic inspection, CSSA applied a number of working definitions to ensure clarity and consistency when reviewing safeguarding practice across dioceses and religious life groups.

Survivor

2.2.2 The Catholic Church in England and Wales does not currently appear to have a single nationally agreed definition of the term survivor for safeguarding purposes. In the absence of a nationally defined term, CSSA adopted the following working definition for the purposes of this inspection: Any person known to a Church body who is alleged to have been harmed as the result of an act of abuse. This applies irrespective of the environment in which the alleged abuse is said to have occurred

or the status of the alleged perpetrator, neither of which need be connected to the Church.

2.2.3 This definition was used solely to support participation and clarity within the survivor thematic inspection and should not be interpreted as representing an ongoing or formal position of CSSA.

Case

2.2.4 For the purposes of this inspection, a case refers to any piece of work undertaken by a Church body safeguarding lead or safeguarding team involving a named or identifiable person where there is an allegation or concern that abuse has occurred, or that there has been a risk of abuse occurring.

2.2.5 This definition does not include the provision of one-off general safeguarding advice where no identifiable individual or safeguarding concern is involved.

2.2.6 The CSSA recognises that the term 'case' can feel impersonal and may not reflect the lived reality of individuals. It is used here solely as a technical term for consistency and analysis, and we remain mindful that each 'case' represents a person with their own experiences and voice.

2.3 Early Engagement and Advisory Input

2.3.1 At the outset of the inspection, CSSA analysts undertook early engagement to inform the design and delivery of the work. This included outreach to survivor organisations to seek advice on best practice in engaging with survivors and to support the development of appropriate and sensitive approaches to survivor participation. In total, five survivor organisations were contacted, and two organisations participated in discussions with CSSA analysts. These organisations also assisted in sharing the public call for information surveys through their networks to support reach and accessibility.

2.3.2 The CSSA Survivor Panel supported methodological development throughout this phase. Panel members reviewed survey instruments and provided guidance on question content, wording and framing to support a survivor-centred approach. The panel also agreed additional questions used during survivor follow-up engagement which are included as Appendix 7.2.

2.3.3 CSSA also engaged with an independent research organisation undertaking a

concurrent review of Safe Spaces[14], in order to align learning and avoid unnecessary duplication of evidence collection.

2.4 Notification and Communication with Church Bodies

2.4.1 To ensure transparency and consistent communication, all Catholic dioceses and religious life groups in England and Wales were notified of the planned thematic inspection. An initial notification email was issued on 3 July 2025, setting out CSSA's intention to conduct a thematic inspection focused on survivor engagement and support.

2.4.2 The notification outlined:

- the purpose and scope of the thematic inspection
- the thematic focus areas, including disclosures, survivor support, inclusion, training and preparedness, and survivor feedback
- the use of a sampling approach for fieldwork
- that survivors could contribute in relation to contact with any diocese or religious life group during the review period
- relevant CSSA contact points for queries or further engagement.

This communication ensured that Church bodies were aware of the inspection and understood the scope and processes involved.

2.5 Sampling and Inclusion of Dioceses

2.5.1 Given the number of dioceses in England and Wales, a stratified random sampling approach was adopted. Twelve dioceses were selected in order to ensure representation across geographical regions and differing contexts, including both urban and rural settings.

2.5.2 For transparency, the dioceses included in the thematic inspection sample are listed as Appendix 7.3.

[14] Safe Spaces England and Wales are a free and independent support service providing a confidential, personal and safe space for anyone who has been abused by someone in the Church, or as a result of their relationship with the Church of England, the Catholic Church in England and Wales or the Church in Wales. Home - Safe Spaces England and Wales

2.5.3 Selected dioceses were notified on 21 July 2025 and invited to participate in the thematic inspection. Each selected diocese was offered an introductory online meeting to explain the inspection process, clarify expectations, and agree practical arrangements for engagement.

2.5.4 Following engagement:

- eight dioceses hosted on-site thematic engagement visits
- two dioceses were unable to accommodate visits within the inspection timeframe and were provided with a summary of relevant information already held by CSSA for review and clarification
- two dioceses were undergoing other CSSA inspections at the time, and evidence relevant to this thematic inspection was gathered through those processes.

2.5.5 The sampling approach was designed to provide insight into a range of safeguarding contexts while remaining proportionate to the scope of the thematic inspection.

2.6 Sampling and Inclusion of Religious Life Groups

2.6.1 Safeguarding arrangements within religious life groups differ from diocesan structures. Religious life groups selected for inclusion were notified of their selection on 29 and 30 July 2025. An initial engagement meeting was held with representatives of the selected religious life groups to outline the thematic inspection and discuss how evidence gathering would take place. During this engagement, a number of religious life groups indicated that safeguarding case management and survivor engagement activity was undertaken on their behalf by the Religious Life Safeguarding Service (RLSS).

2.6.2 Following this discussion, CSSA engaged directly with RLSS to obtain relevant information relating to safeguarding activity within the review period. Religious life groups were subsequently offered a further opportunity to engage directly with the thematic inspection should they wish to provide additional information. RLSS initially identified 32 religious life groups with safeguarding activity within scope. Following review, at least one organisation was removed as outside the inspection scope.

2.6.3 For transparency, the religious life groups included in the inspection sample are listed as Appendix 7.4.

Access to religious life group case information

2.6.4 Many religious life groups stated that RLSS hold all safeguarding case information. CSSA requested case related information to enable inspection activity. RLSS provided a summary dataset and responses to general questions but did not provide case level detail, citing data protection and GDPR considerations. CSSA reviewed this information alongside existing information held from baseline inspections and determined that the RLSS provided data could not be used for detailed case inspection activity within this thematic inspection. As a result, CSSA did not undertake case file review for religious life groups where survivor engagement activity was delivered solely through RLSS.

2.7 Public Call for Information Surveys

2.7.1 Two national surveys formed a core part of the evidence-gathering methodology. These survey questions can be found in Appendix 7.5.

Survivor survey

2.7.2 The survivor public call for information survey was disseminated to dioceses and religious life groups on 15 August 2025. The survey initially closed on 6 October 2025, with the deadline later extended to 27 October 2025.

2.7.3 Survey questions were reviewed with the CSSA Survivor Panel to support a trauma-informed and survivor-centred design. Open ended questions enabled survivors to share experiences in their own words and determine the level of detail they wished to provide.

2.7.4 The survey generated 51 responses, and six survivors contacted CSSA directly. All information received was reviewed. Submissions were assessed for relevance to the defined 12-month review period. Experiences did not need to fall entirely within this period; submissions were included in the analytical sample where at least part of the survivor's experience, such as contact with a Church body, occurred during the review timeframe. Where responses related solely to experiences outside this period and did not include contact with a Church body since July 2024, they were not included within the formal analytical sample for this inspection. However, all information received was reviewed by CSSA analysts and was considered as contextual information to support broader understanding of survivor experience. Some submissions were received anonymously, meaning direct follow up was not always possible. However, where safeguarding concerns were identified, these were

handled in accordance with CSSA safeguarding procedures.

2.7.5 Following this review, 39 survivor submissions were included.

Survivor follow-up engagement

2.7.6 Following survey participation or direct contact, 13 survivors chose to participate in follow-up engagement with CSSA analysts through interviews conducted in person, online, or by telephone, depending on survivor preference and accessibility needs. Some survivors met with analysts on more than one occasion.

2.7.7 Additional follow-up questions were agreed in advance with the Survivor Panel. Follow-up engagement was used to clarify information provided, explore emerging themes, and support accurate representation of survivor experience.

Safeguarding action

2.7.8 One disclosure received through the survey process resulted in a police referral in line with safeguarding procedures.

Church personnel and parishioner survey

2.7.9 A second public call for information survey gathered perspectives from individuals engaged in Church life and governance, including clergy, members of religious congregations, employees, volunteers, parish safeguarding representatives, and parishioners.

2.7.10 The survey was disseminated on 3 September 2025 and closed on 27 October 2025.

2.7.11 A total of 173 responses was received across the following roles:

- Clergy (n=33)
- Religious / Consecrated Life (n=11)
- Parish Safeguarding Representative (n=17)
- Employee (Safeguarding Role) (n=9)
- Employee (Non-Safeguarding Role) (n=30)
- Volunteer (n=18)
- Parishioner (n=43)
- None (n=1)
- Prefer not to say (n=7)
- Other (n=4)

2.7.12 The survey used a combination of Likert scale questions and open-text

responses addressing preparedness to respond to disclosures, safeguarding training, trauma informed practice, awareness of survivor support, leadership and culture, inclusivity, and safeguarding visibility.

2.7.13 Survey results are published alongside this report on the CSSA website.

Dissemination of surveys

2.7.14 Both surveys were distributed through CSSA mailing lists to all dioceses and religious life groups, with a request that they be disseminated widely within local contexts.

2.7.15 Dissemination communications were sent to:

- Archbishops and Bishops
- Diocesan safeguarding coordinators or leads
- the individual recorded by CSSA as the safeguarding contact for the religious life group.

2.7.16 Recipients were asked to share the surveys through diocesan, parish, and organisational communication channels, including websites, newsletters, parish bulletins, and social media. Church bodies were also asked to confirm when and how dissemination had taken place, to support CSSA oversight of distribution activity.

2.7.17 At least 28 religious life groups and 10 dioceses confirmed to CSSA analysts that they had actively shared the surveys. In addition, the surveys were promoted through the CSSA website and Catholic media outlets, supporting broader awareness and access beyond direct mailing lists.

2.8 Meetings, Interviews and Diocesan Engagement

2.8.1 Each sampled diocese participated in an introductory online meeting with CSSA analysts to explain the inspection process and agree practical arrangements.

2.8.2 Interviews were conducted with bishops, safeguarding leads, and other relevant participants. Inspection activity took place between September and November 2025 through a combination of on-site visits and remote engagement.

2.9 Documentary Review and Case Analysis

Document requests

2.9.1 Dioceses and religious life groups were asked to provide documentation including survivor policies, procedures, and case overviews. Responses varied. Some bodies provided documentation in advance by uploading or sending it to CSSA, while others provided access during visits or relied on paper-based systems.

Case review

2.9.2 CSSA requested that dioceses and religious life groups provide lists and summaries of safeguarding cases within the defined review period prior to inspection activity. This request included both higher-level safeguarding cases and low-level concerns recorded within safeguarding systems. However, responses varied due to system limitations, paper-based record keeping, or capacity constraints.

2.9.3 In some cases, information was provided during meetings or visits rather than in advance. The type and volume of case material provided also differed across dioceses. Some dioceses provided comprehensive datasets including both higher-level safeguarding cases and lower-level concerns, resulting in larger numbers of cases being available for review. Others provided smaller numbers of cases, often focusing only on higher-level safeguarding investigations, while a small number reported that no cases within scope had been recorded during the review period.

2.9.4 Given these variations in how safeguarding activity was recorded and reported, the inspection undertook an overview review of the available safeguarding case information rather than a full case-file inspection. Across diocesan and available religious life group sources, this resulted in an overview review of 166 safeguarding cases.

Lower level concerns in parishes

2.9.5 CSSA analysts also requested information relating to safeguarding concerns arising at parish level that may not have resulted in a formal diocesan safeguarding case but had been reported to diocesan safeguarding teams for advice or awareness. While such concerns would ordinarily be expected to be recorded, few dioceses were able to provide comprehensive information in this area. In many instances these lower threshold concerns were not routinely recorded or centrally collated within diocesan safeguarding systems and therefore could not be included within the case review.

Use of baseline audit evidence

2.9.6 CSSA also considered information gathered through earlier baseline audits of dioceses and religious life groups. Some of this material was collected prior to the defined review period and was therefore used for contextual understanding and triangulation where relevant.

2.10 Ethical and Safeguarding Considerations

Ethical and safeguarding considerations and limitations

2.10.1 This thematic inspection involved direct and indirect engagement with survivors of abuse and therefore required careful ethical consideration. The approach prioritised minimising the risk of re-traumatisation, supporting participant autonomy and choice, maintaining clear boundaries between inspection activity and support provision, and ensuring safeguarding responsibilities took precedence at all times. The following sections set out how these considerations were addressed in practice.

Minimising risk of re-traumatisation, participant autonomy and choice

2.10.2 Given the sensitive nature of survivor engagement, care was taken to minimise the risk of re-traumatisation. Surveys were predominantly open-ended and optional, allowing participants to control the level of detail shared. Follow-up engagement with survivors was offered rather than required, and survivors retained control over whether, when, and how further contact took place. Across all engagement methods, participants were able to choose how they engaged (online survey, direct contact, interview), whether to provide identifying details, and whether to take part in follow-up discussions. Survivors participating in interviews selected their preferred format (in person, online, or telephone), and some chose to engage on more than one occasion.

Boundaries of role and support

2.10.3 CSSA analysts were clear about the limits of their role as analysts rather than support providers. Survivor-facing materials included signposting to independent support services, and analysts remained alert to unmet support needs during direct contact. Where appropriate, and with consent, participants were signposted to relevant sources of support.

Confidentiality and data handling

2.10.4 All information was handled in accordance with data protection requirements. Survey responses were anonymised unless participants chose to provide identifying details. Where information was shared with dioceses or religious life groups for the purposes of triangulation, this either excluded personal details that could identify individual contributors or was shared only where explicit consent had been provided by the survivor.

Mandatory reporting and safeguarding priority

2.10.5 Participants were informed of the limits to confidentiality, including mandatory reporting obligations. Where information met the threshold for statutory reporting, safeguarding responsibilities took precedence over inspection activity.

Fairness and proportionality

2.10.6 The inspection approach aimed to be thorough while remaining proportionate, recognising differences in capacity, resources, and record-keeping across dioceses and religious life groups. Engagement methods were adapted where needed to avoid placing unnecessary demands on participants, while keeping the approach consistent.

The right to withdraw

2.10.7 Participants were informed of their right to withdraw from the inspection. Where submissions were identifiable, participants could request withdrawal within clearly stated timeframes. Survivors engaging directly with CSSA analysts retained the right to request partial or full withdrawal of their information, where this was still possible once information had been anonymised or combined with other data.

Limitations of evidence

2.10.8 Survivor evidence is central to this thematic inspection and has shaped the findings throughout the report. However, the experiences described in this report reflect the views of those survivors who chose to engage with CSSA through surveys, interviews or direct contact. Many survivors may not have felt able, safe or willing to participate. Others may not have seen the call for information or may have chosen not to revisit their experiences through an inspection process.

2.10.9 The findings should therefore not be read as representing the views or experiences of all survivors. Rather, they provide important evidence about the experiences of those who did engage.

2.11 Evidence Verification and Thematic Analysis

2.11.1 Following diocesan engagement visits and documentary review, CSSA analysts produced summary documents of the information gathered for each participating diocese. These summaries outlined safeguarding arrangements, survivor engagement activity, and relevant documentation identified during the inspection process. Each diocese was provided with its summary record and invited to review the information to ensure factual accuracy and completeness. Where clarifications or corrections were identified, these were incorporated into the final evidence set.

2.11.2 Once this verification process was complete, the information gathered through diocesan engagement, documentary review, survey responses, survivor follow-up engagement, and available case information was reviewed collectively by CSSA analysts. Evidence from these sources was compared in order to identify recurring issues, patterns of practice, and areas of consistency or divergence across dioceses and religious life groups. Similar findings were grouped together to form thematic categories reflecting key aspects of survivor engagement and safeguarding practice.

2.11.3 Findings presented in this report were developed through thematic analysis of the evidence gathered across the inspection. Information from surveys, survivor engagement, interviews, documentary review, and case information was considered collectively, enabling triangulation across multiple sources to identify recurring themes and patterns in practice.

3. Thematic Findings

3.1 Governance, Oversight and Accountability

3.1.1 This section examines how safeguarding is governed across dioceses and religious life groups, with particular focus on oversight arrangements, transparency of governance, and mechanisms for challenge and accountability.

3.1.2 For the purposes of this report, the term "safeguarding committee" is used to refer to both safeguarding committees and safeguarding sub-committees reporting to trustees. In many dioceses, these arrangements reflect developments following the Elliott Review, which recommended that safeguarding governance

should sit more clearly within trustee accountability structures, replacing earlier models where safeguarding commissions operated with greater independence.

Governance structures and oversight arrangements

3.1.3 Across the diocesan sample included in this inspection, all dioceses operate a safeguarding committee or safeguarding sub-committee (or an equivalently named body) reporting to the board of trustees. This represents a point of consistency across diocesan safeguarding governance. Beyond this, however, there is significant variation in how safeguarding oversight is organised and exercised in practice.

3.1.4 It is important to recognise that this variation is not solely a matter of organisational choice, but is often shaped by the size, capacity, and available resources of each diocese. Smaller dioceses may operate more streamlined arrangements due to limited staffing and volunteer capacity, whereas larger dioceses may sustain more layered governance structures. As a result, governance models reflect differing contexts rather than a single agreed approach.

3.1.5 Examples of best practice were identified in dioceses where safeguarding governance involved several layers beneath trustee board oversight. In these arrangements, trustees were supported by a safeguarding committee which, in turn, received information and assurance from a number of dedicated sub-groups. These included forums focused on safeguarding cases, such as case management panels, case review meetings, or risk advisory groups, alongside additional groups concerned with quality assurance, learning, or inspection. In these contexts, responsibility and information flowed through multiple stages, allowing for clearer separation between strategic oversight, operational case scrutiny, and assurance activity. This supported more robust collective scrutiny and reduced reliance on individual decision making.

3.1.6 In other dioceses, safeguarding governance was more streamlined, with oversight centred on a safeguarding committee working directly with the safeguarding team. In these settings, there were fewer formal sub-groups, and the safeguarding committee was responsible for a broader range of functions, including policy oversight, scrutiny of safeguarding cases, learning, and assurance. Approaches to case oversight within these committees varied. Some received high-level overview reports prepared by safeguarding coordinators, others reviewed a sample of cases, and some received updates on all safeguarding cases as part of routine business. While these arrangements often reflected capacity constraints,

they could place greater reliance on a smaller number of individuals and reduce opportunities for independent challenge.

3.1.7 Between these approaches, many dioceses operated hybrid arrangements, combining elements of layered and streamlined governance. For example, some dioceses had formal case management or risk advisory groups but no separate quality assurance forum, while others relied primarily on committee-level oversight supplemented by focused case discussion led by safeguarding leads or coordinators.

3.1.8 Examples of good practice were identified where dioceses had established dedicated quality assurance or learning focused sub-groups alongside case management forums, providing additional scrutiny of safeguarding practice, consistency of decision making, and opportunities for organisational learning.

3.1.9 These variations meant that dioceses differed not only in structure, but also in how responsibility for scrutiny, decision-making, and assurance was distributed. This could lead to variation in the strength of oversight and clarity of accountability.

3.1.10 Alongside governance structures, dioceses also varied in how safeguarding roles and teams were organised. In some dioceses, safeguarding teams were larger and more differentiated, with caseworkers reporting to a Head of Safeguarding or a safeguarding lead, supported by safeguarding coordinators and, in some cases, administrative staff. In these arrangements, oversight and decision making were shared through case focused forums, with information flowing through defined reporting lines to safeguarding committees and trustees. In other dioceses, safeguarding teams were smaller, with responsibility concentrated in a safeguarding coordinator or lead who coordinated casework and reported directly to the safeguarding committee. While these arrangements often reflected the size and capacity of the diocese, they could place greater reliance on a smaller number of individuals and reduce opportunities for shared decision-making and independent challenge.

3.1.11 Across the diocesan sample, interviewees emphasised the importance of having appropriate expertise within safeguarding governance arrangements. Examples of good practice were identified frequently where governance structures included individuals with relevant professional expertise, such as safeguarding, social care, or legal experience. A number of safeguarding coordinators highlighted the value of individuals with safeguarding, social care, legal, or professional experience sitting on safeguarding committees or advisory groups, describing

how this supported effective challenge, informed decision-making, and a clearer understanding of risk and survivor need. During interviews, some participants noted that statutory agencies were best placed to contribute to case focused forums, such as case management or risk advisory meetings, where their expertise supported assessment of risk, decision-making, and ongoing monitoring. Statutory agencies were generally viewed as less suited to participation in strategic or policy-focused governance forums, and more effective when engaged in operational safeguarding discussions where detailed case knowledge and statutory thresholds were directly relevant. These views reinforced the importance of matching expertise to the purpose of each governance forum.

3.1.12 Evidence from the inspection identified limited but notable examples of survivor involvement within safeguarding governance structures. An example of emerging good practice was identified in one diocese where a survivor organisation was represented on the safeguarding committee, contributing to oversight and challenge. More commonly, however, survivor input was not embedded within formal governance structures.

3.1.13 A further example of good practice was also identified where a diocese had established a dedicated victim liaison lead or specialist survivor support role operating alongside safeguarding leadership and case management functions. In these arrangements, survivor liaison roles were distinct from safeguarding decision making, enabling a clear separation between case oversight and survivor support. These roles provided continuity of contact for survivors, supported understanding of safeguarding processes, and ensured that survivor experience and communication were actively considered as cases progressed. Survivor feedback provided to this thematic inspection was consistently positive in relation to this role, with communication identified as a particular strength, alongside greater clarity and a stronger sense of being listened to and supported. The impact of these roles on survivor experience is explored further in the Survivor Feedback and Engagement section of this report.

3.1.14 Religious life groups demonstrated even greater variation in governance arrangements than dioceses, reflecting the significant diversity in their size, structure, and available resources. These ranged from small communities with one or two members to large congregations, resulting in wide variation in capacity, administrative support, and safeguarding expertise.

3.1.15 Some religious life groups operated safeguarding committees or sub-

committees broadly comparable to diocesan arrangements, providing collective oversight and scrutiny. Others relied primarily on a single safeguarding lead, sometimes supported by additional individuals and sometimes operating largely alone. In these arrangements, safeguarding leads were either employed professionals or members of the religious life group, often holding safeguarding responsibilities alongside other roles. These differences in size and resourcing created varying opportunities and constraints in developing internal safeguarding arrangements, resulting in considerable variation in how oversight, accountability, and survivor engagement were structured in practice. This highlights the importance of proportionate governance arrangements that reflect the size and context of each group.

3.1.16 While dedicated survivor liaison roles were not in place across all dioceses or religious life groups, particularly those with more limited resources, the evidence indicates that such roles make an important contribution to accountability, continuity, and survivor confidence. In smaller dioceses or religious life groups where establishing a dedicated role may not be feasible, alternative approaches may be required. However, the inspection identified that there is not yet a consistent or established model for how this function can be delivered proportionately across different contexts. This highlights an area for further consideration at a national and organisational level, including how survivor focused functions such as communication, continuity of contact, and advocacy can be delivered effectively in settings with more limited capacity. Ensuring that survivors have access to a consistent point of contact and clear, ongoing communication should remain a priority, regardless of the model adopted.

3.1.17 Across both diocesan and religious life group contexts, the inspection identified that governance arrangements, role clarity, and access to appropriate expertise had a direct impact on survivor experience, particularly in relation to continuity, communication, and confidence in safeguarding processes.

Safeguarding complaints and challenge processes

3.1.18 Safeguarding complaints processes provide an important mechanism through which survivors can challenge decisions, raise concerns about practice, and seek accountability. This thematic inspection identified wide variation in how safeguarding complaints are structured and handled across dioceses and religious life groups.

3.1.19 Examples of good practice were identified where safeguarding specific

complaints processes were in place, recognising the distinct nature of safeguarding concerns and the potential vulnerability of those raising them. In contrast, other dioceses and religious life groups relied on general complaints procedures that were not tailored to safeguarding contexts. Information about how safeguarding complaints are handled, how they differ from other types of complaints, and how outcomes are communicated was inconsistent. In some cases, safeguarding policies included information about escalation routes, including contacting the CSSA or accessing alternative support where internal complaints processes had been exhausted. In other cases, this information was absent or difficult to locate.

3.1.20 Survivor evidence indicates that unclear or generic complaints processes created confusion and acted as a barrier to raising concerns. Survivors described uncertainty about whether their complaint related to safeguarding or to general complaints procedures, and about which stage of a process they were currently in. Several survivors reported that the structure and language of complaints policies were complex and not explained to them in clear, survivor focused terms. This lack of clarity contributed to anxiety about raising concerns and uncertainty about what would happen next.

3.1.21 Some survivors expressed fears that complaints would not be understood or would be met defensively, reinforcing a perception that complaints mechanisms were designed primarily to protect the church rather than to provide meaningful challenge or redress. In these contexts, complaints processes were experienced as discouraging rather than enabling, particularly where survivors felt unsupported to navigate the process or unclear about how their concerns would be considered.

3.1.22 Variation was also evident in the use of independent investigations and external reviews. Examples of best practice were identified where independent investigators were used and engaged in a trauma-informed[15] and respectful manner, demonstrating clear independence and taking time to understand the impact of abuse and safeguarding responses. In these cases, survivors recognised these processes as important steps towards accountability. However, even where independent processes were used, survivors frequently described written apologies, investigation reports, and formal outcomes as procedural rather than meaningful, particularly where outcomes were not clearly explained or where survivors were not

[15] "Trauma-informed" or "trauma-aware" practice refers to approaches that recognise the impact trauma can have on memory, communication, trust, behaviour and emotional wellbeing, and which seek to avoid causing further distress or re-traumatisation.

informed about what actions, if any, had been taken as a result of their complaint. This highlights that independence alone is not sufficient; the way findings and outcomes are communicated to survivors is critical in determining whether these processes are experienced as meaningful.

3.1.23 Some survivors described experiencing a cautious or defensive tone in responses, particularly where complaints raised issues of potential liability or compensation. In these situations, communication was perceived as less survivor-centred and more focused on managing organisational risk, which further undermined trust in the complaints process. Evidence gathered during this inspection indicates that this reflects a wider structural tension within safeguarding practice. Safeguarding coordinators are often required to balance providing compassionate, survivor-centred support with the need to operate within legal and insurance frameworks that place constraints on communication, admissions and decision-making. While insurers do not have an active role in safeguarding responses unless a formal claim is made, the requirements of insurance arrangements, including the need to avoid admissions of liability or actions that may prejudice a future claim, can influence how responses are framed and delivered.

3.1.24 In practice, this can place safeguarding staff in a difficult position. Coordinators may seek to offer meaningful support, acknowledgement and reassurance to survivors, while also needing to ensure that their actions do not pre-empt legal outcomes or make determinations about allegations that have not been investigated or cannot be substantiated. This is particularly complex in cases involving non-recent abuse, conflicting accounts or where the respondent is deceased or unable to respond. As a result, communication may become more cautious, generalised or procedural than intended.

3.1.25 From a survivor perspective, these distinctions are not always visible or understood. Where responses are experienced as overly careful, generic or impersonal, this can reinforce perceptions that organisational priorities are focused on risk management rather than survivor care, even where safeguarding staff are acting in good faith. This dynamic risks undermining trust and engagement, particularly at key points such as complaints or challenge processes.

3.1.26 The inspection also highlights a gap in how these complexities are explained to survivors. The interaction between safeguarding responses, legal processes and potential civil claims is not consistently communicated in a way that is accessible or meaningful. This suggests a need for clearer, survivor-focused guidance that

sets out what survivors can expect from safeguarding engagement, including the purpose and limits of responses, how decisions are made, and how different processes interact. Developing this guidance with survivor input may help ensure that it is grounded in lived experience and supports informed engagement. By explaining these constraints transparently, and in a way that acknowledges the impact on survivors, there is potential to reduce misunderstanding and maintain trust, even where responses are necessarily limited.

3.1.27 Overall, survivor evidence consistently demonstrates that complaints and challenge processes are one of the clearest tests of safeguarding governance in practice. Where complaints routes are unclear, inaccessible, or experienced as defensive in tone, survivor trust can be significantly undermined. However, where complaints processes are clearly explained, safeguarding-specific, and communicated in survivor-focused language, they have the potential to support accountability, learning, and confidence in safeguarding arrangements.

Public information and transparency of governance

3.1.28 The inspection identified significant inconsistency in how safeguarding governance arrangements are described and made visible through publicly available information, including diocesan and religious life group websites and published safeguarding documentation.

3.1.29 While governance structures are primarily internal, the visibility and clarity of this information play an important role in helping survivors understand how safeguarding decisions are made, who holds responsibility, and how those decisions can be questioned or challenged. Transparency in this area is therefore closely linked to survivor confidence and trust in safeguarding processes.

3.1.30 Examples of best practice were identified where safeguarding governance structures were clearly explained online, either through dedicated governance pages or within safeguarding policies. In a small number of cases, this information was presented on a single, accessible page that set out the safeguarding governance framework, including named committees or sub-committees, terms of reference, reporting lines, and visual diagrams showing how different groups interconnect.

3.1.31 Survivors who encountered these clearer presentations described them as helpful in making sense of what could otherwise feel complex and unclear. Some noted that simplified explanations and visual diagrams helped them understand where decisions were made, who held responsibility, and how their case or concerns fitted within the wider safeguarding system. This clarity contributed to

greater confidence in safeguarding processes and reduced uncertainty about how information was handled, how decisions were made, and how those decisions could be questioned or challenged.

3.1.32 The availability and visibility of safeguarding complaints information formed part of this wider picture of transparency. The inspection found that safeguarding complaints processes were not always clearly accessible through diocesan or religious life group websites. In some cases, complaints information was not available online at all or was embedded within general complaints pages without clear distinction. In others, safeguarding complaints policies were located within wider policy libraries, requiring survivors to navigate multiple documents to understand how to raise concerns or seek challenge.

3.1.33 By contrast, a small number of dioceses and religious life groups provided survivor-facing pages that included clear feedback or complaints functions, with safeguarding complaints policies clearly linked or explained. These approaches supported accessibility and made it easier for survivors to understand how to raise concerns and what to expect from the process.

3.1.34 However, the inspection also found that even where governance information was presented clearly, it did not always reflect the full operational picture. In some instances, published information omitted smaller but significant forums, such as safeguarding case management meetings or risk and allegations review groups, despite these groups playing a central role in case scrutiny and decision-making. In other cases, governance information was spread across multiple documents, requiring survivors to piece together how safeguarding decisions were made and where accountability sat. At the other end of the spectrum, some dioceses and religious life groups published little or no accessible information about safeguarding governance beyond high-level statements.

3.1.35 Survivor survey evidence indicates that where governance arrangements were unclear or not visible, this contributed to confusion and distress. Survivors described uncertainty about who was responsible for decisions, where their case was being discussed, and how concerns could be escalated or reviewed. In these contexts, safeguarding processes were experienced as opaque, reducing confidence that arrangements were transparent, accountable, or responsive.

3.2 Policies, Documentation and Written Standards

3.2.1 This theme examines the extent to which safeguarding policies, written guidance and documentation provide a clear, consistent and survivor-focused framework across dioceses and religious life groups. It considers core safeguarding policies, management of allegations and decision-making guidance, survivor commitments and charters, approaches to low-level concerns (see para. 3.2.49 for a definition), inclusion within safeguarding documentation, and the systems used to record and manage safeguarding information.

3.2.2 Dioceses and the vast majority of religious life groups operate as independent charities, with trustees responsible for ensuring that appropriate safeguarding policies and procedures are in place, in line with their legal duties and wider safeguarding expectations. While national safeguarding standards set out expectations for safeguarding practice, there is currently no single nationally mandated safeguarding policy or comprehensive national policy framework in place across the Catholic Church in England and Wales.

3.2.3 Some dioceses and religious life groups continue to draw on previously issued national guidance and policy materials, including earlier documents relating to safeguarding practice. However, these do not form a current, unified or centrally maintained framework. In addition, the Bishops' Conference of England and Wales has commissioned a large-scale review and development of model safeguarding policies and procedures over the past two years; this work remains in progress and was not in place at the time of the inspection.

3.2.4 In this context, dioceses and religious life groups retain discretion in how safeguarding policies and documentation are developed and structured. Some religious life groups have adopted or adapted template materials produced by the Religious Life Safeguarding Service (RLSS)[16], and other national guidance has informed local approaches. However, responsibility for ensuring that safeguarding policies are in place, appropriate and effective rests with each individual charity and its trustees.

3.2.5 This thematic inspection is separate from the CSSA inspection and audit programme and does not assess compliance against the eight National

[16] The RLSS is a team of independent safeguarding professionals offering safeguarding services to the Religious of the Catholic Church in England and Wales Religious Life Safeguarding Service

Safeguarding Standards[17]. Instead, it considers the extent to which safeguarding policies and documentation provide sufficient clarity, accessibility and consistency to support survivor understanding, engagement and confidence in safeguarding processes.

3.2.6 While the Catholic Church has stated a commitment to a "One Church" approach to safeguarding, the absence of a single, consistent national policy framework means that safeguarding documentation continues to vary across dioceses and religious life groups. From a survivor perspective, this variation can make it more difficult to understand what safeguarding standards apply, what processes should be followed, and what level of consistency and accountability can be expected across the Church.

Safeguarding policies and core documentation

3.2.7 Review of diocesan and religious life group documentation indicates that the majority of dioceses and religious life groups have formal safeguarding policies in place. These policies are generally aligned with national safeguarding standards and, in many cases, are publicly accessible. Positive practice was identified in many dioceses and religious life groups where safeguarding policies are clearly structured, regularly reviewed and supported by accessible documentation that sets out roles, responsibilities and procedures across the safeguarding lifecycle, enabling clergy, staff, volunteers and survivors to understand how safeguarding operates in practice.

3.2.8 However, this position is not consistent. A small number of dioceses and religious life groups do not appear to have a clearly identifiable safeguarding policy in place, or rely on policies that are outdated, not clearly presented as current, or not publicly accessible. In some cases, websites referenced national safeguarding policies and provided links; however, these links were inactive. This reflects the absence of a current, centrally maintained national safeguarding policy to which organisations can consistently refer.

3.2.9 A safeguarding policy represents a minimum baseline for safeguarding governance and is consistent with expectations of the Charity Commission for England and Wales, which requires charities to have appropriate safeguarding

[17] The eight National Safeguarding Standards were proposed by the Elliott review report and subsequently adopted by the Catholic Church in England and Wales. The Standards are available on the CSSA website here

policies and procedures in place[18]. Where such a policy is absent, this raises concerns regarding clarity of roles and responsibilities, consistency of practice, and leadership oversight. Where policies exist but are not clearly current or publicly accessible, levels of transparency and external assurance are reduced, even where internal safeguarding arrangements may be in place.

3.2.10 In undertaking this thematic inspection, the CSSA has, in limited circumstances, taken account of dioceses and religious life groups that do not hold a single, standalone safeguarding policy but instead operate a suite of related policies and procedures which, when considered together, address core safeguarding requirements. This reflects the way safeguarding arrangements are currently structured in some organisations, rather than an endorsed or standardised approach.

3.2.11 While this approach may enable organisations to meet safeguarding requirements in practice, it can reduce clarity and accessibility for survivors, parishioners, staff and external stakeholders. Positive practice was identified where safeguarding policies are consolidated into a single, clearly presented framework, supporting greater transparency, consistency and ease of understanding, particularly for those seeking to navigate safeguarding processes or understand how decisions are made.

3.2.12 The inspection also identified significant variation in the depth, clarity and survivor focus of safeguarding policies. Some dioceses and religious life groups publish detailed policies that set out expectations, including responding to concerns, safeguarding plans, survivor support, codes of conduct, safer recruitment, confidentiality, data handling and review arrangements. Others rely on shorter, higher-level policies or focused primarily on statements of intent and general principles, with limited procedural detail and greater reliance on supplementary guidance or local practice. In settings where more detailed and clearly structured documentation is available, there is greater clarity about safeguarding processes and expectations, supporting more consistent understanding across clergy, staff, volunteers and survivors.

3.2.13 While dioceses and religious life groups operate as separate legal and

[18] The Charity Commission for England and Wales register and regulate charities in England and Wales to ensure that the public can support them with confidence. Safeguarding for charities and trustees

governance entities, survivors experience safeguarding through their contact with the Catholic Church as a whole. Differences in safeguarding standards, clarity of process or access to support can create uncertainty for survivors and may affect confidence in the Church's response. Greater consistency in core safeguarding expectations and clearer presentation of safeguarding documentation would support clarity, fairness and trust.

National guidance and support for policy development

3.2.14 Interviews with safeguarding coordinators highlighted a consistent request for clearer national guidance and practical support around safeguarding policies and documentation. Coordinators described coming from a wide range of professional backgrounds, and noted that writing formal policies and governance documents is not always a routine part of their role.

3.2.15 Several coordinators explained that they had delayed developing or updating local safeguarding policies while waiting for national direction, expressing concern about creating documents that might later need to be replaced or revised. Others described actively looking for templates or examples to help ensure that local policies were clear, consistent and aligned with wider Church expectations.

3.2.16 These comments were not about unwillingness to act. Coordinators consistently described wanting confidence that local documentation reflects agreed standards and provides clear, consistent information for survivors, clergy, volunteers and parishioners. In the absence of nationally agreed frameworks or templates, dioceses have been required to develop policies independently, contributing to variation in approach and placing additional pressure on local roles.

Terminology, definitions and safeguarding thresholds

3.2.17 The inspection identified variation across dioceses and religious life groups in the terminology used within safeguarding policies and guidance to describe individuals who have experienced abuse, as well as in how vulnerability and safeguarding thresholds are defined and applied. These differences reflect a range of statutory, pastoral, canonical[19] and professional frameworks, but also contribute to inconsistency in written standards and survivor experience.

3.2.18 In relation to vulnerability, some dioceses closely align their safeguarding

[19] Canon law is a set of ordinances and regulations made by ecclesiastical authority for the government of the Church and its members.

definitions with statutory social care frameworks, applying safeguarding thresholds primarily through definitions of "adult at risk" set out in legislation[20]. Other dioceses adopt a broader safeguarding approach, recognising that vulnerability may be situational and that any adult may be vulnerable at particular points in time depending on context, power dynamics or personal circumstances. A further group of dioceses rely more heavily on professional judgement, with limited written guidance setting out how vulnerability should be understood, assessed or recorded.

3.2.19 The absence of shared definitions or consistent written guidance on vulnerability means that similar concerns may be interpreted and managed differently across dioceses. Survivors and staff raised questions about how safeguarding thresholds are applied, particularly in cases that fall outside statutory definitions. This variation affects clarity, consistency and fairness, and can result in uncertainty for survivors about whether their experiences will be treated as safeguarding concerns and what protections or support they can expect.

3.2.20 The inspection also identified variation in the terminology used to describe individuals who raise safeguarding concerns. Some dioceses consistently use the term "survivor", reflecting a trauma-informed approach that emphasises dignity, agency and recovery. Other dioceses use the term "victim", often aligning with statutory, criminal justice or canonical frameworks. In many cases, safeguarding policies and guidance do not clearly define these terms or explain the rationale for their use, and in some documentation the terms are used interchangeably.

3.2.21 In addition, some dioceses use the term "complainant", particularly in the context of ongoing cases. This terminology is often intended to maintain procedural neutrality and avoid the perception of pre-judging matters while investigations or enquiries are underway. However, policies and guidance do not always explain how this terminology relates to the use of "survivor" or "victim" in other contexts, or what the use of different terms signifies for engagement, support and decision-making.

3.2.22 Survivors described uncertainty about what different terms meant in practice and whether changes in language reflected doubt, distance or a shift in how their account was being understood. While some survivors recognised the need for impartial processes, others experienced legalistic or impersonal terminology as distancing or misaligned with their lived experience. Where terminology is unclear

[20] Definitions of an adult at risk are provided by the Care Act 2014 for England and the Social Services and Well-being Act (Wales) 2014 for Wales.

or inconsistently applied, survivors may be unsure how they are viewed within safeguarding processes or what level of recognition and support they can expect.

3.2.23 Taken together, variation in terminology and definitions reflects wider inconsistency in written safeguarding standards. Clearer, more transparent use of language within safeguarding policies and guidance, including explanation of how different terms are used in different contexts, would support clarity, manage expectations and promote more consistent, survivor-centred engagement, while continuing to respect the need for fair and impartial safeguarding processes.

Management of allegations and decision-making guidance

3.2.24 The level of publicly available detail regarding how safeguarding concerns and allegations are managed varies significantly across dioceses. Where Management of Allegations guidance (or equivalent documentation) is published, there is generally clearer explanation of how concerns are received, assessed and progressed. This includes clarity about who is responsible for decisions at different stages, how safeguarding arrangements are reviewed over time, and how survivors can expect to be engaged as decisions develop.

3.2.25 In dioceses with more developed guidance, information about the management of allegations is sometimes contained within a single document, but more often is set out across a suite of linked documents. These may include Management of Allegations guidance, roles and responsibilities frameworks, case management procedures, and governance or escalation guidance. In some dioceses, particularly those with more than one safeguarding caseworker, these frameworks support consistency of systems and decision-making within the diocese, even where responsibilities are shared across different roles or teams.

3.2.26 However, as the structure, depth and accessibility of Management of Allegations guidance varies across dioceses, survivors engaging with different dioceses may experience differing levels of clarity, communication and involvement in safeguarding decision-making.

3.2.27 Some dioceses publish detailed guidance aimed primarily at safeguarding professionals and clergy, while others provide only brief summaries with limited procedural detail. A number of dioceses did not have any publicly available Management of Allegations guidance identified through website and documentation review. Where guidance is limited or absent, survivors described uncertainty about how decisions were made beyond the point of disclosure and about what safeguarding arrangements were in place over time.

3.2.28 Positive practice was identified in some dioceses where Management of Allegations guidance is clearly documented and accessible, setting out decision making processes, roles and responsibilities, and arrangements for reviewing safeguarding measures over time. In these settings, there is greater clarity for both safeguarding personnel and survivors regarding how cases are progressed and how decisions are reached.

3.2.29 In dioceses relying on high-level statements or minimal guidance, information often focuses on initial reporting routes but provides little detail about how cases are monitored, how safeguarding arrangements are reviewed, how long measures remain in place, or how decisions are revisited or concluded. Survivors described discovering safeguarding plans or restrictions only after they had been implemented, without explanation of how or why decisions had been reached. One survivor reflected that "safeguarding plans were happening around me, not with me" reinforcing feelings of exclusion and loss of control. Survivors also raised questions about what information they could reasonably expect to receive and what could not be shared due to confidentiality requirements relating to respondents[21] or others involved. While survivors generally recognised the importance of confidentiality, the absence of clear explanation about decision-making processes, review arrangements and outcomes contributed to confusion and distress.

3.2.30 A further recurring issue within survivor evidence relates to understanding outcomes and ongoing arrangements. Survivors described being told that individuals were barred, restricted or out of ministry, only to later encounter them named publicly or participating in Church life. This created confusion about what safeguarding decisions meant in practice, whether arrangements were still in place, and how decisions were reviewed or lifted. One survivor stated, "I was told he was barred, but his name was still on the newsletter," while another reflected that "it made everything feel hush-hush, like the truth was being hidden."

3.2.31 These experiences highlight the importance of Management of Allegations guidance extending beyond initial response to clearly explain how safeguarding arrangements are monitored, reviewed, concluded or changed, and how survivors will be informed and involved as decisions develop over time. Where this is not clearly set out, safeguarding processes can feel unclear, inconsistent and disconnected.

3.2.32 The inspection also found that clarity about decision making over time is

[21] In this context 'respondents' is a term used for those alleged to have perpetrated abuse.

closely linked to governance arrangements. Where cases are subject to structured case management oversight and regular reporting to safeguarding committees, guidance is more likely to reflect shared responsibility, consistency and ongoing review. Where oversight arrangements are less formalised, written guidance tends to focus narrowly on thresholds and referrals, with less attention to how safeguarding decisions are sustained, reviewed or brought to a close.

3.2.33 During thematic visits, differences were particularly evident in how dioceses manage lower-level concerns, raising questions about whether processes and outcomes vary depending on diocesan arrangements rather than the nature of the concern. While individual circumstances will always require professional judgement, the absence of consistent Management of Allegations guidance risks creating perceptions of unfairness and inconsistency for survivors engaging with different dioceses.

Multi-agency working and memoranda of understanding

3.2.34 Evidence from diocesan interviews indicates that safeguarding coordinators in diocese with formal Memoranda of Understanding (MoUs) reported clearer and more consistent multi-agency working in safeguarding cases. However, such arrangements are not widespread and are often dependent on local relationships, capacity and the complexity of working across multiple statutory partners. Many dioceses operate across more than one police force and local authority area, which can make the development and maintenance of consistent multi-agency arrangements more challenging.

3.2.35 In dioceses where MoUs are in place, safeguarding coordinators described stronger working relationships with police and statutory safeguarding partners, clearer expectations regarding roles and information sharing, and more effective communication during complex cases. These arrangements were reported to support more regular contact and the development of trust over time, reducing reliance on informal or ad hoc communication.

3.2.36 Positive practice was identified in a small number of dioceses and religious life groups where formal MoUs or well-established partnership arrangements were in place with statutory agencies. In these settings, safeguarding teams had access to named contacts and clear escalation routes, supporting timely information sharing and more consistent joint working. This provided greater clarity and assurance in managing safeguarding concerns, particularly in complex or sensitive cases.

3.2.37 Some dioceses and religious life groups also described good examples of

joint casework involving safeguarding professionals working alongside police officers or police victim liaison staff. This was particularly valued in cases where survivors did not wish to engage directly with Church safeguarding teams but were willing to communicate through statutory partners. In these situations, established relationships and formalised arrangements supported survivor choice while ensuring safeguarding responsibilities were met.

3.2.38 Further positive practice was identified where strong relationships with statutory partners had been developed and sustained over time. In one religious life group, this included the continued involvement of an individual with previous experience in a local authority safeguarding role, who remained part of governance arrangements after leaving that position. This supported continuity, independent perspective and informed challenge, and enabled more flexible and responsive engagement, including supporting survivors who preferred not to engage directly with Church personnel.

3.2.39 A small number of dioceses also described MoUs contributing to wider partnership working beyond individual cases. In these settings, statutory representatives were involved in safeguarding committees or sub-groups, supporting shared understanding, challenge and learning. This strengthened governance oversight and reduced reliance on ad hoc relationship building during live cases.

3.2.40 Not all dioceses have formal MoUs in place. While safeguarding work with statutory agencies continues in their absence, some dioceses reported that communication and coordination were, on occasion, less effective than they could have been. This included delays in information sharing or uncertainty about points of contact, particularly in more complex cases or where survivor engagement was sensitive.

3.2.41 Overall, the evidence indicates that where formalised multi-agency arrangements are in place, they can support more consistent collaboration and provide additional routes for survivor engagement. In their absence, partnership working is more likely to rely on informal relationships, which may vary depending on local context and personnel.

Survivor commitments, charters and statements

3.2.42 There is wide variation across dioceses and religious life groups in the presence, visibility and form of survivor commitments. These documents are described using a range of titles, including survivor charters, commitments to survivors, videos,

victim and survivor statements, episcopal messages and, in some cases, survivor or safeguarding strategies.

3.2.43 The inspection identified no shared understanding or guidance at national level regarding what constitutes a survivor charter, commitment or strategy, or what minimum content such documents should include. As a result, documents with similar titles can differ substantially in purpose, scope and level of detail, while documents serving similar functions are often described using different terminology.

3.2.44 Some dioceses and religious life groups have developed explicit survivor focused charters or commitment statements that articulate clear principles and expectations regarding survivor engagement. These commonly reference being listened to, being treated with dignity and respect, being believed and being offered appropriate support, and in some cases include expectations around communication, responsiveness and ongoing engagement. Positive practice was identified where these commitments are clearly structured, accessible and set out what survivors can expect in practical terms, supporting greater clarity and consistency in engagement.

3.2.45 Other dioceses and religious life groups rely primarily on statements from bishops or senior leaders acknowledging harm and expressing commitment to survivors. While these statements often convey pastoral intent and recognition of suffering, they vary considerably in the extent to which they articulate clear, actionable expectations for survivor engagement. These more personal statements can be meaningful in demonstrating acknowledgement, accountability and leadership commitment, particularly where they are visible and specific; however, their impact is strengthened where they are supported by clear and consistent safeguarding processes and documented expectations.

3.2.46 In several dioceses, multiple survivor-facing documents coexist, with values-based commitments, pastoral messages and procedural expectations spread across different documents rather than consolidated into a single, clearly signposted survivor resource. Conversely, some dioceses do not evidence any explicit survivor facing commitments at all.

3.2.47 The absence of consistent terminology, minimum content or shared purpose across survivor-facing documents results in uneven clarity and strength of commitment to survivors across dioceses. Survivors engaging with different dioceses encounter varying levels of detail, formality and assurance regarding how they will be treated and supported. This variability contributes to differing

expectations and experiences of survivor engagement and makes it more difficult to evidence a coherent and consistent approach across the Church.

3.2.48 Some of these issues will begin to be addressed by the forthcoming national policies and procedure, which will be led by the Strategic Council for Catholic Safeguarding[22].

Low-level concerns and early intervention (policy and guidance)

3.2.49 Approaches to the identification, recording and management of low-level safeguarding concerns at parish level vary significantly across dioceses. Low-level concerns include boundary issues, inconsistent or poor practice, behaviour that does not meet safeguarding thresholds, and patterns of conduct that generate concern without amounting to an allegation.

3.2.50 Some dioceses and religious life groups have developed specific guidance and policies addressing low-level concerns. Where this exists, it typically clarifies what constitutes a low-level concern, distinguishes these from allegations requiring statutory and diocesan or religious life group safeguarding intervention, and sets out expectations for a proportionate response, recording and consultation. In these settings, low-level concerns are framed as opportunities for early intervention, reflection and learning. Positive practice was identified where such guidance supports consistent recording, oversight and escalation of concerns, enabling patterns of behaviour to be identified and addressed at an early stage.

3.2.51 In other dioceses and religious life groups, low-level concerns are not clearly addressed in policy or guidance. In these contexts, clergy, safeguarding representatives and volunteers may be uncertain about whether concerns should be reported, how they should be recorded, or who should be consulted. This results in reliance on individual judgement, informal conversations and local practice, with limited documentation or oversight.

3.2.52 Evidence from inspection casework activity, undertaken outside of this thematic inspection, indicates that lower level concerns are frequently reported to safeguarding teams in practice. However, where written guidance is unclear or absent, the consistency of how these concerns are recorded, escalated and reviewed varies, limiting the extent to which patterns of behaviour can be effectively

[22] The SCCS's stated purpose is to ensure the strategic coordination of safeguarding across dioceses and religious life groups in England and Wales, promoting consistency and supporting effective safeguarding practice.

identified and addressed.

3.2.53 For survivors, the relevance of low-level concerns lies in how effectively safeguarding systems identify and respond to early indicators of risk. While individual experiences of abuse may arise in different contexts, survivors emphasised the importance of early concerns being recognised and taken seriously. Where low-level concerns are not clearly understood or consistently acted upon, patterns of behaviour may go unaddressed, increasing the risk of harm escalating over time.

3.2.54 Survivors also described confusion or frustration when concerns they raised were treated informally or dismissed as "not safeguarding," without clear explanation of what would happen next. In these situations, unclear thresholds and inconsistent responses can create a perception that safeguarding decisions are discretionary rather than based on defined standards.

3.2.55 Where guidance is absent, survivors' experiences are more likely to depend on individual interpretation and local culture rather than shared safeguarding expectations. This can discourage survivors from raising concerns or continuing to engage, particularly where they do not see early issues being taken seriously or followed up.

3.2.56 In contrast, where low-level concerns are clearly defined and addressed through written guidance, safeguarding is more likely to be experienced as proactive and preventative. This supports greater confidence that concerns will be recognised, recorded and acted upon appropriately over time.

3.2.57 The practical implications of these policy differences for parish-level recording, oversight and learning from low-level concerns are explored further in Section 3, Parish Safeguarding Inspections and Local Assurance.

Inclusion and equality within safeguarding documentation

3.2.58 Across dioceses, there is no evidence of standalone inclusion policies specifically addressing safeguarding or survivor engagement. Instead, references to inclusion are incorporated inconsistently within safeguarding policies, survivor commitments or guidance, resulting in variable clarity about how inclusion is understood and applied in safeguarding practice.

3.2.59 Some dioceses explicitly recognise that survivors may face additional barriers to disclosure and engagement related to disability, language, culture, ethnicity, age, neurodiversity, sex, sexuality, gender identity, immigration status or experiences of

discrimination. Where this is clearly stated, safeguarding documentation provides greater acknowledgement that survivors' needs differ and that responses may need to be adapted accordingly.

3.2.60 Other dioceses address inclusion more indirectly, using language focused on dignity, respect or pastoral sensitivity without explicitly referring to inclusion or equality. In these cases, safeguarding documentation often emphasises welcome and good intent but offers limited guidance on how safeguarding practice should respond to difference or additional need. In some dioceses, there is little or no explicit reference to inclusion within safeguarding documentation, and written standards appear to assume a single survivor experience.

3.2.61 Evidence from the clergy, safeguarding staff, parishioner and volunteer survey highlights a gap between intention and practice in relation to inclusive safeguarding. Many respondents, particularly clergy and safeguarding staff, expressed confidence that parishes seek to be inclusive and welcoming to survivors. However, high levels of "neither agree nor disagree" responses, particularly among parishioners and volunteers, suggest that inclusive practice is not always visible or clearly understood at parish level. Qualitative responses from some parishioners, including individuals with lived experience of disability or marginalisation, described feeling overlooked or insufficiently recognised within safeguarding arrangements. Several comments referred positively to an intention to "treat everyone the same" as a way of being inclusive. However, these responses also highlight the need for greater awareness that treating everyone in the same way does not always result in inclusive practice. In some cases, this approach limited recognition of differing needs, meaning that survivors who required tailored or adapted responses were not always identified or supported as effectively as intended.

3.2.62 This gap between inclusive intent and lived experience has implications for survivor engagement. Survivors from marginalised backgrounds may feel unsafe, misunderstood or unwelcome, reducing the likelihood of disclosure or continued engagement with safeguarding processes. Where safeguarding documentation does not clearly address inclusion or provide practical direction, responsibility for adapting responses is left to individual judgement, increasing inconsistency and the risk of exclusion.

3.2.63 The evidence suggests that moving beyond general statements of welcome towards clearer, more explicit inclusion within safeguarding documentation would strengthen survivor confidence and engagement. This includes setting out how

inclusion is understood in safeguarding contexts, recognising different survivor needs, and providing practical examples of how safeguarding responses can be adapted in practice.

Recording, case management and documentation standards

3.2.64 Across dioceses and religious life groups, there is significant variation in safeguarding case management and recording systems. Systems in use include electronic platforms, bespoke databases and, in some cases, partial or paper-based records. These systems vary considerably in functionality and suitability for safeguarding contexts.

3.2.65 Where electronic safeguarding case management systems are in place, dioceses use a range of platforms. These include, but are not limited to, safeguarding systems such as CPOMS, MyConcern and PAMIS, as well as systems originally designed for education or youth settings that have been adapted for diocesan use. In some settings, electronic systems are supplemented by spreadsheets, shared drives or paper-based records. Positive practice was identified where structured electronic systems are used consistently to record concerns, actions and outcomes, supporting clearer chronologies and improved oversight of safeguarding activity. Further positive practice was identified where one diocese has commissioned the development of a bespoke safeguarding system specifically designed for use within the church context.

3.2.66 The position for religious life groups is notably different. Very few religious life groups operate their own safeguarding case management systems, and most rely on the RLSS for the management and recording of safeguarding concerns. While religious life groups typically retain some local information, such as records of direct contact with survivors or their own correspondence with the RLSS, they do not consistently hold a complete record of safeguarding activity undertaken on their behalf and do not have direct access to RLSS case management systems. As a result, safeguarding information relating to religious life group cases may be held across more than one organisation, with limited visibility at local religious life group level.

3.2.67 In practice, documentation held by religious life groups may include evidence of communication with the RLSS, survivor contact and agreed actions, but not the full range of safeguarding activity undertaken by the RLSS. This separation of records presents challenges for audit and assurance. As the RLSS is a separate organisation and access to their systems was not granted to the CSSA as part of this thematic

inspection, it was not possible to fully verify the scope of safeguarding activity, decision making or survivor engagement undertaken by the RLSS in religious life group cases. In some instances, documentation submitted by the RLSS for the thematic analysis indicated that no engagement had occurred; however, discussions with religious life group representatives suggested that survivor engagement had in fact taken place. This highlights the limitations of relying solely on local religious life group records where case management and recording are undertaken externally and raises questions regarding the extent to which trustees are able to maintain effective oversight of safeguarding activity carried out on their behalf.

3.2.68 Across both dioceses and religious life groups, the inspection identified significant differences in the functionality and suitability of recording systems. Some systems provide structured fields for recording concerns, actions and outcomes, enabling clearer chronologies and supporting basic reporting. Others are more limited in their ability to record complex safeguarding histories, capture decision-making rationale, or reflect survivor engagement and communication over time. In some cases, systems were better suited to recording discrete incidents than managing ongoing safeguarding processes, requiring workarounds or additional records to track case progression.

3.2.69 In addition, the inspection identified limitations in chronology-building, reporting, thematic analysis and the ability of records to support quality assurance and governance oversight. In some settings, safeguarding information was fragmented across multiple systems or reliant on individual knowledge rather than shared, accessible records. From a case management perspective, this can result in incomplete or inconsistent records, reduced continuity where cases are transferred between personnel, and limited visibility of previous decisions, actions or risk factors. This can affect the ability of safeguarding personnel to make informed decisions, track the progression of cases effectively and ensure that safeguarding responses are consistent over time.

3.2.70 Not all dioceses or religious life groups have clear, standardised recording templates or written standards setting out what information should be recorded, when records should be created or updated, and how safeguarding activity should be documented as cases develop and change. Where such standards are absent or underdeveloped, recording practice relies heavily on individual judgement and local processes. This results in variability in the level of detail captured and, in some cases, limited clarity about why decisions were taken, what alternatives were considered, or how survivor communication and engagement informed

case management.

3.2.71 The new policies, procedures and guidance being introduced nationally place greater emphasis on consistent recording practice, including expectations around chronology-building, documentation of decision-making rationale, recording of survivor engagement and information sharing.

3.2.72 Survivor evidence illustrates the impact of documentation weaknesses. Survivors described being required to repeat their experiences multiple times, experiencing inconsistent communication, or feeling that their case history was incomplete or poorly understood.

3.2.73 Concerns were also raised about survivor access to safeguarding records and decision-making documentation. One survivor described making repeated requests for copies of information relating to their case, which were not provided, contributing to a perception that decision-making was not transparent and that survivors were not routinely given access to information about discussions and decisions that directly affected them.

3.2.74 In addition, some survivors who submitted Subject Access Requests[23] reported identifying gaps in the information disclosed or discovering safeguarding decisions, plans or correspondence that they had not previously been made aware of. In these cases, the information received through the request differed from survivors' understanding of how their case had been managed, contributing to distress and a loss of confidence in the completeness and reliability of safeguarding records.

3.2.75 Taken together, these findings indicate that inconsistent recording standards, variable system capability, fragmented record-holding across organisations, and limited survivor access to records undermine continuity, transparency and trust. Where documentation is incomplete, unclear or inaccessible, survivors are more likely to experience confusion, repeated disclosure and reduced confidence that safeguarding decisions are being properly recorded, reviewed and retained within organisational systems.

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[23] Individuals have the right to access and receive a copy of their personal data held by any UK organisation by making a subject access request. A guide to subject access | ICO.

3.3 Parish Safeguarding Audits and Local Assurance

3.3.1 This section focuses primarily on parish-level safeguarding assurance within dioceses. While religious life groups do not operate parish structures, equivalent safeguarding oversight applies across their ministries and works, although inspection evidence in this area was more limited.

3.3.2 Evidence from diocesan interviews and review of documentation demonstrates wide variation in how local-level safeguarding assurance is undertaken. Approaches range from structured and routine parish safeguarding audits to ad hoc checks or reactive engagement when concerns arise. This variation affects the consistency, visibility and reliability of safeguarding practice at local level.

Approaches to parish safeguarding assurance and record-keeping

3.3.3 In some dioceses, parish safeguarding audits or review processes are well established and form part of routine diocesan oversight. Where these audits are in place, they are typically used to confirm that core safeguarding requirements are present and functioning. This commonly includes checks on the appointment of Parish Safeguarding Representatives[24], safeguarding training records for clergy and volunteers, safer recruitment processes, DBS[25] or equivalent checks, record-keeping arrangements and reporting pathways.

3.3.4 Other dioceses rely on more informal or ad hoc arrangements, such as periodic requests for information, parish self-reporting or reactive engagement following incidents or complaints. In these contexts, diocesan oversight is more limited, and assurance depends heavily on local confidence, individual knowledge and parish capacity. Positive practice was identified where dioceses make use of existing diocesan or curial staff visiting parishes to undertake safeguarding checks as part of their wider roles, providing an additional layer of oversight and enabling more regular and direct engagement with parish safeguarding arrangements.

3.3.5 The inspection also identified variation in how parish safeguarding information is recorded and retained. In some dioceses, information relating to training, DBS

[24] A Parish Safeguarding Representative (PSR) is a volunteer who supports their parish in safeguarding matters such as the safer recruitment of volunteers and liaison with the diocesan safeguarding team.
[25] The Disclosure and Barring Service processes and issues criminal record checks on individuals applying for employment or a voluntary role for employers. Disclosure and Barring Service

checks and safer recruitment is held centrally, allowing diocesan teams to monitor compliance and identify gaps. In others, records are retained locally by parishes, with limited diocesan visibility. This fragmentation reduces assurance and makes it more difficult to identify patterns, risks or emerging issues across parishes.

3.3.6 Where dioceses lack clear mechanisms to track parish safeguarding information, assurance relies heavily on trust and periodic checks. This can limit early identification of gaps and increases the risk that safeguarding arrangements lapse over time, particularly where there is volunteer turnover or changes in parish leadership.

3.3.7 From a survivor engagement perspective, this variation is significant. Survivors engaging with Church safeguarding may have experienced abuse in a range of contexts, including outside of the Church, such as domestic abuse, as well as within Church settings. While survivors may encounter safeguarding through a range of routes, including statutory agencies or direct contact with safeguarding teams, parish settings often represent a key point of interaction within the Church. Where safeguarding arrangements at this level are clearly monitored, regularly reviewed and consistently applied, survivors are more likely to experience safeguarding as reliable and dependable. Where assurance is informal or inconsistent, safeguarding practice may vary between parishes, increasing the likelihood that survivor experience depends on location rather than shared standards.

Parish safeguarding dashboards and simplified assurance

3.3.8 Alongside traditional audit approaches, positive practice identified during the inspection shows that a small number of dioceses are beginning to move beyond simplified parish safeguarding audits through the use of digital dashboard-style tools designed to present safeguarding requirements clearly and concisely. Uptake within the Catholic Church remains at an early stage, and current use does not yet reflect the full range of functionality seen in other settings. These tools aim to reduce reliance on lengthy audit templates or complex written guidance.

3.3.9 Such dashboards typically focus on a limited number of core safeguarding indicators, displayed using clear red, amber and green status markers. Information commonly included confirms whether safeguarding policies are current, whether a Parish Safeguarding Representative is appointed and trained, whether safeguarding training requirements are up to date, whether safer recruitment and DBS processes are complete, whether safeguarding contact details are visible, and whether reporting pathways are clear and understood. Where these approaches

are in place, they translate safeguarding expectations into plain, accessible requirements, supporting parish understanding of safeguarding responsibilities and reducing reliance on individual safeguarding representatives. Positive practice was identified where simplified and visual assurance tools are used to provide a more current and accessible overview of safeguarding arrangements. These approaches support more consistent monitoring, clearer accountability and improved visibility of safeguarding activity at parish level

3.3.10 From a diocesan assurance perspective, dashboards provide a more current and visible overview of parish safeguarding arrangements than periodic audits alone, supporting more proactive identification of gaps and more timely intervention.

3.3.11 For survivors, dashboards offer greater confidence that basic safeguarding arrangements are in place consistently at parish level. By reducing variation and reliance on individual knowledge, they help ensure that survivors encounter clearer pathways, trained contacts and more predictable responses when they seek support.

Low-level concerns and local learning

3.3.12 Some dioceses have developed arrangements that allow parish-level concerns below diocesan safeguarding thresholds to be identified, recorded and reviewed in a proportionate way. In these settings, concerns managed locally are recorded without automatically triggering formal safeguarding case management and are used to support learning and early intervention rather than disciplinary or investigative action. Recording low-level concerns enables dioceses to identify themes such as repeated boundary issues, misunderstandings of safeguarding expectations or gaps in volunteer training. For survivors, this can mean that early concerns are acknowledged and taken seriously, even where they do not lead to formal safeguarding action.

3.3.13 As part of this thematic inspection, dioceses and religious life groups were asked to provide a list of safeguarding cases involving survivors, including concerns linked to parish settings that had been managed locally and had not required further diocesan intervention. Examples included parish-level concerns relating to domestic abuse, boundary issues, concerning behaviour between adults, pastoral situations requiring safeguarding advice, and other incidents discussed and addressed at parish level.

3.3.14 Some dioceses were able to provide comprehensive lists of parish-level

concerns, including those resolved locally without escalation. This was most evident in dioceses that record concerns on central safeguarding or case management systems, allowing oversight of both formal safeguarding cases and lower-level issues. Positive practice was identified where dioceses record parish level concerns within central systems or structured local records, with clear outcomes and follow up actions documented. This supports greater oversight, enables identification of patterns and strengthens opportunities for learning and early intervention.

3.3.15 However, practice is not consistent across dioceses. In many settings, parish-level concerns that do not meet diocesan safeguarding thresholds are managed locally but are not routinely recorded in a way that allows diocesan oversight or analysis. Information may be held informally or recorded with limited detail, if at all. This limits assurance and makes it more difficult to identify recurring issues, emerging patterns or opportunities for wider learning across parishes.

3.3.16 For survivors, inconsistent recording of low-level concerns can affect how safeguarding is experienced. Early worries or boundary concerns raised informally may be recognised in one parish but handled differently in another, depending on local practice rather than shared safeguarding standards. Where concerns are not recorded or reviewed, early warning signs may be missed, and similar issues may be treated in isolation rather than as part of a developing pattern.

3.3.17 Taken together, the evidence indicates that clearer and more consistent approaches to recording and reviewing low-level concerns support earlier learning, reduce reliance on individual judgement and strengthen preventative safeguarding practice at parish and diocesan level.

3.4 Survivor experience of communication and power dynamics

3.4.1 This section draws primarily on survivor survey responses and qualitative submissions, supported by evidence from clergy, safeguarding personnel, parishioners and volunteers, to examine how communication, transparency and power dynamics shape survivor engagement with safeguarding processes over time. While significant challenges were identified, survivor evidence also highlights clear examples of effective, compassionate and sustained communication, demonstrating that positive survivor engagement is achievable in practice.

Early contact and initial response

3.4.2 Survivor survey evidence indicates that initial safeguarding engagement is often experienced positively at the point of first contact. A number of survivors described early interactions with safeguarding teams as timely, respectful and appropriate. In these cases, survivors reported being listened to, believed and treated with seriousness. Some survivors noted that safeguarding staff offered alternative methods of communication and in some instances travelling to meet survivors in person. They also took statements carefully and explained when concerns were being referred to statutory bodies. One survivor noted, "I was seen immediately and kept informed that it was being investigated," while another reflected that "at the beginning, it felt like they were genuinely listening."

Loss of continuity and follow-through

3.4.3 Notably, survivors from one diocese referred repeatedly to the work of specific members of the safeguarding team, describing communication as clear, consistent and supportive. These survivors highlighted being kept informed about progress, receiving updates without having to chase, and feeling that their concerns were taken seriously throughout the process. In addition, some survivors from other dioceses described similar experiences, including ongoing contact through survivor panels or follow-up engagement after cases had formally closed. In these instances, survivors emphasised feeling listened to, respected and valued after the initial point of disclosure.

3.4.4 From a survivor engagement perspective, such responses were experienced as reducing anxiety about the process and increasing confidence that their concerns were being taken seriously. These examples demonstrate that sustained, transparent communication is possible and can be embedded.

3.4.5 However, a significant number of survivor survey responses consistently show that these positive beginnings are often fragile. Even where initial contact was experienced as compassionate and competent, many survivors reported a loss of continuity as cases progressed. Contact reduced, promised actions did not materialise and momentum was lost. Survivors frequently described feeling "dropped" once formal processes began, characterising a shift from relational engagement to bureaucratic procedure. One survivor reflected that "they were very present at the beginning, and then it just stopped," while another stated that "once the paperwork started, the care disappeared."

3.4.6 Survey evidence indicates that this loss of follow-through is a key point at which

survivor engagement breaks down. Survivors described withdrawing emotionally or disengaging entirely when communication reduced without explanation, even where safeguarding processes continued internally.

Communication, information and involvement in decision-making

3.4.7 In several cases, survivors reported discovering safeguarding decisions, plans or restrictions only after they had been put in place, without prior discussion or explanation. Survivors described this as reinforcing feelings of exclusion and loss of control, particularly where safeguarding measures directly affected their sense of safety, wellbeing or involvement in Church life. In these situations, safeguarding was experienced as something done to survivors rather than with them.

3.4.8 Survivors who reported positive engagement linked this positivity to feeling informed, having a clear understanding of the process and clarity about decision making. Where information was limited, delayed or shared retrospectively, survivors were more likely to experience safeguarding processes as unclear or disempowering. One survivor described this lack of communication following the acknowledgement of serious safeguarding failures by external bodies, inspectors or regulators as deeply damaging. They reported that the absence of direct engagement, apology or follow-up from Church authorities contributed to perceptions that information was being withheld or managed, rather than openly addressed. Where such issues were already widely known within parish or diocesan communities, this lack of communication extended beyond individual survivors, reinforcing a broader sense of mistrust and fuelling perceptions of secrecy or avoidance within the Church's response.

Poor communication and defensive responses

3.4.9 Poor communication emerged across survivor survey responses as one of the most damaging features of survivor experience. Survivors described unanswered emails, long delays, contradictory explanations and repeated instances where correspondence was said not to have been received despite evidence to the contrary. Many reported having to chase repeatedly for basic information, which they experienced as exhausting and distressing.

3.4.10 While these findings are not reflected as strongly within diocesan inspection evidence, this may in part be explained by differences in methodology. Diocesan inspections have only relatively recently incorporated public calls for information and have not historically gathered direct, structured feedback from survivors about their experiences of engagement. In contrast, this thematic inspection specifically

sought survivor perspectives, including their direct experiences of communication and engagement with safeguarding teams.

3.4.11 Furthermore, diocesan inspection findings are primarily informed by case audits and responses from safeguarding personnel. As identified within this inspection, case records do not consistently capture survivor perspectives or experiences of communication and are often recorded from the perspective of the safeguarding coordinator. As a result, issues such as repeated attempts by survivors to seek information or perceived delays in communication may not be fully reflected in diocesan records, which this thematic has sought to address through direct engagement with survivors.

3.4.12 Importantly, survivors did not experience these failures as simple administrative inefficiency. Rather, poor communication was commonly interpreted as a lack of care, seriousness or accountability, directly undermining trust and discouraging continued engagement.

3.4.13 Survivors also described communication that felt dismissive or defensive, including the framing of concerns as "perceptions" or the use of language that appeared to minimise distress. These experiences were further intensified where responses were experienced by survivors as legalistic or influenced by insurance considerations, which were experienced as adversarial and incompatible with compassionate safeguarding. In a small minority of cases, the inspection also identified concerns regarding the use of standardised apology wording within safeguarding correspondence. Although limited in number, this practice risks apologies being experienced as procedural rather than meaningful. In one case, a survivor described receiving a written apology alongside correspondence stating that there was "not a semblance of truth" in their account[26]. The survivor reported that this contradiction caused significant additional harm and directly undermined trust in the safeguarding process. While not widely raised through survey responses, the inspection recognises that survivors often communicate through informal networks, and practices perceived as formulaic or contradictory may undermine confidence more broadly.

[26] 'Semblance of truth' has a specific meaning within canon law, which requires that the bishop (or superior or delegate) must make an initial check to see whether an allegation is not obviously false or frivolous. It is only a preliminary screening, not a judgement of guilt or innocence. At this stage, the task is simply to establish the basic facts and whether the accused could actually be responsible, while safeguarding the person's good name and reputation.

Safeguarding, control and power

3.4.14 Some survivors described safeguarding processes as defensive or punitive. In these accounts, safeguarding was experienced as a mechanism to manage risk rather than to protect or support survivors. Survivors reported referrals being made without their consent, unclear thresholds for action and a sense of being scrutinised rather than supported once concerns were raised. One survivor stated, "safeguarding was used against me," while another reflected that "once I challenged them, everything became harder."

3.4.15 Survivor survey responses frequently linked these experiences to dynamics present in their original experiences of abuse. Silence, withholding of information and unilateral decision-making were experienced as replicating patterns of power and control. This was particularly present in hierarchical or enclosed contexts. One survivor stated, "it feels like my abuse never really ended, it just changed form," while another observed that "they hold all the power, and you're expected to accept it."

3.4.16 From a survivor engagement perspective, these dynamics significantly undermine trust. Survivors described becoming more guarded, limiting what they shared or disengaging entirely when safeguarding responses mirrored the power imbalances of their original harm.

Overall inconsistency in communication

3.4.17 Taken together, survivor evidence demonstrates that communication, transparency and attention to power dynamics are central to survivor engagement. Positive practice clearly exists, including examples of sustained, compassionate and transparent communication that survivors experience as supportive and affirming. However, this practice is unevenly embedded and often dependent on individual teams or roles rather than consistent systems.

3.4.18 Survivor survey evidence more frequently highlights that failures in communication, transparency and the management of power have profound effects on survivor wellbeing, faith and sense of belonging. Many survivors described withdrawing from Church life entirely, losing community and feeling unsafe in spaces that had previously been central to their lives. Several survivors stated that Church responses caused more harm than the act of disclosure itself. As one survivor said simply, "what the Church says it's doing, and what it's actually doing, are not the same."

3.4.19 Survivors also consistently recognised and valued individual acts of care, particularly at points of first contact. However, these positive experiences were often undermined by failures in consistency, transparency and follow-through. As one survivor reflected, "there are moments where you think things have changed, and then the system lets you down," while another noted, "I met people who cared, but the process didn't."

3.4.20 These findings reinforce the central theme of this inspection: survivor engagement is shaped less by stated commitments or initial responses, and more by sustained communication, shared decision-making and attention to power throughout safeguarding processes.

3.5 Survivor Facing Guidance, Information and Accessibility

3.5.1 This section examines the availability, quality and accessibility of guidance and information intended for survivors, including how safeguarding processes, support options and routes to engagement are explained. It draws on document review, website analysis and survey evidence from survivors, clergy, safeguarding staff, parishioners and volunteers.

Availability and clarity of survivor-facing information

3.5.2 The availability and quality of guidance specifically written for survivors explaining safeguarding processes and what to expect following disclosure vary significantly across dioceses. Some dioceses provide survivor-focused information that explains how concerns are managed, escalation routes, decision-making responsibilities and the support available. In these settings, information is written in accessible language and framed explicitly for survivors rather than professionals.

3.5.3 As previously discussed, in several instances, the inspection identified detailed internal practice guidance or managing concerns and allegations documents that clearly set out safeguarding processes for clergy, safeguarding staff or parish safeguarding representatives. While these documents demonstrate internal clarity, they are not routinely adapted into survivor-facing material. As a result, information that exists within diocesan systems is not always accessible to survivors in a form that supports understanding or informed choice.

3.5.4 Many dioceses provide little or no written information explaining what happens after initial contact, what stages exist, what outcomes are possible, or what support may be offered. Where information is available, it is often limited to brief statements of support or contact details, without explanation of process or next steps. This gap is

particularly significant in cases where there is no ongoing risk, limited safeguarding action or no criminal process. In such circumstances, survivors may perceive disclosure as leading to little acknowledgement, engagement or support.

Coherence and accessibility of information

3.5.5 Across dioceses, there is no consistent evidence of a single, comprehensive survivor-centred resource that brings together essential information about safeguarding processes, expectations and available support in clear, accessible language. While some dioceses provide partial resources, such as short leaflets or webpages, these typically offer insufficient detail to enable survivors to understand how safeguarding operates in practice.

3.5.6 Elsewhere, survivor charters or commitment statements include limited explanatory content but do not function as practical guides to safeguarding processes or support pathways. In some dioceses, more developed materials exist but are primarily aimed at staff and clergy and use professional or technical language that assumes prior knowledge of safeguarding systems. As a result, information relevant to survivors is often dispersed across multiple documents, webpages and policies, requiring survivors to interpret complex professional guidance to understand what will happen after disclosure.

3.5.7 Diocesan websites reflect similar variation in accessibility and survivor-focus. Some dioceses maintain comprehensive safeguarding sections with dedicated survivor or victim support pages written in accessible and reassuring language. These pages often acknowledge the difficulty of disclosure, clarify confidentiality boundaries, explain what survivors can expect and provide reassurance about being listened to and believed. Many also include downloadable guidance, survivor-focused FAQs and extensive signposting to support organisations, and explicitly state that survivors can seek support even if they do not wish to make a formal safeguarding report.

3.5.8 In contrast, other diocesan websites provide a more limited safeguarding presence, focused primarily on contact details, governance information or professional guidance. In these cases, survivor-specific explanation of process, support and engagement is minimal or absent, and information may be difficult to locate due to navigation design.

3.5.9 The inspection identified notable emerging practice in a small number of dioceses where digital accessibility tools have been embedded into safeguarding webpages. In one diocese, a web accessibility platform has been implemented

across safeguarding content, enabling users to translate information into multiple languages, have text read aloud, adjust font size and contrast, and adapt content to different accessibility needs. This functionality applies across safeguarding policies and guidance and represents a significant step towards inclusive, survivor-centred access to safeguarding information.

Information about support and care pathways

3.5.10 Information about available survivor support options varies considerably across dioceses. Some dioceses clearly document survivor support pathways, including pastoral care, counselling provision, survivor liaison roles and referral routes to independent services, often alongside directories of local and national organisations. In these settings, survivor care is presented as a core component of safeguarding practice rather than an addition to case management, and information supports survivors to understand that help may be available regardless of whether they choose to make a formal safeguarding report.

3.5.11 Other dioceses provide limited written information about support options, relying on verbal explanation or generic signposting. Where information is minimal, survivors may be uncertain about what support is available, how it can be accessed, or whether support is reliant on engaging with safeguarding or statutory processes.

3.5.12 Survey evidence from clergy, safeguarding staff and parish safeguarding representatives indicates high internal awareness of survivor support pathways, with many individuals expressing confidence that support exists and referencing specific diocesan initiatives. However, this confidence is not consistently reflected at parish level. Parishioners and volunteers reported significantly lower levels of awareness of survivor support, with many indicating that they were unaware of any provision beyond safeguarding contact details or posters.

3.5.13 Survivor support information is commonly provided through webpages, downloadable leaflets and printed materials. Review of survivor-facing leaflets across diocesan and religious life group contexts indicates that while these materials often adopt a compassionate and encouraging tone, they vary considerably in the extent to which they support survivor understanding of safeguarding processes and available support. Leaflets typically focus on reassurance and signposting but do not consistently explain what happens after disclosure, what options are available, or how survivors can access support independently of formal safeguarding processes. As a result, leaflets alone are unlikely to provide sufficient clarity or confidence for survivors considering engagement.

3.5.14 The inspection also identified variation in how survivor-facing materials have been developed. In some dioceses, survivors have been involved in shaping the content and tone of leaflets and guidance. Where survivor input informed development, materials were more likely to reflect survivor priorities and address common uncertainties about disclosure, support and next steps. In other settings, materials appear to have been produced without direct survivor involvement and were more likely to focus on institutional messaging or basic signposting.

Parish-level visibility and understanding of safeguarding

3.5.15 Evidence from surveys of clergy, safeguarding staff, parishioners and volunteers, alongside diocesan thematic findings, shows how safeguarding information is understood at parish level and how this affects survivor engagement. Safeguarding posters and written materials are widely present across parishes and are frequently cited by clergy and safeguarding staff as evidence that safeguarding information is available locally. Many respondents in these roles expressed confidence that safeguarding expectations are being met, pointing to posters, noticeboards and parish displays as indicators of visibility.

3.5.16 However, survey responses from parishioners and volunteers present a different picture. Parish-level respondents reported lower levels of awareness and understanding of safeguarding support, with many indicating that they were unsure what help was available beyond seeing posters or contact details. Qualitative responses often described posters as easy to overlook, part of the background of noticeboards, or present without explanation. Several respondents noted that seeing a poster did not help them understand what would happen if someone made contact or give them confidence to do so. This difference between staff confidence and parish level understanding reflects a wider theme across the inspection, visibility does not always translate into accessibility. While safeguarding processes, policies and support pathways are generally well understood by those in formal safeguarding roles, this knowledge is not consistently shared or embedded at parish level in ways that support understanding among parishioners and volunteers.

3.5.17 Survey responses also suggest that safeguarding is rarely discussed openly as part of everyday parish life. Parishioners described limited reference to safeguarding in parish communications, community settings or pastoral conversations, reinforcing the sense that safeguarding exists primarily as static information rather than as part of an ongoing, relational culture. In these contexts, safeguarding practice at parish level often depends on individual confidence and informal knowledge rather than shared understanding. This is reflected not only in day-to-day interactions,

but also in the variability of information provided through parish communication channels, including parish websites. Not all parishes maintain websites, and where they do, the presence and quality of safeguarding information vary. In some cases, safeguarding information is limited or absent, while in others it is provided primarily through links to diocesan safeguarding pages.

3.5.18 The inspection identified variation in how dioceses assure themselves that safeguarding information is both visible and understood at parish level. In dioceses where parish audits, reviews or monitoring processes are in place, there is greater oversight of whether safeguarding information is displayed appropriately, kept up to date and understood. Where such assurance arrangements are limited or absent, dioceses rely more heavily on parish self-reporting, with less insight into how safeguarding information is actually experienced by parish communities.

3.5.19 These issues have direct implications for survivor engagement and early intervention. Evidence elsewhere in the inspection shows that survivors are more likely to disclose initially to people they know or trust, such as volunteers, parish staff or clergy, rather than directly to diocesan safeguarding teams. Where parish-level understanding of safeguarding processes and support is limited, survivors may encounter uncertainty or informal responses that discourage further engagement. This also increases the risk that low-level concerns are managed informally or not raised at all, reducing opportunities for early support.

3.5.20 For survivors who are hesitant, distressed or unsure how they will be treated, posters or contact details alone may feel impersonal and insufficient. Survivors may be aware that safeguarding information exists but still lack the clarity, reassurance or confidence needed to make contact. This is particularly significant for those on the margins of church life, as well as those outside the Church altogether, where posters or websites may represent the only point of access to safeguarding information.

3.5.21 Taken together, the evidence indicates that clear, accessible and survivor-focused information at parish level plays a critical role in whether survivors feel able to disclose and engage. Where safeguarding information is explained, visible in context and supported by confident parish-level understanding, barriers to disclosure are reduced. Where information is minimal, fragmented or primarily professional-facing, survivors may disengage before contact is made, particularly if they are uncertain that disclosure will lead to meaningful support.

3.6 Survivor Support, Care and Therapeutic Provision

3.6.1 This section draws on evidence from diocesan and religious life group interviews, survivor survey responses, and clergy, personnel, parishioner and volunteer survey findings to examine the availability, nature and consistency of survivor support, care and therapeutic provision in practice.

3.6.2 Across the evidence, there is a shared acknowledgement of the importance of supporting survivors. However, how survivor support is understood, resourced and delivered varies significantly across dioceses and religious life groups, resulting in uneven survivor experiences.

Access to counselling and therapeutic support

3.6.3 Approaches to counselling and therapeutic support vary significantly across dioceses. Positive practice was seen in a small number of dioceses and religious life groups, where formal counselling policies are in place and funded therapeutic support is offered proactively at the point of disclosure. Where survivors experienced this approach, therapeutic support was described as a meaningful acknowledgement of harm and an important foundation for recovery. One survivor noted that "the counselling was the one thing that actually helped," while another reflected that funded support "should be the minimum standard, but at least in that case, it was there."

3.6.4 However, this proactive and structured approach is not consistently applied. In most dioceses, access to counselling is managed on a case-by-case basis rather than through a clearly defined and consistently applied framework. Decisions regarding whether counselling is offered, the level of funding, and the duration of support are typically discretionary and are not always underpinned by publicly available guidance or clearly articulated internal standards.

3.6.5 The inspection recognises that, for practical and resource related reasons, decisions about therapeutic support require professional judgement and cannot be fully standardised. However, where these internal decision-making processes are not supported by clear, accessible, survivor facing information, this can result in uncertainty about entitlement, process and continuity of support. Survivors in these contexts described a lack of clarity about whether counselling would be offered, how decisions were made, and whether support might be withdrawn. This lack of transparency contributed to perceptions that therapeutic support was conditional, unevenly applied, and dependent on individual judgement rather than forming part

of a consistent and assured safeguarding response.

Models of survivor support and care

3.6.6 All diocesan safeguarding coordinators interviewed demonstrated a shared understanding of the importance of listening to survivors and, where appropriate, facilitating referrals to external organisations. This reflects a common baseline of intent across dioceses.

3.6.7 Beyond this baseline, however, survivor support is delivered through very different models, which shape survivor experience in practice.

3.6.8 Good practice was identified in a small number of dioceses and religious life groups where survivor support extends beyond safeguarding case management (the formal processes used to respond to concerns, assess risk and manage safeguarding cases) and includes dedicated survivor support or victim liaison roles, survivor forums, structured opportunities for survivor feedback, and emerging peer support initiatives. Where survivors encountered these approaches, support was experienced as relational and ongoing rather than limited to managing a safeguarding case. Survivors valued having a consistent point of contact and described feeling more supported over time, particularly where care was offered without pressure to remain engaged in Church life or safeguarding processes.

3.6.9 Other dioceses provide survivor support through wider diocesan care or social action structures, including charitable or pastoral agencies linked to the Church. In these contexts, support may include emotional, practical and pastoral assistance alongside safeguarding engagement. Where these arrangements were clearly linked to safeguarding processes and explained to survivors, they were experienced as offering a broader and more holistic response to harm.

3.6.10 In contrast, some dioceses provide little internally delivered survivor support beyond safeguarding casework and rely primarily on signposting survivors to external organisations. While survivors recognised the importance of specialist external services, reliance on signposting alone was often experienced as insufficient. Survivors described feeling unsupported once initial contact had passed, particularly where navigating external services required persistence and emotional energy at a time of vulnerability. However, where dioceses took a more active role in supporting referrals, such as assisting with initial contact, explaining processes or helping to complete referral forms, this was experienced more positively by survivors and helped to reduce barriers to accessing support.

Survivor experience of variation and inconsistency

3.6.11 Survivor survey evidence illustrates how these differences are experienced in practice. Survivors repeatedly described what they perceived as a "postcode lottery" in survivor support and safeguarding response, with the quality, timeliness and nature of support shaped by the diocese, religious order or local safeguarding team rather than by survivor need. Survivors who had engaged with more than one Church body were particularly aware of these differences.

3.6.12 Some survivors described receiving timely counselling, structured spiritual support or consistent survivor liaison, which they experienced as compassionate and responsive. Survivors also valued support that was offered without pressure to remain engaged in Church life.

3.6.13 In contrast, other survivors reported being offered only signposting, experiencing delays, or receiving no therapeutic support at all. Differences between dioceses were described starkly. One survivor reflected that "if I'd lived in a different diocese, I think this would have been handled very differently," while another described the experience as "luck of the draw, some places seem to try, others just shut you down." These inconsistencies extended beyond therapeutic provision to communication, follow-up and willingness to engage.

3.6.14 Survivors also described the fragility of support that relied heavily on individual goodwill rather than embedded systems. Several reported positive experiences with individual safeguarding staff or clergy, even where wider systems later failed them. However, where those individuals moved on or were overruled, survivors experienced a sudden loss of care and continuity, reinforcing perceptions that support was unreliable.

Choice, agency and survivor confidence

3.6.15 Survey evidence from clergy and personnel indicates strong agreement in principle that survivors should have choice and agency in how they receive support. Many respondents expressed confidence that survivors are offered options and that care is responsive to individual need.

3.6.16 However, parishioners and volunteers were less confident that survivors consistently experience genuine choice in practice. Survivor evidence suggests that where support options are limited, unclear or inconsistently offered, choice becomes constrained in reality. Survivors described uncertainty about what support they were entitled to, whether declining safeguarding processes would affect access to

care, or whether asking for support would be viewed negatively.

3.6.17 This gap between stated principles and lived experience is particularly significant at early stages of disclosure, where uncertainty about support can undermine trust and discourage engagement.

System factors and sharing of practice

3.6.18 The variation in survivor support identified through the inspection does not appear to stem from a lack of concern or commitment. Instead, it is shaped by practical factors such as differences in resourcing, the availability of specialist staff, access to funded therapeutic support, and whether survivor care is built into safeguarding arrangements or treated as an additional element. The inspection also recognises that trustees have legal and financial responsibilities which they must take into account when making decisions about the allocation of resources. However, where these considerations are not accompanied by clear, consistent and survivor-focused approaches to support, this can contribute to variation in practice and impact the consistency of survivor experience.

3.6.19 The inspection also found limited evidence of consistent mechanisms for dioceses and religious life groups to learn from one another about effective approaches to survivor support. While safeguarding coordinators meet at regional and national levels, and religious life groups engage in shared discussions, including through forums such as the Conference of Religious, these opportunities are not consistently utilised to share learning on survivor support models or to develop more coordinated approaches.

3.6.20 In addition, there is no single forum that brings together safeguarding leads across both dioceses and religious life groups to share learning and develop a more unified approach. Although some religious life group discussions include the sharing of case experience in a confidential manner, this does not routinely extend to the wider sharing of resources, models of care or practical approaches to survivor engagement.

3.6.21 As a result, dioceses and religious life groups often develop survivor support in isolation, leading to uneven provision and missed opportunities to strengthen practice more widely.

3.7 Resourcing, Capacity and Team Structures

3.7.1 This section examines how differences in resourcing, team structures and professional support shape safeguarding practice and survivor experience. Across the evidence, there is wide variation in how safeguarding is organised and resourced. These differences are not minor; they are reflected in how consistently survivors are supported, how communication is sustained over time, and how safeguarding is experienced in practice.

Safeguarding team capacity and organisation

3.7.2 Safeguarding teams vary significantly in size and structure across dioceses. Some dioceses operate multi-person safeguarding teams with clearly defined roles, including caseworkers, survivor support or victim liaison roles, safeguarding coordinators and senior safeguarding leads responsible for oversight and quality assurance. In these settings, responsibilities are shared across a larger team, and greater staff capacity enables safeguarding staff to maintain more regular and consistent contact with survivors. Senior safeguarding leads in these dioceses are often able to focus on policy development, implementation and continuous improvement, including work to strengthen survivor-centred initiatives and engagement.

3.7.3 In other dioceses, safeguarding is managed by a single coordinator, sometimes working part-time. In these arrangements, the coordinator is often responsible for all safeguarding activity, including survivor contact, case management, reporting, liaison with statutory agencies, training, parish support, quality assurance, policy development and safer recruitment. Safeguarding staff working in these roles described high workloads and the need to prioritise constantly, with limited capacity to sustain ongoing, relational engagement with survivors. Where capacity is limited, statutory requirements and immediate risk management inevitably take priority. This can reduce the time available for follow-up, continuity and proactive engagement with survivors, even where there is strong personal commitment to survivor care.

3.7.4 Survey and interview evidence indicates that reliance on single-person or part-time roles can affect continuity. Survivor evidence reflects the impact of these arrangements particularly during periods of leave or illness. Some survivors reported delayed responses or periods of reduced contact, which they found distressing, particularly at early stages of disclosure. Others described uncertainty about who to contact when communication slowed or stopped. While survivors did

not attribute these experiences to individual failings, they contributed to feelings of being unsupported or deprioritised.

3.7.5 Part-time or single-person roles also require safeguarding coordinators to manage complex responsibilities within limited hours. This increases the likelihood that communication becomes reactive or task focused. Survivors engaging with safeguarding services in these contexts may therefore experience slower responses, reduced continuity or more procedural engagement. These impacts reflect capacity constraints rather than individual performance, but they contribute to uneven survivor experience across dioceses.

3.7.6 While some variation in team size reflects the differing scale of dioceses, evidence suggests that capacity pressures become particularly significant when multiple complex cases arise in quick succession. In these circumstances, even relatively well-functioning arrangements can become stretched, affecting responsiveness, continuity and survivor engagement.

3.7.7 Resourcing across religious life groups varies. A number choose to fund dedicated lay safeguarding lead roles instead of a member acting in that capacity. Good practice was observed where religious life groups recruited external safeguarding leads, with these arrangements supporting greater capacity, independence and access to specialist expertise. It also allows access to people with specific safeguarding experience, which can be particularly helpful in areas such as policy development, case processes and record-keeping. In practice, these roles tend to sit alongside the support provided by RLSS, offering more consistent, day to day input at a local level, especially where there is a need for specific policies or ongoing administrative support. It should be recognised that many religious life groups are too small to require this level of safeguarding support.

Specialist survivor support roles

3.7.8 A clear point of difference between dioceses is the presence or absence of specialist roles focused on survivor support, such as survivor support workers or victim liaison leads. Where these roles exist, survivors more consistently described feeling listened to, kept informed and supported over time. Significant positive feedback was received from survivors who had direct contact with safeguarding personnel in these roles, particularly in relation to continuity, clarity of communication and emotional support.

3.7.9 Survey responses indicate that in dioceses with specialist survivor support roles, engagement was more likely to be described as ongoing and consistent,

rather than limited to managing safeguarding processes. Safeguarding staff also described these roles as reducing pressure on coordinators by separating survivor support from statutory or case management responsibilities, improving overall consistency and responsiveness.

3.7.10 In dioceses without specialist survivor roles, many coordinators still received positive survey responses however it was noted by survivors that safeguarding coordinators are required to manage survivor engagement alongside multiple competing responsibilities, including engagement with respondents. Balancing these roles can increase the risk that survivor contact becomes reactive, time limited or more procedural in nature, particularly during periods of high demand.

Supervision and professional support

3.7.11 Access to supervision and professional support for safeguarding staff varies widely. In a small number of dioceses, safeguarding coordinators and safeguarding leads have access to structured professional supervision delivered by an external, qualified supervisor. Staff who received professional supervision described it as essential for managing the emotional impact of their work, reflecting on complex cases and sustaining trauma informed engagement with survivors.

3.7.12 Many dioceses do not provide access to professional supervision. Some safeguarding staff reported that supervision was not considered necessary locally, while others cited cost or resource constraints. Where professional supervision was absent, staff relied on informal peer support, ad hoc discussion or personal coping strategies.

3.7.13 Line manager supervision arrangements are also inconsistent. Some safeguarding coordinators receive regular one to one supervision, while others described supervision as irregular, informal or focused primarily on operational oversight. Case management meetings and safeguarding committees were sometimes described as supervisory, although these forums focus on case progression and accountability rather than reflective or emotional support.

3.7.14 For survivors, these differences in supervision and professional support have practical consequences. Where safeguarding staff have access to regular clinical and professional supervision, survivors are more likely to experience consistent, reflective and emotionally contained engagement. Staff are better supported to manage complex dynamics, respond thoughtfully rather than defensively, and sustain compassionate communication over time.

3.7.15 Where supervision is limited or absent, safeguarding staff may be managing high emotional demands without adequate support. This increases the risk of fatigue, emotional overload or task-focused responses, which survivors may experience as reduced empathy, inconsistent communication or a more procedural approach to their concerns. While these impacts do not reflect a lack of care or commitment on the part of individual staff, they can affect the quality and consistency of survivor engagement.

3.7.16 Taken together, the evidence suggests that access to appropriate supervision and professional support is not only a workforce wellbeing issue, but also a key factor in supporting safe, consistent and survivor-centred safeguarding practice.

Responsibility for resourcing and decision-making, and increasing demands on safeguarding teams

3.7.17 Safeguarding staff consistently described increasing demands on their roles in recent years, including additional training responsibilities, quality assurance requirements and compliance activity linked to national safeguarding arrangements and audit requirements. In many dioceses, safeguarding team staff report these additional expectations have not been matched by corresponding increases in staffing or funding. During interviews some safeguarding teams with limited capacity reported it was difficult to meet these demands while also maintaining meaningful engagement with survivors, with little time available to develop enhanced survivor support.

3.7.18 Safeguarding coordinators were often aware that survivor engagement in their diocese differed from practice elsewhere. In interviews, they explained these differences by reference to workload, staffing levels or the defined limits of their role. Some responses reflected the pressure of operating within constrained capacity while being asked to account for variation in survivor experience. Safeguarding staff consistently emphasised that they sought to provide the best possible support within the resources available to them. While these factors are relevant, the evidence indicates that many of the constraints shaping survivor experience are structural rather than individual. Decisions about staffing levels, funding, specialist survivor support roles and the overall scope of safeguarding activity are made by diocesan leadership and trustees, not by safeguarding coordinators. These findings reflect the perspective of safeguarding teams; other diocesan leaders may hold different views on how resourcing decisions are made and managed.

3.7.19 Where safeguarding teams can present evidence, including survivor feedback

or examples of effective practice in other dioceses, this information should inform diocesan decision making. Responsibility for whether additional provision is resourced, and how those decisions are explained, rests with diocesan governance. Making this clear helps avoid safeguarding coordinators being held responsible for decisions they are not empowered to make.

3.8 Training, Confidence and Preparedness to Respond to Disclosures

3.8.1 This section draws on survey evidence from clergy, safeguarding professionals, employees, volunteers and parishioners, alongside qualitative responses and wider thematic findings, to examine how safeguarding training, confidence and preparedness shape survivor engagement with safeguarding processes.

3.8.2 As this thematic inspection focuses on survivor engagement, training is considered not only in terms of compliance, but in relation to whether survivors feel able to disclose, how they are responded to at first contact, and whether they continue engaging after an initial disclosure. The evidence shows that while safeguarding training structures are in place, preparedness to respond to survivors is uneven and strongly influenced by role, clarity of expectations and organisational support.

Engagement with safeguarding training and confidence at first disclosure

3.8.3 Survey evidence indicates high levels of engagement with safeguarding training among those with formal safeguarding responsibilities. The majority of safeguarding staff, Parish Safeguarding Representatives, clergy and members of religious life groups reported completing safeguarding training within the last year. Many respondents described safeguarding training as "part of the role" and emphasised its importance in helping them "know what to do if someone comes to me." This level of engagement provides a strong foundation for safeguarding practice.

3.8.4 Alongside this, the inspection identified inconsistency in how mandatory training requirements are understood across roles. Survey responses showed uncertainty about which roles require which level of training, how often training should be refreshed, and how diocesan training relates to professional or externally obtained safeguarding training. In some cases, respondents described safeguarding training as "above and beyond" what they expected to undertake, when they were

in fact referring to completing mandatory or refresher training required for their role. This reflects gaps in communication and clarity rather than reluctance to engage with safeguarding.

3.8.5 Within religious life groups, training arrangements vary. Some religious life group members undertake diocesan safeguarding training where their roles involve working in local parish settings, in addition to completing training within their own communities. This was identified as positive practice, supporting alignment with diocesan expectations and strengthening local safeguarding knowledge. In these cases, religious life groups often described strong working relationships with their local diocesan safeguarding teams. However, this is not consistent across all religious life groups and reflects differences in how religious life groups operate, including whether members are engaged in parish-based ministry. The RLSS provide a safeguarding service to most religious life groups, which includes safeguarding training., The provision and effectiveness of RLSS training is outside the scope of this review; however, where religious life groups additionally engage with diocesan training alongside their own arrangements, they often reported strong working relationships with local diocesan safeguarding teams.

3.8.6 Beyond religious life groups, quantitative results showed variation in training is most pronounced among non-safeguarding staff and volunteers. It is important to note that volunteers undertake a wide range of roles, many of which do not involve direct contact with children or young people and therefore do not require the same level of safeguarding training. This context is important when interpreting the findings. However, the evidence also shows that volunteers and non-safeguarding staff account for the majority of those reporting no safeguarding training, uncertainty about when they last trained, or only basic training. Qualitative responses suggest that perceptions of training in these groups are also more varied, with some respondents unclear about what constitutes safeguarding training or whether training completed in other settings is sufficient. Some diocesan safeguarding staff noted that not all volunteer roles were considered to require formal safeguarding training, particularly where roles were not seen as involving direct safeguarding responsibilities. However, the evidence indicates that disclosures can be made to any trusted individual, regardless of their role. This highlights the importance of ensuring that all volunteers receive a proportionate level of safeguarding awareness. This should include how to respond appropriately to a disclosure, such as listening, responding with empathy, avoiding investigation or leading questions, and knowing how and to whom concerns should be reported. In some dioceses, good practice

was found when this was addressed through simple but effective approaches, such as providing all volunteers with a safeguarding information leaflet outlining these key principles. This was identified as positive practice in supporting a consistent baseline of awareness across all roles.

3.8.7 This variation is particularly significant for survivor engagement. Survivor evidence in this inspection shows that survivors often disclose concerns first to people they already know or trust, such as parish staff, volunteers or clergy, rather than directly to safeguarding professionals. Where individuals at these initial points of contact feel unsure, unprepared or unclear about their role, survivors may disengage before concerns reach safeguarding teams. Several respondents acknowledged this risk, noting that while they "knew who to pass it to," they would feel "worried about saying the wrong thing" in the moment.

3.8.8 Quantitative survey responses suggest high confidence (91% of respondents) in knowing how to respond to a disclosure of abuse among safeguarding staff, Parish Safeguarding Representatives, clergy and members of religious life groups. However, neutral and negative responses were concentrated among non-safeguarding staff and volunteers. While this reflects the varying responsibilities within these groups, it also indicates that a minority may lack confidence in responding to disclosures, particularly in more complex or emotionally challenging situations. Qualitative responses indicate that confidence in these groups is often theoretical rather than practical. Several respondents expressed concern about "saying the wrong thing" or not knowing how to respond if someone became distressed. Hesitation or discomfort at the first point of disclosure can prevent survivors from continuing to engage, even where safeguarding systems are otherwise in place.

3.8.9 The evidence also highlights the importance of clear and proportionate training expectations by role. Clergy and safeguarding coordinators, who are most likely to receive disclosures and to hold responsibility for ongoing survivor engagement and decision-making, require more in-depth and regular safeguarding training, including survivor focused and trauma-informed practice. Parish Safeguarding Representatives require a solid working knowledge of safeguarding procedures and confidence in responding appropriately within their role. Volunteers and non-safeguarding staff do not require the same depth of training; however, given that disclosures may occur in informal settings, a consistent baseline of awareness is necessary to support safe and confident responses.

3.8.10 The inspection also identified variation in the training background of

safeguarding coordinators and wider safeguarding team members. While all safeguarding coordinators bring significant professional experience to their roles, the extent to which they have completed recent safeguarding training varies, and this variation is more pronounced in relation to survivor-specific training. Given that safeguarding coordinators are often the primary point of contact for survivors and are responsible for ongoing engagement, communication and decision-making, this inconsistency matters. Where coordinators have not received regular refresher or survivor focused training, this can affect confidence, consistency and the quality of engagement over time, even where commitment and experience are strong.

3.8.11 Training requirements and expectations also vary between dioceses and religious life groups, reflecting differences in structure, roles and ministry contexts. While this variation is appropriate, the evidence suggests that it can lead to inconsistency in how training requirements are understood, applied and recorded in practice. This review does not set out a single approach; however, the development of a clearer, shared framework outlining indicative training expectations by role could support greater consistency across the Church. This could include guidance on baseline training requirements, refresher expectations and the recording of training undertaken. Greater consistency in how training is logged and monitored may also support both dioceses and religious life groups in maintaining oversight, identifying gaps and demonstrating compliance, while still allowing flexibility to reflect local context and responsibilities. A clearer and more consistent framework is also likely to improve the experience of survivors, by supporting more confident, informed and appropriate responses at the point of first disclosure, regardless of who they approach. This may help reduce the risk of survivors encountering uncertainty, inconsistent responses or disengagement when raising concerns.

Survivor specific training and trauma-informed training

3.8.12 Training focused specifically on survivor support and ongoing care is uneven and not consistently recognised across roles. Safeguarding professionals generally reported confidence in listening appropriately, offering reassurance and facilitating referrals. Those who identified having received survivor-specific training consistently described greater confidence and clarity in responding to survivors. Outside safeguarding roles, awareness was more mixed. Clergy and members of religious life groups frequently reported uncertainty about whether they had received training specifically focused on survivor care, while non-safeguarding staff and volunteers overwhelmingly reported that they had not. Qualitative responses suggest this often-reflected uncertainty about what constitutes survivor-support

training, rather than its complete absence.

3.8.13 A similar pattern was evident in relation to trauma-informed practice. Safeguarding professionals demonstrated strong awareness and were able to describe principles such as non-judgemental listening, pacing, awareness of control and sensitivity to triggers. Where trauma-informed training had been received, it was frequently described as particularly impactful. In contrast, awareness dropped sharply outside safeguarding roles, with many volunteers, non-safeguarding staff and some clergy describing responses to disclosures as a matter of personal instinct rather than shared organisational practice. This uneven embedding increases the likelihood that survivor experience depends on individual confidence or personality rather than consistent safeguarding standards, particularly at early stages of engagement.

3.8.14 Evidence from surveys and interviews indicates that survivor-focused and trauma-informed training can have a clear impact on practice. Clergy and volunteers described such training as having "made me stop and think" about how their words, tone and pace might affect whether a survivor feels safe to continue engaging. Others described becoming more aware of the importance of listening without rushing to solutions and allowing survivors to set the pace.

3.8.15 Survivor evidence aligns with these findings. Survivors engaging in contexts where staff and clergy demonstrated survivor-focused responses were more likely to report feeling listened to and taken seriously. As noted elsewhere in this report, one survivor stated that "the safeguarding officer listened and treated me with dignity," while another reflected that "the only reason I didn't walk away completely was because one priest actually cared."

3.8.16 Awareness of safeguarding contacts is high across nearly all roles, with most respondents reporting that they know who to contact and how to do so. However, confidence in approaching safeguarding contacts is significantly lower, particularly among parishioners and some volunteers. Survey evidence indicates that this hesitation is driven less by lack of information and more by trust-related concerns, including fear of not being believed, previous negative experiences, perceived lack of independence or concern that meaningful action would not be taken. Knowing who to contact does not necessarily equate to feeling safe or confident to do so.

3.9 Survivor Voice, Feedback and Involvement

3.9.1 This section draws on survivor surveys and interviews, clergy, staff and volunteer survey responses, and review of diocesan and religious life group documentation to examine how survivor voice, feedback and involvement are understood and embedded within safeguarding practice. As this thematic inspection focuses on survivor engagement, survivor voice is considered a key indicator of whether safeguarding systems are experienced as responsive, transparent and accountable, rather than solely procedural.

3.9.2 Across dioceses and religious life groups, approaches to survivor voice and involvement vary widely. Practice ranges from structured, survivor-informed mechanisms embedded within safeguarding, governance and quality assurance arrangements, to minimal or ad hoc engagement shaped by local confidence, capacity and assumptions about survivor needs and preferences.

Feedback, choice and survivor agency

3.9.3 The inspection identified examples of thoughtful and survivor-led practice in relation to feedback. In a small number of dioceses, feedback is clearly framed as optional and survivor-led, with reassurance that survivors are not expected to provide feedback and that choosing not to do so will not affect support or safeguarding responses.

3.9.4 Some dioceses have developed more structured ways for survivors to share feedback if they wish. These include survivor-specific feedback questionnaires on diocesan websites, optional feedback links included in safeguarding correspondence, or clear contact routes for sharing views about how safeguarding was experienced. Where these approaches are in place, survivors are given space to respond in their own time and on their own terms.

3.9.5 Where feedback options were visible online, practice varied. In some dioceses, feedback mechanisms consisted of generic or blank feedback boxes with little explanation. In a minority of dioceses, feedback routes were clearer, more visible and better explained, with questions that specifically asked about communication, support and how safeguarding was experienced. In these settings, dioceses were better placed to understand how safeguarding processes felt in practice, including the emotional impact, rather than relying on professional assumptions.

3.9.6 However, this practice is not consistent across dioceses. In many cases, feedback is not routinely sought following safeguarding engagement. Safeguarding

staff often explained this as a protective decision, expressing concern that actively asking for feedback could risk re-traumatising survivors, particularly where safeguarding thresholds were not met, no further action was taken, or contact had been limited. These decisions were generally described as well-intentioned and aimed at avoiding further harm.

3.9.7 Survivor interview and survey evidence consistently challenges this approach. Survivors described the use of potential re-traumatisation as a reason for not inviting feedback as an "excuse," explaining that it removes choice rather than protecting wellbeing. Survivors emphasised that decisions about whether to give feedback should sit with them, not be made on their behalf. Several survivors described this as another situation where control was taken away from them within safeguarding processes and noted that not being given the choice to provide feedback could itself feel re-traumatising.

3.9.8 From a survivor perspective, not being invited to give feedback limits their ability to influence how safeguarding is experienced or improved. Where feedback is not offered, survivor experience is often assumed rather than understood. Survivors reported feeling that their views were not part of learning or change within safeguarding systems.

3.9.9 In dioceses where feedback is not routinely sought, decisions are often based on assumptions that survivors would not want further contact or that follow-up would be unhelpful. Where survivors are not given the option to decide for themselves, these assumptions remain largely untested.

3.9.10 This limits the understanding of how safeguarding processes are actually experienced, including whether communication was clear, explanations were helpful, decisions felt fair and contact felt supportive. In these situations, learning depends mainly on professional judgement rather than direct survivor input.

3.9.11 In practice, decisions about whether to seek feedback are often made on a case-by-case basis and rely heavily on individual judgement. Feedback may be sought informally through conversation or occasional follow-up rather than through clear, survivor-facing processes. There is often no agreed wording, guidance or standard approach to support staff in offering feedback opportunities in a consistent and proportionate way. As a result, whether survivors are invited to share their experience often depends on the confidence, capacity or approach of individual safeguarding staff.

3.9.12 Interview evidence also suggests that feedback is rarely sought at the end of safeguarding engagement, and formal reflection meetings are uncommon. Survivors consistently reported that they were not asked how the process had been for them. This contributed to a perception that learning was limited, and that safeguarding practice did not always change in response to survivor experience.

Case closure, review and learning from survivor experiences

3.9.13 The inspection identified limited evidence of formalised case closure processes that routinely include reflection, learning or survivor feedback. In many dioceses, safeguarding cases are brought to an end without a clearly defined closure point or structured review, and while survivors may be informed informally that safeguarding involvement has concluded, this is not consistently communicated through a formal process or recorded within case documentation.

3.9.14 Some dioceses described reviewing selected cases or maintaining a central lessons-learnt log, often focused on particular themes or complex matters. However, this practice was not consistent and was not mandatory for every case. As a result, learning from survivor experience is applied unevenly and depends on local initiative rather than shared expectation.

3.9.15 Where structured case reviews or reflective discussions did take place, these were more likely to inform governance discussions, policy development or practice improvement. However, survivor feedback was not routinely incorporated into these processes, limiting opportunities for organisational learning and accountability.

3.9.16 The inconsistent approach to case closure and review, limits opportunities to embed survivor feedback into governance, support clearer documentation of decisions and actions, and ensure learning from safeguarding experiences.

Survivor involvement, governance and quality assurance

3.9.17 The inspection identified examples of good practice where dioceses are taking steps to involve survivors in safeguarding governance and quality assurance. These approaches vary but include appointing survivors or survivor representatives to safeguarding committees or equivalent bodies, establishing survivor panels or forums, or reviewing survivor feedback at safeguarding sub-committees, including dedicated quality assurance groups. Where such arrangements are in place, documentation and interview evidence indicates that survivor perspectives have informed changes to communication, guidance and practice, including how safeguarding processes are explained and how survivor engagement is

approached.

3.9.18 Dioceses described a range of models for survivor involvement. Some involve individual survivors directly in governance structures, while others use survivor panels, forums or representatives from external organisations. One diocese, for example, works with a survivor representative from an independent organisation that supports survivors of many types of abuse, both within Church contexts and more widely. This approach was described as enabling survivor insight to inform governance without relying on a single individual's personal experience.

3.9.19 Across dioceses using different models, the inspection found that the effectiveness of survivor involvement was shaped less by the specific structure and more by how involvement was supported and used. Where survivors were clear about the purpose of their involvement, informed about how their input would be used, and updated on outcomes or changes, engagement was more likely to be experienced as meaningful and sustainable. Where survivor input was clearly linked to decision-making, policy review or quality assurance activity, it was more likely to result in visible change. This was evidenced in dioceses that involved survivors directly in developing survivor-facing materials, such as leaflets and guidance, where survivor feedback shaped language, tone and content.

3.9.20 Some dioceses expressed concern that involving survivors in governance could be re-traumatising, difficult to sustain, or risk relying on a limited range of perspectives. Others were concerned that survivor involvement could become symbolic rather than meaningful, or that survivors might feel pressure to represent experiences beyond their own. Survivor survey responses offer a different perspective. Survivors who were actively involved in committees, policy reviews or quality assurance activity, and who could see how their input influenced decisions or led to change, consistently reported feeling listened to. Several described this involvement as helping, in a small but important way, to regain a sense of voice following what they had been through.

3.9.21 However, many dioceses do not evidence any formal survivor consultation or representation mechanisms. Where survivor involvement is absent, this is often explained by assumptions that survivors would not wish to engage, that involvement could be harmful, or that appropriate or representative voices would be difficult to identify. As a result, survivor perspectives are not routinely embedded within governance, oversight or learning structures.

3.9.22 From a survivor perspective, this has implications for choice and influence.

Where opportunities for involvement are not offered or clearly explained, survivors are not able to decide for themselves whether or how they might wish to contribute. In these contexts, decisions about survivor involvement are made in advance, rather than being survivor led, and learning relies mainly on professional judgement rather than lived experience.

3.9.23 Some dioceses have started using the term "expert by experience" to describe survivor involvement. Survivors who took part in this work said the approach felt positive when it was clear what they were being asked to contribute, when involvement was optional and when support was available. This language has helped shift survivor involvement from being seen as symbolic to being recognised as a form of expertise that can inform safeguarding processes, policies and culture.

3.9.24 The inspection also noted that survivor involvement is most often drawn from individuals who have already raised concerns or reported abuse within Church contexts. There is limited evidence of survivor involvement roles being openly advertised or widely promoted. While dioceses and religious life groups recognised the need to ensure that survivors involved in governance or policy work are appropriately supported and suited to these roles, the absence of transparent routes into survivor involvement means opportunities are often shaped by existing contact and professional judgement.

3.9.25 As a result, survivor involvement may depend on safeguarding staff identifying individuals they believe are suitable, rather than survivors being able to express interest or choose whether to be involved. This can limit diversity of experience and reinforces the perception that survivor involvement is selective rather than open. The evidence suggests that developing clearer, survivor-facing ways to express interest in involvement, alongside appropriate support and safeguards, would strengthen transparency, widen choice and reduce reliance on individual discretion.

3.9.26 Overall, the evidence shows that survivor involvement is most effective where survivors are given clear opportunities to contribute and where their input is linked directly to governance, policy and quality assurance activity. In dioceses where survivor voice was actively sought, survivors were able to point to clear changes in documentation, processes and how safeguarding engagement was experienced. Where survivor input was not sought, decisions about safeguarding practice, learning and improvement were largely shaped by professional judgement alone. In these contexts, opportunities for challenge, feedback and change were more limited, and safeguarding arrangements were less likely to reflect survivor priorities

or experience.

Survivor engagement beyond individual dioceses and religious life groups

3.9.27 Evidence highlights limitations created by working strictly within diocesan boundaries when seeking survivor input. Most dioceses approach survivor engagement independently, despite the fact that survivor experiences and safeguarding concerns often span more than one diocesan or religious life group context. A small number of dioceses have begun to explore wider approaches, such as shared learning spaces or survivor input that informs practice across neighbouring dioceses. Where this has occurred, survivor insight has supported discussion on survivor-facing materials, communication and policy development beyond a single local setting.

3.9.28 This issue is particularly significant for religious life groups but was also raised by some dioceses. Many religious life groups are small, geographically dispersed and may have had limited direct contact with survivors in recent years. Similarly, some dioceses reported that survivors associated with non-recent cases were unwilling to engage further, or that they did not currently have access to survivors who wished to be involved. In these contexts, reliance on direct local survivor engagement alone can make meaningful survivor involvement difficult or, in some cases, not possible. Without alternative routes for survivor input, dioceses or religious life groups risk having no survivor-informed perspective shaping safeguarding practice, governance or learning. This creates gaps in understanding how safeguarding is experienced and limits opportunities for improvement.

3.9.29 Survivors and safeguarding professionals suggested that broader approaches to survivor involvement could help address some of these challenges. This included sharing survivor input across dioceses, offering survivors the option to contribute to work in neighbouring dioceses, or creating shared forums focused on specific areas such as survivor-facing leaflets, guidance or policies. Others suggested that survivors with lived experience of abuse outside Church contexts could also contribute valuable insight into disclosure, trauma and responses, particularly where engagement is focused on learning rather than case-specific matters. Within Church communities, there are many survivors whose experiences could help shape safeguarding practice without being linked to current or past cases. Involving survivors in this way would give people more choice about whether and how they contribute to and support shared learning across dioceses and religious life groups.

3.9.30 At present, many dioceses take part in safeguarding focused ecumenical meetings with safeguarding teams from other churches and denominations within their area However, these meetings do not usually focus on survivor engagement or safeguarding practice from a survivor perspective. There is also no national or consistent multi diocesan forum or group specifically focused on survivor engagement in safeguarding. As a result, opportunities to share survivor insight, learn from experiences across dioceses, or test survivor-facing materials such as leaflets or guidance are limited. Without shared spaces for this work, learning remains local and informal. Consideration could be given to establishing a national forum or group focused on survivor engagement, to support shared learning, consistency in approach and the development of survivor-informed practice across dioceses.

3.9.31 Evidence gathered during the inspection also highlighted the importance of careful design and facilitation where survivors are involved in national work, such as recent development of national policy and procedure. In one example, survivors were invited to attend a meeting to provide their perspective and views. The meeting was experienced by some participants as an unsafe form of engagement with survivors. Safeguarding professionals at the meeting raised that they felt unable to speak freely with survivors present. The CSSA received information from survivors that they felt "ambushed" and excluded because of comments made and language used within the meeting. The language described to the CSSA is inconsistent with survivor-centred practice. Survivors also expressed concern that poor practice was not visibly challenged during the meeting. For example, one survivor described the impact of the meeting by saying "If they are saying things like that (about survivors) then we have no hope".

3.9.32 While there were differing views about the meeting, the survivor evidence shared with the CSSA highlights the need for survivor engagement to be trauma-informed, transparent and purposeful. Survivors should know why they have been invited, what they are being asked to contribute, what decisions are open to influence, and how their contribution will be used. They should feel safe in any meeting environment. Professionals should also be clear about when a meeting is intended for open technical discussion and when it is intended for survivor consultation or co-production. Effective survivor engagement requires structure and the creation of an environment where their presence is valued, respected and influences the work being carried out. There should be summary and feedback about what will happen next as a result of their contribution, and opportunity for debrief.

Collective survivor engagement, events and cultural impact

3.9.33 There is wide variation between dioceses in the extent to which collective survivor engagement events and opportunities for shared reflection are offered. Some dioceses have developed a range of survivor-focused or survivor-inclusive activities intended to acknowledge harm, provide space for listening and support wider cultural change within the Church.

3.9.34 These activities include diocesan days of prayer for victims and survivors, open listening or "listening sessions", LOUDfence events[27], and safeguarding events that include facilitated spaces for survivors to share experiences in non-case-related contexts. In some dioceses, survivor listening sessions are incorporated into wider safeguarding conferences or diocesan events, ensuring that survivor voice informs learning and reflection alongside discussion of policy and practice. In these settings, good practice was evidenced when some dioceses developed more extensive programmes of activity, including specialist safeguarding conferences where survivor voice is central. These events were often described as well received by both survivors and Church representatives, with feedback highlighting their value in shaping understanding and influencing practice.

3.9.35 Some dioceses also participate in nationally recognised initiatives, such as Safeguarding Sunday[28] and the 16 Days of Activism, which provide opportunities for collective reflection and awareness across parish and diocesan life. The Catholic Bishops' Conference of England and Wales also promote an annual Day of Prayer for Victims and Survivors of Abuse[29], which many dioceses mark locally. While these initiatives are not always designed as survivor engagement events in themselves, they offer a shared framework for acknowledging safeguarding, abuse and violence, and for signalling commitment to survivor awareness without requiring dioceses to develop separate local programmes. Participation varies, but these initiatives provide a common reference point for collective engagement across the Church.

3.9.36 A small number of dioceses have also created physical or symbolic spaces intended to offer recognition, reflection and healing, such as memorials, gardens or dedicated places of prayer. In one diocese, the installation of a survivor memorial

[27] LOUDfence is a reconciliation movement that aims to work with churches to actively foster a culture which is pro-safeguarding and truth telling. LOUDfence
[28] Safeguarding Sunday is an annual awareness campaign promoted by the independent Christian safeguarding charity Thirtyone:eight.
[29] Prayer Day for Survivors of Abuse - Catholic Bishops' Conference

was described as a meaningful and visible statement of acknowledgement and was positively received as a sign of commitment to recognising the experiences of survivors. These initiatives are typically framed as open and optional, providing survivors and others affected by abuse with a place of sanctuary rather than a route into safeguarding processes or case management. In addition, some dioceses have developed survivor-specific groups or sessions, enabling survivors to meet one another, access peer support and engage with the Church in ways that are not limited to individual safeguarding cases. These initiatives are generally survivor-led, voluntary and focused on connection, reflection or healing. The frequency and consistency of these activities vary. In some dioceses, good practice is evident where survivor engagement events form part of an established annual programme or are linked to national or Church-wide initiatives. In others, events are offered more frequently or arranged in response to local interest, survivor feedback or particular moments in the diocesan calendar. In some settings, however, survivor engagement activities are offered on a more sporadic basis, without a clear pattern or longer-term plan. There are also dioceses where no collective survivor engagement activity was evidenced in the last 12 months. In these contexts, engagement with survivors is largely limited to individual case contact, with no structured opportunities for shared listening, reflection or connection beyond safeguarding processes. Where this is the case, survivors may experience engagement as procedural with limited recognition within the wider Church community.

3.9.37 Evidence from survivor surveys and interviews indicates that collective listening and engagement can have a significant impact. From qualitative survey evidence survivors described these spaces as helping them feel recognised within the wider Church community. Safeguarding staff, clergy, leaders and volunteers also described the impact of hearing survivor stories directly, noting changes in understanding, attitudes and behaviour that were not always achieved through policy, training or written guidance alone. Where these activities are sustained, they contribute to cultural change that extends beyond individual cases and supports a more compassionate and responsive safeguarding environment. For survivors, these shifts matter because they influence how safeguarding is experienced in practice. Greater awareness of lived experience can lead to more thoughtful communication and a stronger focus on survivor pace, choice and dignity. Where collective survivor engagement is present and sustained, it contributes to cultural change that extends beyond individual cases and supports a more compassionate and responsive safeguarding environment.

3.9.38 Collective events and public acts of acknowledgement can also serve a wider purpose beyond reflection. Evidence from the Independent Inquiry into Child Sexual Abuse highlights the importance of survivors feeling heard and recognised[30], and research from the Centre of Expertise on Child Sexual Abuse indicates that disclosure is more likely in environments perceived as safe and supportive[31]. In this context, public and collective safeguarding initiatives may contribute to building trust and signalling openness, which in turn may encourage survivors to come forward or engage with support. While this inspection did not directly assess the impact of such events on disclosure, this reflects wider understanding from research and practice. In some dioceses, efforts are also made to share learning from these activities more widely, including the development and dissemination of resources such as guidance, leaflets and survivor-informed materials, as well as the use of external speakers or practitioners. However, opportunities to share this learning consistently across dioceses remain limited. Greater use of shared forums or networks could support the spread of effective practice, enabling dioceses to learn from one another, build collective knowledge and develop more consistent approaches to survivor engagement across the Church.

3.10 Parish Culture, Leadership and Survivor Confidence

3.10.1 Survey evidence shows that positive safeguarding culture does exist in some parishes and is most evident where leadership is visible, confident and compassionate. Many clergy, staff and volunteers described parish leaders who listen carefully, take concerns seriously and make clear through their actions that survivors matter. One respondent noted that "my parish priest genuinely listens and takes concerns seriously," while another described a leader who "made it clear that survivors mattered."

3.10.2 In these parishes, safeguarding was more likely to be experienced as part of everyday parish life rather than as a background or purely procedural requirement. Visible leadership, open discussion and consistent follow-through were associated with greater confidence among parishioners and volunteers.

[30] This was a regularly repeated theme in IICSA reports. See, for example, *The Report of the Independent Inquiry into Child Sexual Abuse*, 2022, p. 27

[31] Centre of expertise on child sexual abuse, *Key messages from research on identifying and responding to disclosures of child sexual abuse*, 2019, Key messages from research on identifying and responding to disclosures of child sexual abuse

3.10.3 In one diocese, the safeguarding coordinator described attending parish Masses on a regular basis and introducing herself to parishioners. This was intended to increase visibility, normalise safeguarding as part of parish life and reduce barriers to contact. However, this approach relies on individual capacity and was often undertaken outside normal working hours, highlighting the wider issue of safeguarding practice depending on personal initiative rather than being consistently embedded through systems.

3.10.4 Survey responses, particularly from parishioners and volunteers, indicate that safeguarding culture is often dependent on individual leadership style rather than shared parish expectations. Several respondents stated that compassion "depends on the priest," or that "some leaders are very good, others avoid it completely." One Parish Safeguarding Representative reflected that "it's very person-led; if the priest is confident, safeguarding feels safe; if not, people stay quiet."

3.10.5 While safeguarding is routinely discussed within diocesan structures, training and internal meetings, it is often far less visible in everyday parish life. Parishioners frequently reported that safeguarding and survivor support are rarely spoken about beyond notices or posters. One parishioner commented that safeguarding was "there on the noticeboard, but never really talked about," while another said that "you'd only know what to do if you already knew." Survey data supports this, with parishioners and volunteers more likely than clergy or safeguarding staff to describe safeguarding information as "sometimes visible" or "easy to overlook."

3.10.6 Where safeguarding is present but rarely discussed, it can feel procedural rather than relational. Survivors and parishioners may be uncertain about whether concerns will be welcomed or how they will be received. As one parishioner reflected, "you don't know how it will be received until you say something, and that's the risk."

3.10.7 Survey evidence also points to a gap between stated commitments to inclusion and lived experience at parish level. Clergy and safeguarding staff often described parishes as welcoming, while parishioners and volunteers expressed more uncertainty. Qualitative responses suggest that treating everyone "the same" is sometimes seen as inclusive but can overlook the different needs of survivors. One respondent observed that "everyone is treated the same, which sounds fair, but it ignores people who need something different," while another commented that inclusion "is talked about more than it's shown."

3.10.8 Taken together, these findings reflect a wider pattern across the inspection. Strong policies, training and assurance mechanisms may be in place, but survivor

confidence is shaped most directly by how safeguarding is lived at parish level. Where leadership, communication, learning from concerns and survivor-centred practice operate together, safeguarding is more likely to be experienced as consistent, credible and supportive. Where safeguarding culture remains person-dependent rather than embedded, trust is more fragile and survivor experience becomes unpredictable. As one respondent observed, "on paper it looks good, but in reality, it depends on who you talk to".

4. Discussion

4.1 This thematic inspection set out to understand how survivors experience engagement with safeguarding across dioceses and religious life groups, and how governance, policy, practice and culture shape those experiences in practice. Taken together, the findings demonstrate that there is clear intent and commitment to safeguarding and survivor care across the Church, alongside examples of thoughtful, compassionate and effective practice. However, survivor experience varies considerably and is often dependent on local structures, capacity and individual practice rather than consistently embedded systems.

4.2 A central theme running throughout the findings is variation. Differences in governance arrangements, safeguarding policies, parish assurance mechanisms, survivor support models, resourcing, training and safer recruitment do not simply reflect local flexibility or proportionality. From a survivor perspective, these differences translate into substantially different experiences of disclosure, communication, support and follow-through. Survivors engaging with different dioceses, parishes or religious life groups may encounter safeguarding responses that range from proactive, transparent and supportive to unclear, inconsistent or procedural.

4.3 These differences are not experienced as flexibility, but as inconsistency and, in some cases, unfairness, particularly where survivors become aware of different approaches or levels of support elsewhere. While variation may be expected in a system operating across diverse contexts, the findings suggest that its impact on survivor experience is significant and, at times, undermines confidence in safeguarding arrangements.

4.4 At the same time, the inspection identified clear examples of strong, survivor-centred practice. Survivors frequently described compassionate and appropriate

initial responses, and safeguarding staff consistently demonstrated a high level of personal commitment to supporting survivors, often within challenging and resource constrained environments. In some dioceses and religious life groups, structured governance arrangements, specialist survivor support roles, and proactive engagement approaches contribute to more consistent and positive experiences. However, where these approaches exist, they are not consistently embedded or shared across the system. As a result, good practice is experienced as exceptional rather than assured.

4.5 This highlights a broader tension between the concept of a unified safeguarding approach across the Church and the reality of locally determined practice. While dioceses and religious life groups operate at different scales and with varying levels of resource, survivors may reasonably expect a consistent standard of response regardless of where they engage. Where this is not achieved, safeguarding is experienced as fragmented rather than unified, which can undermine confidence in the Church's overall safeguarding approach.

The balance between systems and individuals

4.6 Across dioceses and religious life groups, survivors frequently described positive experiences with individual safeguarding staff, clergy or parish leaders, particularly at the point of first contact. Many safeguarding professionals demonstrated compassion, empathy and a strong personal commitment to supporting survivors appropriately, and these interactions were often highly valued.

4.7 However, these positive experiences were often fragile where systems were not sufficiently embedded. Where safeguarding relies heavily on individuals rather than shared processes, survivor experience becomes person dependent. This is most evident in dioceses with limited safeguarding capacity, single-person roles or part-time coordinators, and in parish contexts where safeguarding practice is shaped primarily by local leadership style.

4.8 Safeguarding team structure plays a significant role in this. Dioceses with larger, multi-role safeguarding teams are better able to distribute responsibilities, maintain continuity and sustain engagement over time. The presence of specialist survivor support roles further strengthens this by enabling more consistent, relational engagement, distinct from statutory or case management functions. In contrast, where safeguarding is delivered through single-person or part-time roles, or where responsibilities are combined, reliance on individuals increases and continuity becomes more difficult to maintain, particularly during periods of absence or

increased demand.

4.9 In addition, the findings suggest that in some areas safeguarding practice relies on individual knowledge, experience or informal understanding rather than consistently embedded systems. While this can allow flexibility and responsiveness, it also introduces risk. Where knowledge is not shared, documented or supported by clear processes, it becomes more difficult to ensure consistency, sustainability and accountability over time.

4.10 These findings indicate that while the contribution of individuals is critical, safeguarding systems need to be sufficiently robust to support, sustain and standardise good practice, ensuring that positive engagement is not dependent on individual roles alone.

Governance, oversight and transparency

4.11 Governance arrangements play a critical role in shaping safeguarding practice and survivor experience. Where dioceses and religious life groups have clear governance structures, defined reporting lines and shared oversight mechanisms, there is stronger evidence of consistency, accountability and continuity in safeguarding decision-making.

4.12 In particular, where governance includes formal case management oversight, multidisciplinary input and regular review, safeguarding decisions appear more transparent and less reliant on individual judgement. These arrangements provide greater assurance that safeguarding activity is subject to appropriate scrutiny and challenge.

4.13 However, the inspection also identified that governance arrangements are not always visible or well understood by survivors. Survivors frequently described uncertainty about where decisions were made, who held responsibility and how concerns could be challenged. Even where governance structures are robust internally, this is not always reflected in publicly available information or in the way processes are explained to survivors.

4.14 As a result, safeguarding processes may be experienced as unclear or opaque, reinforcing existing power imbalances and undermining trust. This is particularly evident in relation to complaints and challenge processes, which represent one of the clearest points at which governance is experienced in practice.

4.15 Where complaints processes are clearly explained, safeguarding specific

and supported by independent oversight, they have the potential to support accountability and organisational learning. However, when they are unclear, difficult to navigate or perceived as defensive, survivors may experience them as discouraging rather than enabling.

4.16 In some cases, responses to complaints were described as cautious or risk-focused, particularly where issues of liability or compensation were present. While this inspection did not examine the role of insurers directly, it is important to recognise that legal and insurance considerations may influence how responses are framed. This can create a tension between legal risk management and survivor-centred practice, particularly where communication becomes more formal or limited.

4.17 These findings highlight the importance of governance arrangements that are not only robust internally but are also transparent, accessible and clearly communicated, enabling survivors to understand how decisions are made and how they can seek challenge or review where necessary.

Policy clarity and operational reality

4.18 Policies and guidance provide an essential framework for safeguarding practice, and many dioceses and religious life groups have developed detailed documentation to support this. However, the inspection demonstrates that the presence of policy does not in itself ensure consistent understanding or application in practice.

4.19 Variation in terminology, definitions of vulnerability and safeguarding thresholds contribute to inconsistency in how concerns are interpreted and managed. More significantly, safeguarding processes are not always presented or experienced as a clear and coherent journey for survivors.

4.20 Survivors are often required to navigate multiple stages, decisions and processes without a clear overview of what to expect. This lack of a defined and communicated pathway contributes to confusion, uncertainty and a sense of loss of control.

4.21 This gap between written standards and lived experience is particularly evident in relation to decision-making. Survivors frequently reported uncertainty about how decisions were reached, how safeguarding arrangements were reviewed and how outcomes were determined or communicated. In some cases, safeguarding measures were implemented without prior explanation, reinforcing feelings of exclusion.

4.22 Lower level concerns provide a further example of the disconnect between policy and practice. Where clear guidance is in place, concerns are more likely to be recognised, recorded and used as opportunities for early intervention and learning. Where guidance is absent or unclear, responses rely more heavily on individual judgement, increasing inconsistency and the risk that early warning signs are missed.

4.23 These issues also have implications for governance. Where policy is unclear or inconsistently applied, it becomes more difficult for trustees and leadership to have confidence that safeguarding is being delivered effectively. Strengthening alignment between policy, practice and oversight is therefore critical.

Parish assurance and early intervention

4.24 Many survivors encounter safeguarding within parishes, making parish assurance a critical component of safeguarding systems. The inspection identified significant variation in approaches to parish audits, record-keeping, training oversight and safeguarding structures. These differences directly influence how consistently safeguarding is experienced at the earliest point of contact.

4.25 Where dioceses operate structured parish assurance processes, including central oversight of training, safer recruitment and safeguarding roles, safeguarding practice is more consistent and visible. In these settings, there is clearer accountability, stronger alignment between parish activity and diocesan expectations, and greater confidence that safeguarding standards are being met. These arrangements also support early identification of gaps, enabling timely intervention and reducing the risk of concerns escalating.

4.26 The development of simplified assurance tools, such as parish safeguarding dashboards or structured audit frameworks, illustrates the potential benefits of clearer and more accessible approaches. By translating safeguarding expectations into visible and measurable indicators, these tools reduce reliance on individual knowledge and support more consistent practice across parishes. They also provide a practical mechanism for tracking compliance and identifying areas requiring support or improvement.

4.27 However, these approaches are not consistently embedded across dioceses. In some settings, parish assurance remains informal or reliant on self-reporting, with limited central oversight. This can result in variability in safeguarding practice, particularly where parishes have differing levels of capacity, experience or understanding of safeguarding requirements. In these contexts, safeguarding

arrangements may be more vulnerable to inconsistency, and early warning signs or low-level concerns may be less likely to be identified and addressed.

4.28 Parish assurance is therefore closely linked to early intervention. Where systems are clear, structured and actively monitored, there is greater opportunity to identify patterns, respond to emerging concerns and support preventative safeguarding practice. Where assurance is less developed, safeguarding is more likely to be reactive, responding to concerns only once they reach a higher level of risk.

4.29 Parish assurance also has a direct relationship to trustee oversight and governance. Where assurance processes are clear, consistently applied and routinely monitored, trustees are better able to understand how safeguarding is operating at parish level and to identify areas of risk or inconsistency. This provides a stronger basis for informed decision-making and strategic oversight. In contrast, where assurance is informal or lacks central visibility, it becomes more difficult for trustees to have confidence that safeguarding expectations are being met consistently across all parishes.

4.30 Strengthening parish assurance processes is therefore critical not only for operational safeguarding practice but also for enabling effective governance. It supports greater consistency, improves visibility of risk, and provides assurance that safeguarding arrangements are functioning as intended across the system.

4.31 While approaches to parish assurance may need to reflect local context, the findings suggest that clearer expectations, more structured processes and improved visibility would support both consistency of practice and confidence in safeguarding at all levels of the Church.

Survivor experience, communication and power

4.32 Survivor evidence consistently demonstrates that communication, transparency and power dynamics are central to how safeguarding is experienced. Initial responses to disclosure were often described positively, with survivors highlighting compassionate and appropriate first contact.

4.33 However, many survivors reported a reduction in communication and follow-up as processes progressed. Delays, lack of clarity and limited updates were experienced as distressing and disempowering, even where safeguarding activity continued internally.

4.34 Where responses were perceived as defensive, legalistic or overly procedural,

survivors described these dynamics as reflecting broader power imbalances, in some cases mirroring aspects of their original experiences of abuse. These experiences significantly affected trust and, in some cases, led to disengagement from Church life.

4.35 Across a number of findings, safeguarding engagement appears to be shaped primarily by process and compliance requirements rather than sustained, relational support. This can result in interactions that feel procedural rather than responsive to individual needs, particularly over time.

4.36 At the same time, where communication was sustained, transparent and respectful, survivors described feeling informed, supported and treated with dignity, even where outcomes were difficult. These examples demonstrate that positive survivor engagement is achievable across different contexts.

4.37 These findings also demonstrate that while dioceses and religious life groups may not always be able to provide survivors with the outcomes they seek, the way in which decisions are communicated, explained and handled is the critical factor in shaping survivor experience.

Information, accessibility and inclusion

4.38 The inspection highlights significant gaps in the availability, clarity and accessibility of survivor-facing information about safeguarding processes, support options and what to expect following disclosure. While internal guidance for safeguarding professionals is often detailed and comprehensive, this information is not consistently translated into formats that are accessible, clear or tailored to those engaging with safeguarding.

4.39 As a result, survivors may be required to navigate complex documentation or rely on verbal explanations to understand their safeguarding journey. This can contribute to confusion, uncertainty and a sense of loss of control, particularly where processes are not clearly explained or where information is provided inconsistently over time.

4.40 The findings also suggest that safeguarding information is not always presented as a clear and coherent pathway. Survivors are often engaging with multiple stages of process, decision-making and communication without a clear overview of what to expect, which can make safeguarding feel fragmented and difficult to follow. Providing clearer, structured and accessible information about the safeguarding journey, including key stages, roles and decision points, would support greater

transparency and understanding.

4.41 At the same time, some dioceses demonstrate emerging good practice in this area. This includes the development of accessible materials, use of digital tools to support communication, and increasing awareness of the need to adapt information to meet different needs. These approaches illustrate the potential for more inclusive and responsive safeguarding practice where accessibility is prioritised.

4.42 There is also a need for safeguarding information to be designed for a broader audience. Clergy, volunteers and parish representatives are often the first point of disclosure and require clear, proportionate guidance on how to respond appropriately. This includes understanding how to listen, respond with empathy, avoid investigative questioning and report concerns appropriately. Without this wider awareness, gaps in confidence and preparedness may arise at critical early stages of engagement.

4.43 Accessibility and inclusion extend beyond format and clarity to the ability of safeguarding systems to respond to diverse needs. The findings indicate that while there is a general intention to be inclusive, this is not always reflected in consistent practice. Survivors noted limited availability of accessible materials tailored to neurodivergent individuals or those with additional communication needs, as well as limited evidence of staff training in this area.

4.44 Strengthening accessible, clearly structured and audience-appropriate information therefore represents a key area for development, supporting not only improved survivor experience but also greater consistency and confidence across all those involved in safeguarding.

Survivor support, resourcing and sustainability

4.45 Survivor support models vary widely across dioceses and religious life groups, ranging from the proactive provision of funded counselling, specialist survivor support roles and ongoing engagement, to more limited approaches focused on signposting to external services. Survivors described this variation as inconsistent and, at times, difficult to navigate, particularly where information about available support was unclear or not proactively offered.

4.46 Where support is clearly explained, accessible and sustained over time, survivors are more likely to describe their experience as supportive and responsive, even where safeguarding processes themselves are complex or challenging. In contrast, where support is limited, inconsistently applied or not clearly communicated,

survivors may experience uncertainty about what is available to them, including questions about entitlement, duration and conditions of support.

4.47 Resourcing is central to these differences. Dioceses with larger safeguarding teams, specialist roles and access to supervision are better able to sustain communication, provide ongoing support and maintain relational engagement with survivors. In these settings, safeguarding practice is more likely to extend beyond process management to include proactive and continuous support.

4.48 In contrast, where safeguarding is delivered through smaller or overstretched teams, staff are required to prioritise statutory requirements and immediate risk management. This can reduce the capacity for proactive communication, relationship building and sustained engagement, even where there is strong personal commitment to survivor care. Over time, this can result in a more reactive model of engagement, where survivor contact is shaped by process requirements rather than ongoing support.

4.49 Despite these pressures, safeguarding staff consistently demonstrated a high level of commitment to supporting survivors, often working within limited capacity to maintain engagement wherever possible. This reinforces that the challenges identified are structural rather than individual, and relate to resourcing, capacity and system design rather than a lack of effort or intent.

4.50 Safeguarding roles also involve significant emotional labour, particularly in relation to sustained engagement with survivors and complex or non-recent cases. Where this is combined with high workloads and limited access to supervision or professional support, it may further affect the ability to maintain consistent, relational engagement over time.

4.51 While it is recognised that dioceses and religious life groups operate at different scales and with varying levels of resource, the findings highlight the importance of ensuring that survivor experience does not depend on local capacity. Consideration is therefore needed as to how greater consistency can be achieved, so that survivors can expect a comparable standard of communication, support and engagement regardless of where they come into contact with safeguarding services.

4.52 This does not suggest that all dioceses and religious life groups should deliver identical models of support. Rather, it highlights the need for clearer expectations about the level and nature of support that survivors can reasonably expect, alongside greater transparency in how support is provided and communicated.

Collective survivor engagement and cultural impact

4.53 Opportunities for collective survivor engagement vary across dioceses and religious life groups. Where these activities are present, including listening events, survivor-led sessions, conferences, and symbolic acts of acknowledgement, they are valued by both survivors and Church representatives and contribute to increased awareness of survivor experience.

4.54 These approaches demonstrate the potential for safeguarding to extend beyond individual case management to support wider organisational reflection and cultural change. Hearing survivor experiences directly was described as having a significant impact on understanding, attitudes and behaviour, often influencing safeguarding practice in ways that are not achieved through policy or training alone. In this context, collective engagement can support a shift from compliance-driven safeguarding towards more reflective and responsive practice. This is particularly significant as it helps bridge the gap between safeguarding systems and lived experience, reinforcing the importance of survivor voice within wider Church culture.

4.55 Collective events and public acts of acknowledgement can also serve a wider purpose. By visibly recognising harm and demonstrating a commitment to safeguarding, they may contribute to building trust and signalling openness, which can encourage survivors to come forward or engage with support. While this inspection did not directly assess the impact of such activities on disclosure, this reflects wider understanding from research and practice that environments perceived as safe and supportive are more likely to facilitate engagement.

4.56 However, these approaches are not consistently embedded across dioceses and religious life groups. In some settings, collective engagement forms part of an ongoing programme of activity, with regular opportunities for reflection and survivor involvement. In others, it is more limited or absent, meaning that opportunities for shared recognition, connection and learning are not available.

4.57 Where engagement is limited to individual case contact, safeguarding may be experienced as procedural and isolating, with fewer opportunities for survivors to feel recognised within the wider Church community. This can reinforce a perception that safeguarding is primarily process-driven rather than relational or reflective.

4.58 The absence of consistent approaches to collective engagement also limits opportunities for shared learning across dioceses. Where effective practice exists, it is not always disseminated or replicated, meaning that cultural change is uneven and dependent on local initiative rather than system-wide development.

Survivor voice and organisational learning

4.59 There is significant variation in how survivor voice is invited, heard and acted upon across dioceses and religious life groups. Where survivors are given genuine choice about engagement, and where their input informs governance, policy development or quality assurance processes, engagement is experienced as meaningful and empowering. In these contexts, survivor voice contributes directly to organisational learning and the development of more responsive safeguarding practice.

4.60 However, this approach is not consistent. In some cases, feedback is not actively sought, or opportunities for involvement are limited. In others, involvement is avoided based on assumptions that engagement may be harmful or re-traumatising. While these concerns are often well intentioned, they can result in survivor perspectives being absent from decision-making processes.

4.61 The findings suggest that the key issue is not whether survivor involvement should take place, but how it is approached. Providing survivors with meaningful choice about if, when and how they engage is critical, rather than assuming that non-engagement is inherently protective. Where this choice is not clearly offered, opportunities for learning, reflection and improvement are reduced.

4.62 This has wider implications for organisational learning. Without consistent mechanisms to capture and reflect on survivor experience, safeguarding systems risk developing without direct reference to lived experience. This limits the ability to identify patterns, understand the impact of safeguarding responses and respond effectively to emerging issues.

4.63 Opportunities for shared learning across dioceses and religious life groups are also limited. Survivor engagement is largely local, despite many survivor experiences crossing organisational boundaries. Without system-wide approaches to sharing insight, resources and effective practice, learning remains fragmented and dependent on individual effort rather than collective development.

4.64 Strengthening approaches to survivor voice and organisational learning therefore represents a key area for development, supporting both improved practice and greater consistency across the Church, and contributing to a more unified and survivor-centred safeguarding approach.

5. Conclusion

5.1 Taken together, the findings suggest that the effectiveness of survivor engagement is shaped less by stated commitments and more by how consistently systems support survivor-centred practice over time. Where governance, policy, assurance, resourcing and culture align, survivors experience safeguarding as credible, compassionate and accountable. Where these elements are misaligned, safeguarding is experienced as inconsistent, unclear or procedural, even where individual intention is strong.

5.2 The evidence also shows that a single poor experience can undermine confidence in safeguarding more widely, including in dioceses where practice is strong. Survivors do not experience safeguarding in isolation; experiences are shared, compared and carried across diocesan and organisational boundaries. As a result, uneven resourcing or weak practice in one area risks undermining trust in work being done elsewhere. Where some dioceses are unable to resource survivor-centred approaches consistently, this affects confidence in the Church's safeguarding response as a whole.

5.3 The discussion therefore points to consistency as the central issue running through this thematic inspection. Without shared expectations, minimum standards and reliable resourcing, good practice remains infrequent rather than assured. Addressing these underlying factors is necessary to move survivor engagement from something that depends on individuals to something experienced consistently across the Church.

6. Key areas for action and development

6.1 The following key areas for action and development are intended to support reflection by Church leaders on the findings of this thematic review. While they are not framed as prescriptive recommendations, they identify areas where strengthening of practice is required in order to enhance survivor-centred safeguarding across the Church. They are intended to encourage thoughtful engagement with the evidence presented and to support the development of responses that are appropriate to local context, while contributing to greater consistency and effectiveness in safeguarding practice.

6.2 Recognising the importance of national leadership and coordination in addressing the themes identified, it is expected that the Strategic Council for Catholic Safeguarding will consider the findings of this review and develop a national action plan setting out how these areas will be taken forward across the Church. This action plan should reflect both the need for greater consistency in core safeguarding expectations and the diversity of diocesan and religious life group contexts.

6.3 The Catholic Safeguarding Standards Agency (CSSA) will review progress against this action plan after 12 months, as part of its ongoing role in providing independent scrutiny and assurance of safeguarding arrangements within the Catholic Church in England and Wales.

6.4 These key areas for action and development will also be integrated into CSSA's inspection and audit activity. During inspections and audits of dioceses and religious life groups, CSSA will assess how Church bodies have engaged with these areas, including the extent to which they have reflected on the findings of this review and implemented changes in practice. Evidence of progress, or a lack of engagement, will inform inspection findings, particularly in relation to governance, accountability, and the quality of survivor engagement.

1. Embedding Survivor Voice in Governance

- To what extent is survivor perspective actively informing safeguarding oversight, decision-making, and challenge within governance structures?
- How might survivor input be incorporated in a way that is meaningful, safe, and proportionate?

2. Clarity of Accountability and Oversight

- How clear is it—both internally and publicly—where safeguarding decisions are made, who is accountable, and how those decisions can be challenged?
- Do current structures enable sufficient independence and constructive challenge?

3. Consistency of Survivor Experience Across the Church

- How consistent is the experience of a survivor engaging with different dioceses or religious life groups?
- What steps could strengthen a more coherent "One Church" experience in practice?

4. Accessibility and Transparency of Safeguarding Information

- How easy is it for a survivor to understand safeguarding processes, governance arrangements, and routes for raising concerns or complaints?
- Does publicly available information support confidence and trust?

5. Survivor-Centred Communication

- How effectively are safeguarding processes, decisions, and constraints explained to survivors in a way that is clear, compassionate, and transparent?
- Are there points in the process where communication becomes overly procedural or unclear?

6. The Role and Function of Survivor Liaison

- How is continuity of contact and support for survivors maintained throughout safeguarding engagement?
- What models (formal or informal) could ensure survivors have a consistent, trusted point of contact?

7. Effectiveness of Complaints and Challenge Processes

- Do safeguarding complaints processes enable survivors to raise concerns with confidence and clarity?
- Are these processes experienced as accessible and fair, or as complex and discouraging?

8. Balancing Pastoral Response and Legal Constraints

- How are the tensions between compassionate, survivor-centred engagement and legal/insurance considerations understood and managed?
- How clearly are these constraints explained to survivors?

9. Clarity and Consistency of Safeguarding Policies

- Do safeguarding policies provide a clear, accessible, and coherent framework for both practitioners and survivors?
- How might greater consistency or shared frameworks support understanding and confidence?

10. Understanding and Application of Safeguarding Thresholds

- How consistently are safeguarding thresholds (including low-level concerns) understood and applied?
- Do current approaches support early identification and prevention of harm?

11. Inclusion and Equity in Safeguarding Practice

- How well do safeguarding arrangements recognise and respond to the diverse needs of individual survivors?
- Are there groups for whom engagement with safeguarding may be more difficult or less visible?

12. Recording, Learning and Organisational Memory

- Do current recording systems and practices support clear decision-making, continuity, and organisational learning?
- How effectively is learning from safeguarding activity used to inform improvement?

7. Recommendations

This thematic inspection makes two recommendations:

1. That the leadership and trustees of all individual dioceses and religious life groups review the content of this report and agree an action plan to address the questions raised within the key areas for action and development.

2. That the Strategic Council for Catholic Safeguarding reviews the content of this report and agrees actions to address questions raised within the key areas for action and development that require a national response.

The CSSA will monitor the response of dioceses and religious life groups to this thematic inspection through its ongoing inspection and audit programme. Assurance will be sought from the Strategic Council for Catholic Safeguarding as to how it has responded to this inspection.

8. Appendices

8.1 Terms of Reference

Purpose:

The purpose of this inspection is to assess the current practice of Catholic dioceses and religious life groups (RLGs) in England and Wales in engaging with and supporting survivors of abuse. This includes evaluating the policies, practices, and resources dedicated to survivors and current response to survivors. Preparedness of those receiving allegations will also be considered for the purpose of understanding whether those providing support are sufficiently equipped to do so in a survivor-centred way. The inspection will identify best practice in addition to gaps or areas for improvement, and recommendations will be made. This inspection is being undertaken with the intent of aiding continuous improvement in safeguarding and helping to prevent future harm.

During the course of the inspection, we will hear **directly from survivors about their experience.** This will include a consideration from **their perspective of how the church are engaging** with them, and what the impact of this has been.

Objectives:

- Assess how disclosures of harm are received and responded to by diocesan and RLG personnel.
- Understand whether responses are tailored to individual survivor needs.
- Evaluate the availability, accessibility, and quality of survivor support services (e.g. counselling, spiritual care, referrals to external support).
- Review how well survivors are included in church activities and ministry programs, considering whether survivor engagement happens in a meaningful way.
- Evaluate the experience of those receiving disclosures and/or complaints from survivors to understand whether there are equipped and confident in providing a survivor focussed response.
- Gather survivor feedback on their engagement experience and perceived support.
- Identify areas where the church can improve survivor engagement.
- Make recommendations for improving the church's response to survivors' needs.

Scope:

Covered Areas

- Information relating to activity within the 12 months preceding the start date of the inspection.
- Information gathered from a sample of Catholic dioceses and RLGs in England and Wales.
- Policy and practice review of initial and on-going response to survivors. To include escalation channels, risk and responsibilities.
- Survivor support programs run internally by the church body.
- Inclusion of survivors in church activities, ministries, and leadership.
- Policies related to survivor confidentiality and reporting.
- Response provided to survivors and the recording of such.
- Training and preparedness of church staff and leadership to address survivor needs.

Excluded Areas

- Non-recent abuse allegations and handling of such outside of the review period.
- Issues not directly related to survivor engagement or support.
- Specific legal matters outside of the scope of the CSSA (e.g. ongoing criminal investigations).
- Information relating to diocesan survivor activity planned to take place after the start date of this review.
- Due to the number of dioceses and RLGs in England and Wales, a sampling approach will be taken (and therefore not all dioceses and RLGs will be automatically involved – a representative sample will be taken).
- CSSA will not be responsible for providing a response on complaint matters currently being investigated, unless in circumstances where a safeguarding concern or concern requiring further review by CSSA arises.
- Effectiveness of survivor support programs which operate externally to the church body.

Methodology:

Data Collection

- Interviews with key stakeholders (survivors, church leadership, ministry staff, survivor support staff).
- Surveys distributed to congregational members, specifically those involved in survivor-related ministries.

- Document review of relevant policies, training materials, incident reports, complaints handling. (Some of this may be drawn from existing information held by CSSA as a consequence of baseline audits).
- Review case files or records of previous survivor engagement (within prior 12 months), ensuring that processes followed established protocols.
- Analyse feedback and complaints from survivors (if available) regarding the support they received.

Assessment Tools

- Use of surveys to measure the satisfaction and perceived effectiveness of support programs.
- Public call out for information by the CSSA.

Key Stakeholders:

- Survivors.
- Church leadership.
- Diocesan safeguarding coordinators and teams.
- Survivor support ministry leaders and volunteers.
- Relevant external organisations that the church partners with for survivor support.

Risks

- Resistance from staff or leadership due to concerns about transparency or reputational impact.
- Survivors may be hesitant to engage in the inspection process due to fear of re-traumatisation or concerns relating to confidentiality.
- Incomplete or inconsistent record keeping may cause difficulty in drawing conclusions.
- Diocesan personnel may refuse to share relevant information, calling in to question the reliability and accuracy of information gathered and subsequent recommendations made.
- Unaddressed safeguarding concerns may come to the attention of the CSSA.
- Unexpected delay (e.g. staff sickness, delay in availability of interviewees, delay in gaining required information).

Assumptions

- The church has some level of survivor engagement, whether formal or informal, in place.
- Church leadership will allow access for the CSSA to undertake this work.

- Confidentiality can be maintained.

Resources

- CSSA quality assurance analysts (two staff) for a 6 month period.
- CSSA survivor panel members.
- Survivors coming forward for discussion/interview (necessary venue arrangements/costs associated if in person).
- Access to church staff or volunteer groups involved in survivor support.
- Support from Diocesan staff in gathering and supplying information.
- Trauma-informed or advocacy experts for consultation, if necessary.

Deliverables

A comprehensive inspection report detailing findings on survivor engagement in the church, including:

- Identification of areas working well and areas for improvement in the church's current engagement with survivors.
- Best practice examples for national recommendation (to include implications for national training).
- Actionable recommendations for improving survivor care and engagement.
- A summary presentation of findings for church leadership.
- A follow-up plan to monitor the implementation of recommendations.
- Internal lessons learned report (CSSA) stating what worked well and areas for improvement to inform future thematic inspections.

Evaluation criteria

The success of the inspection will be measured by:

- The clarity and practicality of the recommendations provided.
- Improvement in survivor engagement and support following the inspection.
- Feedback from church leadership and survivors on the inspection process.
- Evidence of organisational learning and change where recommended.

8.2 Survivor Follow-up Questions

Initial Disclosure Experience

- How did the Church respond when you first disclosed abuse?
- Did you feel listened to, respected, and safe at the time?
- Were you given clear information on what would happen next and timelines?

- Were you given choices about who you spoke to (e.g. male/female, layperson, clergy)? Were you offered the opportunity to speak with the Bishop of the diocese or the Provincial of the religious life group?

Support Offered & Ongoing Engagement

- Were you offered emotional, spiritual, or practical support?
- Was the support tailored to your specific needs and preferences? Was a support plan made?
- Did you feel you had control and choice throughout your support journey?
- Were you offered options for support outside of the Church (e.g. independent counselling, Safe Spaces)? If so, were you offered funding for independent counselling? Were there any stipulations from the Church on how long that funding was for?
- Were any practical barriers to support addressed (e.g. cost of counselling, transport)?
- Have you felt included or welcomed in Church life since disclosing? If not, why not?
- Did you feel treated with dignity and compassion throughout the process?
- Were you able to return for support later if needed?
- Were you ever followed up with after initial support ended?
- Did you feel that the Church's response to you was victim/survivor-centred?

Feedback & Influence

- Were you invited to provide feedback on your experience?
- Do you feel your feedback has been heard or used to improve practices?
- Have you seen any changes made as a result of your input?
- Have you had the opportunity to be involved in shaping safeguarding practices (e.g. opportunities to attend panels etc)?

Overall Reflections

- How would you describe the Church's overall approach to supporting survivors of abuse?
- What aspects of the support were helpful?
- What would you have wanted to see done differently?
- What advice would you give to the Church in improving its response to survivors?

8.3 Sample Dioceses

- Birmingham
- Cardiff-Menevia
- Clifton
- East Anglia
- Hallam
- Leeds
- Liverpool
- Middlesbrough
- Plymouth
- Shrewsbury
- Southwark
- Westminster

8.4 Sample Religious Life Groups

- Canonesses of the Holy Sepulchre
- Congregation of Our Lady of the Missions
- Congregation of the Blessed Sacrament
- Congregation of the Dominican Sisters of St Catherine of Newcastle Natal
- Congregation of the Most Holy Redeemer (Redemptorists)
- Daughters of Charity of St Vincent de Paul
- De La Salle Brothers
- English Benedictine Congregation Ampleforth Abbey
- English Benedictine Congregation Belmont Abbey
- English Benedictine Congregation Buckfast Abbey
- English Benedictine Congregation Ealing Abbey
- English Dominican Congregation of St Catherine of Siena
- Franciscan Friars of the Renewal
- Franciscan Missionaries of the Divine Motherhood
- Institute of Charity The Rosminians
- Jesuits in Britain
- Order of Cistercians of the Strict Observance Caldey Abbey
- Order of Preachers (Dominican Friars)
- Order of the Friar Servants of Mary
- Prinknash Abbey (Subiaco Cassinese Congregation of the Order of St

Benedict)
- Salesians of Don Bosco
- Sisters of Charity of Our Lady Mother of Mercy
- Sisters of Charity of St Jeanne Antide
- Sisters of Charity of St Paul the Apostle
- Sisters of Mercy (Oaklea Convent)
- Sisters of Notre Dame de Namur
- Sisters of Providence (Rosminian)
- Sisters of the Cross and Passion
- St Joseph's Society for Foreign Missions (Mill Hill Missionaries)
- Union of the Sisters of Mercy of Great Britain
- Union of the Sisters of the Presentation of the Blessed Virgin Mary
- Verbum Dei Community

8.5 Survey Questions

Public Call for Information – Clergy, Religious, Employees, Volunteers, Parishioners

Please note this survey will take approximately 30 minutes to complete. The duration may vary depending on your responses.

The Catholic Safeguarding Standards Agency (CSSA) are undertaking a thematic inspection focusing on current survivor engagement and support across Catholic dioceses and Religious Life Groups in England and Wales. This is the first of its kind for us as an inspectorate, prioritising this crucial area of the safeguarding standards. We aim to identify and share best practice and areas for improvement across church bodies. It is in addition to our usual audits and inspections of individual church bodies.

We would like to hear the views of as many people as possible regarding either Parish, Diocesan or RLG arrangements for safeguarding. Although our assessment looks at the period from July 2024, we do not wish to limit what you choose to share. This information will support our assessment of the effectiveness of current safeguarding arrangements and contribute to the prevention of abuse. Whatever you tell us will help inform our conclusions about safeguarding today.

This form is anonymous unless you provide your name or contact details. We are only able to remove submissions that can be identified. If you wish to withdraw your contribution, please contact us at qualityassurance@catholicsafeguarding.org.uk

with your identifying details by 6 October 2025.

At the Catholic Safeguarding Standards Agency, we are committed to ensuring that support is available to any person who has experienced abuse within the church environment; free and independent support is available from Safe Spaces at: safespacesenglandandwales.org.uk

The Catholic Safeguarding Standards Agency adheres to the national policy of reporting all disclosures of abuse to the statutory authorities (where sufficient identifiable information is known). Please be aware that any previously unreported disclosures made in this survey, or in subsequent contact with the CSSA, will be reported to the relevant statutory agency. The decision to report will be made in conjunction with you, and an anonymous report can be made on your behalf if you prefer.

More information about the CSSA inspection programme, and a privacy notice, can be found at: catholicsafeguarding.org.uk

If you experience any difficulties using this form, please email qualityassurance@catholicsafeguarding.org.uk or call 020 7901 1920.

Section 1

1. Which Diocese or RLG does the information you're sharing relate to?

(This is an optional question that we ask to help us understand the geographical spread of responses.)

Enter your answer *[indicates a free text box in the electronic survey]*

2. To help us better understand your response, please indicate your role within, or your connection to, the Diocese or RLG.

Survivors who wish to share their experiences and feedback are invited to complete the following questionnaire: *Public Call for Information – Survivor Engagement in the Catholic Church (England and Wales)*.

Please note that optional questions may appear depending on the role you select.

- Clergy
- Religious (Consecrated Life)
- Parish Safeguarding Representative
- Employee (Safeguarding Role)

- Employee (Non-Safeguarding Role)
- Volunteer
- None
- Parishioner
- Prefer not to say
- Other

3. Please indicate your level of agreement with the following statement:

"I know the steps to take and feel prepared to respond if someone disclosed abuse to me."

If you would like to expand on your answer please expand in "Other".

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Other

4. When did you last complete safeguarding training?

- Within the last year
- 1–2 years ago
- Over 2 years ago
- I'm not sure / I can't remember
- I have not completed any safeguarding training

5. Which of the following best describes your experience with safeguarding training?

- I have not completed any safeguarding training
- I have completed minimal or basic safeguarding training
- I have completed some safeguarding training, but it may not fully match my responsibilities
- I have completed training relevant to my role
- I have undertaken training above and beyond what is required for my role

6. Please indicate what training you have completed.

Enter your answer

7. Please describe how your training has influenced the way you understand and respond to survivors' individual experiences.

Enter your answer

8. Have you received specific training in relation to survivor support and ongoing care?

- Yes
- No
- Unsure

9. If applicable, what training have you completed and which did you find most helpful and why?

Enter your answer

10. How confident are you, as a result of your training, in making appropriate referrals for survivor support and ongoing care, including knowing who to report to within your organisation or relevant external agencies?

If you would like to expand on your answer please expand in "Other".

- Not at all confident
- Slightly confident
- Moderately confident
- Very confident
- Extremely confident
- Other

11. Have you heard of a trauma-informed approach?

- Yes
- No

12. What does trauma-informed mean to you?

Enter your answer

13. What does "supporting survivors" mean to you in your role?

Enter your answer

14. Have you ever provided direct support to a survivor of abuse?

- Yes
- No
- Prefer not to say

15. Optional: Can you describe what support you've been able to offer a survivor?

Enter your answer

16. Were you able to access help and/or advice for survivors if/when you needed it?

- Yes
- No
- Somewhat

17. Thinking back on your experience of providing direct support to survivors, what do you feel could have made the experience more positive or effective, for both you and the survivor?

For example, would additional bespoke training, mentoring, supervision, or easier access to support have been helpful?

Enter your answer

18. Have you invited feedback from any victims/survivors you have engaged with on their experience of reporting Church-related abuse?

- No – I have not invited feedback
- Yes, but no response received – I invited feedback, but the survivor chose not to respond
- Yes, but no action taken – I invited and received feedback, but no changes were made as a result
- Yes, and acted on feedback – I invited and received feedback, and changes were implemented
- I do not know

19. Do you know who the safeguarding contact is for your Parish/Diocese/RLG and how to contact them?

- Yes
- No

20. How comfortable would you feel approaching the safeguarding contact if you had a concern?

- Not comfortable at all
- I would be slightly uncomfortable
- I do not know
- I would feel comfortable
- I would feel very comfortable

21. If you have selected "Not at all comfortable" or "slightly uncomfortable" please give reasons for your answer.

Enter your answer

22. How confident are you that a safeguarding concern would be taken seriously by your Parish/Diocese/RLG if this was raised?

- Not confident at all
- Somewhat not confident
- Neutral
- Somewhat confident
- Extremely confident

23. Optional: If you have selected "Not at all comfortable" or "slightly uncomfortable" please give reasons for your answer.

Enter your answer

24. To what extent do you agree with the following statement?

"Adequate support is offered to those who support survivors."

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

25. Optional: Please give reasons for your answer.

Enter your answer

26. To what extent do you agree with the following statement?

"My parish, Diocese or religious community makes active efforts to be inclusive and welcoming to survivors of abuse, including those from under-represented groups (e.g. male survivors, LGBTQ+ individuals, people with disabilities, and those from diverse backgrounds)."

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

27. Please share any thoughts or examples regarding how inclusivity is demonstrated for different groups of survivors (e.g. based on gender, sexual orientation, disability, ethnicity, etc.) or why you have answered "strongly agree" or "strongly disagree".

Enter your answer

28. To what extent do you agree with the following statement?

"I am aware of the support options the Church offers to survivors."

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

29. Optional: Please explain your answer.

Enter your answer

30. To what extent do you agree with the following statement?

"Survivors have choices about how they can receive help."

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

31. Optional: Please explain your answer.

Enter your answer

32. To what extent do you agree with the following statement?

"Survivor support is talked about openly in my church or religious community."

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

33. Optional: Please explain your answer.

Enter your answer

34. To what extent do you agree with the following statement?

"Leaders (e.g. parish priests, superiors) encourage a compassionate response to survivors."

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

35. Optional: Please explain your answer.

Enter your answer

36. How often is safeguarding mentioned within or after Mass or in other public meetings (by clergy or others)?

- At least once a month
- About every three months (quarterly)
- About every six months
- Rarely, less than once a year
- Never

37. How would you rate the availability and visibility of safeguarding information (e.g. posters, newsletters) in your parish/Diocese/RLG?

- Rarely or never available
- Sometimes available but outdated
- Sometimes available but limited
- Often available but not very visible
- Always available and easy to find

38. Is there anything you think could help improve the way the Church supports survivors?

Enter your answer

Section 2 – Summary

39. Would you like to tell us anything further about safeguarding in the Parish/ Diocese/RLG?

Please note all forms are submitted anonymously therefore if you would like to speak to a member of the team directly, please leave your name and contact details and someone will be in contact with you.

Enter your answer

Public call for information- Survivor Engagement in the Catholic Church (Eng-land and Wales)

The Catholic Safeguarding Standards Agency is completing an audit to assess the current practice of Catholic Dioceses' and Religious Life Groups (RLGs) in England and Wales in engaging with and supporting survivors of abuse.

The purpose of this public call is to invite information from anyone who has had recent contact with a Diocese or Religious Life Group (RLG). This includes experiences that are new, ongoing, or connected to non-recent abuse. Although our assessment looks at the period from July 2024, we do not wish to limit what you choose to share. This information will support our assessment of the effectiveness of current safeguarding arrangements and contribute to the prevention of abuse. Whatever you tell us will help inform our conclusions about safeguarding today. We will let you know exactly how we will manage the information you give us.

This form is anonymous unless you provide your name or contact details. We are only able to remove submissions that can be identified. If you wish to withdraw your contribution, please contact us at qualityassurance@catholicsafeguarding.org.uk with your identifying details by 6 October 2025.

At the Catholic Safeguarding Standards Agency, we are committed to ensuring that support is available to any person who has experienced abuse within the church environment; free and independent support is available from Safe Spaces at: https://safespacesenglandandwales.org.uk/

The Catholic Safeguarding Standards Agency adheres to the national policy of reporting all disclosures of abuse to the statutory authorities (where sufficient identifiable information is known). Please be aware that any previously unreported disclosures made in this survey, or in subsequent contact with the CSSA, will be reported to the relevant statutory agency; the decision to report will be made in conjunction with you, and an anonymous report can be made on your behalf if you prefer.

More information about the CSSA inspection programme, and a privacy notice, can be found at: https://catholicsafeguarding.org.uk/

If you experience any difficulties using this form, please email qualityassurance@catholicsafeguarding.org.uk or call 020 7901 1920.

Section 1

1. Which Diocese or Religious Life Group (RLG) does your information relate to?

Single line text.
This helps us understand where the information relates to. You can write the name of the Diocese or RLG if you know it. If you're not sure, feel free to leave this blank.

Enter your answer *[indicates a free text box in the electronic survey]*

2. When was this reported to a Diocese or RLG, (if known)?

You can give an approximate year or timeframe. If you are unsure or do not wish to provide this information please leave this blank

Enter your answer

3. When was your last contact with the Diocese or RLG?

You can give an approximate year or timeframe. If you are unsure or do not wish to provide this information please leave this blank

Enter your answer

4. To your knowledge, were any statutory agencies informed (e.g. police, social services)?

- Yes
- No
- Unsure

5. Please let us know what you would like to tell us about your contact with a Diocese or RLG since July 1, 2024?

Please share any experiences you feel are important, whether recent, ongoing, or linked to a longer history of contact. You may wish to include details relating to safety, accountability, or how you were treated.

Enter your answer

6. Have you received any support from the Diocese or RLG?

You can share whether support was offered, accepted, or how helpful it was.

Enter your answer

7. If you have had longer-term contact with a Diocese or RLG, how would you describe your more recent experiences (since July 2024)?

Enter your answer

8. Have you been asked by a Diocese or Religious Life Group (RLG) to give feedback on your experience?

If yes, please feel free to tell us when this happened, what you were asked about, and how you felt about being asked. You can also include whether you felt your feedback was heard or acted on.

Enter your answer

9. Do you think anything could be improved in how the Diocese or Religious Life Group (RLG) responds to concerns or supports people?

You can include ideas about communication, support, safeguarding, listening, or anything else that feels important. Are there any changes you think could help people feel safer, better supported, or more listened to?

Enter your answer

10. If you would like to speak to a member of the Quality Assurance team, please leave your contact details here and preferred method of contact. Please do let us know if there is anything else that you would like us to be aware of prior to contacting you.

Enter your answer